STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care Center	107 North Watkins Street Cisne, IL 62823

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide opioid pain medication to a resident with chronic and acute pain for 1 of 4 residents (R1) reviewed for pain in the sample of 10. This failure resulted in R1 experiencing opioid withdrawal symptoms and pain at a level of ten on a zero to ten scale, R1 signing herself out of the facility AMA (Against Medical Advice), and R1 calling 911 to have an ambulance take her to the ER (Emergency Room) for treatment. Findings include:R1's admission Record documented an admission Date of 4/3/26 and listed diagnoses including Unspecified Fractures of the First and Second Thoracic Vertebrae, Traumatic Pneumothorax, Bilateral Contusions of the Lungs, Multiple Rib Fractures to the Right Side, One Rib Fracture to the Left Side, Major Laceration of the Liver, Moderate Laceration of the Spleen, Hemoperitoneum, Fracture of the Superior Rim of the Right and Left Pubis, a Displaced Fracture of the Lateral Condyle of the Left Humerus, a Severely Displaced Zone 2 Fracture of the Sacrum, and an Unspecified Fracture of the Ilium.R1's Physicians Orders documented a 4/3/26 order for Ibuprofen 800mg (milligrams) one tablet every 8 hours as needed for pain, and Oxycodone Acetaminophen (Percocet) 5-325mg one tablet every 8 hours as needed for pain.R1's April 2026 Medication Administration Record (MAR) documented 800 mg of Ibuprofen was given on 4/3/26 at 11:06pm by V2, Director of Nurses, for a pain level of 4, and that the medication was 'Ineffective in controlling the pain. There was no documentation on the MAR to indicate that Oxycodone Acetaminophen was given.R1's Hospital Summary of Care document dated 4/3/26 documented, Encounter Diagnosis: Closed fracture of multiple ribs of both sides, trauma. Outpatient medications (R1 was taking before hospitalization): Percocet (Oxycodone Acetaminophen) 5-325mg. (milligrams) take one tablet three times daily.R1's Hospital Discharge Packet dated 4/3/26 documented: Surgical History: Bilateral chest surgery, 3/9/26. Left humerus fracture surgery, 3/10/26. Irrigation and debridement of left elbow, 3/8/26. Bilateral pelvic fracture surgery, 3/8/26. Thoracoscopy, 3/9/26.R1's Hospital Physical Therapy documentation dated 4/1/26 stated, Therapy recommendations: Patient would benefit from continued therapy at a facility level. Barriers to discharge: Does not have assist needed for safe mobility/balance.R1's After Visit Summary dated 4/3/26 documented, Take these medications: Ibuprofen 800mg one tablet every 8 hours as needed for pain. Percocet 5-325mg one tablet three times daily (scheduled). There was no documentation in R1's record to indicate when the last doses of these medications were given at the hospital.R1's Nursing Progress Notes authored by V2 documented the following:4/4/26 at 1:35am: (Late entry) (R1) newly admitted to facility. Resident complains of pain, PRN (as needed) ibuprofen given per order, as other medications have not been delivered at this time. This nurse contacted pharmacy related to narcotic pain medication. Pharmacy states they have not received hard scripts. Contacted hospital due to scripts not being sent to pharmacy on discharge. Awaiting a call back from hospital. Explained this situation to resident, resident not pleased with hospital or care received while there. Resident remains awake at this time, on cell phone. Transferred to recliner per resident request, approximately 10 minutes later, resident used cell phone to call facility phone and ask to be transferred back to bed. Resident educated on use of call light, which was in reach. Resident transferred back to bed via mechanical lift and 2 staff. Appears comfortable at this time. Call light and fluids within reach.4/4/26 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Cisne Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 North Watkins Street Cisne, IL 62823	

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	at 4:27am: (Late entry) Received phone call from local dispatch at 3am that resident had called 911 requesting ambulance transport to hospital. Resident assessed and no distress noted, vital signs within normal limits. Complains of pain and not being able to sleep. PRN ibuprofen had been administered per order as hospital did not send hard scripts for narcotics on discharge and unable to pull narcotics from e(mergency) kit without script. Hospital was notified of need for scripts to be sent to pharmacy, pharmacy stated had still not received scripts at that time. Attempted to notify on call physician at 3:02am. This nurse called (V8, Medical Director) at 03:57am due to no return call from on call physician. (V8) gave orders to send to ER for eval and treat due to resident request. Ambulance arrived at 4am. Resident states she is going to the hospital and then going home and will not be returning to the facility. Resident requesting