STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146171	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Carbondale	2940 W Westridge Place Carbondale, IL 62901

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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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview and record review the facility failed to answer call lights for residents needing assistance in a timely manner to promote dignity for 1 of 3 residents (R1) reviewed for dignity in a sample of 7. This failure resulted in R1 having feelings of desertion, fear, frustration and embarrassment. Findings include: 1. R1's face sheet documents an admitted [DATE]. Diagnoses upon admission included Multiple Sclerosis, cellulites of left lower limb, edema, weakness, difficulty walking, foot drop of right foot, pain, depression, anxiety disorder. R1's MDS (Minimum Data Set) dated 6/14/2024 includes a BIMS (Brief Interview for Mental Status) score of 15 indicating R1 is cognitively intact. Section GG Functional abilities and goals) indicates R1 requires substantial/maximal assistance with toileting, hygiene, also indicates R1 is dependent for walking, sit to stand, chair to bed and toilet transfers. R1's Care plan dated 6/20/2024 indicates, problem of resident at risk for falling related to recent illness/hospitalization and new environment with approach dated 6/1/2024 to instruct resident to use call for assist before getting out of bed or transferring. Encourage resident to stand slowly. Problem start date of 6/1/2024 section named Resident Care Information with approach dated 6/1/2024 indicates bowel and bladder: incontinent, incontinent products, small pull ups. On 8/13/2024 at 3:45 PM, R1 was observed sitting outside on the front porch of the facility visiting with a friend. R1 was alert and oriented. R1 was sitting in wheelchair which she was able to propel around in independently. R1 stated, I did live alone just a few months ago but I had a fall transferring myself, so I landed in the hospital and then was transferred here for therapy. R1 stated, My hopes are to get my strength back and go back home. R1 stated, My diagnosis is a tough one to stay ahead of but with my determination I believe I can stay at home a few more years and stay self-sufficient which isn't the normal for most people, but I have learned to adjust. She said she doesn't want to get anyone in trouble, and she knows how short staffed they are around here, but the care is just not very good. R1 stated the weekends are the worst but last Sunday was horrible. R1 stated she was on her call light asking for help for hours but there was nobody to help her. R1 stated the Occupational therapist was there and she is the one who finally came and helped me get cleaned up and was soaked in urine. My family came and took me home for the day. (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

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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 0550 Level of Harm - Actual harm Residents Affected - Few	On 8/14/2024 at 9:14 AM, R1 was asked to explain what occurred on Sunday 8/11/2024. R1 stated, I was on my call light for hours needing assistance as I needed to use the bathroom. R1 stated she does have episodes of incontinence but for the most part she is able to feel the urge and get to the bathroom with assistance in time. R1 stated, I am really OCD (obsessive compulsive disorder) about continence. I use liners and I do not like being wet so I try to ask for assistance at the first feeling of urgency so I can stay dry. R1 stated, 'Sunday felt like the longest day of my life. There was nobody here to help us and I felt deserted. R1 stated she could hear all the lights ringing nonstop but there was just no help. R1 stated, I was totally soaked through my clothes, and I had to lay like that for hours. R1 stated, I started asking for help before 6 AM and it was after 10 AM before anyone was able to help me. The one that helped me was the OT (Occupational Therapist). R1 was asked how this made her feel and she stated, I was crying so much, I felt deserted, and I was frustrated, embarrassed, and fearful. R1 stated, I fear this will happen again and I know it will because they do not have enough staff to take care of us especially on the weekend. I know it is not their fault and some of the staff go above and beyond but they can't work every day of the week, and they can't do it all either. I was supposed to go to my daughter's house, and I did get to go but we were 2 hours behind leaving because I wasn't ready, nobody could help me get ready. On 8/14/2024 at 11:15 AM, V8 COTA (Certified Occupational Therapist Assistant) stated, I work Sunday through Thursday at the facility. V8 stated, I worked this past Sunday. V8 was asked if there was anything unusual about Sunday 8/11/2024, V8 stated the weekends are always bad, but this past Sunday was bad. V8 stated, I was trying to help by changing resident and getting them up, as I was seeing resident for their therapy. V8 was asked if she cared for R1 and V8 stated yes, I noticed in between my patients that I was treating that (R1's) call light had been on for a long, long time, approximately 45 minutes. She said she went into R1's room to check on her and when she entered the room the smell of urine was very strong as soon as she walked into the room. (R1) was lying in bed crying and was very upset. She said she felt bad for her as (R1) was so soaked with urine, it was so bad. V8 stated (R1) was so embarrassed and just kept apologizing to me for being in such bad shape, it was so sad. V8 stated (R1) is totally dependent with walking so she can't get up by herself. V8 stated, I just started getting her cleaned up. R1 was soaked through the pad, depends, night clothes, bed pad and sheet down to the mattress. the mattress was even wet. V8 stated R1 was even wet all the way up her entire back. V8 said (R1's) family member came in just as she was finishing, and the family member said R1 had been texting her since early that AM stating she needed help. On 8/14/2024 at 2:10 PM, via phone interview, V26, R1's family member stated on Sunday 8/11/2024, R1 called her crying that morning and so she went out to the facility. V26 stated R1 was in a very depressed state. V26 stated she got there just as they were cleaning her up and staff had to change everything as she was soaked in urine. V26 stated weekends are low staff, the ones that show up are good but there are too many residents for just a few staff to care for. V26 stated, Something needs to be done because (R1) was distraught on Sunday and not in a good place when I got here on Sunday. None of the residents deserve this kind of care. On 8/15/2024 at 2:50 PM, V21 (Certified Nurse Assistant/CNA) stated she takes care of R1 frequently. V21 stated R1 is continent of bowel and bladder. V21 stated R1 lets the staff know when she has the urge to use the bathroom and they take her to the bathroom. V21 states R1 still wears a depends (adult brief) because she is always afraid, she may have an accident and that would embarrass R1 as she is very conscious of her hygiene. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 8/14/2024 a call light log provided by V2 was reviewed. The document contained room numbers, time the call light was started and the time the call light was ended. The call light log recorded R1's room for 8/11/2024 as start time 8:24:49 am and end time 9:26 :31am with duration of 1:01:42. On 8/13/2024 at 4:00 PM, V2 was asked if he was aware of call lights not being answered in a timely manner and residents had long wait times for care, V2 stated he was not aware of any real issues. V2 was presented with the document (unnamed) that V2 provided, a log with room numbers, when call lights were triggered with hour, minutes, and seconds, (start time) and call light end time and dates. A specific date was presented to V2 of 8/11/2024 for R1's call light, start time was 8:24:49 am and end time was 9:26 :31am with duration of 1:01:42. V2 was asked to interpret the duration time and V2 stated that is 1 hour, 1 minute and 42 seconds and I missed seeing that when I gave you the call light usage report. V2 was asked if this was acceptable practice and V2 stated, No not at all. V2 was asked what the expectation was for the duration time of call lights being activated, V2 stated, 15 minutes or less. V2 was asked if he knows why this was an issue on 8/11/2024, V2 stated, because of staffing, it was bad. V2 was asked if care was provided adequately to the residents on 8/11/2024 during the day shift, V2 stated, evidently not. V2 was asked if the grievances pertaining to the past weekend were reviewed and V2 stated 'yes they were. On 8/14/2024 at 1:25 PM V19 CNA (Certified Nurse Aid/CNA Supervisor) stated she worked on 8/11/2024. V19 stated the weekends are always bad due to younger staff and they call in all the time or don't show up. V19 stated it is a real struggle but this past Sunday 8/11/2024 was the worse she has ever seen it. V19 stated it has been bad for last 6 months on the weekends. V19 stated trying to get staff. V19 said breakfast was late as well V19 stated R1 is normally continent of bowel and bladder and was made aware that V8 was able to get to her and get her cleaned up. V19 stated this is not acceptable care at all, the care was not good due to staffing. V19 stated I did the best I could but with only me it wasn't enough. Call lights were on too long. On 8/14/2024 at 8:45AM, V6 (Licensed Practical Nurse/LPN) stated he worked on 8/11/2024 and he stated they were very short on CNA's. V6 said it wasn't the idea situation, but we tried our best to take care of the residents. V6 stated he worked on 200 halls and was able to help change some residents and answer lights sometimes. On 8/15/2024 at 7:40 PM, V17 (LPN) was asked if she worked on 8/11/2024 dayshift, V17 stated, Yes and we only had 4 CNAs and there was only 1 CNA on the hall I was working on which was 100 hall. V17 said the care was really delayed that day. On 8/15/2024 at 8:45 AM, V13 (CNA) stated on Sunday 8/11/2024 the staffing was very short. V13 stated, The call lights were on longer than usual because normally we have 2-3 CNAs on that particular hall which is 300 hall, but Sunday there but she was the only one on the hall . V12 stated I wish it could have been better but I did the best I could do. V13 stated V15 CNA came in at around 11:30 AM and helped with lunch and left at 2:00 PM. The nurse on my hall could not help due to restrictions. On 8/14/2024 at 3:55 PM, V1 (Administrator) was asked if she was aware of there only being 4 CNAs in the facility on 8/11/2024. V1 stated, I received a text at 6AM but I didn't see it until I woke up at 7:45 AM and at that time I started calling people. V1 was asked if 4 CNAs for the 4 halls acceptable staffing numbers and she responded it is not preferred. V1 was asked if she was aware of the issues with care such as residents being left wet and call lights not being answered for long periods of time and she stated yes and had received grievances and had addressed the issues.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview, and record review the facility failed provide timely toileting assistance to 3 of 7 residents (R1, R3, and R5) reviewed for ADL (Activities of Daily Living) care in the sample of 7. Findings include: 1. R1's face sheet documents an admitted [DATE]. Diagnoses upon admission included Multiple Sclerosis, cellulites of left lower limb, edema, weakness, difficulty walking, foot drop of right foot, pain, depression, anxiety disorder. MDS (Minimum Data Set) dated 6/14/2024 includes a BIMS (Brief Interview for Mental Status) score of 15 indicating cognitively intact under Section C. Section GG (Functional abilities and goals) indicates R1 requires substantial/maximal assistance with toileting hygiene, also indicates R1 is dependent for walking, sit to stand, chair to bed and toilet transfers. R1's Care plan dated 6/20/2024 indicates, problem of resident at risk for falling related to recent illness/hospitalization and new environment with approach dated 6/1/2024 to instruct resident to use call for assist before getting out of bed or transferring. Encourage resident to stand slowly. Problem start date of 6/1/2024 section named Resident Care Information with approach dated 6/1/2024 indicates bowel and bladder: incontinent, incontinent products, small pull ups. On 8/13/2024 at 3:45 PM, R1 was observed sitting outside on the front porch of the facility visiting with a friend. R1 was alert and oriented. R1 stated the weekends are the worst but last Sunday was horrible, the staffing was low, call lights weren't getting answered, incontinence episode happened, and a therapy person helped me get cleaned up. On 8/14/2024 at 9:14 AM, R1 was asked to explain what occurred on Sunday 8/11/2024. R1 stated, I was on my call light for hours needing assistance as I needed to use the bathroom. R1 stated she does have episodes of incontinence but for the most part she is able to feel the urge and get to the bathroom with assistance in time. R1 stated, I am really OCD (obsessive compulsive disorder) about continence. I use liners and I do not like being wet so I try to ask for assistance at the first feeling of urgency so I can stay dry. R1 stated, 'Sunday felt like the longest day of my life. There was nobody here to help us and I felt deserted. She stated she could hear call lights going off for a long time. She stated she was incontinent and soaked in urine and she laid in urine for hours. R1 stated, I started asking for help before 6 AM and it was after 10 AM before anyone was able to help me. She said the one that helped me was the OT (Occupational Therapist). (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/2024 11:15 AM, V8 COTA (Certified Occupational Therapist Assistant) stated, I work Sunday through Thursday at the facility. V8 stated, I worked this past Sunday. V8 was asked if there was anything unusual about Sunday 8/11/2024, V8 stated the weekends are always bad, but this past Sunday was really bad. V8 stated, I was trying to help by changing resident and getting them up, as I was seeing resident for their therapy. V8 was asked if she cared for R1 and V8 stated yes, I noticed in between my patients that I was treating that R1's call light had been on for a long, long time, approximately 45 minutes. She said she went into R1's room to check on her and when she entered the room the smell of urine was very strong as soon as she walked into the room. V8 stated (R1) was so soaked with urine, it was so bad. V8 stated (R1) is totally dependent with walking so she can't get up by herself. V8 stated, I just started getting her cleaned up. R1 was soaked through the pad, depends, night clothes, bed pad and sheet down to the mattress. the mattress was even wet. V8 stated R1 was even wet all the way up her entire back. V8 said (R1's) family member came in just as she was finishing, and the family member said R1 had been texting her since early that AM stating she needed help. On 8/14/2024 at 2:10 PM via phone interview, V26 (R1's) family member stated Sunday 8/11/2024, (R1) called her crying that morning and so she went out to the facility. She said when she arrived R1 was getting changed and everything was soaked in urine. V26 said weekends are low staff, the ones that show up are good but there are too many residents for just a few staff to provide care for. On 8/13/2024 at 4:00 PM, V2 was asked if he was aware of call lights