

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001061		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/27/2026	
NAME OF PROVIDER OR SUPPLIER Southgate Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST NINTH STREET PO BOX 843, METROPOLIS, Illinois, 62960			
(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) COMPLETION DATE	
S0000	Initial Comments		S0000			04/14/2026	
	Complaint Investigation:						
	2652921/2801209						
S9999	Final Observations		S9999			04/14/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1620e)						
	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						
	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						
	e) The resident's licensed prescriber shall be notified of medications about to be stopped so that the licensed prescriber may promptly renew such orders to avoid interruption of the resident's						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 therapeutic regimen. These Regulations are not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide effective pain management for 3 of 3 residents (R1, R2, and R3) reviewed for pain in a sample of 4. This failure resulted in R1, who has a diagnosis of Multiple Myeloma and at the end-of-life stage, not receiving an ordered narcotic pain medication for 6 hours and R1 experiencing intense pain and suffering prior to her death. Findings Include: 1.R1's Admission Record documents an admission date of 10/16/2025 and an admission date to hospice care on 2/27/2026 with diagnoses of Multiple Myeloma and Pulmonary Embolism. Other documented diagnoses include Asthma, Spinal Stenosis, Chronic Pain, Gastro-Esophageal Reflux Disease, Hyperlipidemia, Hypertension, Osteoporosis with pathological fractures, Acute Respiratory Failure, and Fibromyalgia. R1's Admission Record documents a date of discharge of 3/9/26. R1's Minimum Data Set (MDS) dated (2/27/2026) documents a Brief Interview for Mental Status (BIMS) score of 7, indicating R1 has moderate cognitive impairment. Section J- Health Conditions documents "no" for the following: Received scheduled pain medication regimen; received PRN (as needed) pain medications or was offered and declined; and received non-medication intervention for pain? Section N- Medications documents that R1 is taking an Opioid medication. Section O- Special Treatments, Procedures, and Programs documents that R1 is receiving hospice care. R1's Care Plan documents a "Focus" area of R1 has actual/potential for pain (date initiated 10/16/2025) with a "Goal" of R1 will report satisfactory pain control (date initiated 10/16/2025.) Documented interventions include evaluate for non-verbal indicators of pain, evaluate pain, evaluate the effectiveness of pain interventions every shift, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impacted on functional ability and impact on cognition, monitor for factors/activities that precipitate or aggravate pain, monitor/record pain characteristics every shift and as needed, monitor/report/record complaints of pain or request pain treatment, monitor/record/report signs and symptoms of nonverbal pain: changes in breathing,			S9999			04/14/2026

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S9999	Continued from page 2 vocalizations, and mood/behavior (date initiated 10/16/2025 and revision date of 2/25/2026.) R1's Physician's Orders documents the following orders for pain management: Fentanyl Patch 25MCG/HR every 72 hours with order date of 3/8/2026, Dilaudid oral liquid give 2 milliliters every 2 hours with order date of 3/6/2026, Hydrocodone 5/325mg every 12 hours as needed for breakthrough pain dated 2/2/2026. On 3/17/2026 at 12:34PM, V9 (Family Member) stated R1 was dying on 3/8/2026 and the facility could not get her medication Dilaudid in all that day and R1 suffered all day because she was out of her medications. V9 stated it was so bad and other family members were there like my aunt and R1's son. V9 stated R1 was in so much pain that she kept crawling out of the bed and we were having to hold her as best we could to keep her from falling out of the bed. V9 stated it was absolutely the worst thing I have ever seen. V9 stated we kept calling hospice ourselves to see when they could bring her medications and we kept getting told that they were on their way. This went on all day long. V9 stated this was all so bad and not only hard on R1, but it was also hard on the family to watch. On 3/17/2026 at 12:42PM, V11 (Family Member) stated she was with R1 a lot and was there on 3/8/2026 in the afternoon. V11 stated the staff said they thought they had more Dilaudid for R1, but they didn't. V11 stated she knows the hospice nurse called a local pharmacy, we waited and waited. V11 stated R1 was thrashing all over the bed, trying to get out of bed and she was not comfortable at all, and we could not make her comfortable. V11 stated R1's nurse, V14, was trying but she stated she worked for a different company and was just filling in there for the day. V11 stated R1 was dying, and she died roughly because she did not have her medications she needed, and nobody was doing anything for a long time. V11 stated even after the medications came that evening it took a long time to get R1 settled back down to rest and then she died later. On 3/17/2026 at 1:22PM, V10 (Family Member) stated he was there on 3/8/2026 as R1 was in the process of dying and other family members were present as well. V10 stated "it was so horrible, and I will never forget the suffering my mother had to endure because people did not do what they should and provide her with medication to relieve the pain." V10 stated we normally did not leave R1 alone because if she wouldn't ask for medications when R1 was in			S9999			04/14/2026

