STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146054	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gallatin Manor	900 West Race Street Ridgway, IL 62979

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 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** 43088 Based on interview and record review the facility failed to administer narcotic pain medication as ordered for 1 (R1) of 5 residents reviewed for pain control in a sample of 5. Findings include: R1's Admission Record documented an admitted [DATE] with diagnoses including: Parkinson's disease, low back pain, Crohn's disease, dysarthria, systemic inflammatory response syndrome, and chronic pain syndrome. R1's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. Section J documents under Pain Management that R1 has received a PRN (as needed) pain medication or was offered and declined in the last 5 days from the assessment date. R1's Care Plan documented a focus area initiated on 1/13/23 I currently have an alteration d/t (due to) chronic pain r/t (related to) SIRS (Systemic Inflammatory Response Syndrome). Documented interventions include Administer medication & treatments ordered by MD (Medical Doctor) and monitor for side effects and effectiveness to current medication regimens with an initiation date of 1/13/23. On 5/1/25 at 1:40 PM, R1 was observed in her room in her wheelchair. R1 was non-interviewable related to confusion. R1's Order Summary Report documented the following orders: 4/10/25 fentanyl patch 12 mcg (microgram)/ HR (hour) apply 1 patch transdermally every 72 hours with an order status of discontinued, 4/16/25 fentanyl patch 25 mcg/hr apply 1 patch transdermally every 72 hours with an order status of discontinued, 4/21/25 fentanyl patch 12 mcg/hr apply 1 patch transdermally every 72 hours with an order status of discontinued, 4/25/25 fentanyl patch 25 mcg/hr apply 1 patch transdermally every 72 hours with an order status of discontinued, 5/1/25 fentanyl patch 50 mcg/ HR apply 1 patch transdermally every 72 hours with an order status of active, 1/3/18 hydrocodone- acetaminophen 5-325 mg (milligram) 1 tablet by mouth every 6 hours as needed with an order status of discontinued, and 3/24/25 hydrocodone- acetaminophen 5-325 mg 1 tablet by mouth every 6 hours as needed with an order status of active. (continued on next page)

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

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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	R1's 4/1/25 through 4/30/25 Electronic Medication Administration Record (eMAR) documented a fentanyl patch 12 mcg/hr was administered on 4/13/25 and removed on 4/16/25. R1's eMAR documented on 4/17/25, 4/20/25, and 4/21/25 a code of 9 for the fentanyl patch 25 mcg/ hr. The Chart Code on the eMAR documents 9 indicates Other-See Progress Notes. R1's eMAR documented on 4/21/25 a fentanyl patch 12 mcg/ hr was administered. On 5/1/25 at 10:20 AM, V3 (Director of Nursing/ DON) said on 4/17/25 R1's fentanyl patch order was changed from 12 mcg/ hr to 25 mcg/hr but the pharmacy had not delivered the fentanyl 25 mcg/ hr patches to the facility yet, so the order was changed back to fentanyl 12 mcg/hr on 4/21/25 (5 days later). V3 said she would expect staff to call a medical provider if a medication was not available. On 5/1/25 at 10:30 AM, V16 (Registered Nurse/ RN) said when R1's 4/16/25 order for fentanyl 25 mcg/hr every 72 hours was put into the electronic medical record the administration dates for every 72 hours were wrong and that is how she found R1 had not had a fentanyl patch administered from 4/17/25 through 4/21/25. V16 said she called to get an order to change R1's fentanyl patch back to 12 mcg/hr on 4/21/25 due to the facility having 1 fentanyl patch 12 mcg/hr left and the fentanyl patch 25 mcg/hr had not been delivered to the facility. V16 said R1 did not complain of increased pain during that time. The facility's revised 10/15/23 Administering Medications policy documented in part .3. Medications shall be administered according to physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified and the medication is labeled according to accepted standards .

