Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008163	A. BUILDING: ______ B. WING ______	C 10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF ZION	3615 16TH STREET ZION, IL 60099

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S 000	Initial Comments Complaint Investigations: 2318520/IL165438	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.610a) 300.1210b) 300.3240a) 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.	S9999	**Attachment A** Statement of Licensure Violations	

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations are not met as evidenced by:

Based on interview and record review the facility failed to ensure residents were free from physical and verbal abuse. This failure resulted in R3 and R5 suffering mental anguish and psychosocial harm. This applies to 2 of 8 residents (R3, R5) reviewed for abuse in the sample of 13.

The findings include:

R3's face sheet shows she has diagnoses including anxiety disorder, heart failure, and lack of coordination. R3's cognition care plan initiated on 9/12/23 shows she is cognitively intact, has no apparent memory loss and is oriented. R3's care plan also shows she is able to recall and retain information such as events, directions, time and place of situations. R3's activity of daily living/ADL care plan initiated on 6/12/23 shows she has impaired balance and weakness and requires staff assistance with ADL's.

On 10/16/23 at 9:40 AM, R3 said I have been in bed for a couple weeks following an incident where a CNA (Certified Nursing Assistant) who works for an agency was very rough with me. The CNA was very angry and mean spirited and when she was taking me to the bathroom, she ran my knee into the side of the door frame to the bathroom. After the CNA toileted me she then "threw me into bed" and I was crying out in pain. R3 said her roommate (R5) witnessed the whole

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S9999	Continued From page 2 incident and yelled at the CNA to "Stop hurting {R3}" and at that point the CNA then yelled out to shut up and mind your own damn business. She said she contacted her son the following morning and reported the incident, and she was so scared and fearful because of how angry the CNA's demeanor was. She also stated, "I have also lost quality of life" being in bed since this incident because my knee has been hurting. On 10/17/23 at 10:55 AM, this surveyor verified the date with R3, and she said there was only one incident with this CNA, but she could not believe it had been a month ago already. On 10/16/23 at 9:52 AM, R5 said she witnessed the CNA ram (R3) into the door frame by the bathroom. She said R3 cried out in pain and then the CNA also "threw" R3 into bed and again she cried out in pain. R5 said she yelled at the CNA to "stop hurting (R3) and at that point the CNA yelled at me to "shut the hell up or we will see what will happen to you." R5 said she cannot recall exactly what date this happened. She said she was so scared she literally laid in bed and prayed that someone would come and help them. R5's 9/27/23 facility assessment shows her cognition is intact. A facility reported State of Illinois Serious Injury Incident and Communicable Disease Report form shows on 9/17/23 R3's son (V11) reported an incident that occurred on 9/16/23 where R3 received poor care from a CNA who was determined to be V25 (Agency CNA). The investigation file provided by V1 (Administrator) shows when R5 was interviewed she confirmed that she saw R3 being slammed against the door by V25. It also shows that she was told to "shut the hell up." R3's interview by V1 shows she said	S9999		

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she was thrown in bed by the CNA, and she was mean and rude. R3 said she was run into the side of the door by the CNA. The investigation refers to R3 as being very scared and wanted her son to come sit with her.

On 10/16/23 at 10:25 AM, V17 (R3's physician) said he was not aware of the abuse incident involving R3, but the facility may have notified her Nurse Practitioner about it. He said R3 did report pain in her left knee, and it has been swollen.

On 10/16/23 at 12:50 PM, V11 (R3's son) said his mom called him very upset about an incident where a CNA was rough with her. He said he came into the facility that day and spoke with his mom and R5. R5 had the same story about R3 being thrown into bed by the CNA and being told to shut up and mind her own damn business. V11 said he immediately told the nurse about the incident. V11 said R3 did ask him to come because she was fearful.

On 10/16/23 at 11:30 AM, V1 (Administrator) said she investigated the abuse incident involving R3 and substantiated verbal abuse but not physical because. No injury or bruises were found on R3. She said the CNA (V25) was from an agency and was put on the do not return list. V1 did say that R3 and R5 both told her that R3 was bumped into the doorway and thrown into bed by V25.

