| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057109 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/20/2025 |
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| LINCOLN VILLAGE HEALTHCARE | 2202 NORTH KICKAPOO STREET , LINCOLN, Illinois, 62656 |

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| S0000 | Initial Comments<br><br>Original Complaint Investigation 2526254/196140 | S0000 | | 08/01/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure Violations (1 of 2)<br><br>300.610a)<br><br>300.1210b)<br><br>300.1210d)1)2)<br><br>300.1220b)3)<br><br>300.1630d)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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. | S9999 | | 08/10/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br><br>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:<br><br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.<br><br>Section 300.1630 Administration of Medication<br><br>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.<br><br>These regulations were not met as evidence by:<br><br>Based on observation, interview, and record review the facility failed to administer prescribed opioid medications to keep residents' pain controlled, failed to perform pain assessments and implement pain relieving interventions while the residents were not receiving their prescribed pain relieving opioid | S9999 | | |

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| S9999 | Continued from page 2<br>medications, and failed to notify the physician of the need for a opioid medication refill order and complaints of increased pain for three of three residents (R2, R14, and R22) reviewed for pain in the sample of 30. These findings resulted in R2 experiencing restlessness and unrelieved pain after seven days of going without his prescribed opioid medication, R14 experiencing excruciating and stabbing unrelieved pain to the lower back, and R22 experiencing unrelieved severe pain to the lower back and legs.<br><br>Findings include:<br><br>The facility's Pain Management Policy, dated 1/2025, documents "Purpose: To establish a program with a multi-level approach to pain management to assist the facility in delivering safe, individualized pain care. Policy: It is the policy of the facility to facilitate resident safety, independence, promote resident comfort, preserve, and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish the goals through an effective pain management program. Definition: The facility will utilize a consistent pain assessment. The resident's descriptive words regarding the quality, duration, and location of pain will be used to evaluate the pain and to identify changes in pain. When the resident is unable to describe pain, physical signs such as grimacing, body posturing/protecting, vital sign changes, and changes in behavior and mood will be used to determine the presence of pain. Standards: 1. Pain assessment protocol may be initiated under any of the following situations: Any indication of pain based on the Pain Assessment performed for each resident at the time of admission, quarterly and with any condition change associated with the potential of pain, when the Minimum Data Set triggers an indication of pain (section J2, J3), Resident received routine pain medication and/or pain is not controlled, a change in a resident condition occurs to require pain control, A significant increase in the need for use of as needed use of pain medication, and a change in pain identification related to behavior, cognition or mood. 5. An interdisciplinary process and care plan will be developed and implemented based on the assessed findings, pain rating scale, and pain relieve strategies (interventions). 7. Care plans will be reviewed and updated each time the resident's pain management plan is found not to be effective and at least each quarterly care conference. 11. Documentation of assessments and the resident's response to the pain management plan will be made with each assessment. 12. The resident's physician will be notified of the | S9999 | | |

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| S9999 | Continued from page 3<br>resident's complaints of pain which are not relieved by comfort measures, including pain medications."<br><br>The facility's Physician Orders policy dated 1/23/25 documents, "Nursing staff will follow physician orders. In an event where a resident refused medication, or mediation is not available physician or nurse practitioner will be notified."<br><br>1. R2's Admission Care Plan dated 7/3/25 documents, "(R2) is at risk of complaints of chronic pain related to infection/inflammatory reaction due to internal fixation with removal of hardware and pressure ulcers. (R2) has narcotic and non-narcotic pain medications orders prn (as needed). Approach: Administer medications as per orders. Evaluate/record/report effectiveness and any adverse side effects."<br><br>R2's current Physician Order Report documents R2 was admitted on 6/30/25 with the diagnoses of a Pressure Ulcer of the right hip, Osteomyelitis, Pressure ulcer of the left hip, Pressure Ulcer of the right buttock, Contracture of Right Hip, Contracture of the right knee, Contracture of right lower leg muscle, Infection and inflammation reaction due to internal fixation device, and anxiety disorder. This same Physician Order Report documents, "Start Date 6/30/25 (Admission) Hydrocodone-Acetaminophen (Norco) 10-325 mg (milligrams) one tablet every eight hours as needed."<br><br>R2's Pharmacy Packing Slip dated 7/7/25 documents R2's Hydrocodone/Acetaminophen 10-325 mg 30 tablets was not delivered until 7/7/25 (seven days after R2 was admitted to the facility).<br><br>R2's Medication Administration Records (MARs) dated 6/30/25 through 7/7/25 document R2 did not receive any Norco as ordered during this timeframe.<br><br>R2's Electronic Health Record does not include documentation of R2's Physician (V30) being notified of the need for a prescription to fill R2's Norco, or documentation of pain-relieving interventions utilized while R2 was not receiving his Norco as ordered from 6/30/25 through 7/7/25.<br><br>R2's Progress Notes dated 7/5/25 at 3:45 PM and signed by V28 (Agency RN/Registered Nurse) documents, "(R2) alert with confusion. Very confused on (R2's) whereabouts and day to day things. (R2) very restless at times. (R2) throws his legs and upper half of body out of the bed. Staff repositioned (R2) very frequently. (R2) is however contracted. (R2) has legs drawn up in a fetal position. (R2) frequently yells out | S9999 | | |