AMA (Discharge Against Medical Advice) paperwork. Resident educated of potential dangers related to leaving AMA and continues to request AMA paperwork. AMA papers signed by resident and witnessed by this nurse, 2 EMTs (Emergency Medical Technicians) and CNA (Certified Nursing Assistant) present as well. Ambulance left with resident at 4:20am. On call physician returned call at 4:30am and notified of resident transfer and decision to leave AMA.R1's Hospital ER (Emergency Room) Nurses Note dated 4/4/26 at 5am documented, Presentation: Patient states: Pain management, opioid withdrawal symptoms. Triage Assessment: Triage note: Patient arrived to ED (Emergency Department) via (local ambulance service) from (the facility). Patient signed out of (the facility) AMA and presented to hospital for pain management from injuries from MVA (Motor Vehicle Accident) that occurred in March (2026). Patient was admitted to (the facility) from (regional hospital) on 04/03(26) around 1700 (5pm) where no pain medication had been administered between then and the time of arrival to ED (approximately 12 hours). Patient complains of nausea, vomiting, and diarrhea, and pain in bilateral legs, pelvis, back, and buttocks that is described as sharp, and rated 10/10. Blood pressure 130/89, pulse 96, respirations 16, temperature 98.1 (degrees Fahrenheit) pulse oxygenation 98 percent on room air. Medications administered: Percocet 5-325mg one tablet R1's Hospital ER Physician Note dated 4/4/26 at 5:46am documented, This [AGE] year-old female presents to ED via EMS with complaints of pain all over. Patient was involved in MVA about a month ago, was hospitalized at (regional hospital) and discharged to (the facility) yesterday afternoon. She signed herself out AMA this morning, called 911 and (was) transported here with complaints of pain, nausea, vomiting, and diarrhea. The patient has been recently seen by a physician at (regional hospital). Patient says she is in chronic pain, has been in pain management several years. Data reviewed: Vital signs, nurses notes, EMS record, nursing home records. Counseling: I had a detailed discussion with the patient and/or guardian regarding the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnoses, the need for outpatient follow up with the patients primary care provider. Disposition Summary: Discharge ordered. Diagnosis: Chronic pain syndrome. Prescriptions: Percocet 5-325 mg oral tablets, take one tablet oral route every 6 hours as needed, 20 tablets, refills zero, product selection permitted.On 4/28/26 at 9:30am via phone interview R1 was alert and oriented. R1 stated in early March 2026, she was in the car with her [AGE] year-old son driving and they were hit head on by a semi tractor trailer. R1 stated she sustained multiple fractures and internal injuries, was comatosed and intubated for several days, and had several orthopedic surgeries in the days following. R1 stated previous to the accident, she had been followed by pain management for several years due to an old back injury and was taking Percocet. R1 stated she was admitted to the facility via ambulance on 4/3/26 around supper time and had been discharged on Percocet at the same dose and directions she had been on in the hospital, one tablet three times daily. R1 stated she does not recall the time of the last dose of the Percocet was given to her at the hospital. R1 stated as the evening went on, she was experiencing pain and was told by V2 that the hospital had not sent written prescriptions for her Percocet, but they would be able to give her Ibuprofen. R1 stated she can't remember what her pain was on a ten scale at that time, but the Ibuprofen was not effective in controlling her pain, which then later escalated to a 10. R1 stated she continued to ask for the Percocet and was, Given different (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cisne Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 North Watkins Street Cisne, IL 62823	

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	excuses-they needed to call the pharmacy, the doctor hadn't called them back, etcetera. R1 stated at about 1am to1:30 am she couldn't stand the pain any longer, she had been yelling out in pain, and called 911 and asked for transport to the ER. R1 stated she informed the facility she would not be coming back due to their failure to manage her pain, and she signed the facility AMA paperwork. R1 stated she was given Percocet at the hospital and 20 tablets to take home until she could follow up with her primary care provider.On 4/28/26 at 11:45am, V5 (CNA) stated she was working day shift when R1 was admitted around supper time. V5 stated R1 ate supper and was ready to go lay down. V5 stated she was aware there was a problem with R1 not being able to get her pain pill and R1 was upset about it. V5 stated she left the facility at 6pm and did not interact with R1 further.On 4/28/26 at 2:55pm, V2 stated R1 arrived via ambulance a little after 