not being answered in a timely manner and residents had long wait times for care, V2 stated he was not aware of any real issues. V2 was presented with the document (unnamed) that V2 provided, a log with room numbers, when call lights were triggered with hour, minutes, and seconds, (start time) and call light end time and dates. A specific date was presented to V2 of 8/11/2024 for R1's call light, start time was 8:24:49 am and end time was 9:26 :31am with duration of 1:01:42. V2 was asked to interpret the duration time and V2 stated that is 1 hour, 1 minute and 42 seconds and I missed seeing that when I gave you the call light usage report. V2 was asked if this was acceptable practice and V2 stated, No not at all. V2 was asked what the expectation was for the duration time of call lights being activated, V2 stated, 15 minutes or less. V2 was asked if he knows why this was an issue on 8/11/2024, V2 stated, because of staffing, it was bad. V2 was asked if care was provided adequately to the residents on 8/11/2024 during the day shift, V2 stated, evidently not. V2 was asked if the grievances pertaining to the past weekend were reviewed and V2 stated 'yes they were. On 8/15/2024 at 2:50 PM, V21 (Certified Nurse Assistant/CNA) stated she takes care of R1 frequently. V21 stated R1 is continent of bowel and bladder. V21 stated R1 lets the staff know when she has the urge to use the bathroom and they take her to the bathroom. V21 states R1 still wears a depends (adult brief) because she is always afraid, she may have an accident and that would embarrass R1 as she is very conscious of her hygiene. 2. R3's Face sheet indicates R3 was admitted to facility on 6/23/2022, diagnosis included Type 2 diabetes mellitus, hyperlipidemia, hypothyroidism chronic atrial fibrillation. MDS (Minimum Data Set) dated 6/26/2024, section C contains a BIMS (Brief Interview for Mental Status) score of 15 indicating R3 is cognitively intact. Section GG of MDS indicates requires partial/moderate assistance for toileting hygiene. Section H, Bladder and Bowel indicates occasionally incontinent of bladder and frequently incontinent of bowels. R3's Care plan dated 6/27/2024 documents under section Resident care information bowel and bladder incontinence urinal/bedpan, incontinence products stand brief. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/2024 at 1:35 PM, R3 was alert and oriented sitting in his recliner in his room. R3 stated the care is usually pretty good but the weekends are usually worse. R3 stated this past Sunday was the worst. R3 stated, I know they had several workers call in, so we just had one CNA working our hall and she is very pregnant. She did her best, but it was bad. R3 stated he is always incontinent, and they try to keep him cleaned up but Sunday he had to sit in a wet depends for a while due to not enough staff. R3 stated it took a while to get to the call lights too. R3 said he didn't put his call light on because there were already a lot of lights on, and he knew they would get to him when they could as they always get him up and ready for breakfast. R3 stated the meals were running late too. 3. R5's face sheet documents an admitted [DATE], which includes diagnoses of Cerebral infarction due to unspecified occlusion or stenosis of unspecified precerebral arteries. Aphasia, weakness, malnutrition. MDS (Minimum Data Set) dated 6/19/2024 includes a BIMS (Brief Interview for Mental Status) score of 8, which indicates a severe cognitive impairment. Section GG of the MDS indicates R1 is dependent for toileting, showers dressing and personal hygiene. R5's Care plan dated 7/3/2024, documents under resident care information R5 has a colostomy, and incontinent of bladder, bathroom as tolerated, incontinent products standard briefs. On 8/14/2024 at 12:08PM, V27 (R5's family member) stated he filled out a grievance on 8/12/24 because something must be done with the staffing issues at the facility. V27 stated, I was sick of finding R5 laying in puddles of urine, R5 doesn't deserve that at all. V27 stated, I have had to hire private sitters to be with R5 to give me a rest in the mornings. V27 stated, CNAs in the facility are so few and some of them don't even need to be working anywhere as they don't do anything. V27 stated, 1 CNA on that hall is no way right and the resident 's deserve so much better than that, but that is not an unusual occurrence there. V27 stated, I am old too, but I will do all I can to care for R5 and assure R5 is taken care of. Grievance form dated 8/12/24 by V27 regarding R5 documents, the husband states he has some concerns regarding personal care throughout the weekend and concerns with resident just lying in bed. The same grievance form indicates grievance was substantiated and signed by V1. On 8/15/2024 at 10:05AM, R5 was noted to be sitting in wheelchair and was getting hair done by V24 (private sitter). R5 was alert but non interviewable due to aphasia. V24 said she was hired as a private sitter due to low staff and to make sure R5 is cared for right. V24 stated the number of staff is hit and miss but usually very low staffing. We feel like we must have someone with R5 to assure she gets changed and fed. V24 stated we had to push hard to get showers done but that is better now. R5 is getting therapy right now and our hopes are to take her home so we can care for her there. On 8/14/2024 at 1:25 PM, V19 (Certified Nurse Aid/CNA Supervisor) stated she worked on 8/11/2024. V19 stated the weekends are always bad due to younger staff and they call in all the time or don't show up. V19 stated it is a real struggle but this past Sunday 8/11/2024 was the worse she has ever seen it. V19 stated it has been bad for last 6 months on the weekends. V19 stated trying to get staff. V19 said breakfast was late as well V19 stated R1 is normally continent of bowel and bladder and was made aware that V8 was able to get to her and get her cleaned up. V19 stated this is not acceptable care at all, the care was not good due to staffing. V19 stated, I did the best I could but with only me it wasn't enough. Call lights were on too long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/2024 at 8:45AM, V6 (Licensed Practical Nurse/LPN) stated he worked on 8/11/2024 and he stated they were very short on CNA's. V6 said it wasn't the ideal situation, but we tried our best to take care of the residents. V6 stated he worked on 200 halls and was able to help change some residents and answer lights sometimes. On 8/15/2024 at 7:40 PM, V17 (LPN) was asked if she worked on 8/11/2024 dayshift, V17 stated, Yes and we only had 4 CNAs and there was only 1 CNA on the hall I was working on which was 100 hall. V17 said the care was really delayed that day. On 8/15/2024 at 8:45 AM, V13 (CNA) stated on Sunday 8/11/2024 the staffing was very short. V13 stated, The call lights were on longer than usual because normally we have 2-3 CNAs on that particular hall which is 300 hall, but Sunday she was the only one on the hall . V12 stated I wish it could have been better but I did the best I could do. V13 stated V15 CNA came in at around 11:30 AM and helped with lunch and left at 2:00 PM. The nurse on my hall could not help due to restrictions. On 8/14/2024 at 3:55 PM, V1 (Administrator) was asked if she was aware of there only being 4 CNAs in the facility on 8/11/2024. V1 stated, I received a text at 6AM but I didn't see it until I woke up at 7:45 AM and at that time I started calling people. V1 was asked if 4 CNAs for the 4 halls acceptable staffing numbers and she responded it is not preferred. V1 was asked if she was aware of the issues with care such as residents being left wet and call lights not being answered for long periods of time and she stated yes and had received grievances and had addressed the issues.