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| S9999 | Continued from page 4<br>for someone to "get the people out of there" while he points at his window. Will continue to monitor and follow current plan of care."<br><br>On 7/15/25 at 1:35 PM R2 was lying in a low bed with the head of the bed up 90 degrees. R2 had multiple bruises to the right lower arm and a four-by-four bandage to the right lower arm. R2 had pressure ulcers to the right and left hip and right buttock. R2's legs were drawn up into a fetal position. R2 had facial grimacing and when asked if R2 was in pain R2 replied, "Yes."<br><br>On 7/16/25 at 9:50 AM V27 (CNA/Certified Nursing Assistant Manager) stated, "On 7/5/25 around 2:25 PM (V28/Agency RN/Registered Nurse) was working and told me (R2) seemed to be in pain and had no medication. I called (V3/Prior Director of Nursing) and (V3) said she would take care of getting (R2's) pain medication."<br><br>On 7/16/25 at 1:00 PM V28 (Agency RN) stated, "I was working on 7/5/25 and it seemed throughout the shift that (R2) could not get comfortable. I looked at (R2s) MAR and noticed (R2) did not have Norco. (V27) called (V3) and (V3) was supposed to take care of getting (R2's) Norco. (R2's) Norco never did come in that day.<br><br>On 7/16/25 at 1:30 PM V24 (Director of Rehabilitation) stated, "I have worked with (R2) in therapy since (R2's) admission. It seems like (R2) is in a lot of pain most often when (R2) is being moved. (R2) is very contracted and has a lot of wounds. (R2) does not talk much but does say "ouch" whenever I roll (R2) or move (R2's) legs. I think moving (R2's) legs agitates (R2's) hip pain."<br><br>On 7/18/25 at 11:10 AM V30 (R2's Physician) stated, "(R2) absolutely should not go without his Norco. With all (R2's) illnesses and wounds, going without Norco would cause (R2) severe pain. There is no reason for any of my residents to be without their pain medications. The facility should have gotten ahold of me immediately to get (R2's) Norco ordered. I am always available by phone call and fax."<br><br>2. R14's MDS (Minimum Data Set) Assessment dated 5/13/25 documents R14 is cognitively intact.<br><br>R14's Nursing Home Visits dated 319/25 and 4/9/25 and signed by V30 (R14's Physician) document, "Chronic Pain: On Norco and Ibuprofen."<br><br>R14's current Care Plan documents, "Problem: Pain (R14) is at risk for chronic pain related to spinal stenosis. | S9999 | | |

