STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145415	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irving Park Living & Rehab Ctr	4340 North Keystone Chicago, IL 60641

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on interview and record review, the facility failed to ensure that a resident was free from sexual abuse. This failure affected 1 resident (R1) in the sample of 8. This failure resulted in R1 experiencing psychosocial harm by feeling violated and victimized by R2 due to R2's unwanted touching. Findings include: On 5/29/24 at 2:00 pm, R1 stated that R1 was a resident in the facility for about 2 years. R1 stated, I (R1) did not get out of bed because the electric wheelchair didn't work. I would stay in my bed. R1 stated, (R2) was staring at me (R1). I couldn't sleep. (R2) would try to go under my blanket. Tried to get under my covers. Tried to touch my body. (R2) tried to go and put hands near my privates. I would yell at (R2) to stop. When asked if R2 touched R1's p****, R1 stated, (R2) tried to. (R2) put (R2's) hand under my blanket. I wasn't sleeping. I always had an eye open knowing that I was watched. I left there because I didn't feel safe. R1 stated that R1 recorded a video on R1's cellular phone of R2 touching R1 on 5/6/24 around 6:30 pm. When asked if R1 showed this video (from 5/6/24 around 6:30 pm) to anyone in the facility, R1 stated, Yes, I showed (V4, Social Services Director, SSD) and V1 (Administrator). R1 stated I also showed the cops. R1 stated while in the hospital, I showed them (hospital staff). When asked to describe the video contents, R1 stated that R2 was coming to R1's bed, walking to R1's bed and R1 pushing call light. R2 was then over R1's bedside before they (staff) come in my room. R2 was touching my (R1) body, going under my covers. When asked if this happened the one-time R1 recorded it, R1 stated that it occurred different time periods. When asked if facility staff members knew that R2 was coming over unwanted to R1, V1 stated, Staff members and (V1) knew. I have problems with (V4, SSD). I (R1) said that I am being attacked over here. Nothing got done. Now it involved me (R1) taking pictures. No one is protecting me. Yep, I am protecting myself with the video. R1 stated that it's the same video that R1 showed V1 and V4 where R2 went under R1's covers to try to touch R1's private area. R1 stated, (R4) saw everything. When asked if R2 has come over to R1's bedside and tried to touch R1 before R1 making the video, R1 stated, Most definitely. (R2's) done it before. Trying to touch me. Stealing stuff from my table. I would be calling out. I was agitated. (R2) keeps doing the same thing to me. I wasn't alone. (R2) did that to (R4). I saw him do that to (R4). When asked how it made R1 feel when R2 was touching R1's body on 5/6/24, R1 stated, Very uneasy. I (R1) just don't like to be a victim. I'm watching (R2) all night watch (R1). (R2) pulls my (privacy) curtain and keeps coming in. I say, 'Why are you in my space?' It's a violation of my space. Violation of my body. No matter how many times I brought it up (to staff), it keeps happening. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R1's Face Sheet documents, in part, diagnoses of hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side; contracture of muscle, multiple sites; unspecified convulsions; chronic kidney disease, stage 3 unspecified; adult failure to thrive; traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, sequela; personal history of traumatic brain injury; essential (primary) hypertension; anxiety disorder, unspecified; hyperlipidemia, unspecified; epilepsy, unspecified, intractable, without status epilepticus; major depressive disorder, recurrent, unspecified; neuromuscular dysfunction of bladder, unspecified; schizoaffective disorder, unspecified; old myocardial infarction; other chronic pain; and muscle weakness (generalized). R1's Minimum Data Sheet (MDS), dated [DATE], documents, in part, that R1's Brief Interview for Mental Status (BIMS) score is 13 which indicates that R1 is cognitively intact. R1's Functional Abilities and Goals for functional limitation in range