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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 - Some	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** 43088 Based on interview and record review the facility failed to maintain records of controlled substances for accurate reconciliation and administer controlled substances as ordered for 4 (R1, R2, R3, and R5) of 5 residents reviewed for narcotic medication administration in a sample of 5. Findings include: 1. R1's Admission Record documented an admitted [DATE] with diagnoses including: Parkinson's disease, low back pain, Crohn's disease, dysarthria, systemic inflammatory response syndrome, and chronic pain syndrome. R1's Order Summary Report documented the following orders: 4/10/25 fentanyl patch 12 mcg (microgram)/ HR (hour) apply 1 patch transdermally every 72 hours with an order status of discontinued, 4/16/25 fentanyl patch 25 mcg/hr apply 1 patch transdermally every 72 hours with an order status of discontinued, 4/21/25 fentanyl patch 12 mcg/hr apply 1 patch transdermally every 72 hours with an order status of discontinued, 4/25/25 fentanyl patch 25 mcg/hr apply 1 patch transdermally every 72 hours with an order status of discontinued, 5/1/25 fentanyl patch 50 mcg/ HR apply 1 patch transdermally every 72 hours with an order status of active, and 1/3/18 hydrocodone- acetaminophen 5-325 mg (milligram) 1 tablet by mouth every 6 hours as needed with an order status of discontinued, and 3/24/25 hydrocodone- acetaminophen 5-325 mg (milligram) 1 tablet by mouth every 6 hours as needed with an order status of active. R1's 4/1/25 through 4/30/25 Electronic Medication Administration Record (eMAR) documented a fentanyl patch 12 mcg/hr was administered on 4/13/25 and removed on 4/16/25. R1's eMAR documented on 4/17/25, 4/20/25, and 4/21/25 a code of 9 for the fentanyl patch 25 mcg/ hr. The Chart Code on the eMAR documents 9 indicates Other-See Progress Notes. R1's eMAR documented on 4/21/25 a fentanyl patch 12 mcg/ hr was administered. On 5/1/25 at 10:20 AM, V3 (Director of Nursing/ DON) said on 4/17/25 R1's fentanyl patch order was changed from 12 mcg/ hr to 25 mcg/hr but the pharmacy had not delivered the fentanyl 25 mcg/ hr patches to the facility yet, so the order was changed back to fentanyl 12 mcg/hr on 4/21/25 (5 days later). V3 said she would expect staff to call a medical provider if a medication was not available. On 5/1/25 at 10:30 AM, V16 (Registered Nurse/ RN) said when R1's 4/16/25 order for fentanyl 25 mcg/hr every 72 hours was put into the electronic medical record the administration dates for every 72 hours were wrong and that is how she found R1 had not had a fentanyl patch administered from 4/17/25 through 4/21/25 . V16 said she called to get an order to change R1's fentanyl patch back to 12 mcg/hr on 4/21/25 due to the facility having 1 fentanyl patch 12 mcg/hr left and the fentanyl patch 25 mcg/hr had not been delivered to the facility. On 5/1/25 at 10:40 AM, V1 (Regional Director of Operations) provided a facility undated and untitled spreadsheet of narcotic medication Controlled Substance Proof of Use forms that could not be found. This spreadsheet documented R1's Controlled Substance Proof of Use forms for hydrocodone- acetaminophen 5-325 mg for the 30 tablets delivered on 3/24/25 as missing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Electronic Medication Administration Record (eMAR) dated 3/1/25 through 3/31/25 documented 5 hydrocodone- acetaminophen 5-325 mg tablets were administered. R1's 4/1/25 through 4/30/25 eMAR documented 8 hydrocodone- acetaminophen 5-325 mg tablets were administered. R1's Controlled Substance Proof of Use form documented 30 hydrocodone-acetaminophen 5-325 mg tablets were delivered to the facility on [DATE] and tablets were administered as follows: 4/12/25 3 tablets, 4/13/25 2 tablets, 4/14/25 2 tablets, 4/15/25 3 tablets, 4/16/25 2 tablets, 4/18/25 1 tablet, 4/19/25 2 tablets, 4/20/25 2 tablets, 4/21/25 2 tablets, 4/22/25 4 tablets, 4/23/25 2 tablets for a total of 25 tablets administered. On 4/24/25 at 11:40 AM, V13 (Assistant Director of Nursing/ ADON) said it was the responsibility of V3 to ensure medications were being correctly documented on the Controlled Substance Proof of Use forms and on the resident's eMAR. V13 said she was not sure if that was being completed due to V3 only working in the facility 2 days a week as the interim DON. On 5/2/25 at 10:31 AM, V9 (Licensed Practical Nurse/ LPN) said she tried to but did not always document on the eMAR when an as needed (PRN) medication was administered. V9 said PRN medications were always documented on the Controlled Substance Proof of Use form because that was the form used when nurses counted the narcotic medications at shift change. V9 said the Controlled Substance Proof of Use form would be the most accurate documentation on when a resident received medications. On 5/2/25 at 10:58 AM, V7 (Registered Nurse/ RN) said V7 forgets to document on the eMAR due to medication administration time being chaotic but would always document on the Controlled Substance Proof of Use form. V7 said when controlled substance card was empty the Controlled Substance Proof of Use form would be put in a folder on the Business Office door to be filed. On 5/2/25 at 10:25 AM, V10 (Medical Records) said the Controlled Substance Proof of Use forms were stored in the business office until V10 could scan them into the resident's electronic medical record. V10 said she would scan them monthly so she knew all of them had been scanned. V10 said she had not yet scanned any Controlled Substance Proof of Use forms into any resident chart in 2025. 2. R2's Admission Record documented an admitted [DATE] with diagnoses including: pain in left hip, muscle spasm, low back pain, and sleep related leg cramps. R2's Order Summary Report printed 5/2/25 documented a 12/4/24 order for oxycodone -acetaminophen 5-325 mg 1 tablet by mouth every 8 hours as needed for pain. On 5/1/25 at 10:40 AM, V1 (Regional Director of Operations) provided a facility undated and untitled spreadsheet of narcotic medication Controlled Substance Proof of Use forms that could not be found. This spreadsheet documented on 1/1/25, 1/19/25, 2/12/25, 2/27/25, and 3/11/25 R2's oxycodone- acetaminophen 5-325 mg 30 tablets were delivered to the facility and the Controlled Substance Proof of Use forms were missing. R2's 1/1/25 through 1/31/25 eMAR documented 13 oxycodone-acetaminophen 5-325 mg tablets were administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's oxycodone- acetaminophen 5-325 mg Controlled Substance Proof of Use form documented a delivery date of 2/3/25 and 27 tablets were administered from 2/3/25 through 2/16/25. R2's 2/1/25 through 2/28/25 eMAR documented 15 oxycodone-acetaminophen 5-325 mg tablets were administered. R2's 3/1/25 through 3/31/25 eMAR documented 8 oxycodone-acetaminophen 5-325 mg tablets were administered. R2's oxycodone- acetaminophen 5-325 mg Controlled Substance Proof of Use form documented a delivery date of 3/31/25 and 30 tablets were administered from 3/31/25 through 4/23/25. R2's oxycodone- acetaminophen 5-325 mg Controlled Substance Proof of Use form documented a delivery date of 4/16/25 and 9 tablets were administered from 4/24/25 through 4/30/25. R2's 4/1/25 through 4/30/25 eMAR documented 14 oxycodone-acetaminophen 5-325 mg tablets were administered. 3. R3's Admission Record documented an admitted [DATE] with diagnoses including: dementia, history of falling, schizoaffective disorder, and polyneuropathy. R3's Order Summary Report with a print date of 5/2/25 documents the following orders: 12/1/24 Morphine Sulfate (Concentrate) Solution 20 mg/mL give 10 mg by mouth every 4 hours as needed and 3/15/25 Morphine Sulfate Oral Tablet 30 mg Give 30 mg by mouth every 4 hours as needed for pain. On 5/1/25 at 10:40 AM, V1 (Regional Director of Operations) provided a facility undated and untitled spreadsheet of narcotic medication Controlled Substance Proof of Use forms that could not be found. This spreadsheet documented on 2/18/25 15 doses of morphine 100mg/ 5ml, 3/17/25 18 morphine 30 mg tablets, and 3/24/25 15 doses of morphine 100mg/5ml were delivered to the facility and the Controlled Substance Proof of Use forms were missing. R3's 2/1/25 through 2/28/25 eMAR documented 6 doses of morphine were administered. R3's 3/1/25 through 3/31/25 eMAR documented 4 doses of morphine were administered. R3's 4/1/25 through 4/30/25 eMAR documented 4 doses of morphine were administered. R3's morphine 30 mg tablet Controlled Substance Proof of Use form documented 30 tablets were delivered on 4/24/25 and 9 tablets were administered from 4/28/25 through 4/30/25. 