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F 0697 Level of Harm - 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** 49664 Based on interview and record review the facility failed to administer pain medication as ordered and develop interventions to manage pain for 1 of 5 residents (R2) reviewed for medication administration in the sample of 7. This failure resulted in R2 experiencing increased pain due to missing 4 doses of ordered pain medication on 8/10/24, 8/11/24, and 8/12/24. The findings include: R2's Face sheet documents an admitted [DATE] and includes diagnoses of encephalopathy, end stage renal disease, weakness, low back pain, malignant neoplasm of left kidney except renal pelvis, weakness and hemodialysis. R2's Minimum Data Set (MDS) dated [DATE], section C, Cognitive Patterns, documents a Brief Interview for Metal Status (BIMS) score of 15 indicating R2 is cognitively intact. Section GG, Functional Abilities and Goals, documents R2 requires substantial/maximal assistance with toileting hygiene and shower/bathing, lower body dressing and putting on and taking off footwear, and partial/moderate assist with upper body dressing. Section J, Health Conditions, documents under Pain Management, within the last 5 days (of assessment 7/26/2024) Received scheduled pain medication regimen? with a documented answer of no. The same section documents the questions within the last 5 days, received PRN (as needed) pain medication or was offered and declined? and received non-medication intervention for pain? with documented answers of yes. Under the section titled Pain Assessment Interview of section J of the same MDS dated [DATE], documents the answer of No to the question of have you had pain or hurting at any time in the last 5 days? R2's Care Plan dated 7/25/2024 does not contain problem or focus area regarding pain and does not include any interventions or approaches to manage R2's pain. R2's Pain Management Observation completed on admitted d 6/24/24, documents the answer yes to the question Have you had pain or hurting at any time in the last 5 days? and documents the pain site of back pain. The onset of pain is documented as mid morning and afternoon, duration of pain as comes and goes, and other expressions of pain as crying/whining, grimacing/clenched teeth, and bracing/guarding/ rubbing affected area. (continued on next page)

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Manor Court of Carbondale	2940 W Westridge Place Carbondale, IL 62901

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 8/13/2024 at 2:38 PM, R2 is an alert and oriented male resident observed lying in bed in the fetal position. R2 stated I am in bad pain R2 explained he had a fall the other day when he tried to get up and open his door, he stated he took one step and fell . R2 stated I have bruises to my right butt. R2 stated I am asking for pain medicine now; I usually get my pain medicine, but I had to wait last night, and I was hurting bad. R2 stated he usually gets it around 7 PM but last night (8/12/24) he had to wait until 10 PM because the nurse went on break before she gave him his pain medicine and he was hurting bad for 3 hours. R2 stated they are very particular about pain medications, I ask for it and it takes a long time, I have been asking for a while right now, my back is hurting bad. While in the room with R2, V9 (Licensed Practical Nurse/LPN) came in with pain medication stated to be Hydrocodone-acetaminophen 5/325mg. R2 was given Hydrocodone-acetaminophen 5/325mg by mouth. V9 stated I am trying to get R2's pain under control as R2 is having bad back pain that has increased since the fall. V9 stated R2 is getting Tylenol in between pain meds to help with breakthrough pain. R2 stated The Tylenol is not helping me very much. V9 stated R2's pain medication is now every 6 hours and the next dose will be due at 8:00 PM. V9 offered R2 a warm compress to R2's back to help with the pain and R2 accepted and stated, I will try anything because this pain is bad. V9 stated R2's pain medication is scheduled at 8AM, 2 PM, 8 PM and 2 AM. R2 stated it takes about an hour for the pain medication to start easing the pain. V9 asked R2 to rate his pain and R2 responded it is a 8-9 on a 10 point pain scale. V9 stated she had given Tylenol around 10 AM and R2 stated that didn't help anything. R2's Physician's Order Report dated 6/24/2024 -8/15/2024 documents the following orders: Hydrocodone-acetaminophen 5/325 mg (milligrams) every 6 hours as needed dated 6/24/2024 and a discontinuation date of 7/25/2024, hydrocodone- acetaminophen 5/325mg twice daily dated 7/25/24 and a discontinuation date of 7/30/2024, hydrocodone- acetaminophen 5/325mg three times a day dated 7/30/24 and a discontinuation date of 8/12/2024, hydrocodone- acetaminophen 5/325mg every 6 hours dated 8/12/24 and a discontinuation date of 8/13/2024, and a current order of hydrocodone- acetaminophen 5/325mg dated 8/13/2024 every 4 hours. All hydrocodone- acetaminophen 5/325mg orders have a documented diagnosis of low back pain. The same Physician's Order Report documents a current order dated 6/24/24 for Lidocaine adhesive 5% patch, 1 patch topical once a day for low back pain and an order dated 6/25/24 for acetaminophen 325 mg 2 tablets every 6 hours as needed for low back pain. R2's Medication Administration Record (MAR) with a date range of 8/1/24 through 8/20/24, documents that Hydrocodone-acetaminophen 5-325 MG tablet was Not Administered: Drug/Item unavailable on the following dates and administration times: 8/10/24 at 5:00 PM, 8/11/24 at 5:00 PM, 8/12/24 at 7:00 AM, and 8/12/24 at 2:00 PM. The same MAR documents an order of Assess pain Q (every) shift using the 0-10 pain scale or verbal descriptor scale. R2's pain is documented as a 6 on shift 2 (6PM to 6AM) on 8/10/24, as 9/10 on shift 1 (6AM to 6PM) on 5 on shift 2 on 8/11/24, as 8/10 on shift 1 and 7/10 on shift 2 on 8/12/24. R 2's Progress Note dated 8/12/2024 at 6:03 AM, documents resident gets hydrocodone5-325mg three times a day with PRN (as needed) Tylenol (acetaminophen) throughout the night as needed. Resident is still very much in pain and states that it is generalized, and the pain pills are not controlling his pain and moans in pain. NP (Nurse Practitioner) on call and notified for further orders. R2's Progress Notes dated 8/12/2024 at 11:53 AM by V2 documents, (V14 Nurse Practitioner) gives updated order to increase Norco (Hydrocodone-acetaminophen) to QID (4 times a day/every 6 hours). One time order for Tramadol 50 mg now related to pain prior to appointment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 8/13/2024 at 4:00 PM, V2 (Director of Nursing) stated I know R2 ran out of pain medications on Sunday 8/11/2024 and just gave him Tylenol for his back pain. V2 stated R2 has chronic back pain and hurts most of the time. V2 stated R2 was on pain medications 3 times a day and V2 got orders to increase the frequency to 4 times a day which is every 6 