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S 000	Initial Comments Complaint Investigation 2560990/IL185879	S 000		
S9999	Final Observations Statement of Licensure Violations 300.690b) 300.690c) 300.1210b) 300.1210d)6) 300.1650a) 300.1650b) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or	S9999		

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incident to the Department within seven days after the occurrence.

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

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1650 Control of Medications

a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications.

b) All Schedule II controlled substances shall be stored so that two separate locks, using two different keys, must be unlocked to obtain these substances. This may be accomplished by

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several methods, such as locked cabinets within locked medicine rooms; separately locked, securely fastened boxes (or drawers) within a locked medicine cabinet; locked portable medication carts that are stored in locked medicine rooms when not in use; or portable medication carts containing a separate locked area within the locked medication cart, when such cart is made immobile.

These requirements are NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to store a Schedule II Controlled medication (Morphine Sulfate) in a locked location by leaving the medication on top of the medication cart in plain view, unsupervised, and readily accessible to wandering residents on a dementia care unit. This failure resulted in facility staff observing R1 at the medication cart with the bottle of Morphine placed to R1's lips, when staff removed the bottle, no medication remained in the bottle and then staff later observed R1 unresponsive with a decreased respiration rate followed by staff administering Narcan (an emergency medication that rapidly reverses life-threatening opioid overdoses) and sending R1 to the hospital emergency room for evaluation and treatment. The facility also failed to report the accidental ingestion of the opiate medication to the State Agency. This failure affects one resident (R1) of four reviewed for medication storage in the sample list of ten.

The surveyor confirmed by observation, interview, and record review that the deficient

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practice was corrected on 1/29/2025 prior to the start of the survey and was therefore Past Noncompliance.

Findings include:

R1's Medical Diagnosis list (printed 2/14/2025) documents R1 diagnoses include: Dementia with Psychotic Disturbance, Major Depressive Disorder, and Other Conduct Disorders (a mental health condition characterized by persistent and severe antisocial and aggressive behaviors that violate social norms and rules).

R1's Clinical Census sheet (printed 2/20/2025) documents R1 has resided on the facility's Dementia care unit since admission to the facility.

R1's comprehensive assessment (1/8/2025) documents R1 does not require staff assistance for eating or drinking, does not use any mobility devices (such as a cane, walker, or wheelchair), and has daily wandering behavior in the facility.

On 2/11/2025 at 1:55PM, the nurses' station at the facility Dementia care unit consisted of chest-height countertops and cabinetry arranged in an oval shape in the center of the care unit. Standard swinging doors the same height as the countertops were located at each end (East and West) of the station for staff to enter the work area. Standard lever style door handles were located at the top of each door. Numerous residents (unidentified) were congregating around the station and a medication cart was also stored inside of the station in plain view.

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R1's nursing care plan in effect on 1/28/2025 (printed 2/20/2025) documents R1 walks independently and also wanders in the facility. The same record documents the focus area "Potential Risk of Elopement Cognitive deficit, History of wandering, Walks about aimlessly w/o (without) purpose" with the goal "(R1) will remain safely in facility through review date" with a target date of 5/6/2025. The plan lists the following facility interventions/tasks to achieve the goal: Monitor whereabouts regularly, recognize any unsafe conditions or escalating patterns, and provide re-direction and diversion as needed.

On 2/11/2025 at 1:55PM, V3 (Licensed Practical Nurse) reported R1 has a history of wandering and will wander into the nurses' station if the doors at each end are open. V3 reported R1 had previously drank from staff beverages located inside of the nurses' station. V3 reported R1 also recently drank fingernail polish remover during an activity on 1/19/2025 and "coughed all over" getting the solution on R1's shirt and staff had to call the Poison Control telephone hotline for emergency medical instructions to care for R1. V3 reported R6 is another resident who wanders and will attempt to manipulate the door handles located at each door leading into the nurses' station and other residents also will sometimes reach over the top of the doors to attempt to unlock the handles.

On 2/13/2025 at 11:11AM, V4 (Licensed Practical Nurse) reported R1 does wander in the Dementia care unit and reported R1 has a history of getting inside of the nurses' station on the unit. V4 reported the unit has several residents who like

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to wander and residents will pull on and shake the doors at the nurses' station. V4 stated "Residents will shake the doors, we need more secure doors because of the wandering residents" and "the (door) handle on the East side doesn't lock and it doesn't have a sliding lock anymore." V4 reported if staff leave a soft drink beverage at the nurses' station, R1 will "absolutely" drink it. V4 reported R1 does not normally spill any drinks on R1's self when R1 is drinking a beverage.