of motion documents, in part, impairment on one side of upper extremities and impairment on both sides of lower extremities. R1's mobility for bed to chair transfer is coded as Dependent - Helper does all the effort. Resident does none of the effort to complete the activity, and walk 10 feet is coded as Not attempted due to medical or safety concerns. On 5/28/24 at 1:28 pm, R4 stated that R4 remembers R1 as a former roommate, but that R1 is not in the facility anymore. R4 stated that R4 knows R2 and that R2 is still in the facility. R4 stated, (R2) walked towards my bed and (R2) was going under my covers (while pointing towards R4's left lower leg) and I kicked my foot at (R2). I told (R2) no and (R2) stopped. When asked if R4 had reported this incident with R2 to any facility staff, R4 stated, I (R4) told a number of CNAs and told one of the nurses, but R4 didn't remember their names. When asked if R4 had witnessed R2 going over towards R1's bed touching R1 inappropriately on R1's body, R4 stated, I (R4) did see that. R4 stated that R4 couldn't remember the date but that R2 went to R1's bedside, more than one time. R4 stated that R1 told R2, Stop doing that when R2 touched R1 under the covers, and on that same day, R2 tried to touch R4 under R4's cover. R4 said that R2 kept doing it to R1. R4's Face Sheet documents, in part, diagnoses of Parkinson's disease with dyskinesia, without mention of fluctuations; dyskinesia of esophagus; unspecified severe protein-calorie malnutrition; multiple subsegmental pulmonary emboli without acute cor pulmonale; Dysarthria and anarthria; personal history of other venous thrombosis and embolism; cerebral infarction, unspecified; major depressive disorder, recurrent, mild; posttraumatic stress disorder, chronic; polyneuropathy, unspecified; essential (primary) hypertension; venous insufficiency; spinal stenosis, cervical region; hyperlipidemia, unspecified; pain, unspecified; other lack of coordination; cognitive communication deficit; unspecified voice and resonance disorder; muscle weakness (generalized); and need for assistance with personal care. R4's MDS, dated [DATE], documents, in part, that R4's BIMS score is 15 which indicates that R4 is cognitively intact. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/7/24 at 3:15 pm, V16 (Hospital Registered Nurse, Sexual Assault Nurse Examiner) documents, in part, in R1's hospital emergency records, (R1) states 'I have been being touched by (R2) and I have told staff, and no one believes me. (R2) has been coming to my bed and touching my leg and chest and is trying to move my gown. I have told (R2) to leave me alone. I told (R2) I don't want to be touched' . (R1) stated (R1) had video on (R1's) phone of (R2) touching (R1) and showed the video to (V16). (V16) observed (R2) wearing a hospital gown walking towards the victim (R1) and touching (R1) on the leg and (R1) telling (R2) to stop touching (R1). The video also shows (R2) also touching (R1) on the abdomen and trying to move (R1's) gown. (R1) states 'I have informed staff, and no one believed me until I told them I had video of (R2) touching me.' R1's Police Report, dated 5/7/24 at 12:00 midnight, documents, in part, the incident of battery; with R1 as the victim; and violent crimes and special victims' units are managing R1's case. On 5/29/24 at 10:11 am, V4 (SSD) stated that on 5/7/24, V4 was doing rounds on the floor and spoke with R1. V4 stated that R1 is alert, oriented, stays in bed and does not ambulate. V4 stated that R1 told V4 that R2 approached R1's bed, tried touching R1's stuff and tried to grab R1's covers. V4 stated that R1 informed V4 that staff members were aware with R1 saying 'I (R1) told everybody.' V4 stated that the only names that V4 can remember from R1 are V10 (Certified Nursing Assistant, CNA) and V14 (CNA). When this surveyor showed a witness statement to V4, dated 5/7/24 with R1's name and statement written on it, V4 stated that V4 authored the document from R1's interview on 5/7/24. After reading aloud this authored witness statement from R1, V4 stated that R1 said that R2 touched R1 above R1's stomach and on the knee. V4 stated that this was