STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009542	A. BUILDING: _____ B. WING _____	04/23/2025

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VALLEY HI NURSING HOME	2406 HARTLAND ROAD WOODSTOCK, IL 60098

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Findings 300.610a) 300.1010h) 300.1210b) 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 300.1010 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,	S9999		

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S9999	Continued From page 1 injury or change in condition at the time of notification 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. 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 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 evidence by: Based on interview and record review the facility failed to provide an opioid transdermal pain medication to a resident (R28) with chronic pain. This failure resulted in this resident experiencing	S9999		

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severe breakthrough pain. This failure applies to 1 of 20 residents (R28) reviewed for pain in the sample of 20.

The findings include:

R28's admission record dated 11/9/23 showed R28 was admitted to the facility with a diagnosis of chronic pain.

R28's current care plan showed R28 was identified as being at risk for increased pain on 11/17/23 related to her diagnosis of chronic pain. The care plan showed R28 "is taking scheduled Fentanyl (opioid) patch ..." The plan showed, "Administer medications as ordered ..."

On 4/21/25 at 2:32 PM, R28 stated, "There was one time I went without my Fentanyl patch for over a week. It was horrible. I was in so much pain. I was worried I would go through withdrawals ...." R28 stated she had been prescribed Fentanyl "for years" due to her chronic pain. R28 stated, "I don't know why I didn't get my Fentanyl. They just said there was a problem getting it from the pharmacy."

R28's July 2024 and August 2024 Medication Administration Records showed physician orders for R28 to receive a Fentanyl pain patch, 50 mcg/hr (micrograms per hour), administer/apply one transdermal patch topically every 72 hours. The records showed a Fentanyl patch was applied to R28's back on 7/30/24. The records dated 8/2/24 and 8/5/24 showed a Fentanyl patch was not administered to R28 because "Drug/Item Unavailable". R28 missed two doses of her Fentanyl medication. The record showed a patch was not applied/administered to R28 until 8/7/24.

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R28's progress notes dated 8/5/24 showed, "Resident was screaming so bad for pain ... Resident talked to this writer (V9 Licensed Practical Nurse/LPN) about her Fentanyl that was not been given to her for 5 days ... She was worried that she is going into withdrawals .... Called pharmacy and informed this writer that no request done (for facility to receive R28's medication) ..."

R28's progress note dated 8/6/24 showed the facility called the pharmacy regarding R28's Fentanyl prescription. The note showed, "Patches will be delivered today ..."

R28's progress note dated 8/8/24 showed R28 was seen by and examined by V10 Nurse Practitioner (NP). The note showed R28 "was seen at her request. Concerned about pain medications. Reports she was without her Fentanyl patch for 3 days. Admits muscle tension to right neck ...Has chronic pain issues ... Continue scheduled Fentanyl patches as per pain management ..."

On 4/22/25 at 9:33 AM, V9 LPN stated she provided cares to R28 on 8/5/24. When V9 was asked if R28 appeared to be in pain at that time, V9 stated, "Yes of course she was. I remember. (R28) had run out of her Fentanyl patches. She had been on the patches for awhile due to her chronic pain. I believe she ran out of the medication due to an insurance reason. I am not for sure why. She missed a few doses of the medication because we didn't have the med. I know I did call the pharmacy ... We did try to get give her PRN (as needed) pain medications during that time. Sometimes the PRN meds (medications) helped her pain, sometimes they didn't."

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On 4/22/25 at 12:55 PM, V2 Director of Nursing (DON) stated, "For Fentanyl patch prescriptions, we should reorder the medication when we have 1-2 patches left to ensure the medication is delivered in time, so no doses are missed. I do remember the issue with (R28's) Fentanyl patches. We did reorder the medication timely but for Fentanyl, the ordering physician must sign off on the medication. (R28) missed the doses of Fentanyl because the (facility's) physician did not sign off on the medication so there was a delay in the medication being delivered to the facility." V2 DON stated no numerical pain assessments were completed on R28 from 7/30/24-8/7/24.

On 4/22/25 at 11:59 AM, V10 Nurse Practitioner (NP) stated, "(R28) has chronic pain. She had been seeing a pain doctor in the community prior to her being admitted to the facility. She has been on Fentanyl patches for years. She is someone who really needs the (Fentanyl) patch. She will get to the 72-hour mark of being on the medication, just when she is ready for a new patch, and she will develop breakthrough pain so that's why it's important she gets the patch as prescribed. If she stopped getting the Fentanyl patch abruptly, she could be at risk for going through (medication) withdrawals ..." V10 NP stated it is her expectation that R28 receives her medications as ordered.

The facility's Pain Assessment Policy dated 7/2022 showed, "It is the policy of (facility) to screen all residents to determine their individual pain profile. The purpose of the screening is to identify residents with uncontrolled pain, implement appropriate interventions to improve resident's quality of life and participation in activities of daily living ..."

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S9999	Continued From page 5 B	S9999		