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A 000	Initial Comment Complaint Investigtion IL191505 IL193373 Violations Cited 295.3000a)h) 295.4010d)e) 295.6000a)13) 295.6010a)1)2) 295.7000b)9)10) 295.9040a)b) Facility Reported Incident IL192635 Violations Cited 295.3000a)h) 295.6000a)13) 295.6010a)1)2)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient	A3000		

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personnel to provide the following for its current resident population:
1) All mandatory services;
2) Services established in each resident's service plan;
3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis;

These requirements were not met as evidence by:

Based on observation, interview and record review, the facility failed to ensure a nurse (E6 Licensced Practical Nurse/LPN) was not under the influence of narcotic use while providing direct patient care, failed to ensure the proper dosaging of insulin was given to one resident (R1) and failed to secure medications on a memory care unit when not being used. This failure resulted in R1 being sent to the hospital for emergency treat and E6 being sent to the hopsital for acute narcotic intoxication. These failures have the potential for severe harm to all the residents residing in the facility.

Findings include:

1) On 5/30/25 at 9:42 AM, E6, LPN, was asked to give details of the incident that happened on 5/23. E6 stated "On 5/23, I was in (Memroy Care Unit) med around 6pm. I was bending down to pull medications out of the med cart, got dizzy and passed out. I don't remember anything. The only thing I remember was waking up in the ER (emergency room)." E6 pulled the toxicology report from his 5/23/25 ER visit up on his phone and showed it to this surveyor. E6's toxicology report shows he tested positive for narcotics at

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11:32 PM on 5/23/25. E6 confirmed he was sent to the ER around 7:00 PM and was treated with Narcan upon arrival for a possible narcotic overdose. E6 was asked if he has any prescriptions that would show a positive narcotic result on a toxicology screen. E6 stated he isn't on any prescribed medications for narcotics.

On 5/30/25 at 9:59 AM, E1, Executive Director, stated "I was the one that called 911. I was still in the building and one of the caregivers came up to me and said there was something wrong with (E6). When I got to the memory care unit, (E6) was leaning over the med cart, he was very sweaty and his scrub top was soaked from sweat. He said he hadn't eaten and his blood sugar was probably low. So I sat him down in the chair and got him a grilled cheese and some orange juice. After finishing it, he said "That's not it". That's when the EMTs arrived and took over."

On 5/30/25 at 10:08 AM, Z1, EMT/Firefighter stated that he responded to the 911 call on 5/23/25. Z1 stated "I was dispatched to the facility and was told the patient (E6) may have low blood sugar. When I arrived, (E6) was in the medication room sitting in a chair. He was diaphoretic, shaking and not responding to questions. Almost catatonic like. His blood sugar was 157. Upon assessment, I noted he had poinpointed pupils. I aksed if he had ingested anything and he denied taking anything. His respirations were normal and he was acting strange. He said "I feel like I'm hallucinating right now." He had strong indications of narcotic use. We took him to the hospital via ambulance and during hand-off report, I suggested to the nurse they should giving him narcan for a possible narcotic overdose. Even though he was showing signs of narcotic intoxication, I couldn't give him narcan because

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he didn't meet all the parameters for me to give it. His respirations were not shallow or in distress."

On 5/30/25 at 10:14 am, E2, Director of Nursing, stated "(E1) called me that night (5/23) and told me that (E6) was sent to the ER and I needed to come in and finish the medication pass. I haven't really talked to him about it. (E6) told me it was medical issue and I left it at that."

On 5/30/25 at 10:45 AM, during review of the narcotic count sheet for the memory care unit and the resident's medication adminstraion record (MAR) for prescribed narcotics from 5/23-5/24, it was discovered that R4's Lorazepam count has 2 pills that are unaccounted for. R4's narcotic count sheet dated 5/23/25 at 7:03 am, documents a count of 17.5 tablets of Lorazepam. R4's narcotic count sheet dated 5/24/25 at 7:03 pm, documents a count of 131 tablets of Lorazepam aftert the pharmacy delivered 120 tablets of Lorazepam. R4's MAR dated 5/23 to 5/24 documents R4 was given his scheduled 1.5 tablets of Lorazepam and 3 PRN (As Needed) tablets of Lorazepam. The ending count on 5/24/25 at 7:03 PM, documents 131 tablets instead of 133 tablets. On 5/23 begining count: 17.5 tablets - (1.5 tablets + 3 PRNs tablets) = 13 tablets + 120 tablets received = 133 tablets remaining. The ending count was 131 tablets leaving 2 tablets of Lorazepam unaccounted for.

