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S 000	Initial Comments Annual Licensure and Certification Survey.	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210b) 300.1210d)1)3) 300.1630d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		

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Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1630 Administration of Medication
d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

These requirements were NOT met as evidenced by:

Based on observation, interview, and record review the facility failed to communicate and

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effectively treat a resident's pain; and failed to verify and obtain a resident's ordered pain medication in a timely manner for 1 of 1 resident (R425) reviewed for pain in the sample of 35. These failures resulted in R425 experiencing continued pain and emotional anguish.

The findings include:

On 11/19/24 at 11:46 AM, R425 was lying in bed, on his left side. R425 had a catheter drainage bag on each side of the bed frame. R425 said he's been sick since March and was in the hospital. R425 said the hospital found out that he had urine draining into his right upper leg area (fistula - an abnormal opening in the urinary tract). R425 said that caused him to develop an abscess in his right upper leg. R425 said they had to drain out the fluid from his leg and now he has a catheter in his penis to protect the fistula and a suprapubic catheter (directly through the abdominal wall, into the bladder) to empty most of his urine. R425 said his pain seemed to be getting worse. R425 said in the hospital he was getting 2 Norcos (opiate pain medication), but when he was transferred to the facility it was changed to 1 Norco. R425 started crying and plead, "I'm just so miserable and I can't get anyone to listen to me." R425 shook his head then became irritable. R425 stated, "I just don't feel like anyone communicates with each other. I'm tired of being in pain. I tell them and no one listens. This position (left side lying) is the only position that is even the slightest bit comfortable for me. Any movement of my right leg is excruciating. I can't do therapy because my right leg hurts so bad when it's moved. I'm so f****** frustrated! I'm sorry I'm cussing, but that's how I feel. (R425 began crying again). Most days I just lay here, grip the side rail and cry. This pain is

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awful, and no one is doing anything about it. " V20 (R425's spouse) was seated in a chair at the bedside. V20 said the facility wasn't managing his pain, but they had a tele-visit with R425's pain doctor at 1:30 PM today. V20 reminded R425 of the appointment and attempted to reassure him.

On 11/20/24 at 12:47 PM, R425 was sitting up in the wheelchair in his room. R425 and V20 (R425's spouse) were discussing nutritional supplements with V15 (RN - Registered Nurse). After V15 left the room, the surveyor asked R425 how he was feeling today. R425 reported, "I'm miserable! (and began crying)." R425 became agitated and said they had the tele-visit with V22 (Pain Nurse Practitioner) at 1:30 PM yesterday. R425 said about an hour later V22 called V20 (R425's spouse) to provide an order for Fentanyl patch 12 mcg. R425 said he was supposed to continue the Norco scheduled every 4 hours and start the Fentanyl patch. R425 said V22 (Pain NP) would follow-up with them in a few days to see if his pain was improving. R425 yelled, "I still don't have the damn patch! I guess they don't have the order or something like that! How can that be, it's almost been 24 hours! See what I mean. The communication sucks!" R425 was becoming agitated and crying. V20 (R425's spouse) rubbed his shoulders and tried to calm him. V20 said when V22 (Pain NP) called with the order for Fentanyl, she couldn't find the nurse. V20 said she went to the desk; the nurse wasn't there. V20 said the receptionist was there and said she would make sure the order was put in right away. V20 said she's not sure what the receptionist's credentials were, but she trusted that the information would be communicated. V20 said the receptionist provided the facility's pharmacy information to her. V20 said she provided the pharmacy information to V22 (Pain

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NP), and she said that she would send the Fentanyl patch prescription directly to the pharmacy. V20 said the nurse did not come in the room to discuss it with her later. V20 stated, "I expected the pain patch to be delivered by this morning (at the latest), but it's still not here. They don't even have an order for it here." R425 stated, "I'm so disgusted, miserable, and frustrated! They need to communicate and control my pain." R425 started crying and placed his face into his hands. At 12:55 PM, V16 (NP) entered the room. V16 asked R425 how are you? R425 replied, "Don't even ask!" R425 reported his frustrations to V16. V16 stated, "This is my first time seeing you. I'll have to take a look at your notes. There is no Fentanyl order in the computer at this time." The surveyor walked to the nurses' station where V15 (RN) was on the phone with pharmacy. V15 said there was a prescription for a Fentanyl patch sent yesterday and the family is asking me about it. V15 said he reviewed the chart and R425 did not have an order for Fentanyl and there were no progress notes. V15 said the pharmacy said they received a prescription from V22 (Pain NP), but the prescription was for 30 patches, and they will not accept it. V15 stated, "I don't know why the pharmacy didn't call [V22 - Pain NP] to verify the order. They are the ones that gave the phone number for [V22]." V16 (NP) walked up to V15 sand stated, "I'll give you a one-time order (for Fentanyl patch) now, so the resident can get it right away. He's in pain. Then we can make follow-up appointments to get an order (for ongoing treatment). Don't even bother to call this office [V22]. I'll give the Fentanyl order and [V23 - Pain MD] will follow-up. V16 asked V15 to call the nursing supervisor and see if they can get the Fentanyl patch from the emergency box, so he (R425) doesn't have to wait any longer. V15 said R425's Fentanyl patch