On 2/11/2025 at 2:15PM, V5 (Certified Nurse Aide) reported R1 does not normally spill any liquids when drinking and is not normally messy when drinking.

On 2/11/2025 between 1:50-2:05PM, a medication cart remained stored inside of the Dementia care unit nurses' station. R1 was present and ambulating independently outside of the station in a random pattern before sitting down on a nearby chair. Facility staff then handed R1 an insulated water bottle with a flip top and R1 began drinking independently from the water bottle. R1 did not dribble or spill any of the water when R1 was taking sips from the bottle. When the surveyor attempted to speak to R1, R1 began screaming and was unable to coherently answer any questions.

The facility incident investigation (undated) documents on 1/28/2025, V4 (Licensed Practical Nurse) accidentally left a bottle of liquid morphine (an opiate medication used to treat moderate to severe pain) out in the open and V7 (Certified Nurse Aide) and V10 (Certified Nurse Aide) observed R1 with the bottle in R1's hand

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and then up to R1's mouth. The same record documents V7 retrieved the bottle of liquid Morphine from R1 and observed the bottle was empty.

On 2/23/2025 at 11:11AM, V4 (Licensed Practical Nurse) reported accidentally leaving a bottle of liquid morphine out on top of the medication cart on the facility Dementia care unit on the late afternoon of 1/28/2025. V4 reported opening a new bottle of liquid Morphine Sulfate (30 milliliters total volume at a concentration of 10 milligrams/5 milliliters) at around 3:05-3:06PM and administering 0.25 milliliters to R3 and then replacing the bottle and remaining Morphine (29.75 milliliters of remaining liquid equating to 59.5 milligrams of medication) back inside of the locked medication cart. V4 reported later retrieving the bottle of Morphine and placing the bottle into a small biohazard bag because the bottle was not contained in a cardboard box as is usual when the medication was received from the facility pharmacy provider. V4 reported then placing the bag containing the Morphine bottle on top of the medication cart at about 5:00PM, with the cart located in the Dementia care unit nurses' station, followed by V4 leaving the Dementia care unit.

R3's Physician Orders (printed 2/11/2025) document an order for Morphine Sulfate, 0.25 ml by mouth every 4 hours as needed for severe pain with a start date of 1/25/2025 and end date of 2/3/2025.

R3's Medication Administration Record (1/28/2025) documents V4 administered 0.25 milliliters of Morphine Sulfate to R3 at 3:07PM.

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R3's Controlled Drug Administration Record (January 2025) documents the facility received a 30 milliliter bottle of Morphine Sulfate (10 milligram/5 milliliter solution) and V4 administered 0.25 milliliters to R3 on 1/28/2025 at 3:07PM leaving 29.75 milliliters of solution remaining in the bottle.

The facility incident investigation (undated) documents on 1/28/2025 V5 (Certified Nurse Aide) was walking to the dining room on the Dementia unit to help serve resident supper meals and observed R1 with a bottle of "something" in R1's hand. The investigation documents V7 and V10 were serving resident meals in the dining room at the time and V7 observed R1 in a common area with a bottle up to R1's mouth. The record documents V7 then "grabbed the bottle away" from R1 and observed the bottle was empty and then asked V5 what was in the bottle and V5 reported the bottle contained Morphine and contacted V4 (Licensed Practical Nurse) who was located outside of the Dementia care unit on a break to report the concern (R1 having potentially drank Morphine Sulfate from an unsecured medication bottle). The record documents V4 then immediately returned to the unit and staff called emergency medical services to transport R1 to the hospital emergency room for evaluation and treatment. The investigation documents the incident was a "Medication Incident" and documents "Medication (Morphine Sulfate) as Administered Dose 59.5mg (milligrams)" and "Medication as Administered Name (R1)."

On 2/11/2025 at 2:15PM, V5 (Certified Nurse

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Aide) reported standing at the entrance of the Dementia unit dining room adjacent to the nurse's station on the evening of 1/28/2025 and observing R1 standing beside the medication cart which was located inside of the nurse's station. V5 reported observing R1 with something in R1's hand that V5 initially thought was a candy bar and then realizing R1 had a bottle in R1's hand and then asked nearby staff (V7 Certified Nurse Aide) what R1 had in R1's hand. V5 reported staff then realized R1 had a bottle of Morphine in R1's hand and the bottle was empty and R1 just had the bottle up to R1's mouth. V5 reported V7 then called V4 (Licensed Practical Nurse) back to the Dementia care unit. V5 reported staff did not see any spilled liquid Morphine on R1 anywhere and did not see any spilled Morphine on the medication cart and also looked at nearby surfaces including the interior of a nearby trash can to see if R1 poured or spilled the Morphine out and they did not find any evidence of the Morphine in the environment and concluded R1 drank the entire bottle of Morphine.