hours to help with the increased pain since the fall. On 8/202/2024 at 8:33 PM, V28 (Licensed Practical Nurse) was asked if she had to get medications out of the Stat Safe Machine (emergency medication kit) for R2, she stated she has had to get his pain medications out of there but there was a time recently when there were no more Hydrocodone-acetaminophen 5-325 mg in the Stat Safe Machine so there were none available to administer to R2. V28 stated R2 had bad back pain and as of recently the pain medications kept getting increased to help control the pain as the pain was bad. On 8/20/24 at 10:14 AM, V14 (Nurse Practitioner) said she was called about increase pain so she increased R2's pain medications. V14 was asked if she was aware R2 went without pain medications at times and she stated I know they do run out of medications but they know they should always notify me or the on call (physician) because we will always give orders for available medications from the emergency kit, even though it may not be exactly what was ordered originally but we can substitute until the original medications is delivered. V14 stated Nobody should go without medications, there is a ton of options in the emergency kits. V14 stated she had met with R2's family member in late July and they discussed how R2's pain was getting worse and they had even discussed palliative care in the future. V14 stated R2's family member is very realistic and stated (R2) is miserable with his pain. V14 stated R2 was also kind of hit and miss with his dialysis as well and some of it has to do with his pain. V14 stated R2 didn't always want to participate in therapy or get up. V14 aid R2 wanted to stay on his side with his knees bent up for comfort. That was his position that helped with the pain. V14 stated that it is very sad because R2 was such a kind man and he was very alert and oriented. The facility policy titled Pain Management Policy with revision date of 3/3/2022 documents The facility is dedicated to the philosophy that all residents should be as free of pain as possible, through a combination of medical intervention and functional therapy. Purpose: To identify residents experiencing pain to establish control of pain to the resident's satisfaction and to relieve related symptoms . Procedures: 5. An individualized care plan will be developed and implemented.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49664 Based on interview and record review the facility failed to ensure sufficient staff were available to provide needed care in a timely manner. This failure has the potential to effect all 102 residents residing in the facility. The findings include: On 8/13/2024 at 3:45 PM, R1 was observed sitting outside on the front porch of the facility visiting with a friend. R1 is an alert and oriented to person place and time. R1 stated I don't want to get anyone in trouble, and I know how short staffed they are around here, but the care is just not very good. R1 stated the weekends are the worst but last Sunday was horrible. R1 stated she was on her call light asking for help for hours but there was nobody to help her. R1 stated the Occupational therapist was there and she is the one who finally came and helped me get cleaned up. I was soaked in urine. My family came and took me home for the day. On 8/13/2024 at 1:35 PM, R3 was observed sitting in his recliner. R3 is alert and oriented. R3 stated the care is usually pretty good but the weekends are usually worse. R3 stated this past Sunday (8/11/24) was the worst. R3 stated I know they had several workers call in, so we just had one CNA (Certified Nursing Assistant) working our hall and she is very pregnant. She did her best, but it was bad. R3 stated he is always incontinent, and they try to keep him cleaned up but Sunday he had to sit in a wet depends for a while due to not enough staff. R3 stated it took a while to get to the call lights too. R3 stated the meals were running late too. On 8/13/2024 at 1:59 PM, R4 was observed lying in bed reading a book. R4 is alert and oriented. R4 stated I would be better if I could walk by myself. R4 stated she has been in the facility about a year and a half. R4 stated as far as getting my call light answered, it varies, sometimes it gets answered quickly and other times it never gets answered. R4 stated They have staffing issues here, sometimes staff don't even show up for work, they call in, and I believe it is the pay. R4 stated this last Sunday (8/11/24) there was only one CNA for this whole hall. R4 stated there was only one CNA working for many hours on Sunday. R4 states she is continent of bowel and bladder but requires assistance to the bathroom. R4 stated she was able to hold her urine until they could get to her on Sunday. R4 stated Sunday was a rough day for everyone and the staff did the best they could do. On 8/14/2024 at 12:08PM, V27 (R5's family member) stated he filled out a grievance because something has to be done with the staffing issues at the facility. V27 stated I was sick of finding (R5) laying in puddles of urine, (R5) doesn't deserve that at all. V27 stated I have had to hire private sitters to be with (R5) to give me a rest in the mornings. V27 stated CNA's in the facility are so few and some of them don't even need to be working anywhere as they don't do anything. V27 stated 1 CNA on that hall is no way right and the resident 's deserve so much better than that, but that is not an unusual occurrence there. V27 stated I am old, too, but I will do all I can to care for (R5) and assure (R5) is taken care of. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Grievance form dated 8/12/24 by V27 (family member) regarding R5 documents, the husband states he has some concerns regarding personal care throughout the weekend and concerns with resident just lying in bed. The same grievance form indicates grievance was substantiated and signed by V1 (Administrator). On 8/15/2024 at 10:05AM, R5 was observed sitting in a wheelchair and was getting hair done by V24 (private sitter). R5 is non interviewable. V24stated, (V27) has hired a private sitter due to low staff and to make sure (R5) is cared for right. V27 stated the amount of staff is hit and miss but usually very low staffing. We feel like we must have someone with (R5) to assure she gets changed and fed. V27 stated we had to push hard to get showers done but that is better now. (R5) is getting therapy right now and our hopes are to take her home where we can all take care of her at home. On 8/15/2024 at 10:00 AM, R6 is observed sitting in her room in her wheelchair. R6 is alert and oriented. R6 stated care is alright here but night shift is the worse. R6 stated the staff does not come in and check on me or my roommate very often through the night. R6 stated on this last Sunday (8/11/24) the day shift was very short staffed and we had to wait on care, and it took a while to get our call light answered. R6 stated she is usually continent but does have episode of