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| S9999 | Continued from page 5<br>(R14) is no routine narcotic pain medication and PRN (as needed) non-narcotic medication for pain. 2/9/25 history of fracture o lumbar vertebrae. Goals: (R14) will verbalize reduction of pain. Approach: Administer medications as ordered. Monitor and record effectiveness. Report adverse side effects. Assess past effective and ineffective pain relief measures. Problem: (R14) has been asking for more pain medications, asking other nurses for pain \medications and telling other staff that (R14) did not get his pain medications. Approach: Nursing staff will give (R14) a sticky note of times he takes his schedules pain medications at the beginning of each shift."<br><br>R14's Physician's Order Report dated 6/15/25 through 7/15/25 document R14 has the diagnoses of Spinal Stenosis of the Lumbosacral Region and Low Back Pain. This same Physician's Order Report documents, "Start Date 10/16/23: Hydrocodone-Acetaminophen (Norco) 5-325 mg two tablets every six hour for low back pain. Start Date 9/1/23 Pain Scale/Evaluation every shift. Pain Scale 0-10. 0=No pain. 1=Mild Pain of uncomfortable/annoying. 4=Moderate Pain that is distressing/miserable. 10=Excruciating Pain that is the worst possible and interferes with the ability to carry on with daily routine, socialization, or sleep."<br><br>R14's MARs dated 5/1/25 through 7/15/25 documents R14 did not receive his schedule Norco 5-325 mg as ordered on 13 occasions due to the Norco being unavailable.<br><br>R14's MARs dated 5/1/25 through 7/15/25 document on 5/23/25 during the R14 was rating his back pain at a level "7" on a "0-10" pain scale. According to R14's MARs R14 did not receive his Norco 5-325 mg as ordered on 5/23/25 at 8:00 AM, 2:00 PM, or 8:00 PM and on 5/23/25 R14 was rating his back pain at a level "7" on a "0-10" scale.<br><br>R14's MARs dated 5/1/25 through 7/15/25 document on 6/15/25 during the entire day R14 was rating his back pain at a level "7" on a "0-10" pain scale and on 6/16/25 during the night R14 was rating his back pain at a level "10" on a "0-10" pain scale. According to R14's MARs R14 did not receive his Norco 5-325 mg as ordered on 6/15/25 at 8:00 PM or 6/16/25 at 2:00 AM.<br><br>R14's Electronic Medical Record does not include any pain-relieving interventions, physician's notification, or comprehensive pain assessments after the 13 occasions between 5/1/25 through 7/15/25 when R14 did not receive his Norco as prescribed.<br><br>On 7/15/25 at 10:05 AM R14 was walking with a walker in | S9999 | | |

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| S9999 | Continued from page 6<br>the dining room. R14 stated, “The facility runs out of my Norco every month. I was an iron worker and hurt my back years ago. I have been on Norco for the pain in my lower back and was seeing a specialist for the pain. When I don’t get my scheduled Norco I have excruciating, stabbing pain to my lower back. The pain keeps me awake. I really wish the facility would get this fixed, so I do not have to go without the Norco.”<br><br>On 7/16 /25 at 10:30 AM V2 (Director of Nursing) stated, “(R14) did not get his Norco as ordered on 13 occasions between 5/1/25 through 7/15/25. (R14) has a lot of back pain and should not go without his scheduled Norco.”<br><br>On 7/16/25 at 1:20 PM V1 (Administrator-In-Training) stated, “I was made aware that (R14) was running out of his Norco frequently. I know (R14) needs his Norco for lower back pain and should not ever run out of Norco."<br><br>On 7/16/25 at 2:00 PM V19 (Regional Nurse Consultant) stated, “(R14) has not had a comprehensive pain assessment completed since 5/13/25.” V19 verified (R14) should have had a comprehensive pain assessment completed anytime (R14) went without his ordered Norco and was experiencing pain.<br><br>On 7/18/25 at 11:00 AM V20 (R14’s Family Member) stated, “I know agency nurses do not get (R14’s) medication refills done on time. (R14) has always had chronic pain and was a construction worker and hurt his back by following out of a third-floor window of a building. (R14) has had multiple back surgeries. (R14) is usually out of his pain medications on the weekends and calls me when (R14) does not get his pain medication because he is having pain. If (R14) misses even one dose of Norco (R14) is in pain.”<br><br>On 7/18/25 at 11:10 AM V30 (R14’s Physician) stated, “(R14) should never have to go without his Norco. (R14) is dependent on the Norco and needs the Norco routinely to control his back pain. The facility should get ahold of me before (R14’s) Norco runs out.”<br><br>3. R22’s current Pain Care Plan documents R22 has complaints of chronic pain due related to osteomyelitis, pressure ulcer to the right ischium, tear of the hamstring tendon, and peripheral vascular disease, and is receiving hospice services for pain control management. This same care plan documents R22’s pain medications should be administered as ordered and R22 will verbalize reduction of pain and/or show no signs of non-verbal pain. | S9999 | | |

