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	IL6009245	A. BUILDING: _____ B. WING _____	03/05/2025

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)1) 300.1620a) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

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includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10

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calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to administer a prescribed opioid medication to keep resident's pain controlled, failed to perform a pain assessment while the resident was not receiving her prescribed opioid medications, and failed to notify the physician of the need for a refill order and complaints of increased pain for one of one resident (R32) reviewed for pain in the sample of 35. These findings resulted in R32 experiencing stress and excruciating pain for over a week, that radiated to the neck and jaw.

Findings include:

The Facility's Management of Pain Policy dated 4/4/12 documents "Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and involvement. We will achieve these goals through: Promptly and accurately assessing and diagnosing pain." "Monitoring treatment efficacy and side effects." "Using pain medication judiciously to balance the residents desired level of pain relief with the avoidance of

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unacceptable adverse consequences. A standard format for assessing, monitoring and documenting pain in both cognitively intact and cognitively impaired residents will be utilized. As part of a comprehensive approach to pain assessment and management, pain will be considered the "fifth" vital sign at the facility, along with temperature, pulse, respiration, and blood pressure. For the purpose of this policy, pain is defined as "Whatever the experiencing person says it is, existing whenever the experiencing person says it does." Procedure 1. Resident/Family Involvement Upon admission, all residents and families will receive the facility handout, "A Message of Care to our Residents and Families - Facts about pain," encouraging residents to report pain early so pain management can be more effective. Residents will be asked to periodically measure satisfaction related to pain and its management. 2. Physician Communication and Involvement - Pain will be assessed and managed in a timely fashion, especially if it is a recent onset. The physician will be notified of resident's complaint of pain when not relieved by medication as ordered by the physician. Thorough communication with the physician will ensure an appropriate pain management plan. Pain Screening- By receiving input from someone who knows the resident well, pain management can be more specific to the resident. If the resident scores five or above on the pain questionnaire the comprehensive pain assessment must be completed."

The United States Food and Drug Administration Safety Communication Website article dated 4/9/19 documents, "Opioid's are a class of powerful prescription medicines that are used to manage pain when other treatments and medicines cannot be taken or are not able to

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provide enough pain relief. Rapid discontinuation can result in uncontrolled pain."

R32's Face Sheet documents R32 is a 71-year-old female admitted to the facility on 8/16/22 with the following, but not limited to, diagnoses: Primary Generalized (Osteo) Arthritis, Neuropathy, and GERD (Gastroesophageal Reflux Disease).

R32's current Care Plan documents "(R32) is at risk for pain related to arthritis, neuropathy, GERD. Goal: (R32) will not have an interruption in normal activities due to pain through the review date. Interventions: Administer analgesia as ordered and monitor effectiveness of pain medications used. Evaluate the effectiveness of pain interventions utilized, both medical and non-medical. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Monitor/record/report to Nurse (R32's) complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from (R32's) past experience of pain."

R32's MDS (Minimum Data Set) Assessment, dated 2/21/25, documents R32 is cognitively intact. This same MDS documents R32 frequently had pain or was hurting in the last five days that occasionally made it hard to sleep, occasionally limited her day-to-day activities due to pain, and rated her worst pain as a seven out of ten.

R32's Progress Note dated 2/23/25 at 11:41 AM documents "Fentanyl Transdermal Patch 72 Hour

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100 MCG (microgram)/Hr (hour) apply 1(one) patch trans dermally in the afternoon every 3 (three) days for chronic pain and remove per schedule. Waiting for signed order from doctor."

R32's Medication Administration Record (MAR) dated 2/1/25 through 2/28/25 documents "Fentanyl Transdermal Patch 72 Hour 100 MCG/HR. Apply one patch trans dermally in the afternoon every three day(s) for chronic pain and remove per schedule." Start date 9/11/24. This same MAR documents R32 did not receive her scheduled Fentanyl Transdermal Patch 100 MCG/HR from 2/17/25 through 2/24/25. The pain assessment documents that R32 rated her pain at a level "five" or above eight times between 2/17/25 through 2/25/25.

R32's Electronic Medical Record and Progress Notes dated 2/17/25 through 2/25/25 (dates R32's pain was rated above a five) includes evidence of only one comprehensive pain evaluation being completed on 2/21/25 during this timeframe.

R32's Pain Evaluation dated 3/21/25 documents R32 was experiencing pain frequently over the past five days, rated at a level seven (indicating the pain was as bad as it could be). This same Evaluation documents no new care plan interventions or clinical suggestions were made to address R32's pain.

On 3/3/25 at 10:45 AM, R32 stated "I wear a pain patch and on 2/17/25 I did not get my new patch. I kept asking the staff and nothing was done about it. I was told at one point that they needed to get a physician's order. I don't know if it was not followed up on or what happened. On 2/25/25 I was so upset because it had been well over a

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week that I had waited for the pain patch to be replaced. I was having stabbing pain in my neck and jaw I think from the stress from the amount of pain I was under. I thought I was having a heart attack. I was hurting and frustrated that no one would help me get my medication. I was in excruciating pain for over a week. I didn't get the patch until 2/25/25."

On 3/4/25 at 11:35 AM, V21/Pharmacist stated "We did not get a request to refill (R32's) Fentanyl patch until 2/24/25. The last time the order was filled was 1/13/25 which should have lasted a month."

On 3/4/25 at 11:51 AM, V22/R32's Primary Care Physician's Nurse stated "2/24/25 was the first time we were notified that (R32) needed the order for her fentanyl patch. Our office should have been notified of the need for (R32's) Fentanyl Patch refill before (R32) ran out."

On 3/5/25 at 8:50 AM, V1 (Administrator) stated, "When (R32) was out of her Fentanyl Patch somebody should have reached out to (R32's) physician to get the refill order or to see if the patch could have been pulled from back-up. The staff should have let the physician know that (R32) was in pain and see if there was something else, we (the facility) could do to control (R32's) pain. (R32) should not have had to go without her Fentanyl Patch. The staff should have contacted me or (V2/Director of Nursing) when the Fentanyl Patch was not available so one of us could have followed up on it. There is no documentation that the physician, me, or (V2) were notified of (R32) going without her scheduled Fentanyl Patch or (R32's) complaints of pain from 2/17/25 to 2/25/25. During the timeframe of 2/17/25 to 2/25/25 we had agency staff taking care of (R32)

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S9999	Continued From page 7 and were not familiar with (R32). I think that is why there was no follow-up. Any pain rating above a seven indicates pain that is as bad as it can be." On 3/5/25 at 9:00 AM V18 (CNA/Certified Nursing Assistant) stated, "Every time I would take (R32's) meal tray into her between 2/17/25 to 2/25/25, (R32) would complain of pain and say to me, "I just do not understand why they (the staff) are not getting me my pain patch and I have to go this long in pain." (B)	S9999		