R4's medical record documents the following:
Lorazepam 0.5mg Take 1 1/2 tables by mouth three times a day.
Lorazepam 0.5mg Take 1 tablet by mouth every six hours as needed for anxiety

On 5/30/25 at 11:10 AM, E2, Wellness Director, and this surveyor did a physical narcotic count

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reconciliation of the memory care unit's narcotic medication. R4's Lorazepam shows he had 120 Lorrazepam delivered on 5/24/25 bringing the total count to 137.5 Lorazepam. E2 was given R4's MAR dated 5/23-5/24 and confirmed R4 was given the following beteween narcotic count - 5/23 1.5 scheduled tab, 5/23 1 PRN tab, 5/24 1 PRN tab and 5/24 1 PRN tab. According to the count, there should be 133 Lorazepam tablets left. The narcotic count shown 131 tablets. There are 2 Lorazepam tablets unaccounted for. E2 stated he was unaware there are 2 pills missing and stated "There was an issue where the nurses were giving (R4)'s PRN medication for his scheduled dose. There were popping 2 Lorazepam, cutting one in 1/2 and putting the 1/2 back and taping the bubble pack. I assumed the missing lorazepam were from them doing that. E2 was asked when he addressed this with the nurses and he stated "I talked to (E6) that day about not cutting the PRN tablets in 1/2 and told them they can't be doing that. They would have to order the scheduled lorazepam. That's why the MAR has the circle around and it says not available. It was pointed out to E2, that the count prior to him talking to E6 was reconciled at 17.5 tablets with 1.5 given before the nurse documented the medication as not given. The nurses did not administer the scheduled medication after that. E2 stated "I'm not sure why there's 2 missing. I'll have to look into it. I just assumed the 2 missing were from the PRNs being cut in 1/2."

On 5/30/25 at 11:50 AM, E6 was asked about the 2 missing Lorazepam. E6 stated E2 told them not to give the scheduled medication out of the PRN card and that's why they were documented as not given. E6 confirmed through the MAR and Narc count sheet that he only administered R4 the 1.5

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scheduled Lorazepam and the 1 PRN Lorazepam prior to him being sent to the ER.

On 5/30/25 at 3:24 PM, E7, LPN, was asked about the 2 Lorazepam that are unaccounted for. E7 stated "I texted (E2) after I completed the narc count the moring of 5/24 letting him know that (R4) has 2 Lorazepam missing. I texted him at (pulling up her phone to look text messages) 7:14am letting him know that (R4)'s Lorazepam count was 13 and the count should be 15." E7 stated E2 came into the facility and cleared the count thinking the mistake was from the PRN administration issue."

On 5/31/25 at 7:00 AM, review of E6's report, documents E6 was treated in the emergency room on 5/23/25 for an acute narcotic intoxication. The report documents the follwing:
Admission Type: Emergency Point of Origin: Transfer From Skilled Nursing Facility by Ambulance.
Patient works at (Facility) house. He was seen by coworkers in the medication room on the ground, slow to respond,possible brief loss of consciousness. Per EMS, there were many pills of hydrocodone next to him. Patient absolutely denies taking any of these. He does admitting to taking 2 Ativan (Lorazepam), that apparently belong to patient's at (Facility) house. He does not give me a particular reason for why he took them, other than for recreation.
Multiple doses of Narcan were administered due to slow responses.
Toxicology report
UR AMPHETAMINE DETECTED
UR BENZODIAZEPINES DETECTED
UR OPIATES DETECTED
UR CANNABINOID DETECTED

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A3000	Continued From page 6 On 5/31/25 at 9:20 am, E1 stated "When there's narcotics missing, (E2) is required to do an investigation going back to the previous correct narcotic count, who all had access to the narcotics during that time frame and what was administered to the resident and then report it to me. I wasn't aware there were missing narcotics until you told me yesterday." On 5/31/25 12:59 PM, E8 Caregiver, stated "(E6) started acting weird. He was standing in the doorway of the med room running his hands up and down the door frame and repeatedly squatting. I could tell he was having a balance issue. He fell like four time and kept banging his head against the wall. When I checked on him he said "I'm not ok" and his blood sugar was low. (E10 caregiver) went over to the Assisted Living side to get (E1). (E1) arrived and I helped her get (E6) in the chair because he was falling. (E6) was alert, but not with it. You need to talk to (E10), he witnessed some really strange behavior right before all this happened. Apparently (E6) was trying to give a resident medication, but didn't have anything in his hand. (E10) told (E6) to go back to the med room because he didn't have anything." On 5/31/25 at 4:27 PM, E10 stated, "I was in (R2)'s bathroom with her getting her ready for bed. (E6) walked in, didn't say anything and started hovering over (R2). His knees kept buckling and he would catch himself and stand up. He kept doing that over and over. I asked what he needed because he still didn't say anything. He told me he was there to give (R2) her medication. I looked at his hand and he didn't have anything. I told (E6) he doesn't have anything in his hand and he needs to go back to the med room. He kept trying to give her meds. I	A3000		

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told him to leave and pointed him in the direction of the medication room. After I finished with (R2), I talked to (E8) about his odd behavior. That's when I saw him hitting his head against the wall becuase he was having difficulty standing up. That's when I went over and got (E1)."

2) The facility's medication error report datd 4/30/25 documents R1 was given the wrong medication during a medication pass.