On 10/16/23 at 2:15 PM, V10 (Hospice Nurse) said R3 did tell her a CNA was rough with her during cares that "during the transfer her leg was bumped."

On 10/17/23 at 9:42 PM, V21 (Licensed Practical Nurse/LPN) said he was the one who got the report of R3's abuse incident. He said R3

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confirmed that the CNA was rude, but he thought she told him her arm was bumped during the transfer. He said he checked her and did not note any injuries.

On 10/17/23 at 10:06 AM, V18 (Nurse Practitioner/NP) said she was informed that R3 was being taken to the washroom and a CNA banged her left knee. She said R3 did report the CNA was rough with her.

On 10/18/23 at 11:45 AM, V18 (NP) said I have serious concerns about this incident and the CNA. What if she did this to patients who were non-verbal.

Progress notes in R3's electronic medical record show the following:
9/17/23 completed by V21 (LPN) at 3:53 PM, "Got a call from patient son, (V11) complaining of (R3) being treated roughly by V25."
9/24/23 2:17 PM nursing note- "resident (R3) complained of left knee pain."
9/27/23 2:33 PM, physician note completed by V18, says R3 complained of left knee pain from an injury sustained "during a transfer."

R3's progress notes document the pain to her left knee and referring it to an injury "during a transfer" continuing on the following dates: 10/2/23, 10/11/23, 10/16/23 and again on 10/17/23.

The facility provided Abuse, Neglect and Exploitation policy revised 2/23 says all residents have the right to be free from abuse. The policy describes abuse as the infliction of injury, unreasonable confinement, intimidation and punishment with physical harm, pain or mental anguish.

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(B)

Statement of Licensure Violations 2 of 2:
300.610a)
300.1210b)
300.1210d)6)

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.

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:

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S9999	Continued From page 6 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the safety of a resident (R1), with left sided weakness, by not providing a wheelchair that was measured and properly fit. The facility failed to ensure fall interventions were implemented for a resident (R4) with history of falls for 2 of 7 residents (R1, R4) reviewed for falls in the sample of 13. This failure resulted in R1 falling from her wheelchair and sustaining a left hip fracture. The findings include: 1. The facility's Serious Injury Incident Report dated 10/4/23 shows "Upon entering the R1's room, R1 was observed lying on her left side between the bed and the north wall. Resident reported pain to left hip 10/10. Resident was transferred to Hospital. Resident sustained a non-displaced left intertrochanteric fracture (hip). " R1's Hospital Papers dated 10/4/23 shows "R1 is a 95-year-old with medical history of left hemiparesis from prior stroke and frequent falls presenting to the emergency room for evaluation of a fall. Patient reports she was sitting in her chair today when she went to reach for something causing her to fall off her chair and onto her left	S9999		

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side. Reports pain primarily to the left thigh. Reports she recalls the entire event. X-ray of left hips shows left nondisplaced left intertrochanteric fracture. Power of Attorney reports R1 does not want surgical repair and plan for comfort measures."

R1's Post Fall Evaluation dated 10/4/23 shows "resident current medical condition contributing to the fall: left side paralysis from old CVA (cerebral vascular accident), resident did not have wheelchair locked, resident wearing socks (not non-skid) when reaching for something in her bureau, no footrests were in the way, and no safety evaluation or teaching was completed/documented prior to the fall. R1's weight 118.4"

On 10/17/23 at 11:01 AM, V4 Registered Nurse said R1 had complaints about her wheelchair just not being comfortable. V4 said she inquired to management about why R1's wheelchair was changed but never got an answer. V4 said R1 went to management, and they did swap out R1's wheelchair but R1 was still not really happy with it. V4 said R1 was very alert and oriented and described her as "a very spry lady." V4 said she was working when R1 fell, and she heard R1 calling for help and when she entered the room R1 was on the floor on her left side. V4 said R1 told her she leaned forward reaching for something in a bottom drawer and fell. V4 said R1 could not bear weight on her left leg and did not have footrests on the wheelchair at the time of the fall.