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| S9999 | Continued from page 7<br>R22's current Physician Order Report documents R22 has the diagnoses of strain of muscle of the fascia and tendon of the posterior muscle group at right thigh level and malignant neoplasm of the large intestine and receives hospice services. This same Physician Order Report documents the following orders, "Start Date 6/10/25 pain scale/evaluation every shift. Start Date: 7/7/25 MS Contin (Morphine) tablet extended release 15 mg twice daily at 8:00 AM and 8:00 PM.<br><br>R22's Physician's Order dated 6/26/25 documents an order to increase R22's Hydrocodone/Acetaminophen from 5-325 mg every four hours to 10-325 mg every four hours and then discontinue on 7/7/25.<br><br>R22's Medication Administration Record dated 6/10/25 through 7/15/25 documents R22's MS Contin 15 mg was not received on 7/7/25 at 8:00 AM or 8:00 PM due to the medication being unavailable.<br><br>R22's Medication Administration Record dated 6/10/25 through 7/7/25 documents R22's Hydrocodone/Acetaminophen from 10-325 mg was not received as ordered on 15 occasions due to the Hydrocodone/Acetaminophen being unavailable.<br><br>R22's Electronic Medical Record documents R22's last Comprehensive Pain Assessment was completed 6/26/25.<br><br>On 7/16/25 at 11:00 AM R22 was lying in bed. R22 stated, "I have cancer, and I hurt all over. I do not like to complaint. I have had pain all over and especially in my lower back and legs. I had no idea I was out of my pain medication. That would explain why I was hurting so bad."<br><br>On 7/18/25 at 10:30 AM V12 (Hospice RN/Registered Nurse) I was not aware that (R22) was not getting his Hydrocodone/Acetaminophen 10mg-325 mg as ordered or his MS Contin 15 mg for two doses. I made (R22's) Hydrocodone/Acetaminophen 10mg-325 mg scheduled around the clock due top (R22) having wound pain, back pain, arm pain, and leg pain. It is unacceptable for (R22) to go without pain medication and (V9/Hospice Physician) was not notified. (V9) should have been notified so me or (V9) could have reached out to the pharmacy to make sure (R22) was getting his medication or we would have ordered something else to control (R22's) pain until the Hydrocodone/Acetaminophen and MS Contin was received."<br><br>(B) | S9999 | | |

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| S9999 | Continued from page 8<br>(2 of 2)<br>300.610a)<br>300.1210b)<br>300.1210d)1)2)<br>300.1220b)3)<br>300.1630d)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>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:<br><br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br><br>2) All treatments and procedures shall be administered | S9999 | | |

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| S9999 | Continued from page 9<br>as ordered by the physician.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.<br><br>Section 300.1630 Administration of Medication<br><br>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.<br><br>These regulations were not met as evidence by:<br><br>Based on observation, interview, and record review the facility failed to implement a process for the timely ordering and reordering of medications, failed to notify the physician of the need for opioid analgesic medications and anti-anxiety medication prescription refill orders, failed to notify the physician of the need for an alternative to ordered Ozempic, and failed to obtain physician ordered opioid analgesic medications, anti-antianxiety medication, and weight-loss medication from the pharmacy for four of four residents (R2, R14, R18, and R22) reviewed for pharmacy services in the sample of 30. These findings resulted in R2 experiencing restlessness, increased anxiety, and unrelieved pain after seven days of going without his prescribed opioid medication and anti-anxiety medication, R14 experiencing excruciating and stabbing unrelieved pain to the lower back and withdrawal symptoms, and R22 experiencing unrelieved | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057109 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/20/2025 |
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| LINCOLN VILLAGE HEALTHCARE | 2202 NORTH KICKAPOO STREET , LINCOLN, Illinois, 62656 |