5:30pm on 4/3/26. V2 stated R1 had been hospitalized due to a bad car accident and was admitted to the facility for continuing care. V2 stated R1 was asking for her narcotic pain medication but the hospital had not sent a prescription with her. V2 stated R1 told her she had been given one pain pill that day by the hospital and she couldn't remember when. V2 stated R1's family came and brought all her home meds except for the narcotic pain medication, so they were able to give her R1 8pm medications. V2 stated the family brought 800mg Ibuprofen, which there was an order for, so she gave that around 11pm. V2 stated the Ibuprofen and frequent repositioning were ineffective in controlling R1's pain, although V2 stated she could not recall if she did any further pain scales with R1. V2 stated as the night went on R1, Was having behaviors-hollering, and calling the facility phone with requests although she knew how to use the call light. She said she was in horrible pain, but her vital signs were all normal and she was able to talk on her cell phone all night. V2 stated around 1:30am she got a call from EMS dispatch that R1 had called 911 wanting to go to the ER. V2 stated said there was no medical indication that R1 needed hospitalization, and she tried the on-call physician, who didn't answer. V2 stated at some point later she contacted V8, who gave the order to send R1 to ER. When the ambulance arrived R1 stated due to the issue with her pain meds not being available she would not be returning from the ER, and she signed AMA paperwork.On 4/28/26 at 3:30pm, V9 (CNA) stated she worked with R1 on the evening of 4/3/26. V9 stated R1 was complaining about needing pain pills, was on the call light constantly asking for pain pills, was threatening to sign out AMA, and was yelling out, which V9 felt was behavioral in nature. On 4/29/26 at 9:40am, V7 (Pharmacist/Pharmacy Director) stated the facility did call their after-hours service about the resident on 4/3/26 at 8:12pm, and the facility was told with a written prescription they could send the pain medication out STAT from a local pharmacy, but staff said the hospital had not sent written prescription and they were going to try to get ahold of their on call physician. V7 stated the facility had the correct dose of Percocet in the emergency kit which also would have been available with a written prescription. On 4/29/26 at 10:55am, V8 (Physician/Medical Director) stated he didn't specifically recall the facility contacting him at 3am on 4/4/26 about R1. V8 stated if the facility had contacted him sooner, he could possibly have given them a verbal order to access the Percocet from the emergency kit, or failing that, given the order to send her to the ER. V8 stated he felt the failure in the situation was totally on the hospital not sending the scripts, and felt the facility was not at fault. On 4/29/26 at 12:05pm, V2 stated she was not sure how long she waited back to hear from the on call physician before contacting V8, and she said she wasn't sure of the exact times of making phone calls that night. When asked why V2 didn't contact a provider when she first realized R1 arrived without scripts, V2 stated there was a lot going on that night. When told V8 was of the opinion he could have given her a verbal order to access the emergency kit, V2 stated she was not aware that was an option. When asked why the facility POS stated the Percocet was to be given three times daily prn and the hospital discharge documentation said it was to be given three times daily scheduled, V2 stated she had not been aware of the discrepancy.On 4/30/26 at 9:45am, V2 stated she did recall R1 having two loose stools the evening of 4/3/26 but she did not think they were related to opioid withdrawal. On 4/30/26 at 11:45am, V7 clarified that if a provider had contacted them with an emergency verbal order for the medication, they could have given the facility (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cisne Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 North Watkins Street Cisne, IL 62823	

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a code to access the emergency kit to obtain the pain medication. The facility's Pain Management Policy dated 12/24 documented, It is the policy of this facility to respect and support the residents right to optimal pain assessment and management. Use of opioids for pain management: See Opioid Use Policy and Procedure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care Center	107 North Watkins Street Cisne, IL 62823