On 10/17/23 at 12:26 PM, V29 Certified Nursing Assistant (CNA) said R1 had been complaining to her that the wheelchair doesn't fit her, it was wider than her hips. V29 said when R1 fell she

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stated "I told you it's the wheelchair. I kept asking to change the wheelchair, it's not right."

On 10/17/23 at 12:34 PM, V30 CNA said when R1 fell, and she came to the room to help. V30 said R1 was saying "the chair is all wrong, it's too big for me. I told everyone the chair is going to cause me to fall." V30 said R1 told the nurse she was reaching for something in the bottom drawer and slipped. V30 said there were no legs rests on R1's wheelchair.

R1's Statement of Incident by V32 previous DON (director of nursing) dated 10/10/5/23 shows "resident alert and oriented and able to make her needs known at time of interview. Resident states she doesn't know why she fell today because she never had any issues with her old wheelchair. Resident became visibly upset at this time further mentioning that she never had a problem putting things into her drawer or getting things from different areas of her room. Resident began verbalizing concerns about her old wheelchair and how it was better for her than her current wheelchair. Historically the resident had been in the original wheelchair beginning 6/20/18. On 7/18/18 the chair was swapped out for a larger size from 16" to 18". On 3/28/23 another swap was completed from an 18' to a 20" by restorative nurse at that time. On 5/24/23 restorative nurse ordered resident a new wheelchair. On 8/21/23 Quality Improvement form was received for resident complaints of wheelchair not being comfortable. Resolution: new in-house wheelchair offered; resident accepted. On 9/1/23 staff reported resident wanted the original wheelchair back and not the one that was supplemented in house."

R1's Grievance Improvement Form dated 8/21/23

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S9999	Continued From page 9 shows "new wheelchair is not comfortable." The same form shows the resolution was a new wheelchair was provided. R1's Progress Notes dated 8/31/23 shows "resident offered new wheelchair and accepted. R1's Progress Note dated 9/1/23 shows" resident decided to go with the original wheelchair and did not want the new chair being offered." R1's Physician Orders dated 9/15/23 shows R1 has diagnoses of cerebral infarction, weakness, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, and history of falling and an order "Evaluate for wheelchair. Resident requires a wheelchair with leg support since left sided weakness and not able to move left lower leg and protect during ambulation." On 10/16/23 at 1:15 PM, V2 Director of Nursing (DON) said when she received R1's grievance about the wheelchair and she asked R1 what was wrong with her wheelchair. V2 said she learned that when the facility changed ownership, their medical supply company changed and so R1 received a wheelchair from the new company (V2 showed purchase order from supplier of 20-inch wheelchair) V2 stated "from my understanding, R1's new wheelchair was identical to the old one and it was in R1's mind that is was different." V2 said she did have maintenance bring R1 another wheelchair (from the basement) that was the same size but R1 decided she didn't like that one and wanted to go back to the other one. V2 said R1 complained that she wanted to be lower to the floor so her feet didn't dangle so she could propel in her room better. V2 said R1's new wheelchair was not measured or fit it was just replaced with the same size as her previous one. V2 said R1's	S9999		

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original wheelchair was measured by the previous Restorative Nurse. V2 said now moving forward therapy will measure and fit wheelchairs.

On 10/16/23 at 1:42 PM, V7 Therapy Director said if a wheelchair is too big for a resident and/or the resident's legs dangle, it could cause a fall if the resident leans forward and they can't put their legs down to steady themselves. V7 said his department had not measured R1's wheelchair.

On 10/17/23 at 10:45 AM, V7 said he was not aware of any physician order for R1 for wheelchair measurements. V7 said wheelchairs are ordered based on the width of the seat of the wheelchair and then the wheelchair is further adjusted for each resident. V7 said R1 was measured and fit for her wheelchair by the previous Restorative Nurse. V7 said R1 was not strong enough in her legs to stabilize herself if she leaned forward in the wheelchair due to left sided weakness from a cerebral vascular accident. V7 said if a wheelchair seat is too big, the resident can slip to the side in the seat and lose stability as well.