the first expressed to me that R2 had been walking over to R1's bedside. V4 confirmed that on 5/7/24, R1 showed V4 the video on R1's cellular phone of R2 coming over to R1's bedside. When asked if R2 is clearly identifiable in R1's video, V4 stated, Yes. It was clear that it was (R2). Facility document titled Witness Statement, dated 5/7/24 with R1's printed name, and signed by R1, documents, in part, (R1) reported that incident occurred on May 6, 2024, around change of 2nd shift. (R1) stated, 'Last night, (R2) standing in window and (R2) walks to my way and tries to touch me. I (R1) see (R2) try to put (R2's) hand here and here but I put my leg up so (R2) can get (R2) away from me.' . (R1) pointed to kneecap and gown. R1's ADT (Admissions, Discharges, Transfers) History document indicates that R1 was admitted to the facility on [DATE] and discharged to another long-term care facility on 5/17/24. R1's room remained the same in the facility from admission to discharge. Facility document titled Census Detail Report, dated 5/6/24, documents, in part, that R1, R2 and R4 were roommates. In R1's Social Services-Screening to Determine Abuse, dated 5/7/24, V4 (SSD) documents, in part, an abuse screening indicator score is 5 which indicates that R1's risk measure for likelihood for a history of previous/recent mistreatment and/or potential future problems/symptoms related to mistreatment is high. In review of R1's complete care plan, printed on 5/28/24, no focus, goal or interventions are documented for R1's allegation of sexual assault from R2 or R1's risk of abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/28/24 at 1:25 pm, R2 stated that R2 does not remember R2's former roommate, R1, and that on May 6, 2024, R2 did not touch R1's body. R2 stated that R2 walks around with a walker (observed next to R2's bed). When asked if R2 has recently been hospitalized after incident in facility with R1, R2 stated, No. No. R2's Face Sheet documents, in part, diagnoses of dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance; hypothyroidism, unspecified; atherosclerosis of aorta; dysphagia, unspecified; cognitive communication deficit; difficulty in walking, not elsewhere classified; adult failure to thrive; muscle weakness (generalized); need for assistance with personal care personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits; pain, unspecified; dehydration; and pneumonia, unspecified organism. R2 resides in a room by himself. R2's MDS, dated [DATE], documents, in part, a BIMS score of 6 which indicates that R2 has severe cognitive impairment. R2's ADT History document indicates that R2 was a roommate of R1's since 1/2/24 and was hospitalized from 5/7/24 to 5/20/24. On 5/29/24 at 10:11 am, V4 (SSD) stated that R2 does not converse a lot, is not all the way there and is in (R2's) bubble. V4 stated that R2 has not many issues at all, but when asked about R2 being placed in different rooms several times in May 2024 and R1 and R4's statements of R2 coming to their bedsides uninvited, V4 stated that R2 has poor personal boundary issue. In R2's Progress Notes, dated 5/7/24 at 7:21 pm, V4 (SSD) documents, in part, Resident (R2) was involved in alleged sexually inappropriate behaviors. This resident (R2) has multiple medical diagnoses. Resident (R2) presents with no unusual behaviors . Resident (R2) was interviewed by the appropriate staff. Resident presents with poor insight to (be) interviewed and denies any behaviors. On 5/29/24 at 10:28 am, V3 (RN) stated that V3 was R1 and R2's primary nurse routinely on the day shift. V3 stated that on 5/7/24, V11 (Agency CNA) informed V3 that R1 had taken a video of R2 on R1's phone. V3 stated that on 5/7/24, R1 had not voiced R1's allegation of R2 touching R1, and V3 educated R1 on not taking pictures of fell ow residents. V3 stated that V3 did not view R1's cellular phone video of R2. V3 stated that later 5/7/24 at 11:00 am to noon, V4 (SSD) was talking to R1, and then V3 removed R2 from R1's room. This surveyor read V3's progress note from 5/7/24 about R2 being sexually inappropriate towards a care giver, and V3 stated that V11 (Agency CNA) informed V3 on 5/7/24 that R2 has touched V11's body while V11 was rendering R2's care. When asked what part of V11's body did V11 say that R2 touched, V3 stated, (V11) said it was on (V11's) side (pointing to hip) close to buttock area. V3 stated that V3 sent R1 to the hospital for evaluation and that R1 returned to the facility on [DATE]. V3 also stated that a couple weeks prior, R2 was taking R1's food from R1's bedside and that V3 told R2 to stay on R2's side of room and don't touch other residents' items. In R2's Progress Notes, dated 4/21/24 at 5:52 pm, V3 (RN) documents, Observe resident (R2) taking personal belongings (food items) from roommate's bedside table, educated resident (R2) to keep to (R2's) side of room and not to interfere with roommate's belongings, stated I (R2) know, I know, will continue to monitor and educate. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In R2's Progress Notes, dated 5/7/24 at 4:23 pm, V3 (RN) documents, 9;(:)30 am - Resident (R2) sexually inappropriate toward caregiver (V11, Agency CNA), counseled and educated on appropriate behavior, verbalized understanding, will continue to monitor. On 5/29/24 at 12:45 pm V11 (Agency CNA) stated that V11 works in the facility 3 to 4 times a week primarily on R1, R2, and R4's floor. V11 stated that R1 is alert, oriented, normal, always is in bed and needs help with personal care needs. V11 stated that R2 is more confused and walks with an unsteady gait, and that V11 has observed R2 walking unassisted in R1, R2 and R4's room. When asked about V11 reporting to V3 on 5/7/24 that R2 was sexually touching V11, V11 stated that R2 is confused, but then R2 says, I like it. V11 stated that V11 told R2 that it's inappropriate to touch someone like that. V11 stated that R2 touched V11 on the lower back while V11 was rendering activities of daily living care with R2 behind the privacy curtain on the morning of 5/7/24. V11 stated that when V11 told R2 to stop touching V11 inappropriately, V11 heard R1 say from behind the privacy curtain, (R2) do that to me too and (R2) comes to my bed. V11 stated that R1 then showed V11 a video of R2 next to R1's bed. V11 stated that when asked about R2's behavior of touching staff inappropriately, V11 stated that all the CNAs complain about it. V11 stated that V11 provided a statement to V1 for the abuse investigation for R1 and R2 on 5/7/24 and that R1 said that R2 is always trying to be friends with R1. V11 stated that R1 said, I (R1) don't want to be friends with (R2). Those were (R1's) words. On 5/29/24 at 2:54 pm, V15 (Agency RN) stated that V15 was working on 5/6/24 from 3:00 pm to 11:00 pm and remembers R1 and R2. V15 stated that during V15's shift on 5/6/24, V15 heard R1 yelling out, and V15 immediately went to R1's room. V15 stated that V15 observed R2 standing next to R2's bed, and R1 laying in the bed saying that R2 was coming over to R1. When asked what was R1 yelling out to get V15's attention, V15 said that V15 can't recall if R1 said help but what R1 was saying was in a louder tone. V15 stated that when V15 went in R1 and R2's room, Someone (R2) was by (R1) that doesn't belong there. On 5/29/24 at 2:37 pm, V14 (CNA) stated that V14 was working on 5/6/24 from 3:00 pm to 11:00 pm and is familiar with R1 and R2. V14 stated that R2 is a wanderer, confused with R2's mind be all over the place and that R2 just like to get into things a lot of the time. V14 stated that on 5/6/24 during the evening shift, V14 answered R1's call light to observe that R2 was by R1's bed. V14 stated, (R1) would be screaming or on a call light for someone to remove (R2). On 5/29/24 at 3:20 pm, V6 (CNA) stated that V6 was working on 5/6/24 from 3:00 pm to 11:00 pm and that V6 answered the call light two times, for R1, with R2 observed at the end of R1's bed. V6 stated, They (R1 and R4) would pull the light when they see (R2) coming towards in their direction. Both of them (R1 and R4). On 5/29/24 at 2:43 pm, V7 (CNA) stated that V7 was working on 5/6/24 from 3:00 pm to 11:00 pm and that V7 answered R1's call light to observe R2 standing in the middle of their room trying to come over to R1's side of room. V7 stated that V7 takes R2 back to R2's bed saying that R2 can't go over to R1's bedside. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/29/24 at 11:05 am, V9 (CNA) stated that V9 was working on 5/6/24 from 3:00 pm to 11:00 pm and that R1 doesn't get out of bed and is a mechanical lift transfer. V9 stated that R2 is confused and walks independent in R2's room. V9 stated that on 5/6/24, V9 stated, I (V9) only heard (R1) shouting, then then nurse (V15) went into R1's room. V9 stated that later on 5/6/24 shift, around bedtime, V9 came into R1's room when R1 was shouting. V9 stated that V9 asked why R1 was shouting, and that R1 said that it was R1's roommate (R2) again. V9 stated that V9 told R1, You (R1) have to calm down. By shouting, think of your head. On 5/29/24 at 11:35 am, V10 (CNA) stated that V10 routinely works on R1 and R2's floor. V10 stated that R1 is alert and oriented, and that V10 assists R1 with all ADL care except feeding R1. V10 stated that R1 would use call light and or would shout out for help, and V10 would come into room. V10 stated that R1 would not want R2 on R1's side of room and that R2 was touching R1's personal belongings. On 5/30/24 at 10:50 am, V2 (Director of Nursing, DON) stated that nursing staff are to treat residents with respect, perform purposeful rounding and there's not subpar nursing in this facility. When asked if R1 has the right to be free from R2 coming into R1's space and touching R1's things or person, V2 stated, Yes, that is correct. V2 stated that R2 would walk in room with a shuffle gait; that R2 would walk over to R1's bedside; and that (R2) is harmless. When asked if a resident should feel safe to not have another resident touching them, V2 stated, No, they should not experience that. V2 further stated, regarding R2 staff know to keep an eye on them, they do purposeful rounding, make sure he is getting enough to eat and give R2 something to do. On 5/30/24 at 12:54 pm, V1 (Administrator) stated that V1 is the abuse coordinator for the facility with the responsibility is to ensure safety of the residents. V1 stated that on 5/7/24, V1 was notified of R1's allegation of R2 touching R1 inappropriately. V1 stated that V1 interviewed R1 on 5/7/24, and asked R1 where R2 touched R1. V1 stated that R1 said that R2 was by R1's bedside and that R1 touched over (R1's) diaper to indicate where R2 had touched R1. V1 stated that R1 then showed V1 the video on R1's cellular phone with no sound, with a date stamped of 5/6/24 after dinner around 6:30 pm, and V1 could clearly see that it was R2 in the video at R1's bedside. Facility policy titled Abuse Prevention and Reporting-Illinois with effective date of 11/28/2016 and last revision date of 10/24/2022, documents, in part, Guidelines: This facility affirms the right of our residents to be free from abuse . or mistreatment. This facility therefore prohibits abuse . and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse . and mistreatment of residents. This will be done by: . Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; Identifying occurrences and patterns of potential mistreatment . Definitions: Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means . Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions . Sexual abuse includes, but is not limited to, . sexual assault . 'Sexual abuse' is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but is not limited to: Unwanted intimate touching of any kind especially of breasts or perineal area . Generally, sexual contact is nonconsensual if the resident . does not want the contact to occur. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on interview and record review, the facility failed to ensure that a as needed (PRN) dose of pain medication was administered to a resident for breakthrough pain which affected one (R3) resident in the total sample of 8 residents reviewed. Findings include: On 5/28/24 at 1:41 pm, R3 stated, There was a mix up, and the nurses were not giving me (R3) the PRN medication for pain when I was receiving the scheduled pain medication every 8 hours. They (nurses) were not wanting to give me the PRN medication if it hadn't been a lapse of 4 hours after my scheduled dose. That means that I would only be able to have 3 PRN doses per day (24 hours) when I should be able to get 4 PRN doses. R3 stated that R3's doctor wrote instructions for the nurses not to wait until 4 hours after the scheduled dose to give the PRN. R3 stated that the instructions also restrict the total doses of the PRN pain medication to 4 doses every 24 hours. R3 stated that R3 requests for the PRN pain medication, if I (R3) hurt in between scheduled doses. R3 stated, I think the doctor's intent didn't mesh up with the nurses doing the orders, and the nurses needed teaching notes. I explained to the nurses, but they weren't accepting it. I was a medic. When asked about R3's allegation of not receiving R3's PRN pain medication on 4/23/24 at 11:40 pm, R3 said, I didn't get this PRN dose when I asked the nurse when R3 was experiencing pain. R3 stated that R3 has chronic back pain, and it comes from an injury from R3's service in the military. R3's Face Sheet documents, in part, diagnoses chronic pain syndrome; other chronic pain; essential tremor; hyperlipidemia, unspecified; major depressive disorder, single episode, unspecified; hypothyroidism, unspecified; opioid dependence, uncomplicated; type 2 diabetes mellitus without complications; sleep disorder, unspecified; other abnormalities of gait and mobility; muscle weakness; and need for assistance with personal care. R3's admitted to the facility is documented as 2/14/24. R3's Minimum Data Set, dated dated [DATE], documents, in part, that R3's Brief Interview for Mental Status (BIMS) score is 15 which indicates that R3 is cognitively intact. R3's Order Form dated 4/22/24 at 3:45 pm and authored by V20 (Advanced Practical Registered Nurse, APRN) documents, in part, Medication Directions. Notes: To Whom It May Concern at (Facility): The following pertains to our patient (R3) . Please DO NOT withhold administration of as needed 10 mg Oxycodone based upon administration time of last scheduled dose of Oxycontin. Please base administration times of as needed 10 mg Oxycodone on time of last administered as needed 10 mg Oxycodone. Please limit as needed 10 mg Oxycodone to one tablet every four hours, with a maximum of four tablets per day. Please administer scheduled 60 mg Oxycontin to one tablet every eight hours, no more than three tablets per day. Please DO NOT withhold administration of scheduled 60 mg Oxycontin based upon last administration time of as needed 10 mg Oxycodone. Facility document titled Daily Nursing Schedule and dated 4/23/24, documents, in part, that V5 (Registered Nurse, RN) was working on R3's floor from 3:00 pm to 11:00 pm and 11:00 pm to 7:00 am. (continued on next page)

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	145415	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irving Park Living & Rehab Ctr	4340 North Keystone Chicago, IL 60641

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 3:08 pm, V5 (RN) stated that V5 is familiar with R3's care and that R3 receives scheduled and PRN pain medication. V5 stated that R3 does have complaints of pain and asks for R3's PRN pain medication after R3 receives the scheduled pain medication every 8 hours. When asked where is R3's pain, V5 stated, It's in (R3's) back. (R3) was in the military and has chronic pain. This surveyor reviewed R3's current pain medications with V5: Oxycodone 10 mg oral every 4 hour for PRN pain and Oxycontin 60 mg extended release (ER) oral every 8 hours. When V5 was asked if R3 receives a scheduled dose of Oxycontin ER, can R3 receive an PRN dose of the Oxycodone 10 mg for breakthrough pain 2 hours later, V5 stated, Yes, now (R3) can. The pain clinic approved the PRN dose. When asked if V5 did not administer a PRN dose of Oxycodone to R3 if R3 requested the PRN dose less than 4 hours after receiving the scheduled Oxycontin ER dose, V5 stated, Yes. V5 stated that V5 would ask R3 to wait for R3's PRN medication because it was only 1 hour after the scheduled Oxycontin was given, and it hasn't really kicked in. V5 stated that one week after R3 went to the pain clinic, V5 knows now that R3 can have the PRN dose of Oxycodone every 4 hours for breakthrough pain. V5 