STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510119	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPER CREEK COTTAGES	203 STAHLHUT DR LINCOLN, IL 62656

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Annual Licensure Survey and investigation of Facility Reported Incident IL183554	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 2) Storing and controlling medication; 4) Assisting in the self-administration of medication and medication administration, as applicable; and i) Except for medication organizers, resident medication shall not be pre-poured. Medication organizers may be prepared up to one month in advance by the following individuals: Type 3 Violation Based on interview and record review, the establishment failed to follow and or develop policies for storing and controlling controlled substances, and giving medication without a physician's order. This could affect all 25 residents currently residing in the establishment. The establishment staff prepoured medications for R1, one of three residents reviewed for	A5000		

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A5000	Continued From page 1 medications in a sample of three. Findings include: On 1-2-25 at 9:30 am, a controlled substance count was performed with E7 (LPN/Licensed Practical Nurse). Nineteen of the 25 residents have orders for a controlled substance. The establishment's Medication Management policy dated 12/2024 does not address storage or control of controlled substances. On 1-15-25 at 9:20 am, E7 (LPN) stated on 11-20-24, when R1 returned from a skilled nursing facility, E7 set up (pre-poured) R1's evening medications in a cup including one Oxycodone/Apap 5-325 MG (milligrams) and stored them in the locked cabinet inside a locked medication room. Later when giving R1 her medication, it was noted there were two Tylenol instead of one Oxycodone in the cup. E7 stated she went ahead and gave the Tylenol instead of the Oxycodone/Apap. E7 stated the Oxycodone was an as needed order. E7 stated there was no order for the Tylenol. E7 stated at times she will set up her medications ahead of time and store them in the locked cabinet inside the medication room in a cup with the resident's name on it. E7 stated the Administrator and Assistant Administrator have a key to the medication room and cabinet. R1's January 2025 Physician Order Sheet documents an order dated 11-20-24 for Oxycodone/Apap (Acetaminophen) 5-325 mg, take 1 tablet by mouth every 6 hour as needed." R1's November 2024 Physician Order Sheet documents no order for Tylenol.	A5000		

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A5000	Continued From page 2 The establishment's Medication Management policy dated 12/2024 documents that giving the wrong medication (not ordered by the physician) to a resident is a medication error. This policy also documents "medication shall be stored in the original labeled container, except for medication organizers, and according to instructions on the medication label."	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Violation Based on interview and record review, the establishment failed to prevent the theft of medications for R1, one of three residents reviewed for theft in a sample of three. Findings include: The establishment's Incident Report dated 1-3-25 documents "(R1) was given Tylenol instead of the Oxy (Oxycodone/Apap) pain pill. The nurse noticed that the Oxy was not there and in its place	A6000		

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A6000	Continued From page 3	A6000		

was a Tylenol. She reported it this morning. We did an investigation, watched cameras, and did 3 urine tests on all when were in the nurse's office on the date in question. The Administrator of the facility did come up positive for Oxy and due to the results, we did terminate her employment, effective immediately."

On 1-15-25 at 1:20 pm, E6 (Corporate Administrator) stated on 1-2-25, E7 (LPN/Licensed Practical Nurse) reported that an Oxycodone tablet was missing for R1. On 1-2-25, E7 had set up R1's medications including her Oxycodone and put them in the locked medication cabinet in the nurse's office. When returning from an appointment later in the day, E7 noticed R1's Oxycodone was missing with a Tylenol added in its place. On 11-20-24, E7 stated R1 returned from a skilled nursing facility. E2 (Former Administrator) gave E7 R1's medications. E7 set up R1's medications early and stored them in the locked cabinet in the medication room. When E7 went to pass them later, R1's family noted there was an extra "white" pill. E7 found the Oxycodone gone and two Tylenol were in its place. E7 found the admission paperwork for the number of Oxycodone had been altered. E7 did not report this to Administration.

E6 stated she initiated an investigation including watching camera footage. The camera footage only showed who entered the medication room. They drug tested all four staff who were in the medication room during the time the Oxycodone disappeared. E2 (Former Administrator) tested positive for Oxycodone and was terminated.

On 1-15-25 at 9:20 am, E7 (LPN) stated on 1-2-25, she set up R1's medication between 1:30

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A6000	Continued From page 4	A6000		

and 3pm. Later when she was starting her evening medication pass, she noted R1's Oxycodone/Apap was missing and in it's place was a Tylenol. E7 stated she reported the incident to E6 (Corporate Administrator) the next day as both E2 (former Administrator) and E1 (present Administrator and former Assistant Administrator) both had keys to the medication room and cabinet.

E7 stated on 11-20-24, when R1 returned from a skilled nursing facility, E2 gave her R1's medications stating there was no narcotic count sent for the Oxycodone/Apap medication card received. There were 11 tablets in this card. E7 set up R1's medications in a cup including one Oxycodone and stored them in the locked cabinet and locked medication room. Later when giving R1 her medication, it was noted there were two Tylenol instead of one Oxycodone in the cup. E7 stated she rechecked and found the narcotic count sheet from the skilled nursing facility which had a printed 12 hand written over with an 11 indicating the number of tablets present in the medication card. E7 stated she did not verify the Oxycodone count with R1's skilled nursing facility nor did she report the incident to Administration.

R1's 11-19-24 skilled nursing facility Discharge Plan/Recapitulation of Stay/Discharge Instruction sheet under medications documents "Oxycodone-Acetaminophen Oral Tablet 5-325 mg (milligrams) Quantity 11." The discharge instructions are printed. The Oxycodone quantity printed documents 12 but someone hand wrote over it to say 11.

R1's January 2025 Physician Order Sheet documents an order dated 11-20-24 for Oxycodone/Apap (Acetaminophen) 5-325 mg,

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A6000	Continued From page 5 take 1 tablet by mouth every 6 hour as needed." The establishment's Medication Management policy dated 12/2024 does not address storage or control of controlled substances.	A6000		