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prescription was sent directly to the pharmacy, but they didn't call the doctor's office to get the quantity changed. V15 stated, "They should have done that. They gave me the number. Why didn't they call? I'm putting the orders in now. Hopefully they can get the Fentanyl patch from the emergency box. This is the first time I've experienced Pharmacy not liking a quantity. They (Pharmacy) didn't call us to check. The previous nurse would have told me that. The pharmacy should have sent at least 1 Fentanyl patch to get the resident's pain controlled, then got the clarification. It's important to control the resident's pain. That's why I was surprised someone came to me and said he was asking for his pain medication. I didn't know anything about the Fentanyl. I checked the orders and progress notes and there wasn't anything. It's true that there was a communication break down and I'm sorry this happened to them." V15 said R425 has prostate cancer and had pain to his lower back and right hip area. V15 said R425 had therapy in the gym and that may have triggered more pain again. V15 said V23 (Pain MD) is at the facility 1-2 times per week and will see R425 tomorrow.

On 11/20/24 at 1:23 PM, V17 (RN - Registered Nurse/Unit Manager) said she is not sure what happened with R425's Fentanyl. V17 said she called V18 (LPN - Licensed Practical Nurse) because she was R425's nurse yesterday (11/19/24). V17 said V18 didn't know anything about a Fentanyl order sent to the pharmacy. V17 states if an outside physician order's medication, then the facility needs to get approval from an in-house provider and enter an order. V17 said R425 did not have a Fentanyl order entered into the EMR (electronic medical record) yesterday. V17 said the emergency box does not contain Fentanyl patches. V17 said pharmacy was called

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and a STAT order was placed. V17 said the pain patch should be here in 2-4 hours.

On 11/20/24 at 1:34 PM, V19 (Guest Services Associate) said she works at the reception desk on R425's floor. V19 said she works 8 AM to 4 PM. V19 said she answers the phones, assists with scheduling appointments, and orders equipment and supplies for the unit. V19 said she was working 11/19/24 and spoke with V20 (R425's spouse). V19 said the nurse was busy and V20 was asking what pharmacy we used and what their phone number was. V19 said she gave V20 the information because the nurses were busy. V19 said she didn't ask V20 why she needed the pharmacy number.

On 11/21/24 at 9:08 AM, V18 (LPN) said she worked 11/19/24 and took care of R425. V18 said she was not aware that R425 had a tele-visit with a pain NP. V18 said V19 (Guest Services Associate) did tell me that V20 (R425's spouse) was asking for the pharmacy we use and for the number. The surveyor asked why V20 would be asking about the pharmacy information. V18 replied, "I'm not sure why she would be asking for the pharmacy information. That's a good question." V18 said she didn't follow-up with R425 or V20 regarding their request for the pharmacy information. V18 said she worked until 7 PM on 11/19/24. V18 said they didn't mention they were waiting for a pain patch. V18 said if she knew, then she would have checked to see if there was an order in the EMR. V18 said if there wasn't an order, then she would call the facility provider to obtain an order, enter it into the EMR, and notify pharmacy. V18 said there should have been follow-up to V20's request for the pharmacy information. V18 said she didn't speak to the pharmacy about R425's Fentanyl patch because

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she didn't know anything about it.

On 11/21/24 at 9:26 AM, V21 (Pharmacist) said an electronic order for Fentanyl patch 12 mcg was sent on 11/19/24 at 7:43 PM by V22 (Pain NP). V21 said it looks like there was a discrepancy on the quantity. I see documentation that the pharmacy attempted to contact the facility at 9:11 PM and was not get in contact with facility staff. There was a note in the system that the Fentanyl patch was "pending clarification." V21 said there is no further documentation, and he is unsure if the pharmacist made contact with someone at the facility. V21 said on 11/20/24 at 1:13 PM, V16 (NP) entered an order for 1 Fentanyl patch for R425. V21 said the delivery left the pharmacy at 2 PM and arrived at the facility a few hours later. V21 said the pharmacy director will follow-up with more details on 11/22/24.