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| S9999 | Continued from page 10<br>severe pain to the lower back and legs.<br><br>Findings include:<br><br>The facility's Controlled Substance Prescription Pharmacy Policy, dated 10/25/2014, documents "Policy: Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe. To facility effective communication, documentation, and aide in prevention of medication errors, medication orders should be clear and concise and free of potentially dangerous abbreviations. Procedures: A. Elements of a controlled substance prescription: 12) Manual signature of prescriber. C. The prescriber and/or nurse are contacted for direction when delivery of a medication will be delayed, or the medication is not or will not be available. E. New Controlled Substance Prescriptions: 1) For emergency-controlled substance orders, the nurse will review the Emergency Kit list for available medications prior to contacting the prescriber. The nurse will communicate to the prescriber the emergency medications available to provide appropriate care to the patient. 4) In order to communicate Controlled II orders orally/verbally between the prescriber and pharmacist, the prescription must meet DEA's (Drug Enforcement Administration) criteria of an "emergency situation." Conformance with such criteria must be discussed between the prescriber and pharmacist and documented on the prescription: a. Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user. b. No appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II; AND c. It Is not reasonably possible for the prescriber practitioner to provide written prescription to be present to the person dispensing the substance prior to dispensing. 4) Only after verifying that the above communication has occurred and the pharmacy and facility receive a complete prescription, the nurse reviews the Emergency Kit List to assess the contents. After finding the medication list, the nurse unlocks the container seal and removes the required medication if it is available in the emergency kit. If the medication is not available in the emergency kit, the nurse contacts the pharmacy using the afterhours emergency number(s) if necessary. (See IC5: Emergency Pharmacy Service and Emergency Kits)."<br><br>The United States Food and Drug Administration Safety Communication Website article dated 4-9-19 documents, | S9999 | | |

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| S9999 | Continued from page 11<br>"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 provide enough pain relief. Patients taking opioid pain medicines long-term should not suddenly stop taking your medicines without first discussing with hour health care professional a plan for how to slowly decrease the dose of the opioid and continue to manage your pain. Even when the opioid dose is decreased gradually, you may experience symptoms of withdrawal. Rapid discontinuation can result in uncontrolled pain or withdrawal symptoms. These include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide."<br><br>1. R2's Admission Care Plan dated 7/3/25 documents, "(R2) is at risk of complaints of chronic pain related to infection/inflammatory reaction due to internal fixation with removal of hardware and pressure ulcers. (R2) has narcotic and non-narcotic pain medications orders prn (as needed). Approach: Administer medications as per orders. Evaluate/record/report effectiveness and any adverse side effects."<br><br>R2's current Physician Order Report documents R2 was admitted on 6/30/25 with the diagnoses of a Pressure Ulcer of the right hip, Osteomyelitis, Pressure ulcer of the left hip, Pressure Ulcer of the right buttock, Contracture of Right Hip, Contracture of the right knee, Contracture of right lower leg muscle, Infection and inflammation reaction due to internal fixation device, and Anxiety Disorder. This same Physician Order Report documents, "Start Date 6/30/25 (Admission) Hydrocodone-Acetaminophen (Norco) 10-325 mg (milligrams) one tablet every eight hours as needed."<br><br>R2's Admission Physician's Orders dated 6/30/25 document, "Lorazepam 0.5 mg twice daily as needed for Anxiety."<br><br>R2's Pharmacy Packing Slip dated 7/7/25 documents R2's Lorazepam 0.5 mg 28 tablets was not delivered until 7/7/25 (seven days after R2 was admitted to the facility).<br><br>R2's Pharmacy Packing Slip dated 7/7/25 documents R2's Hydrocodone/Acetaminophen 10-325 mg 30 tablets was not delivered until 7/7/25 (seven days after R2 was admitted to the facility).<br><br>R2's Medication Administration Records (MARs) dated 6/30/25 through 7/7/25 document R2 did not receive any Norco as ordered during this timeframe. | S9999 | | |