On 2/13/2025 at 11:11AM, V4 (Licensed Practical Nurse) reported receiving a call from V5 on 1/28/2025 informing V5 that staff found R1 with a bottle of Morphine Sulfate up to R1's mouth on the Dementia unit. V4 reported V5 stated "please tell me this (Morphine) bottle was empty (prior to staff observing R1 placing the bottle to R1's lips)." V4 reported returning to the Dementia care unit after receiving the call and helping staff look around to see if R1 had spilled instead of drank the liquid Morphine. V4 stated "We looked around and went to trash can and didn't find any moisture anywhere (to indicate R1

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spilled part or all of the Morphine instead of ingesting the contents of the bottle)."

The facility Physician Notifications form (a facsimile sent to R1's attending medical provider, V12, after the incident on 1/28/2025) documents R1 was sent to the hospital emergency room "after accidentally ingesting another residents liquid morphine."

R1's Progress Notes (1/28/2025 at 5:15PM) document: "Incident Note: Medication error occurred. Resident refused V/S. Only able to obtain respiratory rate. Facility protocol followed."

The facility Medication Incident report (undated) documents the facility sent R1 to the hospital emergency room on 1/28/2025 at 5:50PM.

The emergency medical services (EMS) Patient Care Report (0263) documents facility staff called EMS on 1/28/2025 to transport R1 to the hospital emergency room due to R1 possibly ingesting 29.75 milliliters of liquid Morphine. The report documents the dispatch reason as "Overdose/Poisoning/Ingestion" and documents R1 was not cooperative and would not walk to the EMS cot to be transported by ambulance to the hospital so EMS staff carried R1 by R1's extremities to the cot. The report documents R1 had constricted pupils at the time of transportation to the hospital. The report documents R1 was taken to the hospital emergency room at 5:37PM.

The hospital emergency department report (1/28/2025) documents R1 arrived at the hospital

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awake and "irritated" and V27 (Registered nurse) at the emergency room contacted the facility to get information about R1. The report documents V31 (former Director of Nursing) reported to V27 that R1 "got 29.75ml (milliliters) of morphine at 1715" and "the bottle was completely empty when the nurse found it and she called 911." The same report documents the bottle of Morphine had a concentration of 2 milligrams per milliliter and was sitting on top of the medication cart unattended (at the nursing home). The report documents R1 arrived at the hospital emergency room via ambulance with a chief complaint of accidental overdose, was evaluated, and then sent back to the nursing home with the medication Narcan (an emergency medication that rapidly reverses life-threatening opioid overdoses) and printed patient care instructions titled "Opioid Overdose: Care Instructions." The report does not document the hospital emergency room attempted to obtain any laboratory specimens from R1 at the time of R1's visit to the emergency room to directly screen for Morphine (opiate) ingestion. The report documents V28 (Emergency Room physician) signed R1's discharge instructions at 6:32PM.

Progress notes (1/28/2025) document R1 returned to the facility from the hospital at 7:09PM via emergency medical services.

On 2/7/2025 at 2:43PM, V6 (Registered Nurse) reported starting a work shift at 6PM on 1/28/205 on the Dementia care unit where R1 resided. V6 reported R1 had already been sent to the emergency room at the hospital and V4 (Licensed Practical Nurse) had reported to V6 during shift change report that R1 had gotten

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ahold of some Morphine that facility staff left unsupervised and staff were not sure if R1 drank or spilled the Morphine but staff could not find evidence the Morphine was spilled. V6 reported the hospital called emergency room called V6 around 6:30-6:45PM about sending R1 back to the facility. V6 reported emergency medical services brought R1 back to the facility and R1 was at R1's baseline but a "bit more lethargic." V6 reported around 10:00PM, R1's oxygen saturation fell off to around 88% and R1's respiration rate started becoming lower and lower and R1 was less responsive. V6 reported when R1 is normally in R1's room, staff can not go into R1's room without R1 screaming and V6 stated "you certainly can't check her vitals (without R1 screaming)." V6 reported when V6 was in R1's room taking R1's blood pressure, R1 looked at V6 but was silent. V6 reported a Certified Nurse Aide (unidentified) was doing a fifteen minute check on R1 later and reported to V6 that R1's respiration rate was at 13 and so V6 went to R1's room immediately. V6 reported observing R1's respiration rate decrease to 10 and that R1 does not have any history of having a low respiration rate. V6 reported then calling 911 to get emergency medical services to transport R1 to the hospital emergency room a second time and then administering 4mg (milligrams) of Narcan to R1 as R1 seemed "less and less responsive."