4. R5's Admission Record documented an admitted [DATE] with diagnoses including: cerebral palsy, unspecified abdominal pain, peptic ulcer, Huntington's disease, and epilepsy. R5's Order Summary Report with a print date of 5/25/25 documents the following orders: 11/12/24 Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for pain, 3/18/25 Hydrocodone-Acetaminophen Oral Tablet 5-325 mg give 1 tablet by mouth every 6 hours as needed for pain, and 3/24/25 Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/25 at 10:40 AM, V1 (Regional Director of Operations) provided a facility undated and untitled spreadsheet of narcotic medication Controlled Substance Proof of Use forms that could not be found. This spreadsheet documented on 1/7/25 26 hydrocodone-acetaminophen 7.5-325 mg tablets, 1/20/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets, 2/2/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets, 2/7/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets, 2/17/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets, 3/6/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets, 3/11/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets, 3/24/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets, 3/30/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets, and 4/2/25 30 hydrocodone-acetaminophen 7.5-325 mg tablets were delivered to the facility for R5 and the Controlled Substance Proof of Use forms were documented as missing. R5's 1/1/25 through 1/31/25 eMAR documented 10 hydrocodone-acetaminophen 7.5-325 mg tablets were administered. R5's hydrocodone-acetaminophen 7.5-325 mg Controlled Substance Proof of Use form documented 30 tablets were delivered to the facility on [DATE] and 30 tablets were administered from 2/26/25 through 3/9/25. R5's hydrocodone-acetaminophen 7.5-325 mg Controlled Substance Proof of Use form documented 30 tablets were delivered to the facility on [DATE] and 6 tablets were administered from 3/22/25 through 3/23/25. R5's 2/1/25 through 2/28/25 eMAR documented 10 hydrocodone-acetaminophen 7.5-325 mg tablets were administered. R5's 3/1/25 through 3/31/25 eMAR documented 24 hydrocodone-acetaminophen 7.5-325 mg tablets were administered. R5's 4/1/25 through 4/30/25 eMAR documented 18 hydrocodone-acetaminophen 7.5-325 mg tablets were administered. The facility's revised 10/15/23 Administering Medications policy documented in part . 2. The Director of Nursing Services is responsible for the supervision and direction of all personnel with medication administration duties and functions. 3. Medications shall be administered according to physician's written/ verbal orders . 8. The individual administering the medication shall sign off on the Electronic Medication Administration Record (eMAR) date for that specific day before administering the medication . 10. If it is discovered the person administrating [sic] medications has forgot to initial in the appropriate space, the supervisor shall notify that person to investigate if the medication/ treatment has been administered/ performed. 1. If the response indicates the medication/ treatment was administered the staff member shall return to the facility, sign off on the Electronic Medication Administration Record (eMAR)/ Electronic Treatment Record (eTAR) [sic] to indicate a late entry. 2. A late entry note will be documented indicating the administration of the medication . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated Controlled Substances policy documented in part . Policy . II. Drugs listed in the Schedule II, II [sic], IV and V of the Federal Comprehensive Drug Abuse Program and Control Acro 1970 shall not be accessible to any personnel other than licensed nursing, pharmacy and medical personnel designated by the facility. III. The Director of Nurses is designated by the facility to be responsible for the control of such drugs . 2. Ordering of Controlled Substances-Schedule 11-V a) All scheduled medications require a written prescription from the physician. b) Pharmacy will accept an original written prescription order by the physician or a facsimile of said order followed by the actual original prescription. c) If a written prescription is not available, the pharmacy can accept verbal authorization directly from the physician to dispense a one time, 5 day emergency supply of a Scheduled medication, and an original prescription must be sent to the pharmacy within 7 based on applicable state law . 4. Accountability of Controlled Substances . a) A declining inventory form will be provided with each Controlled Substance (CS) prescription dispensed by the pharmacy . b) When the nurse receives a CS medication from the pharmacy, he/ she will verify the contents with the label and will note the date received and quantity on the declining inventory form. c) When a CS medication is administered, in addition to following proper procedure for charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/ her initials. d) An inventory count of all CS medications stored on each nursing unit shall be performed at each change of shift. Both the incoming and outgoing nurse on each unit that is responsible for handling controlled substances will sign the inventory count .