On 11/21/24 at 9:59 AM, V24 and V25 (Restorative Aides) were donning gowns and gloves to provide R425 incontinence care and get him up to the wheelchair. R425 looked up and started crying and motioned for the surveyor to come talk. R425 stated, "This is a f****** mess! The system is broken down. I tell every f****** person that comes in that I'm in pain. I lay here in unbearable pain. One time I laid here crying for what seemed like 5 hours, but only 1 f****** hour had passed. I don't feel like I'm moving forward with pain control. I had that tele-visit on Tuesday at 1:30 PM (11/19/24) with [V22 (Pain NP)]. [V22] called back within an hour to give an order. It took damn near 24 hours to get the pain patch (Fentanyl patch). When I finally got the patch, they started messing with my Norco. I don't like taking narcotics. It scares the s*** out of me, but I need them! I don't like it, but I NEED them. (R425 was lying on his back in bed, speaking loudly,

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cursing frequently, and his eyes welled up with tears.) I've never not been in pain. I can't even say if this pain patch is working because they quit giving my Norco last night. [V22 - Pain NP] knew I was on Norco every 4 hours and said it wasn't effective and added the Fentanyl patch. They were NOT supposed to stop my Norco! I got a couple doses of my scheduled Norco with the Fentanyl patch, but then the nurse last night said she I couldn't have them both together. I told her I was in pain and needed them. (R425 began crying). Why do they keep messing with stuff. I can hardly take this and their poor communication. See what I mean? They don't communicate! It's beyond frustrating and I'm still in pain." V24 and V25 came in the room to assist R425. They provided incontinence care and dressed R425, rolling him side to side. Each time R425 was rolled onto his right side, or his right leg was touched, he groaned in pain and grimaced. R425 told V24 and V25 that it hurt whenever his right leg was moved. They assisted R425 to roll up on his right side to sit up on the edge of bed. R425's right side was on the bed, and he started crying, "It hurts, lying on this side hurts. I'm lying on my sore spot." V24 and V25 assisted off his right side and to a sitting position on the edge of the bed.

On 11/21/24 at 11:17 AM, V20 (R425's Spouse) said the facility's pain doctor (V23) just left R425's room. V20 said they are going to allow him to take his scheduled Norco every 4 hours and the Fentanyl patch to see if it works. If that doesn't work, then they will come up with a different plan. V20 said R425 seemed to be in better spirits after the visit and he feels like they are finally starting to listen to him. V20 said R425 had been in so much pain every day, so they decided to call his pain doctor because he needed some relief. V20

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said she told the receptionist (V19) why she needed the pharmacy number because the nurse wasn't around. V20 said she doesn't know what happened after that because she went back to R425's room. V20 stated, "All I know is when I came back yesterday (11/20/24) he still didn't have his pain patch and he was very upset about it. It didn't come until around 4 PM."

R425's Facesheet dated 11/20/24 showed he had diagnoses to include, but not limited to: urinary tract infection; sepsis; cutaneous abscess of right lower limb; diabetes; prostate cancer; obstructive and reflux uropathy; other injury of the ureter; chronic kidney disease; and benign prostatic hyperplasia with lower urinary tract symptoms.

R425's Brief Interview for Mental Status (BIMS) Evaluation dated 11/17/24 showed he was cognitively intact.

R425's Physician Order Sheet dated 11/20/24 showed Norco 5-325 mg - Give 1 tablet by mouth every 4 hours for pain was started on 11/15/24. On 11/20/24 an order for Fentanyl 12 mcg transdermally every 72 hours for pain was entered. (The facility did not have an order in the EMR prior to 11/20/24. V20 (R425's spouse) requested the facility's pharmacy information at approximately 2:30 PM. The nurse did not follow-up with V20 and R425 regarding their request for the pharmacy information).

R425's November 2024 MAR (Medication Administration Record) showed he received the Fentanyl patch at 4:09 PM on 11/20/24. This document showed that R425's Norco tablet scheduled for midnight on 11/21/24 was held. The code "5" was documented. This form showed "5" means hold, see progress notes. R425's

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Progress Notes did not contain an entry explaining why this dose was held.

R425's NP Progress Note dated 11/20/24 showed the patient is upset he has not received his Fentanyl patch. The wife relayed it was ordered by his pain MD. Spoke to RN and gave order for Fentanyl patch and V23 (Pain MD) to follow-up with patient for pain control. The patient is complaining of right thigh pain.

