STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510099	A. BUILDING: _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR TRAILS SENIOR LIVING	490 URBANA DRIVE FREEBURG, IL 62243

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A 000	Initial Comment FRI IL177018 FALL REPORT IS SUBSTANTIATED, HOWEVER, NO VIOLATION IS CITED FRI IL177121 FALL REPORT IS SUBSTANTIATED, HOWEVER, NO VIOLATION IS CITED FRI IL177241 NARCOTIC DIVERSION/THEFT REPORT IS SUBSTANTIATED VIOLATION AT 295.6000 IS CITED	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that	A6000		

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promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect;

13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;

Based on interview and record review the facility failed to ensure residents are protected against narcotic theft/diversion in the facility.

Findings include:

1. R3's Reportable Incident Report dated 8/27/24 documents," 8/25/24. Agency Nurse signed out narcotics at 0800 and 1600. Resident states she did not receive any pain medication from the nurse. All Department Heads notified. Witness Statements collected. Cameras were reviewed, the nurse never entered R3's room. Police, family notified."

R3's Individual Resident Controlled Substance Record dated 6/4/24 documents on 8/25/24, Z1 signed out one tablet of Hydrocodone Acetaminophen 5-375 mg at 0800 and one tablet at 1600. Last dose signed out prior to 8/25/24 was 6/4/24.

R3's Written Statement dated 8/26/24 documents, "I did not ask the nurse for pain medication yesterday. I take my medications that are in my pill planner and that is all. I did not see a nurse Sunday."

2. R4's Reportable Incident Report dated 8/27/24

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documents, "Nurse signed out narcotics at 8 AM and 5 PM. Resident denies getting any prn pain medication and denies having any pain on 8/25/24. Cameras reviewed. Witness statements taken, notified all department heads. Police, family notified."

R4's Individual Resident Controlled Substance Record 3/26/24 documents on 8/25/24, Z1 signed out one tablet of Tramadol 50 mg at 0800 and one tablet at 1700. Last signed out entry prior to 8/25/24 was 4/1/24.

R4's Written Statement dated 8/26/24 documents,"I did not have any pain yesterday. I did not receive any pain medication from the nurse yesterday."

3. R5's Reportable Incident Report dated 8/27/24 documents, "Agency Nurse (Z1) signed out PRN (as needed) narcotic medication at 0800 and 1700. Cameras reviewed. Nurse did not give resident her pain medication. Nurse entered Apartment 13 one time on 8/25/24 at 10:47. All department heads notified, witness statements gathered. Family and police notified. "

R5's Individual Resident Controlled Substance Record dated 9/22/23 documents that on 8/25/24, Z1 signed out one tablet of Hydrocodone Acetaminophen 5-375 mg at 0800 and one tablet at 1700. Last signed out entry prior to 8/25/24 was 10/21/23.

4. R6's Reportable Incident Report dated 8/27/24 documents, "Agency Nurse (Z1) signed out narcotics stating she administered hydrocodone acetamenophen 5-325 mg at 0900 and 1700. Resident stated she did not see nurse all day. Witness statements taken, cameras reviewed,

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police and family notified."

R6's Individual Resident Controlled Substance Record dated 7/28/24 documents that on 8/25/24, Z1 signed out one tablet of Hydrocodone Acetaminophen 5-375 mg at 0900 and one tablet at 1700.

R6's Written Statement dated 8/26/24 documents," I did not ask the nurse for pain medication Sunday 8/25/24 and I did not receive any pain medication that day."

On 9/3/24 at 9:25 AM, R6 stated she has pain medication as needed ordered a month ago but she has not asked for it yet.

On 9/3/24 at 9:10 AM, E5 (Care Partner/CP) stated she worked on 8/25/24 and observed Z1 was either on her phone or sleeping at the desk inside the nurses station.

On 9/3/24 at 9:18 AM, E4 (CP) stated she worked on 8/25/24 and had gone to the nurses station a few times and noted Z1 was either on her phone or sleeping at the desk.

On 9/3/24 at 10:32 AM, E3 (Licensed Practical Nurse/LPN) stated she was the nurse who found out something was not right when she was doing the narcotic count on 8/26/24 and noted residents who normally don't ask and don't get narcotic pain medication were given narcotics twice on 8/25/24. E3 stated all counts were correct. E3 stated she reported it to E2 (Director of Wellness) right away.

A review of the video footages taken from sensor cameras and foresight cameras installed throughout the facility showed Z1 never went to

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R3's, R4's, R5's and R6's apartments or approached them in the common areas to give them medication at the times she documented she administered the pills in their Controlled Substance Records.

On 9/3/24 at 9:05 AM, E2 stated she initiated the investigation immediately and reported it to IDPH and Law Enforcement, also notified the residents primary physicians and pharmacy. E2 stated the nurse involved was an agency nurse who came for the first time to work from 7AM through 7 PM on 8/25/24. E2 stated they interviewed all possible staff and resident witnesses and E1 viewed all video footages that day.

On 9/3/24 at 9:00 AM, E1 (Executive Director) stated she viewed all footages from 7AM to 7PM on 8/25/24 and nothing showed to support Z1's documentation that she gave the narcotics to R3, R4, R5 and R6.

Z2's (Chief Police Officer) Initial Report dated 8/27/24 documents,"I arrived on scene and met with (E2) Director of Wellness in her office. She stated they hired an employee (from an agency) to work a shift on 8/25/24 from 0700 until 1900. During this time this employee wrote down that she handed out prescription medication to residents and on Monday 8/26/24 found out this employee did not hand out anything. She stated they spoke with and obtained written statements from everyone that this employee did not hand anything out to the residents. Reviewed the surveillance cameras and observed the employee never made contact with any of the residents. (E2) stated they want to press charges against the employee."

The Facility Policy on Controlled Substance

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A6000	Continued From page 5 Handling, undated, documents,"Policy: Controlled Substances within the community will be strictly monitored to ensure proper use, handling, and disposal is maintained at all times. Only authorized licensed or certified Wellness, agency, and/or Pharmacy personnel shall have access to controlled substances in the community. Discrepancy or Suspected Drug Diversion. 1. If there is a discrepancy in any narcotic reconciliation, the Wellness Director or designee shall immediately investigate to determine if there has been a diversion and notify the Executive Director.. 2. If diversion is suspected or confirmed the following steps will be taken: Notify the Executive Director who will follow the Investigations Policy. In addition to the internal investigation procedure, the Wellness Director will notify the pharmacy and primary physician. 3. The internal investigation must be completed as soon as possible, but no longer than 72 hours. Any agency deadlines for completing reports of reportable incidents that are shorter than the 72-hr requirement supersede this policy and the agency timeframe must be followed."	A6000		