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EVERGREEN PLACE SENIOR LIVING - ORLAND PARI	10820 183RD STREET ORLAND PARK, IL 60467

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A 000	Initial Comment Complaint Investigation: 2595655/ IL 195018 Investigation unable to be completed due to subject of the complaint not residing at the facility. Complaint Investigation 2595626/ IL 194905- Substantiated 295.5000 f) 1-3)	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 2 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 1) Obtaining and refilling medication; 2) Storing and controlling medication; 3) Disposing of medication. These Requirements Were Not Met as Evidenced By: Based observation, interview and record review the facility failed to maintain an accurate count of controlled substances, failed to obtain prescribed medications from the pharmacy, and failed to document destruction of controlled substances for 3 of 3 residents in the sample of 3.	A5000		

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Findings include:

1. R1s admission record shows she was admitted to the facility on 10/14/24 with multiple diagnoses including secondary Parkinsonism, diabetes mellitus and hypertension. Her 10/14/25 service plan documents her medications are administered by a licensed nurse and includes eye drops and insulin injections. The Order summary sheet of 10/14/25 shows R1 had an order for caregiver supervised medications until 8/23/25, when she was changed to the clinical nurse to give her medications. R1 also had an order for alprazolam (xanax) 0.25 mg every 8 hours as needed for anxiety.

The controlled drug receipt/record/disposition form for R1s Alprazolam 0.25 mg shows on 12/4/25, 30 tablets were signed for by E5 Licensed Practical Nurse (LPN). The sheet shows doses given on 12/7/24, and 1/15/25 with a remaining balance of 28 tablets. On 6/17/25, E5 noted the balance to be 26, and dispensed one tablet for R1, and the balance was 25. On 10/14/25 at 1145 AM, said she reported the discrepancy to the Director of Nursing at the time (E4). She said E4 did not have her complete any report, and E4 then resigned. E5 said she did not know if the issue was followed up. On 10/10/25 at 2:00 PM, messages were left for E4 and no return call was received.

R1s controlled drug record for Alprazolam shows on 9/4/25, E7 LPN signed out 1 pill, and noted the balance to be 24, then changed it to 22 tablets. On 10/14/25, E7 said she took one xanax out of the roll, and signed it out and put the balance as 24 per the sign out sheet. She then counted the tablets left, and there was only 22. She then reported to E2 Director of Nursing (DON) to

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remind the care givers to sign out their doses given to the resident. She said the pill count discrepancy was not reported, but she should have reported there were 2 pills missing.

R1s controlled drug record for the Alprazolam shows after E7 left the balance of 22 pills, no other doses were signed out, and on 9/10/25, E6 Registered Nurse (RN) noted there to be 20 tablets when she gave a dose, leaving a balance of 19 tablets. On 10/14/25, messages were left for E6, without any return call.

R1s Licensed Nurse Administration Record (LNAR) shows the Alprazolam was given on 6/10/25, and no pill was signed out on the controlled drug record. The July and August LNARs show no doses given. The September 2025 show 2 doses given on 9/4/25, and only 1 pill was signed out. Additional doses given for September 12,13, 17,19, and 20 were not documented on LNAR, but doses of the medication were signed out.

On 10/14/25 at 11:24 AM, E2 DON said medications are kept in locked boxes in resident rooms,the caregivers, CNA's and nurses all have keys. The locked boxes do include controlled medications, and whoever gives the medication is to sign it out on the count sheet. There have been no recently reported discrepancies. The staff should not be fixing or correcting a controlled substance count sheet, and not report it. If the medication is not counting down right we need to know that immediately.

The facility's undated policy for Counting controlled PRN (as needed) medications (Narcotics) provided by Green Tree Pharmacy. The purpose is to have an accurate count of

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controlled PRN medication and/or narcotics. 4. When the resident requests the controlled PRN narcotic the CNA, caregiver, or licensed nurse will: a) check the PRN MAR (LNAR) that it has been the appropriate amount of time between doses b) Count the number of tabs in the pouches and compare that count tot he controlled count sheet c) If the count is NOT the same the CNA or caregiver will stop, not provide assist with medication and notify a licensed nurse immediately e) The CNA, caregiver or licensed nurse will then document on the PRN MAR date, time, medication name, number of tabs and reason for the medication. f) If the count is noted to be incorrect, then a licensed nurse will investigate by counting the number of tabs in the pouches; compare the controlled count sheet sign out documentation against the PRN MAR documentation to see if it matches.
2. R2's Admission Record, provided by the facility on 10/14/2025, showed diagnoses including, but not limited to, wedge compression fracture of T11-T12 vertebra, asthma, idiopathic gout multiple sites (a type of inflammatory arthritis where the underlying cause of high uric acid levels and subsequent gout attacks is unknown), polyosteoarthritis (a condition where multiple joints are affected by osteoarthritis), rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints causing inflammation, pain and stiffness), spinal stenosis sacral and sacrococcygeal region (a narrowing of the spinal canal at the base of the spine or tailbone), vitamin D deficiency, hypertension, and Vitamin B deficiency. R2's Order Summary Report, provided by the facility on 10/14/2025, showed an order dated 8/7/2025 for Hydrocodone-Acetaminophen 5-325 mg (milligrams) one tablet every six hours as needed for pain. No end date was on the Order Summary Report.