On 10/17/23 at 11:30 AM, V7 said physical therapy did do an evaluation on 9/18/23 and R1 was not appropriate for further physical therapy. V7 said there were no measurements or fittings done by the therapy department for R1's wheelchair at that time. V7 said when a wheelchair is "measured or fit" in addition to the width of the seat, the back of the wheelchair is looked at to determine if a high back or low back chair is needed, you assess if the seat is too wide and the resident slides side to side in the chair, the seat height is assessed to make sure feet can touch the floor for stability, arm rests are adjusted, and the need for foot rests for leg

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impairment is assessed. V7 said these assessments are all resident specific to make sure the resident is in the best fit for comfort and safety.

On 10/16/23 at 3:08 PM, V8 Nurse Practitioner said she had concerns regarding R1's fall from her wheelchair related to R1's complaints about the wheelchair being too big. V8 said she put orders in for R1 for a Physical Therapy Evaluation and Treatment and wheelchair assessment due to R1's complaints of her wheelchair not fitting (being too big). V8 said she was not sure if this was done or not, but it could have contributed to R1 falling out of the wheelchair. V8 said R1 fell out of her wheelchair, sustained a hip fracture, and went on hospice.

On 10/18/23 at 11:25 AM, V24 Regional Consultant said they were unable to locate an admission fall risk assessment on R1.

R1's Care Plan shows R1 had a cerebral infarction affecting left side, had activities of daily living deficits, and limited physical mobility related to hemiplegia and left sided weakness. This same Care Plan does not address R1's risk for falls until after R1's fall on 10/4/23.

R1's Progress Note dated 10/4/23 shows R1 returned to the facility from the hospital with order for palliative care and complete bed rest.

R1's Progress Noted dated 10/14/23 shows R1 expired.

2. On 10/16/23 at 9:27 AM, R4 was in bed sleeping. R4's call light was clipped to the quarter side rail with the touch pad at the end of the cord tucked down between the mattress and the rail.

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R4's wheelchair was at the foot of the bed. R4's bedside table with food and personal items was approximately 3 feet away from R4's bed (not within reach).

On 10/16/23 at 9:30 AM, V4 Registered Nurse said R4 is a fall risk and has had several falls from trying to get up by herself.

On 10/16/23 at 10:28 AM, V5 Certified Nursing Assistant said R4 is a fall risk and has sight impairment and at times some confusion. V5 said R4 should have a clip alarm on her wheelchair but was not sure about fall interventions when in bed.

On 10/16/23 at 10:38 AM, V2 Director of Nursing (DON) said when a resident falls and investigation is done to determine root cause. V2 said a fall risk assessment is done as part of the investigation and new interventions are determined. V2 said fall interventions should be updated with each fall and the resident's Care Plan is updated. V2 said the previous DON investigated R4's falls and should have put interventions in place.

On 10/16/23 at 11:35 AM, V1 Administrator said she recalls that R4 was a fall risk and R4's falls were discussed in the morning meetings, but she could not recall what fall interventions were put in place.

R4's most recent Care Plan shows "R4 had a fall on 3/29/23 while attempting to move furniture in her room. Another fall on 5/1/23 while ambulating unassisted to open the door to let someone in. R4 is at risk for falls due to impaired vision (legally blind), unsteady gait, and generalized muscle weakness. Fall interventions are staff

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rearranged furniture to accommodate resident's preference. Keep call light within reach at all times. Requires for call for assistance when needed. (Date initiated 3/29/23)." No other interventions were added after 5/1/23 fall. The same Care Plan shows "Risk for falls. If resident is a fall risk, initiate fall risk precautions. Resident had a fall occurrence on 6/23/23." No interventions were added after 6/23/23 or 8/29/23 falls.