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S9999	Continued from page 3 pain then she would not have ever gotten any pain medications. V10 stated R1 had a pain pump with Dilaudid for 5 years due to back pain. V10 stated they had been cutting down the dose because they were substituting the Dilaudid with the liquid form because R1 was no longer going to be on the pump due to hospice providing the medications. V10 stated the pump was barely delivering any medication if any so that is why R1 needed the liquid Dilaudid by mouth. V10 stated when R1 died it was the worst thing to watch, and it was so bad that he would not let R1's grandchildren come and say their goodbyes because it would have been hard for them to see, and they would not understand. V10 stated the thrashing in the bed was so bad and R1 was so miserable. V10 stated this was no way to treat a human being and let them suffer like that. V10 stated the nurse on 3/8/2026 was V14 and she was trying her hardest to get the medication brought to the facility. V10 stated he even called local hospital emergency room to see if there was anything they could do to help R1 get some pain control. V10 stated he was told by the hospital that R1 could be sent to the emergency room, but they transferred the phone call to the hospice department, but nobody answered. V10 stated hospice came to the facility that morning and stated they were trying to figure out why the Dilaudid did not come in. V10 stated this was an experience that no resident or family should ever have to go through. V10 stated we did everything we knew to do and called hospice and even hospitals to try to get R1 some help but nothing helped. V10 stated finally in the evening the medicine came in and the nurse gave it to her. V10 stated it still took a few hours to get R1 settled down and then about midnight R1 passed away, she was just worn out from struggling all day long. V10 stated R1 should not have had to struggle like that while dying. On 3/19/2026 at 3:40PM, V20 (Hospice Registered Nurse) stated she was R1's hospice nurse for 3/7/2026 and 3/8/2026. V20 stated when she was in the facility to see R1 on 3/7/2026 she noted that R1's Dilaudid was almost empty and would not have enough available to make it through 3/8/2026. V20 stated she talked with the nurse and was told by the facility nurse if she got the orders to the facility's pharmacy by 3:00PM that the pharmacy would deliver the medication that evening. V20 stated "I sent the orders to the facility's pharmacy before noon and instructed the nurse that if the medication did not get delivered that evening to notify hospice immediately so they could get the medication from another pharmacy and get it to the facility in time for there to be no breaks in the medication's availability			S9999			04/14/2026

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S9999	Continued from page 4 for the resident." V20 stated she never received a call, so she assumed the medication had arrived as planned. V20 stated she was not made aware the medication did not get delivered until the medication was depleted. V20 stated she went to the facility as soon as she was notified and checked on R1 and at that time R1 was resting and had no signs of pain, but this was right after the 10:00AM dose of Dilaudid was given. V20 stated she instructed V14 to give R1 a dose of her Hydrocodone around 11:00AM to help with pain until she could get the medication (Dilaudid) in the facility. V20 stated it took a while to get the medications back in the facility and felt so bad for R1 and the family. V20 stated without R1 getting the Dilaudid it caused R1 to be in pain and uncomfortable. V20 stated she also told V14 to increase the Fentanyl Patch to 25mcg/hr (micrograms/hour) but was unsure if they had the 25mcg/hour in their emergency drug kit. V20 stated the family had called her that morning and was asking for an increase in R1's anxiety medications so she got the Ativan increased. V20 stated the family was also calling about the Dilaudid not being available. V20 stated it took a while to find a pharmacy open then I had to get a signed script from the doctor then I headed out of town to get the medication. V20 stated when I finally got to that pharmacy, the pharmacist was on lunch, so I had to wait for them to get back. V20 said once I finally got the meds I headed back to the facility, and we initiated a dose of the Dilaudid as soon as I got the medication checked in. V20 stated "it must have been a little after 3:00PM or so when I got the medication back to the facility." V20 stated the family was very upset and rightly so and V20 stated she apologized several times to the family, and she felt bad that this had happened. V20 stated she knew R1 had to be in pain and feeling discomfort without her pain medications. V20 stated R1 then started relaxing about 5:30ish and another dose was given at 6:00PM. V20 stated she knew R1 had a Dilaudid pump but the medication in the pump was being tapered down and was to be discontinued on 3/10/2026. V20 stated R1 passed away a little after midnight. On 3/26/26 at 6:20 PM, V23 (LPN) stated she worked on 3/7/26 on day shift. V23 stated that V20 came in on 3/7/26 between 12:45PM and 1:00PM and they checked R1's Dilaudid and there was 12-14mL remaining. V23 said that R1 was mottled and anxious so V20 increased R1's Dilaudid to 2mL every 2 hours. V23 said that V20 thought R1 would expire before her Dilaudid ran out but ordered more to be safe. V23 said she called the pharmacy and they stated as long as they had the script for the			S9999			04/14/2026