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A5000	Continued From page 4 On 10/14/2025 at 10:55 AM, R2 was in her apartment sitting on the couch. R2 was alert and oriented x 4 (to person, place, time and event). R2 said her medications are locked in the cabinet in her apartment. R2 said the nurses give her all her medications. R2 said she thinks the nurses are the only ones that have the key to her locked medication box. R2 said she does not take prescription pain medications. R2 said she takes Advil dual action with acetaminophen for her pain. R2 said the nurse also puts a patch on her back for pain. R2 was asked about the order for hydrocodone-acetaminophen (Norco) that was listed as active in her orders. R2 said I better not have any in my medications, I told them I do not want to take it, I do not do well on it and do not want to take it. On 10/14/2025 at 11:14 AM, E9 (CNA/Caregiver) said she has worked at the facility for about two months. E9 said the caregivers help the residents with their medications. E9 said the residents' medications are kept in a locked box in their rooms. The CNAs and the nurses have keys to the residents' locked medication boxes. E9 said they have a master key that opens all the residents' locked medication boxes. E9 said when it is time for a resident's medications, they go in, unlock the medication box in front of the resident. The resident usually sits at the table. We make sure it is the right medication, the right time, and the right date. E9 said the CNA will open the pouch and hand the pouch to the resident. E9 said the nurses prepare the medications for two weeks and put them in the residents locked box. E9 said pain medications are in the locked box as well. We are able to access the pain medications and pass them to the resident. E9 said the CNAs cannot take the medications out of the pouch for	A5000		

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the residents, they just open the pouch and hand the pouch to the resident. If the resident is having a hard time, we get the nurse so the nurse can assist them. E9 said the CNAs document in the resident's electronic system if the resident takes the medications or refuses.

On 10/14/2025 at 12:10 PM, E2 (Director of Nursing) accompanied this surveyor to R2's room to look for any controlled medications. E2 did not have a key to open the locked box. E2 called E8 (Licensed Practical Nurse-LPN) to come unlock R2's medication tote. E2 unlocked R2's medication tote, then E2 and this surveyor reviewed the medications in the tote. The tote did not have any Tramadol or a reconciliation sheet for Tramadol in the tote, nor did it contain any Norco (hydrocodone-acetaminophen) tablets or reconciliation sheet in the tote.

On 10/14/2025 at 1:29 PM, E2 (Director of Nursing) said R2 has an order for as needed Norco. E2 said R2 had the order when she was admitted to the facility. E2 said there was no hard script sent with the order, so the medication was not delivered. E2 said the pharmacy did not notify the facility that they did not have a script for the medication. E2 said when a resident is admitted, the nurses double check the orders to verify that they are correct, and they send the orders to the facility's contracted pharmacy. E2 said if there is a hard copy of a script, it is sent with the orders. E2 said if there is no script, the pharmacy should call us and let us know, so that we can reach out to the physician. E2 said the nurses and I are responsible for making sure the ordered medications are in place and delivered, so they are available to the residents. E2 said R2's tramadol was ordered on 8/19/2025. One tablet was given on 8/19/2025. The nurse documented

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that one tablet was given, then the remaining 31 pills were attached to the medication roll. E2 said the Tramadol should be signed out when given. E2 said both the nurses and the caregivers should be documenting on the eMAR (electronic medication administration record) and signing the disposition form.

R2's progress note dated 8/20/2025 showed "Resident stated Tramadol upsets her stomach and wanted meds (medications) d/cd (discontinued). NP (Nurse Practitioner) gave orders to d/c (discontinue)."

R2's Controlled Drug Receipt/Record/Disposition Form showed on 8/19/2025 32 Tramadol 50 mg tablets were received from the facility's contracted pharmacy. The form showed on 8/19/2025 R2 received one of the Tramadol and the remaining 31 Tramadol were attached to R2's med roll. No other accounting of R2's Tramadol was documented on the form.

R2's August 2025 Medication Administration Record did not list an order for Tramadol or show that one tablet was administered on 8/19/2025 per the Controlled Drug Receipt/Record/Disposition Form.

On 10/14/2025 at 1:50 PM, E7 (Licensed Practical Nurse-LPN) said R2's Tramadol was a scheduled medication, that is why it was attached to the med roll. If it is scheduled, you attach the medications to the med roll and signed off on the reconciliation form that the medications were attached to the med roll. E7 said once a medication is scheduled, we do not sign the reconciliation form, the medication is signed as given on the MAR (medication administration record). E7 said when a new resident is admitted,

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the nurse should reach out to the pharmacy, if there is no hard script for medications that need a script. E7 said then the nurse should reach out to the resident's doctor to get the script and send it to the pharmacy.