incontinence. R6 stated she was incontinent on Sunday but that is not unusual at times. R6 stated they just didn't have enough workers. On 8/13/2024 at 1:44 PM, R7 was observed sitting in her wheelchair eating a snack. R7 is alert and oriented. R7 stated her care is normally good and they answer my call light a quick as they can. R7 stated they are short on staff here and they do the best they can, but it does sometimes take them a while to answer the call lights, I have had to wait up to 15 minutes but that was on the night shift. I can't really say which shift is worse though. On 8/13/2024 at 2:19 PM, V4 (CNA) stated staffing is doing ok and we usually have 4 CNA's on our hall. So, with 4 we are able to answer call lights quickly and care of the residents very good. Weekends are a bit challenging, but we do the best we can do. On 8/13/2024 at 3:31 PM, V7 (CNA) stated I work 6AM-6:30PM, lately staffing has been fine except the weekends. V7 stated Weekends are the worst, usually we have 10-11 CNA's over here scheduled, meaning all halls except the memory hall, but that doesn't mean that is how many shows up for work. V7 stated we already don't have enough scheduled for this coming Saturday. V7 stated I am sometimes by myself on a hall and when I am by myself, I have trouble answering call lights quickly and providing good care but I try my best. The call light log report provided by V2 documents room numbers, time the call lights were started and the time the call light was ended. On 8/11/24, the call light log recorded R1's call light start time was 8:24:49 am and end time was 9:26 :31am with duration of 1:01:42. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/13/2024 at 4:00 PM, V2 (Director of Nursing) was asked about staffing on Sunday 8/11/2024, V2 stated we were a bit short on Sunday. V2 stated we normally run 8-10 on the weekends but we had 5 this weekend. V2 stated we had 2 CNA's and a nurse on one hall and 1 CNA and a nurse on the other halls except on the memory hall. V2 was asked if he was aware of call lights not being answered in a timely manner and residents had long wait times for care, V2 stated he was not aware of any real issues. V2 was asked to interpret the duration time documented on the call light log report for R1's call light wait time on 8/11/24 and V2 stated that is 1 hour, 1 minute and 42 seconds. V2 said he missed seeing that when he reviewed the call light log report. V2 was asked if this was acceptable practice and V2 stated No not at all and I seen some call light times with a duration of 30 minutes and I thought that was bad. V2 was asked what the expectation was for the duration time of call lights being activated, V2 stated 15 minutes or less. V2 was asked if he knows why this was an issue on 8/11/2024, V2 stated because of staffing, it was bad. V2 was asked if care was provided adequately to the residents on 8/11/2024 during the day shift, V2 stated evidently not. V2 was asked if the grievances pertaining to the past weekend was reviewed and V2 stated yes they were. On 8/14/2024 at 2:44PM, V2 was asked when V2 was made aware of the staffing issues on 8/11/2024, V2 checked his phone and replied 8:31 AM is when I was notified via text. V2 stated I then called the on-call nurse V11 (Licensed Practical Nurse) and told her to go into the facility and help. V2 stated this would have made 5 working the floor. V2 stated I then sent a text to V19 (Certified Nurse Assistant/CNA Supervisor) and let her know V11 was heading in to help. V2 was asked if he knew what time V11 arrived at the facility and V2 stated not sure. V2 stated 4 CNA's is not the ideal situation for sure. V2 stated this is not the normal standard, but I feel the residents were tended to. V2 was asked if the CNA's or Nurses that work Memory Lane ever come over to the other halls to help out, V2 stated No they have their own supervisor that does their own staffing, so they only work that side of the building. They don't count on the other halls. On 8/14/2024 at 11:15 AM, V8 (Certified Occupational Therapist Assistant/ COTA) stated I work Sunday through Thursday at the facility. V8 stated I worked this past Sunday. V8 was asked if there was anything unusual about Sunday 8/11/2024, V8 stated well the weekends are always bad, but this past Sunday was really bad. V8 stated I was trying to help as I was seeing resident like changing them or getting them up. On 8/14/2024 at 1:20 PM, V11 (Licensed Practical Nurse/LPN) stated she was the on-call nurse for 8/11/2024 so she was called in to help due to only 4 CNA's showed up to work. V11 stated she arrived about 10:00AM and worked until 2:30 PM. V11 stated she just floated between halls to help where she could. V11 stated there was only 1 CNA on100 hall which was V19 (CNA). V11 stated she has never worked on 100 hall so she didn't know any of the residents. V19 stated I did what I could to help but it was bad, weekend staffing is bad. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/14/2024 at 1:25 PM, V19 (Certified Nurse Aid/CNA Supervisor) stated she worked on 8/11/2024. V19 stated the weekends are always bad due to younger staff and they call in all the time or don't show up. V19 stated it is a real struggle but this past Sunday, 8/11/2024, was the worst she has ever seen it. V19 stated it has been bad for last 6 months on the the weekends. V19 stated when she got to work on 8/11/2024 and noted the number of staff that were present, she then tried to call V1 and V2, but they were still sleeping so she was able to reach another manager. V19 stated she received a return call about 7:00AM from V1 and said V2 would be calling someone in to help. V19 stated she received a text later from V2 informing her the on-call nurse, V11, would be coming in to help. V19 stated V11 arrived around 10 :00 AM. V19 stated that breakfast was late getting served around 8:30 AM. V19 stated this is not acceptable care at all, the care was not good due to staffing. V19 stated I did the best I could but with only me it wasn't enough. Call lights were on too long. On 8/14/2024 at 2:10 PM, spoke with V26 (R1's family member) via phone. V26 stated on Sunday 8/11/2024, R1 called her crying that morning and so V26 came out to the facility. V26 stated R1 was in a very depressed state. V26 stated she got there just as they were cleaning her up and staff had to change everything as she was soaked in urine. V26 stated weekends are low staff, the ones that show up are good but there are too many residents for just a few staff to care for. On 8/14/2024 at 3:55 PM, V1 (Administrator) was asked if she was aware of only having 4 CNA's in the facility on 8/11/2024. V1 stated I received a text at 6AM but I didn't see it until I woke up at 7:45 AM and at that time I started calling people. V1 was asked if 4 CNA's for the 4 halls is acceptable staffing, V1 stated, it is not preferred. V1 stated they should have used the emergency number in this case. On 8/14/2024 at 8:45AM, V6 (LPN) stated