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S9999	Continued from page 5 Dilaudid by 3:00PM, it would be delivered with that days shipment. V23 sometimes their medication deliveries do not arrive until midnight or 1:00 am. V23 said during shift report, she told the night shift nurse to notify hospice if R1's Dilaudid was not delivered. V23 said she could not recall the nurse's name that she reported it to but is was a nurse from the staffing agency. On 3/26/26 at 7:08PM, V24 (Agency Licensed Practical Nurse) said that she worked the night shift on 3/7/26. V24 stated that she does not recall being told in report to notify hospice if R1's Dilaudid was not delivered. V24 said that if she would have known that, she would have notified hospice because pain medication is important for hospice patients. On 3/18/2026 at 1:37PM, V14 (Licensed Practical Nurse/LPN) stated she was the nurse in charge of R1 on 3/8/2026. V14 stated that she gave R1 what was left of her Dilaudid for 10:00AM on 3/8/2026 and sated it was "probably not a full dose at all." V14 stated R1's Dilaudid 2 milliliters (ml) was ordered every 2 hours routinely. V14 stated she searched for another bottle of Dilaudid but there was none. V14 stated she was in contact with hospice requesting Dilaudid be delivered to the facility. V14 said hospice had told her they would see why R1 was out of Dilaudid and get her some to the facility. V14 stated the hospice nurse came to the facility and saw R1 and then started working on finding a pharmacy available to fill the prescription of Dilaudid. V14 stated V20 (Hospice Registered Nurse) stated she would have to run to an out-of-town pharmacy to get the medication due to the Pharmacy in town being closed. V14 stated this was right around 10:00AM on 3/8/26. V14 stated she kept waiting on V20 to bring the medication, but it was taking a long time. V14 stated while they were waiting, she felt so bad for R1 because she was throwing her legs out of the bed and trying to get out of bed. V14 stated the family was at bedside and were really upset at the lack of pain control for their loved one. V14 stated she works through an agency so she is not in the facility too often but was unsure how the resident's medications could just run out without being refilled in a timely manner. V14 stated she spoke to a nurse manager at one point for direction, but she wasn't sure who it was and no solution to the problem was given. V14 stated she even gave R1 a pain pill (Hydrocodone-Acetaminophen 5/325 milligrams) that was ordered every 12 hours but that did not offer hardly any pain relief and only settled R1 for a very short time. V14 stated she felt so bad for R1 as she was so uncomfortable and agitated due to pain. V14	S9999				04/14/2026	