R4's Progress Notes on 8/29/23 shows R4 had a fall at 12:00 AM from her wheelchair while in the dining room and then another falls later that same day in her room.

The facility's Fall Prevention Program Policy dated 2022 shows "each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. High risk Protocols: The resident will be placed on the facility's Fall Prevention Program-Implement interventions. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care: interventions will be monitored for effectiveness and the plan of care will be revised as needed."

(No Violation)

Statement of Licensure Violations 3 of 3:
300.610a)
300.1010h)
300.1210b)
300.1210d)1)
300.1630e)

Section 300.610 Resident Care Policies

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S9999	Continued From page 14 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, 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.	S9999		

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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 300.1630 Administration of Medication

e) Medication errors and drug reactions shall be immediately reported to the residents physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall be described in an incident report.

These Regulations are not met as evidenced by:

Based on interview and record review the facility failed to clarify a resident's pain management orders with the primary care physician prior to administering additional opiate pain medications and failed to discontinue a resident's pain patch. These failures resulted in R2 experiencing a mental status change, lethargy, and required emergent hospitalization for suspected opiate overdose. This applies to 1 of 6 residents (R2) reviewed for pain management in the sample of 13.

The findings include:

R2's face sheet shows she was an 88-year-old female admitted to the facility on 6/20/23 with

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diagnoses including: low back pain, and a fracture in her spine. R2's electronic medical record (EMR) shows she was discharged from the facility to an inpatient hospice center on 9/8/23. R2's EMR shows her weight on 8/3/23 was 110 lbs.

R2's nursing progress notes show she went for an appointment with an outside provider V28 (consulting physician) on 8/10/23. A plan of service report for R2 completed by V28 on 8/10/23 shows his plan was to discontinue R2's scheduled Norco (pain medication) and add on Morphine 15 mg. every 6 hrs. and Voltaren 75 mg. (anti-inflammatory medication) every 12 hours. There is no mention in V28's report of being aware R2 was also receiving a Fentanyl (opiate pain medication) patch.

R2's physician order summary shows the Morphine order was entered into the system using V19 (R2's primary care physician) as the prescribing doctor (not V28 the actual prescribing physician) and the medication began on 8/11/23. R2's nursing progress notes have no documentation that V19 was contacted prior to the facility starting the Morphine on 8/11/23.

R2's Medication Administration Record (MAR) shows she received the following pain medications between 8/11/23 and 8/14/23 Fentanyl pain patch change every 3 days, 7 doses of diclofenac (generic for Voltaren), 4 lidocaine patches on in am and off in pm, and 11 doses of Morphine sulfate 15 mg.

R2's nursing progress note completed by V31 (Nurse Practitioner) on 8/14/23 at 4:20 PM, states. " Patient seen this morning for a rehab follow-up in her room laying in bed, daughter and

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son in law are at bedside visiting and are concerned she is lethargic and not very interactive and asking about her pain medication regimen. They mention she saw a back doctor last week who ordered Morphine and diclofenac. She is able to answer some of my questions but doesn't stay engaged and appears very lethargic. Discontinue Fentanyl patch, decrease MSO4 (Morphine) to 1/2 tablet every 8 hours due to lethargy."

R2's physician order note states, "Please take off Fentanyl patch today 8/14/23, pt (patient) is lethargic on current pain regimen."

An EMAR note signed by V23 (RN) on 8/14/23 at 9:13 PM, documents "unavailable" to remove the Fentanyl patch.

R2's nursing progress note completed by V20 on 8/15/23 states, "At 10:55 AM, resident noted very lethargic, confused. Seen by {V8 Nurse practitioner} at the same time. New order, send to local community hospital ER (emergency room) by 911. Resident sent to local community hospital ER at 11:07 AM via 911." A nursing progress note on 8/15/23 shows R2 was admitted to the hospital.

R2's records from a local community hospital show the following: A physician History and Physical note completed on 8/15/23 shows R2 was admitted through the emergency department and was found to have "Acute Encephalopathy-suspected incidental opioid overdose." The notes says that R2 was receiving large amounts of opiates at the skilled nursing facility and had both oral Morphine and Fentanyl patches applied.

