STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A383	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Oaks	2750 West Highland Avenue Elgin, IL 60123

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to prevent the diversion of a resident's controlled substance medication. This applies to 1 of 3 residents (R1) reviewed for misappropriation of resident property in the sample of 3. The finding include. R1's Controlled Drug Receipt / Record / Disposition (commonly referred to as a count sheet or controlled substance count sheet) showed the facility received, on R1's behalf, 120 tablets of 50 milligram (mg) tramadol, a schedule IV narcotic pain medication. The count sheets showed the tablets were delivered on 5/13/24 and were dispensed in four separate punch cards, each card containing 30 tablets of tramadol. R1's count sheet showed each individual punch card was delivered with its own accompanying count sheet (4 punch cards, 4 count sheets). The first dose of the first punch card of tramadol, from the delivery on 5/13/24, was dispensed on 5/16/24 at 11:59 AM. The final dose of the first card was given on 5/26/24 at 12:25 PM. The second punch card was started on 5/26/24 at 9:00 PM and the final dose of this card was given 6/5/24 at 11:40 AM. The third punch card was started 6/5/24 at 9:00 PM and completed on 6/15/24 at 5:01 AM (this completes 90 tablets of 120 tablets delivered on 5/13/24). Following the completion of R1's third card of tramadol, the next dose given was on 6/15/24 at 11:50 AM. The dose given on 6/15/24 at 11:50 AM was from a new delivery of 120 tablets of tramadol, which was delivered to the facility on [DATE]. (The fourth card of tramadol delivered on 5/13/24 was not accounted for.) On 8/14/24 at 12:30 PM, V2 (Director of Nursing) stated the facility was not able to account for R1's missing card of tramadol delivered on 5/13/24. V2 stated the only explanation for this missing tramadol punch card is theft. V2 stated tramadol is double locked and only the nurses on duty have access to the controlled substances. V2 stated the medications maintained by the facility are the resident's property. V2 said controlled substances are the most likely medications to be diverted for either financial gain or personal use. On 8/14/24 at 9:52 AM, V1 (Administrator) stated the facility was not able to locate R1's missing card of tramadol. V1 stated it appears a nurse took R1's count sheet and his punch card of tramadol. V1 stated the medications are the resident's property. The facility's Abuse and Neglect Prevention Protocol Policy showed, Misappropriation of resident property means using a resident's cash, clothing, or personal possessions without authorization by the resident or the resident's authorized representative .

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A383	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Oaks	2750 West Highland Avenue Elgin, IL 60123

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to implement policies to identify and prevent the diversion of controlled substances. This applies to 1 of 3 residents (R1) reviewed for controlled substances in the sample of 3. The findings include: R1's Controlled Drug Receipt / Record / Disposition (commonly referred to as a count sheet or controlled substance count sheet) showed the facility received, on R1's behalf, 120 tablets of 50 milligram (mg) tramadol, a schedule IV narcotic pain medication. The count sheets showed the tablets were delivered on 5/13/24 and were dispensed in four separate punch cards, each card containing 30 tablets of tramadol. R1's count sheet showed each individual punch card was delivered with its own accompanying count sheet (4 punch cards, 4 count sheets). The first dose of the first punch card of tramadol, from the delivery on 5/13/24, was dispensed on 5/16/24 at 11:59 AM. The final dose of the first card was given on 5/26/24 at 12:25 PM. The second punch card was started on 5/26/24 at 9:00 PM and the final dose of this card was given 6/5/24 at 11:40 AM. The third punch card was started 6/5/24 at 9:00 PM and completed on 6/15/24 at 5:01 AM (this completes 90 tablets of 120 tablets delivered on 5/13/24). Following the completion of R1's third card of tramadol, the next dose given was on 6/15/24 at 11:50 AM. The dose given on 6/15/24 at 11:50 AM was from a new delivery of 120 tablets of tramadol, which was delivered to the facility on [DATE]. (The fourth card of tramadol delivered on 5/13/24 was not accounted for.) On 8/14/24 at 9:24 AM, V4 (Licensed Practical Nurse) stated, At the time, we did not have a process in place to prevent a nurse from taking the card (narcotic punch card) and the sheet. I have heard of that being an issue at other facilities . On 8/14/24 at 9:52 AM, V1 (Administrator) stated the theft of a resident's controlled substance was first identified on or about 7/17/24 for R100, a resident in a licensed only (private pay) bed. V1 stated, during the investigation, other instances of missing controlled substances were identified, including R1's missing tramadol. (R1's missing tramadol was not discovered for at least one month and not until an investigation was initiated.) V1 stated she was not aware card counting (A method of accounting for all the controlled substance cards from one shift to the next). On 8/14/24 at 12:30 PM, V2 (Director of Nursing) stated the only explanation for the missing tramadol is theft. V2 stated it appears the nurse who stole R1's tramadol took the count sheet and the entire card of medication. V2 stated she was not aware nurses taking the count sheet and the punch card was a relatively method for individuals to divert controlled substances. V2 stated, at the time of the theft, the facility did not have policies and procedures in place to prevent or identify the theft of an entire punch card and count sheet. The facility's Controlled Substances Accountability Policy (7/19/24) showed, .The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure .