STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145518	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mascoutah Rehab and Nursing	201 South 10th Street Mascoutah, IL 62258

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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 - Immediate jeopardy to resident health or safety 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** 42108 Based on observation, interview, and record review the facility failed to administer prescribed opioid medications, muscle relaxants, and anticonvulsants prescribed for pain control to two of three residents (R1 and R2) reviewed for pain in the sample of three. This IJ began on 3/30/2025 when R2, who suffers from spinal muscular atrophy, restless leg syndrome, neuralgia and neuritis, and muscular dystrophy described experienced, symptoms of medication withdrawal, pain described as being ongoing, uncontrolled, excruciating, and unbearable to her head, neck, back and both lower legs, which resulted in an emergency room treatment for pain relief. R2 described a decrease in her quality of life, along with expressions of feeling forgotten and wanting to die. Additionally, R1 who suffers from cervical spinal cord injury, disorder of right wrist tendon and chronic pain syndrome too described experiencing ongoing, uncontrolled, severe pain, rated 9 on pain scale (1 to 10) to left side of his body. This failure resulted in Immediate Jeopardy on 3/30/2024 when R2 was transferred to the emergency room for pain treatment due to not receiving scheduled pain management and experiencing ongoing excruciating pain. R1 experiencing ongoing unrelieved pain. On 5/19/2025 at 8:51 AM V1, Administrator was notified of the Immediate Jeopardy. The surveyor confirmed by interview and record review, the Immediate Jeopardy was removed on 5/20/2025, after abatement reviews dated 5/19/2025 at 11:43 AM, 2:17 PM, 3:56 PM, 4:09 PM, 5/20 11/59 AM, 12:07 PM but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-servicing training. Findings include: R1's Admission Record, print date 5/14/2025, documents that R1 was admitted [DATE] and lists cervical spinal cord injury, disorder of right wrist tendon and chronic pain syndrome as diagnosis. R1's Care Plan dated, 1/28/2025, documents that the resident has pain. Interventions include Administer analgesia (specify medication) as per orders. Give 1/2 hour before treatments or care. Evaluate the effectiveness of pain interventions (FREQ). Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. R1's Minimum Data Set, (MDS), dated [DATE], documents that R1 is cognitively intact, dependent on staff for ADLs (activity of daily living). It also documents that R1 experience pain almost constantly that frequently interferes with day-to-day activities. It also documents that R1 receives pain medication routinely and as needed and has experienced pain at level of 7. (continued on next page)

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

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Progress Note, dated 4/9/2025 to 4/24/2025, documents that Orders -Administration Note, Note Text: Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 18 MG Give 1 capsule by mouth two times a day for Pain not in stock. R1's Controlled Substances Proof of Use, dated 3/25/2025, documents last dose of Xtampza ER 18mg was administered 4/8/2025 at 4 PM. R1's Controlled Substances Proof of Use, dispense date 4/24/2025, documents the first dose of Xtampza ER 18mg administered 4/26/2025 at 10 AM. R1's Progress Note, dated 4/21/2025, 4/22/2025, documents that Orders -Administration Note, Note Text: oxycodone HCl Oral Tablet 15 MG Give 15 mg by mouth six times a day for pain give 15mg PO q 4 hours routine for pain med out of stock(OOS). R1's Controlled Substances Proof of Use, dispense date 4/22/2025, documents that the first dose of Oxycodone HCL 15mg tab was administered on 4/23/2025 at 12 AM. R1's Progress Note, dated 4/28/2025 at 7:27 PM, documents that Orders -Administration Note, Note Text: Lyrica Oral Capsule 100 MG Give 100 mg by mouth every 12 hours for pain take 100 mg PO q12 hours med out of stock. R1's Medication Administration Record, dated April 2025, documents 10/10/2024 Baclofen 20mg tablet 3 times a day. It also documents blank 4/1 at 4 PM, 4/8 at 12 PM, 4/18 at 8AM, 12PM, and 4 PM. 4/19 at 12 PM and 4 PM, 4/20 at 8AM, 12 PM and 4 PM. R1's Progress Note, dated 5/6/2025, 5/8/2025, 5/9/2025 documents that Orders -Administration Note Note Text: Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 18 MG Give 1 capsule by mouth two times a day for Pain OOS. R1's Controlled Substances Proof of Use, dispense date 4/24/2025, documents that the last dose of Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 18 MG was administered on 5/5/2025 at 4PM. R1's Controlled Substances Proof of Use, dispense date 5/6/2025, documents that the first dose of Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 18 MG was administered on 5/7/2025 at 4AM and last dose administered 5/7/2025 at 4 PM. R1's Medication Administration Record, dated May 2025, documents 10/10/2024 Baclofen 20mg tablet 3 times a day. It also documents blank on 5/3 and 5/4 at 8AM, and 12PM. On 5/13/2025 at 11:50 AM R1 stated that when he doesn't have his pain medication his pain is ongoing, uncontrolled, and severe. R1 stated that his pain, is rated 9 on pain scale (1 to 10) to left side of his body. R1 stated that the pain gets so high that when he finally gets his medication it takes a while for the pain to lower. R1 stated that they don't do anything different for him he just waits till the medication comes in. R1 stated that he goes out of the facility but that can be difficult because of the pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. R2's Admission Record, print date 4/14/2025, documents that R2 was admitted [DATE]. It lists R2, who suffers from spinal muscular atrophy, restless leg syndrome, neuralgia and neuritis, and muscular dystrophy as diagnosis. R2's Care Plan, dated 4/10/2024, documents (R2) has potential impairment to skin integrity. It also documents Administer Morphine and Hydrocodone as per orders. R2's MDS, dated [DATE], documents that R2 is cognitively intact. It also documents that R2 experience pain almost constantly that rates a 10 (1-10) on pain scale and receives routine and as needed pain medication. R2's Progress Note, dated 3/27/2025 and 3/28/2025, documents that Orders -Administration Note, Note Text: Morphine Sulfate ER Oral Tablet Extended Release 60 MG Give 1 tablet by mouth every 12 hours for pain HOLD IF PATIENT IS NODDING OR SHOWING S/S of BEING OVER-MEDICATED med out of stock, insurance issue, pharmacy notified. R2's Progress Note, dated 3/29/2025, documents that new order for liquid morphine given. Morphine Sulfate ER Oral Tablet Extended Release 60 MG discontinued. Morphine Sulfate(Concentrate) Solution 20 MG/ML Give 5 mg by mouth every 4 hours for pain med out of stock, pharmacy notified. R2's Progress Note, dated 3/30/2025 at 3:15 AM, documents that Health Status, Note Note Text: Resident c/o uncontrollable pain requesting to be sent to ER (emergency room). Call placed to 911 at this time. 0330 Resident leaving facility with (local) Ambulance service at this time. Report giving to (local hospital). At 1:07 PM Health Status Note Note Text: Resident returned to facility via ambulance at 11:15am after being sent out r/t back pain. Hospital treated pain with medications this morning. No new dx or medication orders at this time. Resident is currently in her room sitting up. R2's Progress Note, dated 4/7/202508:50 Orders -Administration Note, Note Text: Gabapentin Oral Tablet 800MG Give 1 tablet by mouth four times a day for neuropathy MEDICATION CURRENTLY UNAVAILABLE R2's progress Note, dated 4/12/2025 12:25 PM, documents that Health Status Note, Note Text: Resident was able to find local pharmacy that had previous Morphine script in stock wanted to know if it would be possible to change Morphine script back to Morphine 60mg: 1 tablet by mouth every 12 hours for pain scheduled at 8AM & 8PM. Spoke with (V19's) office asked if she could notify the provider of this and asked if they did approve change if they could send over Morphine ER 60mg to (local pharmacy). (V19's) Morphine 60mg 1 tab every 12 hours was approved and sent to (Local pharmacy) Will update prescription changes in EMR (electronic medical record). R2's Progress Note, dated 5/11/2025, 5/12/2025, 5/13/2025, and 5/14/2025 documents that Orders -Administration Note, Note Text: Morphine Sulfate ER Oral Tablet Extended Release 60 MG Give 1 tablet by mouth every 12 hours for pain med unavailable. R2's Resident Controlled Substance Record, not dated, documents the last dose of Morphine ER 60mg was administered 5/11/2025 at 8AM. R2's MAR, dated April 2025, documents blank for Baclofen 10mg on 4/1, 4/14, 4/18, 4/19, 4/20 Baclofen 20mg 4/6 at 6AM, 4/19 at 2Pm and 8 PM, 4/20 at 6AM and 8 pm. Gabapentin 800mg 4/1 at 4pm and 8 pm, 4/14 at 4 8 pm 4/18, 4/19, 4/20 at 4PM and 8 PM. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's MAR, dated May 2025, documents Baclofen 10mg at bedtime and 20mg 5/10 blank. Gabapentin 800mg 5/3 and 5/4 at 8AM and 12 PM. 5/10 at 8PM blank. On 5/12/2025 at 2:30 PM V3, LPN, stated that they have had some issues with medication. V3 stated that more on the other halls. V3 stated that they had a recent change in pharmacy and causes some delays with the change. V3 stated that when there is a blank in a routine medication the system highlights that and it alerts her to verify if the medication was given because at that time it would look as it was not. On 5/12/2025 at 3:00 PM V2, Director of Nursing, stated that the facility is chaotic. V2 stated that she has been at the facility for about 3 months. V2 stated that prior to the changeover it was difficult to get medications from the pharmacy. Communication was horrible. V2 stated that the medication would be ordered and not delivered. V2 stated that they would have to call the pharmacy and then they were told it was an issue with the script or insurance. V2 stated that the previous pharmacy had emergency boxes in the medication room, but it was no good if you can't access it. V2 stated that it was difficult to care for the residents. V2 stated that then the changeover happened and again there were some challenges with getting medication. V2 stated that there were delays with getting medication. V2 stated that she feels its getting better. V2 stated that she is aware of medications not being delivered. V2 stated that when the medications are administered, they are signed off. V2 stated that the medication being blank would indicate that it wasn't given. V2 stated that she expects the staff to administer medication as ordered. V2 stated that she was aware of R1's medication being out and difficulty with getting the medications. V2 stated that R1 has a lot of pain and withdrawals from not receiving his pain. V2 stated that R1 goes out of the facility and when this happened the medication are to have documentation there shouldn't be an empty space on the MAR. The system is set up to make you document. V2 stated that if it's not documented it's not given. V2 stated that R2 medication is out currently, and they are trying to get it. V2 stated that R2 takes a lot of medication for pain and needs her medication. V2 stated that she likes to stay in her room, but she is different and lays in the bed more. V2 stated that due to R2's pain and the amount of pain medication she takes to manage it when the medication is not administered her pain is horrible and she has withdrawals depending on the length of time she is without. V2 stated r1 and R2 did not received their medication as ordered and did not receive medication from emergency kit or pixis. On 5/12/2025 at approximately 3:30 PM R2 stated that the pain scale did not cover her pain, the pain is excruciating and continuous. R2 stated that she went to the emergency room for pain relief. R2 stated that she stays in bed due to the pain, it hurts to breathe. R2 stated that due to her diagnosis of spinal muscular atrophy her muscles in her head and face are continuously being pulled downward. The pain is already horrible but without the pain medication it is horrid. R2 stated that she smokes cigarettes but not as much. R2 stated that smoking cigarettes helps with her anxiety which is elevated due to pain, and she doesn't go out to smoke as much because of it. R2 stated that she feels forgotten and the pain gets so bad she wants to die. R2 stated that this is not the first time. R2 stated that she has experienced withdrawal symptoms as well. R2 stated that she is always nauseated and has anxiety but it is more its extreme and she can't stand it. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/14/2025 at 2:16 PM, V17, Pharmacist, stated that the pharmacy took over April 1st. V17 stated that R2's Xtampza is a medication that is not in the pyxis and not available in the facility. V17 stated that 2 doses were sent on 5/6/2025 and then 5/9/2025 a 2 week dosage was sent. V17 stated as soon as they received the request and script the medication was sent out. V17 stated that the were notified of refill needed for R2's Morphine on 5/8/2025. V17 stated that the script was written by a physician that was not Medicaid eligible. V17 stated that the facility was notified about this. V17 stated that they were awaiting a script from another physician. V17 stated that at this time the medication has not been filled. V17 stated that the medications are scheduled medications and would be a significant medication error. V17 stated that R2's medication was not taken from Pixis. On 5/14/2025 at 2:45 PM V1, Administrator, stated that she was made aware by the pharmacy that there was an issue with script from V20. V1 stated that V19 was notified and requested a script from him for the medication. V1 stated that the medication is now being filled at a local pharmacy and awaiting call from pharmacy for pick up. On 5/14/2025 at 3:47 PM, V16, CNA, stated that R2 is having pain. Appetite has decreased. V16 stated that R2 usually sits up in her chair and has not been doing that as much. On 5/13/2025 at 4:00 PM V18, LPN, stated that she gave R2 the last dose. V18 stated that she ordered the morphine at that time. V18 stated that she has been off and today was her first day back. On 5/15/2025 at 9:40 AM V20, Nurse Practitioner, stated that she was aware that the facility recently went through and change and new pharmacy. V20 stated that there were some problems with getting medication when that transition occurred. V20 stated that she was made aware when a resident is getting low on the medication, and she will get the medication. V20 stated that R1 and R2 not receiving their schedule meds this is a significant medication error. V20 stated that obviously R1 and R2 would experience some discomfort related to not receiving the pain medication. V20 stated that it's obvious if they don't get the medication. V20 stated that she would expect the patients to get there medications as prescribed. V20 stated that she would expect the staff to address the pain with alternate interventions. V20 stated that she has ordered pain management in the past. On 5/15/2025 at 10:43 AM, V15, Medical Director, stated that he is usually notified of need for refills. V15 stated that he expects medication to be administered as prescribed. V15 stated that it is unfortunate that the medications were not available and administered to the patient as ordered. As of 5/15/2025 at 4:00 PM observed R2 outside leaning against wall crying. R2 stated that she is in so much pain that she didn't want to live like this and wanted to die. R2 stated that it hurts to sit and hurts to stand. R2 stated that it was miserable. R2 stated that her pain medication has not been delivered and she has not received her medication. The facility Pain management policy, dated November 22, 2021, documents Policy Statement: To provide a broad spectrum of treatment for pain management as they apply specifically to older people and with specific recommendations to aid in decision making about pain management of acute or chronic pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administering Medication policy dated October 15, 2023, documents 3. Medications shall be administered according to physician written/verbal orders upon verification the right medication, dose, route, time and positive verification of resident identity when no contraindications are identified, and the medication is labeled according to accepted standards. 8. The individual administering the medication shall sign of the electronic Medication Administration Record date for the specific day before administering the medication. The Facility Abatement Plan documents as follows: This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1.x The corrective action for the alleged deficient practice has been achieved by the following: a. Medical Director consulted regarding the availability of pain medication for R1 and R2 on 5/14/25. b. Medication for R1 and R2 were ordered, received, and administered as prescribed. c. All medication orders received by pharmacy on 5/14/25, from the physician, for R1 and R2 and delivered STAT to the facility. d. An audit for all resident medications for pain was completed by the ADON on 5/14/25. e. Medical Director provided pain medication orders to pharmacy on 5/14/2025. f. Education provided to nursing staff initiated on 5/15/25 and completed on 5/20/25, by the Administrator to ensure appropriate identification, documentation, and timely treatment for pain, as well as processes and procedures that assure the accurate acquiring, receiving, dispensing, and administering of medication for pain. The Director of Nursing or Designee will provide on-going education to any new or agency nursing staff, not in-serviced, prior to the start of their next shift. 2. Residents with active orders of pain medication have the potential to be affected by the alleged deficient practice. 3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: a. Education provided to nursing staff initiated on 5/15/25 and completed on 5/20/25, by the Administrator to ensure appropriate identification, documentation, and timely treatment for pain, as well as processes and procedures that assure the accurate acquiring, receiving, dispensing, and administering of medication for pain. The Director of Nursing or Designee will provide on-going education to any new or agency nursing staff, not in-serviced, prior to the start of their next shift. b. Pain assessment on the MAR/TAR to be completed by nurse every shift and addressed if pain noted. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Director of Nursing or designee will conduct audit of pain medication administration 3x a week x 4 weeks, to ensure appropriate knowledge and understanding of narcotics delivery, documentation, and administration practices. d. The Director of Nursing or designee will address all concerns identified during the audit. 4. The following Quality Assurance Programs have been implemented to achieve and maintain substantial compliance with the alleged deficient Practice: a. The Director of Nursing or designee will report audit findings to the Quality Assurance and Performance Improvement Committee monthly for at least three months, and thereafter as determined by the QAPI Committee. Completion Date: 05/20/2025

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation, interview, and record review the facility failed to administer prescribed opioid medications, muscle relaxants, and anticonvulsants prescribed for pain control to two of three residents (R1 and R2) reviewed for pain in the sample of three. This failure resulted in R2, who suffers from spinal muscular atrophy, restless leg syndrome, neuralgia and neuritis, and muscular dystrophy described experienced, symptoms of medication withdrawal, pain described as being ongoing, uncontrolled, excruciating, and unbearable to her head, neck, back and both lower legs, which resulted in an emergency room treatment for pain relief. This failure also resulted in R1 who suffers from cervical spinal cord injury, disorder of right wrist tendon and chronic pain syndrome too described experiencing ongoing, uncontrolled, severe pain, rated 9 on pain scale (1 to 10) to left side of his body. Findings include: 1. R1's Admission Record, print date 5/14/2025, documents that R1 was admitted [DATE] and lists cervical spinal cord injury, disorder of right wrist tendon and chronic pain syndrome as diagnosis. R1's Care Plan dated, 1/28/2025, documents that the resident has pain. Interventions include Administer analgesia (specify medication) as per orders. Give 1/2 hour before treatments or care. Evaluate the effectiveness of pain interventions (FREQ). Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. R1's Minimum Data Set, (MDS), dated [DATE], documents that R1 is cognitively intact, dependent on staff for ADLs (activity of daily living). It also documents that R1 experience pain almost constantly that frequently interferes with day-to-day activities. It also documents that R1 receives pain medication routinely and as needed and has experienced pain at level of 7. R1's Progress Note, dated 4/9/2025 to 4/24/2025, documents that Orders -Administration Note, Note Text: Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 18 MG Give 1 capsule by mouth two times a day for Pain not in stock. R1's Controlled Substances Proof of Use, dated 3/25/2025, documents last dose of Xtampza ER 18mg was administered 4/8/2025 at 4 PM. R1's Controlled Substances Proof of Use, dispense date 4/24/2025, documents the first dose of Xtampza ER 18mg administered 4/26/2025 at 10 AM. R1's Progress Note, dated 4/21/2025, 4/22/2025, documents that Orders -Administration Note, Note Text: oxycodone HCl Oral Tablet 15 MG Give 15 mg by mouth six times a day for pain give 15mg PO q 4 hours routine for pain med out of stock(OOS). R1's Controlled Substances Proof of Use, dispense date 4/22/2025, documents that the first dose of Oxycodone HCL 15mg tab was administered on 4/23/2025 at 12 AM. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R1's Progress Note, dated 4/28/2025 at 7:27 PM, documents that Orders -Administration Note, Note Text: Lyrica Oral Capsule 100 MG Give 100 mg by mouth every 12 hours for pain take 100 mg PO q12 hours med out of stock. R1's Medication Administration Record, dated April 2025, documents 10/10/2024 Baclofen 20mg tablet 3 times a day. It also documents blank 4/1 at 4 PM, 4/8 at 12 PM, 4/18 at 8AM, 12PM, and 4 PM. 4/19 at 12 PM and 4 PM, 4/20 at 8AM, 12 PM and 4 PM. R1's Progress Note, dated 5/6/2025, 5/8/2025, 5/9/2025 documents that Orders -Administration Note Note Text: Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 18 MG Give 1 capsule by mouth two times a day for Pain OOS. R1's Controlled Substances Proof of Use, dispense date 4/24/2025, documents that the last dose of Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 18 MG was administered on 5/5/2025 at 4PM. R1's Controlled Substances Proof of Use, dispense date 5/6/2025, documents that the first dose of Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 18 MG was administered on 5/7/2025 at 4AM and last dose administered 5/7/2025 at 4 PM. R1's Medication Administration Record, dated May 2025, documents 10/10/2024 Baclofen 20mg tablet 3 times a day. It also documents blank on 5/3 and 5/4 at 8AM, and 12PM. On 5/13/2025 at 11:50 AM R1 stated that when he doesn't have his pain medication his pain is ongoing, uncontrolled, and severe. R1 stated that his pain, is rated 9 on pain scale (1 to 10) to left side of his body. R1 stated that the pain gets so high that when he finally gets his medication it takes a while for the pain to lower. R1 stated that they don't do anything different for him he just waits till the medication comes in. R1 stated that he goes out of the facility but that can be difficult because of the pain. 2. R2's Admission Record, print date 4/14/2025, documents that R2 was admitted [DATE]. It lists R2, who suffers from spinal muscular atrophy, restless leg syndrome, neuralgia and neuritis, and muscular dystrophy as diagnosis. R2's Care Plan, dated 4/10/2024, documents (R2) has potential impairment to skin integrity. It also documents Administer Morphine and Hydrocodone as per orders. R2's MDS, dated [DATE], documents that R2 is cognitively intact. It also documents that R2 experience pain almost constantly that rates a 10 (1-10) on pain scale and receives routine and as needed pain medication. R2's Progress Note, dated 3/27/2025 and 3/28/2025, documents that Orders -Administration Note, Note Text: Morphine Sulfate ER Oral Tablet Extended Release 60 MG Give 1 tablet by mouth every 12 hours for pain HOLD IF PATIENT IS NODDING OR SHOWING S/S of BEING OVER-MEDICATED med out of stock, insurance issue, pharmacy notified. R2's Progress Note, dated 3/29/2025, documents that new order for liquid morphine given. Morphine Sulfate ER Oral Tablet Extended Release 60 MG discontinued. Morphine Sulfate(Concentrate) Solution 20 MG/ML Give 5 mg by mouth every 4 hours for pain med out of stock, pharmacy notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145518	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mascoutah Rehab and Nursing	201 South 10th Street Mascoutah, IL 62258

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R2's Progress Note, dated 3/30/2025 at 3:15 AM, documents that Health Status, Note Note Text: Resident c/o uncontrollable pain requesting to be sent to ER (emergency room). Call placed to 911 at this time. 0330 Resident leaving facility with (local) Ambulance service at this time. Report giving to (local hospital). At 1:07 PM Health Status Note Note Text: Resident returned to facility via ambulance at 11:15am after being sent out r/t back pain. Hospital treated pain with medications this morning. No new dx or medication orders at this time. Resident is currently in her room sitting up. R2's Progress Note, dated 4/7/202508:50 Orders -Administration Note, Note Text: Gabapentin Oral Tablet 800MG Give 1 tablet by mouth four times a day for neuropathy MEDICATION CURRENTLY UNAVAILABLE R2's progress Note, dated 4/12/2025 12:25 PM, documents that Health Status Note, Note Text: Resident was able to find local pharmacy that had previous Morphine script in stock wanted to know if it would be possible to change Morphine script back to Morphine 60mg: 1 tablet by mouth every 12 hours for pain scheduled at 8AM & 8PM. Spoke with (V19's) office asked if she could notify the provider of this and asked if they did approve change if they could send over Morphine ER 60mg to (local pharmacy). (V19's) Morphine 60mg 1 tab every 12 hours was approved and sent to (Local pharmacy) Will update prescription changes in EMR (electronic medical record). R2's Progress Note, dated 5/11/2025, 5/12/2025, 5/13/2025, and 5/14/2025 documents that Orders -Administration Note, Note Text: Morphine Sulfate ER Oral Tablet Extended Release 60 MG Give 1 tablet by mouth every 12 hours for pain med unavailable. R2's Resident Controlled Substance Record, not dated, documents the last dose of Morphine ER 60mg was administered 5/11/2025 at 8AM. R2's MAR, dated April 2025, documents blank for Baclofen 10mg on 4/1, 4/14, 4/18, 4/19, 4/20 Baclofen 20mg 4/6 at 6AM, 4/19 at 2Pm and 8 PM, 4/20 at 6AM and 8 pm. Gabapentin 800mg 4/1 at 4pm and 8 pm, 4/14 at 4 8 pm 4/18, 4/19, 4/20 at 4PM and 8 PM. R2's MAR, dated May 2025, documents Baclofen 10mg at bedtime and 20mg 5/10 blank. Gabapentin 800mg 5/3 and 5/4 at 8AM and 12 PM. 5/10 at 8PM blank. On 5/12/2025 at 2:30 PM V3, LPN, stated that they have had some issues with medication. V3 stated that more on the other halls. V3 stated that they had a recent change in pharmacy and causes some delays with the change. V3 stated that when there is a blank in a routine medication the system highlights that and it alerts her to verify if the medication was given because at that time it would look as it was not. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 5/12/2025 at 3:00 PM V2, Director of Nursing, stated that the facility is chaotic. V2 stated that she has been at the facility for about 3 months. V2 stated that prior to the changeover it was difficult to get medications from the pharmacy. Communication was horrible. V2 stated that the medication would be ordered and not delivered. V2 stated that they would have to call the pharmacy and then they were told it was an issue with the script or insurance. V2 stated that the previous pharmacy had emergency boxes in the medication room, but it was no good if you can't access it. V2 stated that it was difficult to care for the residents. V2 stated that then the changeover happened and again there were some challenges with getting medication. V2 stated that there were delays with getting medication. V2 stated that she feels its getting better. V2 stated that she is aware of medications not being delivered. V2 stated that when the medications are administered, they are signed off. V2 stated that the medication being blank would indicate that it wasn't given. V2 stated that she expects the staff to administer medication as ordered. V2 stated that she was aware of R1's medication being out and difficulty with getting the medications. V2 stated that R1 has a lot of pain and withdrawals from not receiving his pain. V2 stated that R1 goes out of the facility and when this happened the medication are to have documentation there shouldn't be an empty space on the MAR. The system is set up to make you document. V2 stated that if it's not documented it's not given. V2 stated that R2 medication is out currently, and they are trying to get it. V2 stated that R2 takes a lot of medication for pain and needs her medication. V2 stated that she likes to stay in her room, but she is different and lays in the bed more. V2 stated that due to R2's pain and the amount of pain medication she takes to manage it when the medication is not administered her pain is horrible and she has withdrawals depending on the length of time she is without. V2 stated r1 and R2 did not received their medication as ordered and did not receive medication from emergency kit or pixis. On 5/12/2025 at approximately 3:30 PM R2 stated that the pain scale did not cover her pain, the pain is excruciating and continuous. R2 stated that she went to the emergency room for pain relief. R2 stated that she stays in bed due to the pain, it hurts to breathe. R2 stated that due to her diagnosis of spinal muscular atrophy her muscles in her head and face are continuously being pulled downward. The pain is already horrible but without the pain medication it is horrid. R2 stated that she smokes cigarettes but not as much. R2 stated that smoking cigarettes helps with her anxiety which is elevated due to pain, and she doesn't go out to smoke as much because of it. R2 stated that she feels forgotten and the pain gets so bad she wants to die. R2 stated that this is not the first time. R2 stated that she has experienced withdrawal symptoms as well. R2 stated that she is always nauseated and has anxiety but it is more its extreme and she can't stand it. On 5/14/2025 at 2:16 PM, V17, Pharmacist, stated that the pharmacy took over April 1st. V17 stated that R2's Xtampza is a medication that is not in the pyxis and not available in the facility. V17 stated that 2 doses were sent on 5/6/2025 and then 5/9/2025 a 2 week dosage was sent. V17 stated as soon as they received the request and script the medication was sent out. V17 stated that the were notified of refill needed for R2's Morphine on 5/8/2025. V17 stated that the script was written by a physician that was not Medicaid eligible. V17 stated that the facility was notified about this. V17 stated that they were awaiting a script from another physician. V17 stated that at this time the medication has not been filled. V17 stated that the medications are scheduled medications and would be a significant medication error. V17 stated that R2's medication was not taken from Pyxis. On 5/14/2025 at 2:45 PM V1, Administrator, stated that she was made aware by the pharmacy that there was an issue with script from V20. V1 stated that V19 was notified and requested a script from him for the medication. V1 stated that the medication is now being filled at a local pharmacy and awaiting call from pharmacy for pick up. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 5/14/2025 at 3:47 PM, V16, CNA, stated that R2 is having pain. Appetite has decreased. V16 stated that R2 usually sits up in her chair and has not been doing that as much. On 5/13/2025 at 4:00 PM V18, LPN, stated that she gave R2 the last dose. V18 stated that she ordered the morphine at that time. V18 stated that she has been off and today was her first day back. On 5/15/2025 at 9:40 AM V20, Nurse Practitioner, stated that she was aware that the facility recently went through and change and new pharmacy. V20 stated that there were some problems with getting medication when that transition occurred. V20 stated that she was made aware when a resident is getting low on the medication, and she will get the medication. V20 stated that R1 and R2 not receiving their schedule meds this is a significant medication error. V20 stated that obviously R1 and R2 would experience some discomfort related to not receiving the pain medication. V20 stated that it's obvious if they don't get the medication. V20 stated that she would expect the patients to get there medications as prescribed. V20 stated that she would expect the staff to address the pain with alternate interventions. V20 stated that she has ordered pain management in the past. On 5/15/2025 at 10:43 AM, V15, Medical Director, stated that he is usually notified of need for refills. V15 stated that he expects medication to be administered as prescribed. V15 stated that it is unfortunate that the medications were not available and administered to the patient as ordered. As of 5/15/2025 at 4:00 PM observed R2 outside leaning against wall crying. R2 stated that she is in so much pain that she didn't want to live like this and wanted to die. R2 stated that it hurts to sit and hurts to stand. R2 stated that it was miserable. R2 stated that her pain medication has not been delivered and she has not received her medication. The Administering Medication policy dated October 15, 2023, documents 3. Medications shall be administered according to physician written/verbal orders upon verification the right medication, dose, route, time and positive verification of resident identity when no contraindications are identified, and the medication is labeled according to accepted standards. 8. The individual administering the medication shall sign of the electronic Medication Administration Record date for the specific day before administering the medication.