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow it's policy to obtain emergency controlled medications for 1 of 7 residents (R1) reviewed for pharmacy services in the sample of 10.R1's admission Record documented an admission Date of 4/3/26 and listed diagnoses including Unspecified Fractures of the First and Second Thoracic Vertebrae, Traumatic Pneumothorax, Bilateral Contusions of the Lungs, Multiple Rib Fractures to the Right Side, One Rib Fracture to the Left Side, Major Laceration of the Liver, Moderate Laceration of the Spleen, Hemoperitoneum, Fracture of the Superior Rim of the Right and Left Pubis, a Displaced Fracture of the Lateral Condyle of the Left Humerus, a Severely Displaced Zone 2 Fracture of the Sacrum, and an Unspecified Fracture of the Ilium.R1's Physicians Orders documented a 4/3/26 order for Ibuprofen 800mg (milligrams) one tablet every 8 hours as needed for pain, and Oxycodone Acetaminophen (Percocet) 5-325mg one tablet every 8 hours as needed for pain.R1's April 2026 Medication Administration Record (MAR) documented 800 mg of Ibuprofen was given on 4/3/26 at 11:06pm by V2, Director of Nurses, for a pain level of 4, and that the medication was 'Ineffective in controlling the pain. There was no documentation on the MAR to indicate that Oxycodone Acetaminophen was given.R1's Hospital Summary of Care document dated 4/3/26 documented, Encounter Diagnosis: Closed fracture of multiple ribs of both sides, trauma. Outpatient medications (R1 was taking before hospitalization): Percocet (Oxycodone Acetaminophen) 5-325mg. (milligrams) take one tablet three times daily.R1's After Visit Summary dated 4/3/26 documented, Take these medications: Ibuprofen 800mg one tablet every 8 hours as needed for pain. Percocet 5-325mg one tablet three times daily (scheduled). There was no documentation in R1's record to indicate when the last doses of these medications were given at the hospital.R1's Nursing Progress Notes authored by V2 (Director of Nurses) documented the following:4/4/26 at 1:35am: (Late entry) (R1) newly admitted to facility. Resident complains of pain, PRN (as needed) ibuprofen given per order, as other medications have not been delivered at this time. This nurse contacted pharmacy related to narcotic pain medication. Pharmacy states they have not received hard scripts. Contacted hospital due to scripts not being sent to pharmacy on discharge. Awaiting a call back from hospital. Explained this situation to resident, resident not pleased with hospital or care received while there. Resident remains awake at this time, on cell phone. Transferred to recliner per resident request, approximately 10 minutes later, resident used cell phone to call facility phone and ask to be transferred back to bed. Resident educated on use of call light, which was in reach. Resident transferred back to bed via mechanical lift and 2 staff. Appears comfortable at this time. Call light and fluids within reach.4/4/26 at 4:27am: (Late entry) Received phone call from local dispatch at 3am that resident had called 911 requesting ambulance transport to hospital. Resident assessed and no distress noted, vital signs within normal limits. Complains of pain and not being able to sleep. PRN ibuprofen had been administered per order as hospital did not send hard scripts for narcotics on discharge and unable to pull narcotics from e(mergency) kit without script. Hospital was notified of need for scripts to be sent to pharmacy, pharmacy stated had still not received scripts at that time. Attempted to notify on call physician at 3:02am. This nurse called (V8, Medical Director) at 03:57am due to no return call from on call physician. (V8) gave orders to send to ER for eval and treat due to resident request. Ambulance arrived at 4am. Resident states she is going to the hospital and then going home and will not be returning to the facility. Resident requesting AMA (Discharge Against Medical Advice) paperwork. Resident educated of potential dangers related to leaving AMA and continues to request AMA paperwork. AMA papers signed by resident and witnessed by this nurse, 2 EMTs (Emergency Medical Technicians) and CNA (Cerified Nursing Assistant) present as well. Ambulance left with resident at 4:20am. On call physician returned call at 4:30am and notified of resident transfer and decision to leave AMA.R1's Hospital ER (Emergency Room) Nurses Note dated (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	4/4/26 at 5am documented, Presentation: Patient states: Pain management, opioid withdrawal symptoms. Triage Assessment: Triage note: Patient arrived to ED (Emergency Department) via (local ambulance service) from (the facility). Patient signed out of (the facility) AMA and presented to hospital for pain management from injuries from MVA (Motor Vehicle Accident) that occurred in March (2026). Patient was admitted to (the facility) from (regional hospital) on 04/03(26) around 1700 (5pm) where no pain medication had been administered between then and the time of arrival to ED (approximately 12 hours). Patient complains of nausea, vomiting, and diarrhea, and pain in bilateral legs, pelvis, back, and buttocks that is described as sharp, and rated 10/10. Blood pressure 130/89, pulse 96, respirations 16, temperature 98.1 (degrees Fahrenheit) pulse oxygenation 98 percent on room air. Medications administered: Percocet 5-325mg one tablet R1's