stated that V5 would administer R3's scheduled Oxycontin ER dose at 10:00 pm, and then R3 would usually ask for the PRN Oxycodone 45 minutes to 1 hour after that. V5 stated that V5 would inform R3 that it usually takes 30 minutes to 1 hour for an oral pain medication to take it's full effect. When asked if there is a difference with absorption for full effectiveness of extended-release medications, like Oxycontin 60 mg ER, V5 stated, It takes a long time. It wouldn't be effective within 30 minutes to 1 hour. V5 stated that R3 can only have 4 tablets of Oxycodone PRN daily and can have both the scheduled and PRN doses. When asked about R3 requesting the PRN Oxycodone dose on 4/23/24 at 11:40 pm (per R3's statement), V5 stated, I (V5) do not recall. When asked where V5 documents administration of R3's medications, V5 stated that it would be in the electronic medication administration record (EMAR). When this surveyor stated that there are no doses of PRN Oxycodone documented for R3 on 4/23/24 to 4/24/24 while V5 was working (3-11 pm shift and 11 pm-7 am shift), V5 stated that it may be on the narcotic log which is in paper form where V5 would remove the controlled substance (Oxycodone) from the locked medication cart. R3's EMAR, dated April 2024, documents, in part: Oxycodone 20 mg (milligram) tablet . Give 0.5 tablet (10 mg) by oral route every 4 hours as needed with a start order date of 2/15/24 and Oxycontin 60 mg tablet, extended release, give 1 tablet by oral route every 8 hours . do not crush or chew with a start order date of 3/26/24. On R3's April 2024 EMAR, nurses' documentation for administration of R3's scheduled pain medicine (Oxycontin 60 mg extended-release oral every 8 hours) is as follows: 4/23/24 at 2:00 pm as not administered for the reason of awaiting pharmacy (with V21's initials); 4/23/24 at 10:00 pm as administered (with V5's initials); and 4/24/24 at 6:00 am as administered (with V5's initials). On R3's April 2024 EMAR, on 4/23/34 and 4/24/24, nurses' documentation for R3's PRN pain medicine (Oxycodone 10 mg oral every 4 hours PRN) is indicated charted with PRN. In this PRN section for R3's PRN Oxycodone, the type is administered for R3's Oxycodone 10 mg every oral 4 hours PRN on 4/23/23 at 11:31 am (by V21, Agency Licensed Practical Nurse, LPN) and then next on 4/24/24 at 7:24 am (by V12, Agency LPN). No Oxycodone 10 mg PRN was administered to R3 for pain complaint at 4/23/24 at 11:40 pm, per R3's allegation. Facility document for R3's 60 tablets of Oxycodone 10 mg (4 a day) is a paper log signed by nurses with the date, time administered, quantity used, and quantity left for a controlled drug accountability record. On 4/23/24 at 11:31 am, V21's initials are noted for quantity used of 10 mg (Oxycodone) with the quantity left as 45. On 4/24/24 at 7:24 am, V12's initials are noted for quantity used of 10 mg (Oxycodone) with the quantity left as 44. No documentation is noted from V5 of removing or administering R3 the PRN Oxycodone 10 mg on 3:00 pm to 11:00 pm shift or 11:00 pm to 7:00 am shift as R3's nurse. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility document for R3's 90 tablets of Oxycontin ER 60 mg tablets is a paper log signed by nurses with the date, time administered, amount given, and amount left for a controlled drug accountability record. On 4/23/24 at 6:00 am, V22 (Agency LPN) documents that 1 tablet of Oxycontin ER 60 mg is given with the quantity left as 8. On 4/23/24 at 10:00 pm, V5 documents that tablet of Oxycontin ER 60 mg is given with the quantity left as 7. No documentation is noted from V21 (who previously charted not given due to awaiting pharmacy) of removing or administering R3's Oxycontin 60 mg dose on 4/23/24 at 2:00 pm. On 5/30/24 at 10:31 am, V2 (Director of Nursing, DON) stated, Once you take a resident (in the facility), you have to meet the services of that resident. V2 stated that nurses are to document administration of medications to residents in the EMAR. V2 stated that the controlled substance receipt form is used for total medication count to ensure that the count is accurate when nurses remove the controlled substance medications for