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S9999	Continued from page 6 stated she really thought about just calling an ambulance to send R1 out to the nearest emergency room for some pain relief but R1 was in such pain. V14 felt it would make R1's pain even worse and R1 would not tolerate the move very well, so V14 stated she just kept waiting and hoping the medication would be delivered soon. V14 said that finally 6 hours later, V20 walked through the door, and it was around 4:00PM and V14 stated, "I grabbed the medicine and ran to (R1's) room and administered her dose of Dilaudid." V14 stated it still took an hour and a half to two hours to get R1 settled down and rest a little bit. V14 stated she kept thinking that if this would have been one of her loved ones that she would have been having a fit and this was hard on the family as well. V14 stated R1 was receiving Ativan as ordered every 2 hours but was not making a difference with the agitation and pain. On 3/19/2026 at 2:03PM, V16 (Licensed Practical Nurse/LPN) stated she was working on 3/8/2026. V16 stated V14 came to her and asked what she should do with R1 being out of medications and did not have another dose to give. V16 stated this was right after the last dose was given around 10:00 AM. V16 stated she went to V14's hall and looked at the narcotic book to check on the Dilaudid and she asked her if hospice ordered the medication, and if she had checked out allergies to see if R1 could get Morphine, but R1 had Morphine as an allergy. V16 stated we were at a standstill. V16 stated this was after the 10AM dose so R1 was resting and curled up on her side. V16 stated V20 (Hospice Registered Nurse) came in and checked R1 and started messaging the hospice physician and trying to find a pharmacy that was open. V20 reported that she had to go to an out-of-town pharmacy to get medication. V16 stated it took V20 a little while to find a pharmacy that was open. V16 stated they went ahead and gave R1 a Hydrocodone to help with her pain. V16 stated the facility's pharmacy does not make deliveries on Sundays. V16 stated there was an order put in at some point that day for an increase in Fentanyl 25mcg, so they checked the e kit and there was a Fentanyl patch, so they put it on R1 but was not sure of the time frame. V16 stated hospice usually does a narcotic check on their patients when they are in the facility but was unsure how this one got missed. On 3/19/2026 at 2:19 PM, V18 (Certified Nurse Assistant/CNA) stated she was working on 3/8/2026 and helped care for R1. V18 stated R1 was hurting, tired and not doing her best. V18 stated R1's family was at her bedside. V18 stated when she went in the family was complaining that R1 was in pain. V18			S9999			04/14/2026

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S9999	Continued from page 7 stated the family stated they thought R1 was nauseated too. V18 stated the family told her they had asked for pain medication but could not get it but she didn't know why. V18 stated R1 was grimacing and restless at different times throughout the day on 3/8/2026. On 3/19/2026 at 3:22PM, V19 (CNA) stated she took care of R1 on 3/8/2026 and R1 was not doing great, and she would not eat anything. V19 stated she went in and checked R1 every 2 hours. V19 stated she knows R1 just kept scooting herself around the bed and R1 seemed weak and in pain. V19 stated the family kept asking for pain medications for R1. R1's Hospice Visit Note dated 3/7/26 authored by V20 documents "...Dilaudid ordered from (name of pharmacy). Requested that saff call hospice if it is not delivered so other arrangements could be made to refill Rx (prescription)" R1's Hospice Discharge-Transfer Summary Report dated 3/9/26 documents that R1's date and of death as 3/9/26 at 1:45 AM. This same report documents that R1 had an intrathecal pump (surgically implanted device delivering medications to the spinal fluid) delivering Dilaudid 0.25 mg daily, in addition to the Dilaudid 1mg/mL oral liquid dose of 2mL every 2 hours. The last decrease adjustment to the intrathecal pump is documented as being completed on 3/2/26 at (name of clinic) and was due for another adjustment 3/9/26. R1's Progress Notes dated 3/8/2026 document the following: 9:15AM- documents Dilaudid Oral Liquid 1 mg/ml: give 2 ml by mouth every 2 hours for Pain/Shortness of Breath. Last dose in bottle administered, hospice notified. Authored by V14. 9:20 AM- Hospice notified of medication needing refilled, family also requesting Ativan increased from every 4 hours to every to every 2 hours, relayed message to hospice, awaiting response. 11:56 AM- Give 2 ml by mouth every 2 hours for pain/shortness of breath, out of medication, hospice notified and is obtaining medicine from pharmacy. 1:34PM- hospice on way with medication. 3:20PM- New order received from hospice to change fentanyl patches to 25mcg/hr. Will have to pull patches from emergency kit and call for code before pulling from kit until arrival from pharmacy. Remove			S9999			04/14/2026

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S9999	Continued from page 8 both patches AM of 3/9/2026 and apply 25mcg/hr patch from emergency kit. Continue order of Ativan and Dilaudid every 2 hours. If resident is still not comfortable at 9:00PM this afternoon 3/8/2026 then call hospice again for increase in dosage of Dilaudid. 5:38PM- Fentanyl Patch 72 hours for pain Rotate site and remove per schedule patch already in place, to be removed in AM 3/9/2026 per hospice and apply 25mcg/hr patch from emergency kit. Authored by V14. R1's Progress Note dated 3/9/2026 at 12:30AM documents "Res has no breath or heart sounds detected, verified with another nurse. Hospice notified and will be coming into facility. Resident has family member present at bedside. Extended family have elected not to come in to visit resident before the funeral home arrives. (V13 Primary Physician) has been informed by this writer of resident status. (V2 Director of Nursing/DON) notified. CNA to complete postmortem care on residents. No further issues at this time. Authored by V22 (Licensed Practical Nurse/LPN.) R1's Narcotic count sheet for Dilaudid 1mg/ 1ml solutions documents on 3/8/2026, R1 received Dilaudid 2 milliliters as ordered at 8:00AM and 10:00AM and documents that 10:00AM was the last dose with V14's initials. R1's Medication Administration Record (MAR) dated 3/1/2026-3/31/2026 documents on 3/8/2026 at 10:00 AM R1 was administered Dilaudid 2mL as ordered with a pain level of "0" and V14's initials. R1's 12:00 PM and 2:00 PM dose on 3/8/26 documents an administration code of "9" and document a "X" for R1's pain level and V14's initials. The Chart Codes on the MAR documents that a "9" indicates "Other/ See Progress Notes Ineffective." The 4:00 PM dose on 3/8/26 of Dilaudid is documented as being administered by V14 and documents a pain level of "0." On 3/17/2026 at 2:00PM, V3 Assistant Director of Nursing (ADON) was asked if she was made aware of the situation on 3/8/2026 and V3 stated she was not made aware of the situation of the Dilaudid on 3/8/2026. V3 was asked if the nurse could have sent the resident to the emergency room to get some pain control and V3 stated "(R1) was hospice and if she had gotten sent out, (R1) would have lost her services from hospice." V3 stated we generally do not send hospice patients to the hospital because they are under the care of hospice. V3 stated she			S9999			04/14/2026

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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) COMPLETION DATE
S9999	Continued from page 9 was not on call that weekend so she will have to look into this issue. V3 said pain assessments are documented on the MAR and are done every shift or three times a day. On 3/18/2026 at 9:30AM, V13 (R1's primary physician/medical director) was asked if he was notified on 3/8/2026 of R1 being out of her Dilaudid medication and having increased pain. V13 checked his phone and his computer and stated, "no, I was not notified and was not aware of that occurrence at all." V13 stated the notification I do have is that R1 expired on 3/9/2026. The facility policy titled "Pain Assessment and Management" dated October 2022 documents the purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain. "Recognizing Pain" 2. Possible Behavioral Signs of Pain, include negative verbalizations and vocalizations such as groaning, crying, screaming; facial expressions such as grimacing, frowning, clenching of the jaw, set., behaviors such as resisting care, distressed pacing, irritability, depressed mood, participation in usual physical and/or social activities, guarding, rubbing or favoring a particular body part. 5. Review the medication administration record to determine how often the individual request and receives PRN (as needed) pain medication, and to what extent he administered medications relieve the resident's pain. A "Pharmaceutical Service Agreement" dated 2/10/2025, documents under section "Pharmacy Supplies and Services" C. Pharmacy agrees to deliver to Facility once daily, six days a week, Monday through Saturday, and any emergency deliveries 24 hours a day seven days per week; except for circumstances and conditions beyond its control, which shall expressly include, but not limited to, out-of-stock situations, to which Facility will notify. 2. R2's Admission Record documents an admission date of 2/26/2022 and includes diagnoses of Multiple Sclerosis, Local Infections of the skin and subcutaneous tissue, Type 2 Diabetes Mellitus, Paralytic Syndrome following Cerebrovascular Disease, Convulsions, Major Depressive Disorder, and Dysphagia. R2's MDS dated 2/27/2026 documents a BIMS score of 12 indicating R2 has moderate cognitive impairment. Section J- Medical Conditions			S9999			04/14/2026

