STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Macomb Post Acute Care Center	8 Doctors Lane Macomb, IL 61455

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have adequate processes in place for acquiring /receiving refill prescriptions for narcotic medications for one (R4) of three residents reviewed for pharmaceutical services in a sample of four. Findings include:The facility's policy, Medication Orders IB2: Controlled Substance Prescriptions, dated November 2021, documents not in it's entirety, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations. Before a controlled drug can be dispensed, the pharmacy must be in receipt of a prescription from a person lawfully authorized to prescribe. A chart order is not equivalent to a prescription for controlled drugs. Therefore, the prescriber issuing the chart order must also provide the pharmacist with a valid prescription to ensure delivery of medication. The Director of Nursing and the contracted consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized, licensed nursing and pharmacy personnel have access to controlled medications.A verbal prescription for a schedule II medication may be called in to a pharmacist directly by the prescriber only, if: Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user.The prescriber is contacted for direction when delivery of a medication will be delayed, or the medication is not, or will not be available.Refill Requests for CIII-CV, and Partial Fill Requests for CII: 1) Additional supplies of controlled drugs are ordered by the facility from the provider pharmacy. 2) Re-orders for controlled substances should be made allowing for appropriate time for the pharmacy to obtain the prescription and to assure an adequate supply is on hand. R4's admission Record documents R4's admitted to the facility on [DATE] and R4's diagnoses on admission include but are not limited to Encounter for Other Orthopedic Aftercare, Other Nonrheumatic Aortic Valve Disorders, Heart Failure, Type 2 Diabetes Mellitus without Complications, Opioid Dependence Uncomplicated, and Depression. R4's physician order dated 1/30/25 documents that R4 has an order for Fentanyl (Narcotic Pain Reliever) Patch 72 Hour 75 mcg (microgram)/HR (hour) apply every 72 hours for pain and remove per schedule. R4's Medication Administration Record for April 10, 26 shows R4 was due to have a Fentanyl (Narcotic Pain Reliever) Patch of 75mcg (microgram)/HR (hour) applied at 9:07am but lacks documentation that it was applied, area blank. R4's progress notes dated 4/10/26 at 15:55 documents, called pharmacy fentanyl patches will be delivered in tonight's shipment. unable to pull from backup. R4's progress notes dated 4/10/26 at 16:43 documents, wife brought in fentanyl patch and placed on left rear shoulder. On 5/6/26 at 2:30pm, V13/Registered Nurse stated that if Fentanyl (Narcotic Pain reliever) Patches are noted to be down to one or two patches remaining the nurse will contact the physician to receive a new prescription so the patches can be refilled before the resident runs out of the supply on hand. V13 also stated that they have had issues prior with obtaining R4's prescription for his Fentanyl Patches and have had to reach out to V10/R4's spouse to have her bring in one from home until they can get the physician to send in a new prescription by repeated calls to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the office. On 5/6/26 at 2:40pm, V10/R4's spouse stated that since R4's admission to the facility in October of 2024 she has had to bring in a total of 11 Fentanyl (Narcotic Pain Reliever) Patches to the facility because of issues with getting his prescription filled. On 5/12/26 at 8:30am, V2/Director of Nursing stated that R4 has had only one issue this year with the facility getting his prescription filled for his Fentanyl (Narcotic Pain Reliever) Patches and verified that it is documented in the nurse's progress notes that one was obtained from R4's spouse, V10, on April 10th at 4:43pm and placed at that time with no documentation on R4's Medication Administration record that R4 received the dose. V2 stated that the facility has difficulty in getting prescriptions for controlled substances from V14/R4's Physician in a timely manner. V2 also stated that it is the expectation of the nursing staff to contact the doctor for a new prescription when a resident's Fentanyl patches have two remaining in hopes that the prescription will be to the pharmacy in time to refill so no missed doses occur. When asked if the prescription is not received and dose is due what does the facility do, V2 stated they keep calling the doctor's office and inform them they need a new prescription now. V2 also stated that the facility has never reached out to V15/Medical Director for assistance because they do not want to upset the community doctors they work with, they want to keep a good rapport.