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| S9999 | Continued from page 12<br><br>R2's Electronic Health Record does not include documentation of R2's Physician (V30) being notified of the need for a prescription to fill R2's Norco or R2's Lorazepam, or documentation of pain-relieving interventions utilized while R2 was not receiving his Norco as ordered from 6/30/25 through 7/7/25.<br><br>R2's Progress Notes dated 7/5/25 at 3:45 PM and signed by V28 (Agency RN/Registered Nurse) documents, "(R2) alert with confusion. Very confused on (R2's) whereabouts and day to day things. (R2) very restless at times. (R2) throws his legs and upper half of body out of the bed. Staff repositioned (R2) very frequently. (R2) is however contracted. (R2) has legs drawn up in a fetal position. (R2) frequently yells out for someone to "get the people out of there" while he points at his window. Will continue to monitor and follow current plan of care."<br><br>On 7/15/25 at 1:35 PM R2 was lying in a low bed with the head of the bed up 90 degrees. R2 had multiple bruises to the right lower arm and a four by four bandage to the right lower arm. R2 had pressure ulcers to the right and left hip and right buttock. R2's legs were drawn up into a fetal position. R2 had facial grimacing and when asked if R2 was in pain, R2 replied, "Yes."<br><br>On 7/16/25 at 9:50 AM V27 (CNA/Certified Nursing Assistant Manager) stated, "On 7/5/25 around 2:25 PM (V28/Agency RN/Registered Nurse) was working and told me (R2) seemed to be in pain and anxiety and had no medication. I called (V3/Prior Director of Nursing) and (V3) said she would take care of getting (R2's) pain medication."<br><br>On 7/16/25 at 1:00 PM V28 (Agency RN) stated, "I was working on 7/5/25 and it seemed throughout the shift that (R2) could not get comfortable. (R2) was seeing things and very fidgety and anxious. I looked at (R2s) MAR and noticed (R2) did not have Norco. I also did not have (R2's) Lorazepam to give (R2) to help with his restlessness. (V27) called (V3) and (V3) was supposed to take care of getting (R2's) Norco. (R2's) Norco never did come in that day."<br><br>On 7/18/25 at 11:10 AM V30 (R2's Physician) stated, "(R2) absolutely should not go without his Norco or Lorazepam. With all (R2's) illnesses and wounds, going without Norco would cause (R2) severe pain. There is no reason for any of my residents to be without their pain medications. The facility should have gotten ahold of me immediately to get (R2's) Norco ordered. I am always | S9999 | | |

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| S9999 | Continued from page 13<br>available by phone call and fax to get the prescription to pharmacy."<br><br>2. R14's MDS (Minimum Data Set) Assessment dated 5/13/25 documents R14 is cognitively intact.<br><br>R14's Nursing Home Visits dated 319/25 and 4/9/25 and signed by V30 (R14's Physician) document, "Chronic Pain: On Norco and Ibuprofen."<br><br>R14's current Care Plan documents, "Problem: Pain (R14) is at risk for chronic pain related to spinal stenosis. (R14) is no routine narcotic pain medication and PRN (as needed) non-narcotic medication for pain. 2/9/25 history of fracture o lumbar vertebrae. Goals: (R14) will verbalize reduction of pain. Approach: Administer medications as ordered. Monitor and record effectiveness. Report adverse side effects. Assess past effective and ineffective pain relief measures. Problem: (R14) has been asking for more pain medications, asking other nurses for pain \medications and telling other staff that (R14) did not get his pain medications. Approach: Nursing staff will give (R14) a sticky note of times he takes his schedules pain medications at the beginning of each shift."<br><br>R14's Physician's Order Report dated 6/15/25 through 7/15/25 document R14 has the diagnoses of Spinal Stenosis of the Lumbosacral Region and Low Back Pain. This same Physician's Order Report documents, "Start Date 10/16/23: Hydrocodone-Acetaminophen (Norco) 5-325 mg two tablets every six hour for low back pain. Start Date 9/1/23 Pain Scale/Evaluation every shift. Pain Scale 0-10. 0=No pain. 1=Mild Pain of uncomfortable/annoying. 4=Moderate Pain that is distressing/miserable. 10=Excruciating Pain that is the worst possible and interferes with the ability to carry on with daily routine, socialization, or sleep."<br><br>R14's MARs dated 5/1/25 through 7/15/25 documents R14 did not receive his schedule Norco 5-325 mg as ordered on 13 occasions due to the Norco being unavailable.<br><br>R14's MARs dated 5/1/25 through 7/15/25 document on 5/23/25 during the R14 was rating his back pain at a level "7" on a "0-10" pain scale. According to R14's MARs R14 did not receive his Norco 5-325 mg as ordered on 5/23/25 at 8:00 AM, 2:00 PM, or 8:00 PM and on 5/23/25 R14 was rating his back pain at a level "7" on a "0-10" scale.<br><br>R14's MARs dated 5/1/25 through 7/15/25 document on 6/15/25 during the entire day R14 was rating his back pain at a level "7" on a "0-10" pain scale and on | S9999 | | |