R425's Nursing Note dated 11/20/24 at 12:50 PM showed, "Resident and family asking about the order for Fentanyl patch is from pain MD office. As nurse writer verified today (11/20/24). Pharmacy received order/prescription directly from Pain MD office on 11/19/24 for Fentanyl 12 mcg every 72 hours; but it was not delivered due to questions regarding the prescription. [The pharmacy] did not call [the unit] for verification of order. Upon knowledge, nurse immediately contacted primary attending NP to inform resident circumstance of investigation and approved orders for Fentanyl by outside MD, with current med order on Norco given at 12 PM for pain 8/10 (rated at 8 on 1-10 scale, 10 being worst pain ever experienced)... 4 PM Resident comfortable in bed, left side lying; received from pharmacy and applied Fentanyl patch 12 mcg on right upper chest... 6 PM Resident comfortable in bed, with some relief of pain observed.

On 11/21/24 at 11:29 AM, V3 (ADON - Assistant Director of Nursing) said if the pharmacy has questions regarding a medication order, then they usually call the floor nurse of the 24/7 supervisor. V3 said the staff receiving the call should address the clarifications as soon as possible. V3 said the pharmacy makes three scheduled deliveries per day and can make STAT deliveries in between.

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V3 said STAT deliveries usually arrive to the facility in 2 hours. V3 said if a resident is complaining of pain, then the staff should believe it. The nurse should perform a pain assessment and determine the level of pain. If the resident is already receiving pain medications, then the nurse will need to notify the physician of continued pain. V3 said the resident may need additional pain medications or a different approach to pain control. V3 said as soon a resident is complaining of pain, then the nurse should start working on obtaining orders for pain control. V3 said the R425, and his family shouldn't have felt they needed to call an outside pain clinic. V3 said V23 (Pain MD) rounds at the facility 1-2 times per week and is available for consults when residents complain of pain. V3 said she expects her staff to communicate a resident's complaints of pain to each other and continuity of care should be maintained. V3 said if R425's wife was asking for pharmacy information, then the staff should have followed-up with her. I don't know why the nurse didn't follow up. There isn't a progress note that showed the nurse was aware of the request for pharmacy information. V3 said pain control is important to a resident's healing, rehab, overall health, and resident comfort. V3 said she was not aware that R425 was unhappy and experiencing such pain. The surveyor asked why R425's scheduled Norco was held at midnight 11/21/24. V3 said she didn't know, but "5" stands for "hold, see progress notes." The surveyor asked V3 to review R425's progress notes for an entry for the held 11/21/24 midnight dose of Norco. V3 reviewed R425's chart and said there isn't a note, but there should be one. V3 stated, "I'm not sure everyone is aware that he is in pain. It's expected that we would do our best to control the resident's pain. We must listen to them. I can't say what

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	IL6005607	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	800 WEST OAKTON STREET ARLINGTON HTS, IL 60004

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happened because the nurse didn't chart anything to explain why the Norco was held. She should have."

On 11/22/24 at 12 PM, V33 (Director of Pharmacy) said he followed up regarding my questions for R425's Fentanyl patch. V33 said the electronic order was received from pharmacy at 7:43 PM on 11/19/24. V33 said there were errors with the prescription regarding the quantity and duration. V33 said the order was not entered as a STAT, so the pharmacist reviewed the orders later in the evening. V33 said pharmacy sent an email to V34 and V35 (Supervisors) regarding the need for order clarifications. V33 said it's the facility's procedure to email V34 and V35. V33 said a new order was entered for Fentanyl on 11/20/24 by V16 (NP) and it was filled STAT. V33 said he would expect the facility staff to communicate effectively to address any pharmacy concerns or resident complaints with pain.

The facility's Pain Assessment and Management Policy reviewed 11/27/24 showed, "A comprehensive and effective pain management program is provided to residents who require such services to ensure comfort, facilitate independence, and preserve dignity. The purpose of this policy is to provide guidelines for the assessment and identification of the resident's pain with underlying causes, and the development of pain management interventions consistent with professional standards of practice, person-centered care plan, and the resident's goals and preferences. Guidelines: 1. The pain management program is based on professional standards of practice and the resident's preferences related to pain management. 2. "Pain management" is defined

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S9999	Continued From page 13 as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessments and recognition of pain. b. Identifying the underlying causes and characteristics of pain; c. Developing and implementing a treatment/pain management plan; d. Monitoring for effectiveness and modifying interventions; and 3. Documentation and reporting... Documentation and Reporting: 1. The following information shall be documented and reported to the physician/medical provider immediately: a. Significant changes in the level of the resident's pain... d. Prolonged, unrelieved pain despite care plan interventions." (B)	S9999		