Progress Notes (1/28/2025) document R1 was sent back to the emergency room at 10:41PM due to decreased respirations.

The emergency medical services (EMS) Patient Care Report (0265) documents facility staff

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called EMS on 1/28/2025 to transport R1 to the hospital emergency room due to a report of a resident "who is unresponsive, but breathing" and "Respirations down to 11. 1 dose of Narcan has been administered" and "Staff reports that during their assessment they found pt's (patient's) respirations to be between 11-13 breaths per minute. After noting this change in pt (patient) condition staff administered 4mg (milligrams) of nasal Narcan. EMS assessed pt respirations and found them to be at 18 breaths per minute." The report documents the dispatch reason as "Breathing Problem." The report documents R1 was taken to the hospital emergency room at 10:48PM.

The hospital emergency department report (1/28-1/29/2025) documents R1 presented to the hospital emergency department due to the chief complaint of possible overdose and R1 was uncooperative and yelling at hospital staff in the emergency department. The record documents nursing home staff reported completing fifteen minute checks on R1 when R1 was found unresponsive with a respiration rate of 11 and an oxygen saturation of 88% followed by nursing home staff administering Narcan to R1.

The emergency department report documents R1 received an intravenous catheterization in R1's arm at 11:30PM on 1/28/2025 which R1 pulled out of R1's arm at 11:47PM followed by the notes "bleeding controlled at this time" and "ER MD notified." The same report documents hospital staff inserted a second intravenous catheter into R1's arm at 12:10AM on 1/29/2025. The report also documents hospital emergency room staff performed a urinary categorization on R1 at

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(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
S9999	Continued From page 13	S9999		

11:27PM on 1/28/2025 to obtain a urine specimen for a urinary drug screen and at 11:47PM, the screen resulted positive for the presence of Morphine (an opiate) in R1's urine.

The emergency department notes document on 1/28/2025 at 11:50PM, V28 (Emergency department physician) stated R1's urine drug screen was positive for opiates but R1 did not currently have any opiates on R1's medication list and that V29 (Hospitalist) was concerned R1's positive urine drug screen may be an actual (Morphine) ingestion and the hospital will observe R1 in the Emergency Department overnight.

On 2/13/2025 at 11:45AM, V9 (facility Quality Assurance Pharmacist) looked at R1's medication records and reported R1 was opiate naïve prior to the incident (had not been taking any opiates recently) and if R1 had ingested the bottle of liquid Morphine containing 59.5 milligrams, V9 would expect to see traditional signs of opioid overuse, especially respiration rate depression and mental status changes. V9 reported additional signs would include lethargy and trouble concentrating. V9 reported expecting the onset of liquid Morphine to be within 30-60 minutes but possibly longer. V9 reported it would be reasonable for R1 to not show signs of opiate overdose for some time after ingestion depending on food in R1's stomach and other factors. V9 reported death is possible with opioid overdose and other possible outcomes include temporary or permanent harm.

On 2/14/2025 at 11:26AM, V9 reported typical dosing for Morphine Sulfate at a concentration of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007090	A. BUILDING: _____ B. WING _____	C 02/26/2025

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2 milligrams/milliliter is as low as a few milligrams for an opiate naive patient and reported standard dosing for a patient without previous use would be 5 milligrams or lower per dose.

R1's Medication Administration record (January, 2025) does not document R1 was taking any opiate medications at the time of the incident on 1/28/2025.

On 2/14/2025 at 12:21PM, V12 (R1's attending medical provider at the facility) reported if R1 was positive for opiates on a urinary drug screen, then R1 must have ingested some of the liquid Morphine. V12 reported facility staff leaving the Morphine out on the medication cart unsupervised was a "high risk" for residents.

V12's (R1's attending medical provider in the facility) Progress Note (1/30/2025) documents V12 "discussed in great detail with nursing home staff" that they should not leave any medication unattended to prevent future incidents with any resident. The note documents V12 recommended to provide all staff necessary education and discussed this with V1 (Administrator) and V31 (former Director of Nursing) and they agreed.

On 2/11/2025 at 10:00AM, V1 (Administrator) stated the facility did not report R1's 1/28/2025 incident to the (State Agency)

(A)