Yes, I worked on 8/11/2024 and we were very short on CNA's. V6 said We did the best we could. It wasn't the ideal situation, but we tried our best to take care of the residents. V6 stated he worked on 200 hall on 8/11/2024 and was able to help change some residents and answer lights sometimes. On 8/15/2024 at 8:38 AM, V12 (CNA) stated staffing is normally pretty good but weekends are hectic. We have young ones that don't know how to separate work from play. V12 stated on this past Sunday (8/11/2024) we only had 4 CNA's, but we worked together as best we could. V12 stated I was on 200 hall, which is my normal hall. There are many residents on that hall that are dependent and lifts. V12 stated the call lights were on too long. On 8/15/2024 at 8:45 AM, V13 (CNA) stated on Sunday 8/11/2024 the staffing was very short. V13 stated the call lights were on longer than usual because normally we have 2-3 CNA's on 400 hall which is 200 hall but Sunday there was just 1, me. V12 stated I wish it could have been better, but I did the best I could do. V13 stated V15 (CNA) came in at around 11:30 AM and helped with lunch and left at 2:00 PM. The nurse on my hall could not help due to restrictions. On 8/15/2024 at 7:40 PM, V17 (LPN) was asked if she worked on 8/11/2024 dayshift, V17 stated yes and we only had 4 CNA's and there was only 1 CNA on the hall I was working on 100 hall. V17 stated care was really delayed that day. Something has to be done because this is horrible for the residents and we try, the ones that are there but there is just no way to take care of them with such a small amount of staff. V17 also stated that call lights were going off for a long, long time and they just couldn't get to them like they should have been. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Midnight Census Worksheet dated 8/13/2024 documents the total census of 102 residents residing at the facility. A document titled Time Detail Report for 8/11/2024 documents the total number of CNA's clocked in for 6 AM were 6 CNA's (total includes 2 CNAs for 300 hall, 5 LPNs (Licensed Practical Nurse) at 6 AM, 1 came in at 10:00 AM, and 1 LPN came in at 1:00PM.)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on observation, interview, and record review the facility failed to acquire medication refills timely resulting in missed doses of medications for 3 of 5 residents (R1, R2, and R3) reviewed for medication administration in a sample of 7. The findings include: 1. R1's face sheet documents an admitted [DATE], documented diagnoses upon admission included Multiple Sclerosis, cellulites of left lower limb, edema, weakness, difficulty walking, foot drop of right foot, pain, depression, anxiety disorder. R1's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 15 indicating R1 is cognitively intact. R1's Physician Order Report dated 6/1/2024 through 8/15/2024 documents and order dated 6/1/24 for Dextroamphetamine-amphetamine (Adderall) - Schedule II, 10 mg once a day, diagnosis Generalized Anxiety Disorder. R1's Medication Administration Record (MAR) dated 7/14/2024 through 8-13-2024 documented on 8/11/2024 and 8/12/2024 Dextroamphetamine-amphetamine (Adderall) was not administered and documented drug /item unavailable. On 8/13/2024 at 3:45 PM, R1 stated they have not been giving me my meds correctly and was out of some of medications especially my anxiety medication. My anxiety medication is just as needed but when I needed it last week, they told me I was out, and they would have to wait to get it in from pharmacy. I also asked for my Vicodin, but they said they were out of that medication too. R1 said I don't know what is going on, but I need my medications On 8/14/2024 at 2:10 PM, spoke with V26 (R1's family member) via phone. V26 stated another issue is that they always run out of R1's medications and I know because she has asked for them when I am here and the nurses say, 'we are out of this medication or that medication and we have to order them.' On 8/14/2024 at 2:40PM, V5 (Licensed Practical Nurse/LPN) was asked to check supply of Xanax for R1. 30 pills were observed in the card and there were no other cards for this medication for R1. V5 stated the card arrived last night and is marked on the label that the medication was processed on 8/12/2024. That means it was delivered last night 8/13/2024. On 8/13/2024 at 4:00 PM, V2 (Director of Nursing/DON) was asked if he was aware of resident's running out of medications and having to go without some of their medications, V2 stated yes I know of some medications that were out and not given due to being out. V2 was asked to explain, V2 stated R1 was out of Adderall Sunday (8/11/24) and Monday (8/12/24). V2 stated said that there was a clerical error with V14's (Nurse Practitioner/NP) DEA (Drug Enforcement Agency) number, so they had to send scripts to V29 (Physician/MD), and it ended up being a mess. V2 stated if the drugs were schedule III, IV, or V, I could have taken care of those as I am an agent for V29 but I cannot reorder schedule II drugs. (continued on next page)

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	146171	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Carbondale	2940 W Westridge Place Carbondale, IL 62901

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/2024 at 3:05 PM, V14 was asked if there were issues with her DEA number that prohibited her from being able to address new prescriptions or refills for scheduled drugs, V14 stated she did have a little issue but it didn't cause an issue because she would contact V29 and all the background work was done by them and should not have caused any issues or delays for the facility. V14 stated there is however an issue here at the facility with letting the providers know when a prescription is about to expire or refills that require a providers authorization. V14 stated there needs to be a way to flag those medications so resident's get their medications refilled before they totally run out. V14 stated, we have had a discussion about running out of medications, we are working on that, and we have on call available 24 hours a day. R1's Progress Notes dated 8/11/2024 at 3:29 PM, authored by V17 (Licensed Practical Nurse) documents in part .Amphetamine/Dexro (Adderall) 10mg is o/s (out of stock). Pharmacy communicated to avail the order on Monday 8/12/2024. R1's Progress Note dated 8/12/2024 at 2:52 PM, authored by V2, documents (name of contracted pharmacy) contacted regarding alprazolam (Xanax). Medication will be delivered tonight per (V20 Pharmacist). New scripts for Norco and Adderall sent to (name of provider) for signature. The pharmacy invoice pharmacy with a delivery date of delivery 8/13/2024 at 1:30 AM, indicated medications for R1 including Hydrocodone 5/325 mg 30 tabs, Alprazolam 1 mg 30 tablets, and Dextroamphetamine-Amphetamine 10mg 30 tabs. 2. R2's face sheet documents an admitted [DATE], with documented diagnoses including Encephalopathy, end stage renal disease, weakness, low