Illinois Department of Public Health

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S9999	Continued from page 10 documents that R2 receives a scheduled pain medication regimen. Section N- Medications documents that R2 receives an opioid medication. R2's Care Plan documents R2 has potential for pain and discomfort and pain to bilateral feet/toes related to contractures dated 9/9/2025. Documented interventions include administering medications as ordered dated 12/11/2025, anticipating the resident's need for pain relief and responding immediately to any complaint of pain, monitor/record/report to nurse any signs or symptoms of nonverbal pain, monitor record and report to nurse resident complaints of pain, turn and reposition every 2 hours to help alleviate pain dated 12/11/2025. On 3/17/2026 at 9:58AM, R2 was observed sitting in bed. R2 stated he is on Hospice care. R2 was asked if he has pain and R2 stated yes. R2 stated they will give me a pain pill when I ask for it, and sometimes I forget to ask then my pain gets really bad. R2 was asked if the staff usually ask him if he is in pain and R2 stated "no, I don't remember them asking me and I have to ask them." On 3/17/2026 at 10:05AM, V8 (Registered Nurse/treatment nurse) came into R2's room and stated she would be changing out R2's dressing during his bath. R2 was complaining of pain during care. On 3/18/2026 at 12:29PM, V4 (Hospice Certified Nursing Assistant) stated she always asks R2 about his pain and he always states that he is in pain, and he said she is the only one that ever asks him about his pain. R2's MAR dated 3/1/2026-3/31/2026 documents R2 receives Norco Oral Tablet 10/325mg, give 1 tablet by mouth three times a day for pain. Scheduled times of medication are 6:00AM, 2:00PM, and 10:00PM. Pain level for these doses for March 1st through March 17th show "0" for pain level throughout the entire days documented. R2 has an order for Dilaudid Oral Liquid 1mg/ml, give 2 ml by mouth every 3 hours as needed for moderate to severe pain, dyspnea dated 10/16/2024. R2's MAR documents no dosages were administered for the dates of 3/1/2026-3/17/2026. 3. R3's Admission Record documents R3 was admitted to the facility on 5/7/2024 and was admitted to hospice care on 7/26/2025 with diagnoses of Parkinson's Disease, Dementia Severe, Palliative Care, Heart Failure, Major Depressive			S9999			04/14/2026

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S9999	Continued from page 11 Disorder, Anxiety Disorder, and Adult Failure to Thrive. R3's MDS dated 1/30/2026 documents a BIMS score of 3 indicating R4 has severe cognitive impairment. Section J-Health Conditions documents that R3 receives PRN (as needed pain medication or was offered and declined. Section N- Medications documents that R3 is taking opioid medications. R3s undated Care Plan documents R3 has the potential for pain and discomfort related to Parkinson's Disease and Diabetes with interventions of: Monitor/record/ pain characteristics every shift and as needed; monitor/report/record to nurse residents' complaints of pain or request for pain treatment; notify the physician of interventions are unsuccessful or if current complaints is significant change from residents past experience from pain; nursing to administer medications as ordered; observe/record/report to nurse any signs or symptoms of non-verbal pain changes in breathing, vocalization, facial expression (sad, crying, worried, scared, clinching teeth and grimacing). R3's MAR dated 3/1/26 to 3/31/26 documents an order for Hydromophone HCL 1mg/ml every 4 hours as needed with no doses recorded for the month of March 2026. R3's MAR also has order for Oxycodone HCL 10mg four times a day for pain every 6 hours with start date of 10/26/2024. R3's MAR dated 3/1/2026-3/31/2026 documents Pain assessments every shift for days, evenings, and night shift with documentation of pain scale at "0" for all three shifts from 3/1/2026-3/17/2026 dayshift. On 3/18/26 at 12:29 PM, V4 stated R3 has complaints of pain at times with her and she always has to go tell the nurses. On 3/17/2026 at 11:37AM, R3 was sitting in a geri chair outside of his room. R3 was observed with flinching in his legs and was grimacing and gritting his teeth. R3 was noted to be trying to adjust both feet. R3 was unable to answer any questions at this time. (B)	S9999				04/14/2026	