administration. R3's Care Plan, dated 2/14/24, documents, in part, a focus of pain management that (R3) has alteration in comfort: Pain related to dx (diagnosis) of chronic pain with an intervention of administer medications as ordered by MD (doctor). On 5/30/24 at 10:50 am, V2 stated that V2 is very familiar with R3's pain management care. When asked the process of nurses assessing for a resident's pain, V2 stated, Nurses must assess pain. Every shift and as needed. V2 stated that when a resident is admitted to the facility, the nurse will perform a full pain assessment and screening, review medications, and then call the physician to verify medication orders. When asked about R3's pain, V2 stated that R3 experiences back pain from a long time ago and that R3 is anxious especially with (R3's) pain meds. I (V2) give (R3) assertion that (R3's) meds are here. V2 stated, If (R3's) suffering pain, it's pain. Then that's (R3's) opinion and that the facility treats R3's pain. V2 stated that R3 receives scheduled Oxycontin ER every 8 hours at 2:00 pm, 10:00 pm, and 6:00 pm. V2 stated, We have a lot of agency nurses who were not giving (R3's) Oxycodone. V2 stated that R3 was requesting for PRN Oxycodone 1-2 hours after receiving the scheduled Oxycontin, and then the doctor said it was okay to give within a 2-hour span. V2 stated that V2 educated all the nurses, and said, This is the order that R3 can have Oxycodone every 4 hours for breakthrough pain. V2 stated, I made this clear to them (nurses). V2 stated, Our nurses (facility nurses) knew what to do. But agency nurses follow stuff by the book. V2 stated, We (facility) took complete control over (R3's) meds. When (R3) first came, it was 30 tabs a month. Now, we have 90 tabs a month. V2 stated that R3 was worried that the facility would run out of R3's pain medications; therefore, V2 has approved receiving 90 tablets from the pharmacy. V2 stated that R3 can't wait for pain medications to arrive from pharmacy when R3's in pain. This surveyor showed V2 R3's April 2024 EMAR, asking what 'PRN' means, and V2 stated that PRN means that the nurse gave the PRN medication with the administer type, date, and time, that would be documented in the PRN section on the EMAR. On 5/30/24 at 2:32 pm, surveyor reviews with V2 the EMAR for R3 for April 2024, with R3's PRN Oxycodone 10 mg oral every 4 hours PRN documented as administered on 4/23/23 at 11:31 am and then next dose on 4/24/24 at 7:24 am. When asked about this time frame (approximately 19-20 hours) in between PRN Oxycodone doses for R3 on 4/23/24 to 4/24/24, V2 stated that a PRN Oxycodone was not administered, and it's safe to say it. The computer doesn't lie. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Pain Management and dated 2/23/2022 documents, in part, Purpose: The purposes of this procedure are to help the staff to identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. 1. The pain management program is to provide comfort to the resident. 2. 'Pain Management' is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals . Steps in the Procedure: . 3. Review the medication administration record to determine how often the individual requests and receives pain medication, and to what extent the administered medications relieve the resident's pain . Implementing Pain Management Strategies: . 2. Pharmacological interventions (i.e. {that is}, analgesics) may be prescribed to manage pain . b. If the pain medication given to the resident is not effective, then a stronger type of pain medication may be given if ordered by the physician. 3. Addiction to narcotic analgesics is not likely if used appropriately for moderate to severe pain . 5. Strategies that may be employed when establishing the medication regimen include but not limited to: . c. Combining long acting medications with PRNs for breakthrough pain. Facility policy titled Medication Administration and Storage Policy and dated 7/2/2018 documents, in part, Policy: To ensure medications are administered & (and) stored in accordance with Standard of Practice. Procedure: . 19. Narcotics must be signed out in the EHR (Electronic Health Record) and the narcotic sheet.