A hospital consultation notes for R2 completed on

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8/16/23 states R2 had "Opioid overdose because of cognition Morphine and Fentanyl. She became agitated over the past 24 hours, for which she received Ativan." R2's hospital records show her pain medications were adjusted and she returned to the facility on 8/18/23.

A Medication Error Reported completed on 8/15/23 by V2 (Director of Nursing) shows that R2's Fentanyl patch was not removed until 8/15/23 and was supposed to be removed on 8/14/23.

On 10/16/23 at 11:36 AM, V2 said "(R2) was seen by an outside provider and was on multiple pain medications prescribed by two different providers. She started experiencing altered mental status and went to the hospital. She was alerted by (V8) Nurse Practitioner who discovered the Fentanyl patch that was supposed to be removed on 8/14/23 was not removed. When she asked the nurse (V23) why the patch was still on she told her she didn't see the patch.

On 10/17/23 at 12:13 PM, V2 said the nursing staff should have consulted with the R2's Primary Care Physician (V19) before starting the Morphine that was prescribed by V28. She said V8 was furious when she found out about the Morphine being started without consulting their office and (V19) first. V2 said she feels the Morphine was the cause for R2's altered mental status.

On 10/16/23 at 3:08 PM, V8 (Nurse Practitioner) said R2 was experiencing a lot of back pain from a fracture but she was not aware of R2 being prescribed the high doses of Morphine until V31 (Nurse Practitioner) called her and told her about it. She said no one contacted their office from the

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facility about the Morphine and they should have before they started it. V8 said they would not prescribe that high of a dose of Morphine on top of a Fentanyl patch because of the risk of overdose and death could occur from Opiate overdose. V8 said when she saw R2 on 8/15/23 she was very lethargic, and she suspected a Opiate overdose as the cause and she also discovered the Fentanyl patch was still on her. She had the facility call 911 and sent her to the Emergency Room.

On 10/17/23 at 9:35 AM, V19 R2's (Primary Care Physician) said he was not contacted by the facility about the Morphine orders. He said the facility should have called me prior to starting the medication because she was already on a Fentanyl pain patch, and I am not sure if the consulting physician (V28) knew that. V19 said he wasn't aware that the facility used his name as the prescribing physician for the Morphine, but he did not, and would have not ordered that pain medication because it is a risky medication. V19 said R2's lethargy was likely the result of the high dose of the pain medication Morphine and Fentanyl combined.

On 10/17/23 at 9:25 AM, V20 (RN) said she carried out the Morphine order that V28 had prescribed without consulting V19. She said they facility nurses don't call to consult orders they just carry them out because they are from a physician. V20 said when R2 returned from the appointment she entered the Morphine orders in the computer using V19's name because she could not select V28 as he is not in their system since he is outside physician. She said after the initiation of the Morphine R2 did begin to have lethargy and they called to report it to the Nurse Practitioner. When this surveyor asked V20 if she

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was aware the facility policy states any outside provider orders should be clarified with the residents Primary Care Physician, she indicated she was not.

On 10/17/23 at 11:10 AM, V22 (Licensed Practical Nurse/LPN) said it is the policy of the facility to clarify medication orders and a Morphine order should not just be started without clarifying it with the Primary Care Physician first.

On 10/17/23 at 2:08 PM, V23 (RN) said she went to remove R2's pain patch after the Nurse Practitioner told her it needed to be stopped but she looked all over R2 and did not see it. V23 also said the nurses should always reconcile medication orders from an outside provider and not just start the medications.

A pain policy was requested from the facility, and they provided the F697 citation text from the State Operations Manual/ SOM which states, "The facility must ensure that pain management is provided to the residents who require such services, consistent with professional standards of practice..."

The facility provided policy titled Consulting Physician/Practitioner Orders says the facility should call the attending physician in a timely manner to verify consulting physician/practitioner orders.

(A)