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| S9999 | Continued from page 14<br>6/16/25 during the night R14 was rating his back pain at a level “10” on a “0-10” pain scale. According to R14’s MARs R14 did not receive his Norco 5-325 mg as ordered on 6/15/25 at 8:00 PM or 6/16/25 at 2:00 AM.<br><br>R14’s Electronic Medical Record does not include any pain relieving interventions, physician’s notification, or comprehensive pain assessments after the 13 occasions between 5/1/25 through 7/15/25 when R14 did not receive his Norco as prescribed.<br><br>On 7/15/25 at 10:05 AM R14 was walking with a walker in the dining room. R14 stated, “The facility runs out of my Norco every month. I was an iron worker and hurt my back years ago. I have been on Norco for the pain in my lower back and was seeing a specialist for the pain. When I don’t get my scheduled Norco I have excruciating, stabbing pain to my lower back. I know when I don’t get the Norco because I start to have withdrawals and start feeling sick and jittery. The pain keeps me awake. I really wish the facility would get this fixed, so I do not have to go without the Norco.”<br><br>On 7/16 /25 at 10:30 AM V2 (Director of Nursing) stated, “(R14) did not get his Norco as ordered on 13 occasions between 5/1/25 through 7/15/25. (R14) has a lot of back pain and should not go without his scheduled Norco.”<br><br>On 7/16/25 at 1:20 PM V1 (Administrator-In-Training) stated, “I was made aware that (R14) was running out of his Norco frequently. I asked (V3/Prior Director of Nursing) sometime around April 10th to start doing narcotic medication audits on every Monday and Friday each week after I was made aware that narcotics were running out and residents were not getting their pain medications as ordered due to not getting renewal prescriptions in time. I wanted (V3) to make sure all residents were getting their narcotic medications as ordered. (V3) did not complete those audits as I instructed. I know (R14) needs his Norco for lower back pain and should not ever run out of Norco. If a resident does not have their narcotic the nurses should know the process and should call the physician immediately to get the prescription and call pharmacy to get a code to get the narcotic out of the facility’s back-up supply.”<br><br>On 7/16/25 at 2:00 PM V19 (Regional Nurse Consultant) stated, “(R14) has not had a comprehensive pain assessment completed since 5/13/25.” V19 verified (R14) should have had a comprehensive pain assessment completed anytime (R14) went without his ordered Norco | S9999 | | |

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| S9999 | Continued from page 15<br>and was experiencing pain.<br><br>On 7/18/25 at 11:00 AM V20 (R14's Family Member) stated, "I know agency nurses do not get (R14's) medication refills done on time. (R14) has always had chronic pain and was a construction worker and hurt his back by following out of a third-floor window of a building. (R14) has had multiple back surgeries. (R14) is usually out of his pain medications on the weekends and calls me when (R14) does not get his pain medication because he is having pain. If (R14) misses even one dose of Norco (R14) is in pain."<br><br>On 7/18/25 at 11:10 AM V30 (R14's Physician) stated, "(R14) should never have to go without his Norco. (R14) is dependent on the Norco and needs the Norco routinely to control his back pain. The facility should get ahold of me before (R14's) Norco runs out."<br><br>3. R18's MDS Assessment dated 5/6/25 documents R18 is cognitively intact.<br><br>R18's Physician's Progress Note dated 5/3/25 and signed by V5 (R18's Primary Physician) documents, "Chief complaint: (R18) is a 61-year-old who is trying to lose weight. (R18) wants to get stronger and hopefully go home. Hopefully will get (R18) started on an agent that will help (R18) lose some weight. Obesity."<br><br>R18's current Physician Order Report documents R18 has the diagnoses of Severe Morbid Obesity and Type II Diabetes Mellitus. This same Physician Order Report documents, "Start Date 6/16/25: Ozempic pen injector 0.25 mg subcutaneous once a day on Wednesdays."<br><br>R18's Medication Administration Record dated 6/16/25 through 716/25 documents R18 did not receive Ozempic 0.25 mg as ordered on Wednesdays dated 6/18/25, 6/25/25, 7/2/25, 7/9/25, and 7/16/25.<br><br>R18's Pharmacy Notice of Rejection dated 6/26/25 documents, "Ozempic 2mg/3 ml quantity 3 not covered. Reason for denial: (Insurance Plan) requires additional information from medical doctor. Alternative: Trulicity 0.74 m/0.5 ml subcutaneous once a week."<br><br>R18's Electronic Medical Record does not include notification or follow-up with the physician or pharmacy once insurance rejected to fill R18's Ozempic.<br><br>On 7/15/25 at 11:00 AM R18 was sitting outside in a wheelchair. R18 stated, "(V5/Physician) order me Ozempic so I can get my weight off and get my hip surgery. My insurance will not cover it. I really need | S9999 | | |