back pain, malignant neoplasm of left kidney except renal pelvis, weakness. R2's MDS dated [DATE], section C, documents a BIMS score of 15 indicating R2 is cognitively intact. R2's Physician's Order Report dated 6/24/2024 -8/15/2024 documents the following orders: Hydrocodone-acetaminophen 5/325mg three times a day dated 7/30/24 and a discontinuation date of 8/12/2024, hydrocodone- acetaminophen 5/325mg every 6 hours dated 8/12/24 and a discontinuation date of 8/13/2024, and a current order of hydrocodone- acetaminophen 5/325mg dated 8/13/2024 every 4 hours. R2's Medication Administration Record (MAR) with a date range of 8/1/24 through 8/20/24, documents that Hydrocodone-acetaminophen 5-325 MG tablet was Not Administered: Drug/Item unavailable on the following dates and administration times: 8/10/24 at 5:00 PM, 8/11/24 at 5:00 PM, 8/12/24 at 7:00 AM, and 8/12/24 at 2:00 PM. The same MAR documents and order of Assess pain Q (every) shift using the 0-10 pain scale or verbal descriptor scale. R2's pain is documented as a 6 on shift 2 (6PM to 6AM) on 8/10/24, as 9/10 on shift 1 (6AM to 6PM) on 5 on shift 2 on 8/11/24, as 8/10 on shift 1 and 7/10 on shift 2 on 8/12/24. An inventory/ sign out sheet for the Statsafe machine (emergency medication kit) with a date range of 8/10/24 to 8/13/24, documents that 2 tablets were signed out on 8/11/24 at 5:42 AM, 4 tablets signed out on 8/12/24 at 4:54 PM, and 1 tablet on 8/13/24 at 4:45 PM of Hydrocodone/APAP 5-325mg for R2. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/2024 2:38 PM, R2 is an alert and oriented male resident observed lying in bed lying in the fetal position. R2 stated I am in bad pain. R2 stated I am asking for pain medicine now; I usually get my pain medicine, but I had to wait last night, and I was hurting bad. R2 stated he usually gets it around 7 PM but last night he had to wait until 10 PM because the nurse went on break before she gave him his pain medicine and he was hurting bad for 3 hours. R2 stated they are very particular about pain medications, I ask for it and it takes a long time, I have been asking for a while right now, my back is hurting so bad. While in the room with R2, V9 (Licensed Practical Nurse) came in with pain medication and stated it was Hydrocodone-acetaminophen 5/325mg. V9 asked R2 to rate his pain on a pain scale of 0-10, and R2 responded it is an 8-9. V9 was observed administering Hydrocodone-acetaminophen 5/325mg by mouth to R2 at this time. On 8/13/2024 at 4:00 PM, V2 (Director of Nursing) stated I know R2 ran out of pain medications on Sunday 8/11/2024 and we just gave him Tylenol for his back pain. V2 stated (R2) has chronic back pain and hurts most of the time. V2 stated R2 was on pain medications 3 times a day and V2 got orders to increase the frequency to 4 times a day which is every 6 hours to help with the increased pain since the fall. 3. R3's face Sheet documents that R3 was admitted to the facility 6/23/2022, with diagnoses including Type 2 diabetes mellitus, hyperlipidemia, hypothyroidism, and chronic atrial fibrillation. R3's MDS dated [DATE], section C, documents a BIMS score of 15, indicting R3 is cognitively intact. R3's Physician Order Report dated 8/1/2024 - 8/20/2024 documents an order dated 5/1/24 for Accu-checks twice a day, and an order dated 5/1/24 and a discontinuation date of 8/20/24 for Trulicity (dulaglutide) 1. 5mg/0.5ml; amount: 0.75mg subcutaneous once a week on Wednesdays, 6:00 PM-12:00AM. R3's Medication Administration Record dated 8/1/2024-8/15/2024 documents the order for the Trulicity injection once a day on Wednesday, with the last documented dose administered on 8/7/2024. The next dose was due on 8/14/2024 and documents Not Administered: Drug/item unavailable. On 8/15/2024 at 12:45 AM, R3 stated you had asked me the other day about my medications, well last night I was due to have my Trulicity injection, the medication nurse came in and told me the box was empty and the medication is not available at this time, but she would reorder it. R3 stated I am supposed to have it every Wednesday but did not get it this week. R3 stated I told you the other day that I do not have any issues with my medications, and I usually don't, maybe a few times, but this is my diabetic medication, and it is important. On 8/15/2024 at 12:45 PM, V18 (Licensed Practical Nurse) was asked to look for R3's Trulicity injection. V18 looked through the medication cart and noted the Trulicity was not on the cart. V18 was observed entering the medication room and look through the refrigerator for R3's Trulicity and noted the medication was not there. On 8/15/2024 at 1:06 PM, V20 (Pharmacist) was asked if he has received a request for a refill for R3's Trulicity, V20 stated yes last night. V20 stated R3's last Trulicity was filled on July 12th, 2024, and is a 28-day supply. V20 was asked if the nurses must request refill or does it get refilled automatically as it is evidence that it is outside of the 28-day supply, V20 stated they can reorder electronically. V20 was asked when the missed dose was due and V20 stated on Wednesday 8/ 14/2024. V20 stated it will not hurt R3 if it is a few days late as it is a weekly medication. V20 stated it will arrive 8/16/2024 on the midnight delivery. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/202/2024 at 8:33 PM, spoke with V28 (Licensed Practical Nurse) was asked if she has ever known resident's being out of medications, V28 stated yes, and I come into many meds that need reordered. I try to keep up with this, but I only work 3 nights a week. V28 stated they have had issues with running out of medications because V14 (Nurse Practitioner) had issues with her DEA number being suspended. V28 said that V14 is the one that would pick up the prescriptions needed and take them with her, and they were not taken care of, and we ran out of narcotics. V14's DEA number is fixed now, and she can sign scripts again, so things are getting back on track. The (name of pharmacy) Policy and Procedural Manual (revision date 6/24), under General Pharmacy Information documents Refills: Monday-Friday by 3pm, Saturday by 1pm. Refills after above time will be sent with the next day's delivery unless the nurse calls the pharmacy to request it that day. For facilities with electronic integration, refills are to be communicated electronically through the interface. For facilities without electronic integration, refills are to be requested via fax using the refill sheet and barcoded stickers. [NAME] the section titled Administration of Medication step A documents 1. PRN (as needed) medication cards are to be ordered as needed (not necessarily on a monthly basis}. Do not wait until the card is empty to notify the pharmacy of a needed refill. The section titled Stat Safe Machine documents under step E, The use of the Stat Safe Machine is to be for starter doses only. Normal ordering procedures should follow to ensure the resident receives a full quantity of the ordered medications.