On 10/14/2025, E2 provided an order to discontinue R2's hydrocodone-acetaminophen 5-325 mg order due to resident not using medication, not filled by pharmacy. The order was dated 10/24/2025.

On 10/15/2025 at 10:13 AM, E2 was called to see if she found any information regarding R2's Tramadol and if it was destroyed or not. E2 said she was still looking for documentation on it. At 1:33 PM, E1 (Executive Director) sent an email saying the facility was not able to find the destruction sheet for R2's Tramadol. No further information was provided showing what happened to R2's remaining 31 Tramadol tablets.

3. R3's History and Physical documents from admission to the facility showed diagnoses including type II diabetes mellitus, hypertension, coronary artery disease, vitamin D deficiency, memory problem, mild persistent asthma, a history of coronary artery bypass graft and nonrheumatic mitral valve regurgitation. R3's Order Summary Report, provided by the facility on 10/14/2025, showed an order for Tramadol 50 mg (milligrams) one tablet every six hours as needed for pain was received on 6/6/2025.

On 10/14/2025 at 10:47 AM, R3 was observed in her room. R3 was alert and oriented. R3 said her medications are locked in a tote in her cabinet. R3 said staff get the tote down and hand her the medications. R3 said she does not take prescription pain medications; she only takes

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Tylenol for pain. At 11:58 AM, E2 (Director of Nursing) accompanied this surveyor to R3's room to look for any controlled medications. E2 did not have a key to open the locked box. E2 called E8 (Licensed Practical Nurse-LPN) to come unlock R3's medication tote. E2 unlocked R3's medication tote, then E2 and this surveyor reviewed the medications in the tote. The tote did not have any Tramadol or a reconciliation sheet for R3's prescribed Tramadol in the tote. At 1:27 PM, E2 said the order for R3's tramadol was received in June. The nurse on duty put the order in PCC to the facility's pharmacy. E2 said the pharmacy never got an actual script from the physician, so they never sent it to us. E2 said the pharmacy usually notifies the doctor to get a script. E2 said nursing staff should have followed up with the order, by calling the pharmacy first to see why it was not sent, then notifying the doctor to get the script and send it to the pharmacy.

On 10/14/2025 at 3:22 PM, E2 said she contacted the pharmacy, and the pharmacy does not have any documentation to provide showing they notified R2 and R3's doctors to obtain a hard script because the pharmacy notified the doctors electronically. E2 said she did not have any documentation to provide regarding any correspondence with the pharmacy or the doctors showing the nursing staff addressed the need for a hard script because the pharmacy did not notify the facility that a script was needed. E2 said the nursing staff should have followed up with the pharmacy when the medications were not delivered. E2 said she is still looking for documentation regarding R2's Tramadol and if it was destroyed or not. E2 said she would email this surveyor if she found anything.

On 10/14/2025, E2 provided an order to

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discontinue R3's Tramadol HCl 50 mg order due to resident not using medication, not filled by pharmacy. The order was dated 10/14/2025.

The facility's undated procedure for Counting Controlled PRN medications (Narcotics) provided by (the facility's pharmacy) showed 1. The pharmacy will deliver medication as indicated with a controlled count sheet. 2. Licensed nurse will reconcile medication per protocol, count the number of tablets in the pouches and confirm it is the same number on the controlled count sheet ...4. When the resident requests the controlled as needed narcotic, the CNA, caregiver, or licensed nurse will: a. Check the PRN MAR (or for AL-assisted living-the PRN POC device) that it has been the appropriate amount of time between doses. B. Count the number of tabs in the pouches and compare that count to the controlled count sheet. C. If the count is not the same, the CNA or caregiver will stop, not provide assist with medication and notify a licensed nurse immediately. D. If the count is the same, the licensed nurse, CNA, or caregiver will sign out the appropriate dose (number of tabs) on the controlled count sheet, including the date, time, and their signature. The remaining s=doses left will be recorded and should match the number of pills in the pouches. E. The CNA, caregiver, or licensed nurse will then document on the PRN MAR (AL will use utilize the companion to document) date, time, medication name, number of tabs, and the reason for the mediation. F. If the count is noted to be incorrect, then a licensed nurse will investigate by counting the number of tabs in the pouches, compare the controlled count sheet sign-out documentation against the PRN MAR (AL will use the companion) documentation to see if it matches. G. If it is discovered that a CNA, caregiver or licensed

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A5000	Continued From page 10 nurse failed to document on either the PRN MAR or the controlled count sheet, that staff member will be asked to correct, and a licensed nurse will co-sign. The licensed nurse will then re-educate the CNA or caregiver in the process.	A5000		