Hospital ER Physician Note dated 4/4/26 at 5:46am documented, This [AGE] year-old female presents to ED via EMS with complaints of pain all over. Patient was involved in MVA about a month ago, was hospitalized at (regional hospital) and discharged to (the facility) yesterday afternoon. She signed herself out AMA this morning, called 911 and (was) transported here with complaints of pain, nausea, vomiting, and diarrhea. The patient has been recently seen by a physician at (regional hospital). Patient says she is in chronic pain, has been in pain management several years. Data reviewed: Vital signs, nurses notes, EMS record, nursing home records. Counseling: I had a detailed discussion with the patient and/or guardian regarding the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnoses, the need for outpatient follow up with the patients primary care provider. Disposition Summary: Discharge ordered. Diagnosis: Chronic pain syndrome. Prescriptions: Percocet 5-325 mg oral tablets, take one tablet oral route every 6 hours as needed, 20 tablets, refills zero, product selection permitted.On 4/28/26 at 9:30am via phone interview R1 was alert and oriented. R1 stated in early March 2026, she was in the car with her [AGE] year-old son driving and they were hit head on by a semi tractor trailer. R1 stated she sustained multiple fractures and internal injuries, was comatosed and intubated for several days, and had several orthopedic surgeries in the days following. R1 stated previous to the accident, she had been followed by pain management for several years due to an old back injury and was taking Percocet. R1 stated she was admitted to the facility via ambulance on 4/3/26 around supper time and had been discharged on Percocet at the same dose and directions she had been on in the hospital, one tablet three times daily. R1 stated she does not recall the time of the last dose of the Percocet was given to her at the hospital. R1 stated as the evening went on, she was experiencing pain and was told by V2 that the hospital had not sent written prescriptions for her Percocet, but they would be able to give her Ibuprofen.On 4/28/26 at 2:55pm, V2 stated R1 arrived via ambulance a little after 5:30pm. V2 stated R1 had been hospitalized due to a bad car accident and was admitted to the facility for continuing care. V2 stated R1 was asking for her narcotic pain medication but the hospital had not sent a prescription with her. V2 stated R1 told her she had been given one pain pill that day by the hospital and she couldn't remember when. V2 stated R1's family came and brought all her home meds except for the narcotic pain medication, so they were able to give her R1 8pm medications. V2 stated the family brought 800mg Ibuprofen, which there was an order for, so she gave that around 11pm. On 4/29/26 at 9:40am, V7 (Pharmacist/Pharmacy Director) stated the facility did call their after-hours service about the resident on 4/3/26 at 8:12pm, and were told with written prescription they could send it the pain medication out STAT from a local pharmacy, but staff said the hospital had not sent written prescription and they were going to try to get ahold of their on call physician. V7 stated the facility had the correct dose of Percocet in the emergency kit which also would have been available with a written prescription. On 4/29/26 at 10:55am, V8 (Physician/Medical Director) stated he didn't specifically recall the facility contacting him at 3am on 4/4/26 about R1. V8 stated if the facility had contacted him sooner, he could possibly have given them a verbal order to access the Percocet from the emergency kit, or failing that, given the order to send her to the ER. V8 stated he felt the failure in the situation was totally on the hospital not sending the scripts, and felt the facility was not at fault. On 4/29/26 at 12:05pm, V2 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	stated she was not sure how long she waited back to hear from the on call before contacting V8, and she said she wasn't sure. When asked why V2 didn't contact a provider when she first realized R1 arrived without scripts, V2 stated there was a lot going on that night. When told V8 was of the opinion he could have given her a verbal order to access the emergency kit, V2 stated she was not aware that was an option. On 4/30/26 at 11:45am, V7 clarified that if a provider had contacted them with an emergency verbal order for the medication, they could have given the facility a code to access the emergency kit to obtain the pain medication. The facility's Stat Safe Policy and Procedure dated March 2024 documented, The facility may use electronic first dose kits (example given, stat safe) for first dose and emergency medications where permitted by regulation or law. Procedure, facility: G. If a controlled substance is needed, facility staff should contact the pharmacy/after hours service to retrieve an access code to remove doses from the electronic first dose kit.