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| S9999 | Continued from page 16<br>it."<br><br>On 7/16/25 at 9:00 AM V2 (Director of Nursing) stated, "I was not aware that (R18) was not getting her ordered Ozempic."<br><br>On 7/16/25 at 11:12 AM V31 (V5's Registered Nurse) stated, "The nursing home has not called or followed up with (V5) to let us know (R18) was not getting Ozempic to get an alternative to (R18's) Ozempic or more information to get (R18's) Ozempic covered by insurance."<br><br>4. R22's current Pain Care Plan documents R22 has complaints of chronic pain due related to osteomyelitis, pressure ulcer to the right ischium, tear of the hamstring tendon, and peripheral vascular disease, and is receiving hospice services for pain control management. This same care plan documents R22's pain medications should be administered as ordered and R22 will verbalize reduction of pain and/or show no signs of non-verbal pain.<br><br>R22's current Physician Order Report documents R22 has the diagnoses of strain of muscle of the fascia and tendon of the posterior muscle group at right thigh level and malignant neoplasm of the large intestine and receives hospice services. This same Physician Order Report documents the following orders, "Start Date 6/10/25 pain scale/evaluation every shift. Start Date: 7/7/25 MS Contin (Morphine) tablet extended release 15 mg twice daily at 8:00 AM and 8:00 PM.<br><br>R22's Physician's Order dated 6/26/25 documents an order to increase R22's Hydrocodone/Acetaminophen from 5-325 mg every four hours to 10-325 mg every four hours and then discontinue on 7/7/25.<br><br>R22's Medication Administration Record dated 6/10/25 through 7/15/25 documents R22's MS Contin 15 mg was not received on 7/7/25 at 8:00 AM or 8:00 PM due to the medication being unavailable.<br><br>R22's Medication Administration Record dated 6/10/25 through 7/7/25 documents R22's Hydrocodone/Acetaminophen from 10-325 mg was not received as ordered on 15 occasions due to the Hydrocodone/Acetaminophen being unavailable.<br><br>R22's Electronic Medical Record documents R22's last Comprehensive Pain Assessment was completed 6/26/25.<br><br>On 7/17/25 at 1:00 PM V1 (Administrator-In-Training) verified R22 never received the | S9999 | | |

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| S9999 | Continued from page 17<br>Hydrocodone/Acetaminophen 10-325 mg as ordered due to the mediation not being delivered from the pharmacy. V1 also verified she was not aware of R22 not receiving the Hydrocodone/Acetaminophen 10-325 mg and should have been informed and the nurses should have notified the physician immediately to get a signed prescription and ensure the medication was received. V1 verified R22 did not receive the first two doses of MS Contin 15 mg due to the medication being unavailable.<br><br>On 7/18/25 at 10:30 AM V12 (Hospice RN/Registered Nurse) I was not aware that (R22) was not getting his Hydrocodone/Acetaminophen 10mg-325 mg as ordered or his MS Contin 15 mg for two doses. I made (R22's) Hydrocodone/Acetaminophen 10mg-325 mg scheduled around the clock due top (R22) having wound pain, back pain, arm pain, and leg pain. It is unacceptable for (R22) to go without pain medication and (V9/Hospice Physician) was not notified. (V9) should have been notified so me or (V9) could have reached out to the pharmacy to make sure (R22) was getting his medication or we would have ordered something else to control (R22's) pain until the Hydrocodone/Acetaminophen and MS Contin was received."<br><br>(B) | S9999 | | |