R1's medical record dated 4/30/25 documents "Residents BS (blood sugar) this morning was 174. Resident was given Humalog 50 units, resident was suppose to take Lantus 50 units."

R1's medical record documents the following medications:
Humalog Kwik Injection - Inject subcutaneously per sliding scale after meals and every night at bedtime.
Lantus Solostar - Inject 50 units every day.

On 5/30 at 3:24PM, E7, LPN, was asked about R1 receiving 50 units of Humalog. E7 stated "(E6) was training with me that day. I had (R1)'s insulin pen on the top of the med cart and (E6) walked in, grabbed the Humalog insulin pen and said "Im giving (R1) her insulin" and walked out. He didn't ask me how much to administer. I was the one on the MAR, so I don't know how he knew how much to give. When he got back, I asked how much he gave and he said 50 units. I said "50 Units! Oh my God" and I immediately called (E2) and we sent (R1) to the hospital. How could a nurse give 50 units of Humalog and not question that! All nures should know that's way too much."

On 5/31/25 at 10:22 AM, R1 stated "The whole thing is my fault. I'm a retired nurse and I should

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have known better. The nurse came in here to give me my insulin and he forgot how much I was supposed to get. I thought he had my Lantus so I told him 50 units. So he drew up 50 units and gave it to me. I should have asked which one he had." R1 was asked if E6 verified the insulin with her prior to administering it. R1 stated no, he just asked me how much I get and gave it to me."

3) On 5/30/25 at 7:16 AM, E6, LPN, observed coming out of the memory care medication room, with medications in a medicience cup, and walked to the common area tv room. The door to the medication room was left propped open. The medication cart is unlocked and there are medications sitting on the counter. The medication room can not be observed from the nurses position in the common area. As E6 was administering medication to the resident in the common area, an ambulatory resident passed by the open room several times. E6 then adminstered the medication to the resident and returned to the medication room at 7:18am. E6 repeated this process 5 more times, from 7:16am to 7:35am, leaving the medication room door propped open during the entire observation.

On 5/31/25 at 4:20PM, E1, Executive Director, stated the medication room door should be closed and the medication cart locked when the nurse exits the medication room to prevent the memory care unit resident from going in there.

The facility's medication policy documents: Medication: Administered by Qualified and Trained Bickford Family Members (BFM's)
a. Prescription medication shall be administered by qualified and trained BFMs on Medication Administration Policies and Procedures, Pharmacy Manual and electronic medication

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A3000	Continued From page 9 management software that meet state requirements. b. Medication administration includes the following activities, based on the needs of the resident: (Personal Protective Equipment (PPE) to be worn, if indicated or while handling hazardous medications and wash hands). i. Identify the correct Resident, the right medication, the right dose, the right route and the right time.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). These requirements were not met as evidence by: Based on interview and record review, the facility	A4010		

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A4010	Continued From page 10 failed to update a residents service plan with new interventions after repeated falls. This failure resulted in (R2) having contuned falls. Findings Include: R2's medical record documents R2 had falls on the following days: 5/19/25 (3 falls), 5/22/25, 5/23/25, 5/25/25 and 5/29/25. R2's service plan does not documents these falls and documents the last service plan update was completed on 5/16/25 at 1304. On 6/6/25 at 1:15PM, E1, Executive Director, confimred R2's service plan was not updated to include R2's falls.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements were not met as evidence	A6000		

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A6000	Continued From page 11 by: Based on observation, interveiw and record review, the facility failed to prevent the theft or a resident's (R4) narcotic medication by a nurse. Findings include: On 5/30/25 at 9:42 AM, E6, LPN, was asked to give details of the incident that happened on 5/23. E6 stated "On 5/23, I was in (Memroy Care Unit) med around 6pm. I was bending down to pull medications out of the med cart, got dizzy and passed out. I don't remember anything. The only thing I remember was waking up in the ER (emergency room)." E6 pulled the toxicology report from his 5/23/25 ER visit up on his phone and showed it to this surveyor. E6's toxicology report shows he tested positive for narcotics at 11:32 PM on 5/23/25. E6 confirmed he was sent to the ER around 7:00 PM and was treatd with Narcan upon arrival for a possible narcotic overdose. E6 was asked if he has any prescriptions that would show a positive narcotic result on a toxicology screen. E6 stated he isn't on any prescribed medications for narcotics. On 5/30/25 at 9:59 AM, E1, Executive Director, stated "I was the one that called 911. I was still in the building and one of the caregivers came up to me and said there was something wrong with (E6). When I got to the memory care unit, (E6) was leaning over the med cart, he was very sweaty and his scrub top was soaked from sweat. He said he hadn't eaten and his blood sugar was probably low. So I sat him down in the chair and got him a grilled cheese and some orange juice. After finishing it, he said "That's not it". That's when the EMTs arrived and took over."	A6000		

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A6000	Continued From page 12 On 5/30/25 at 10:08 AM, Z1, EMT/Firefighter stated that he responded to the 911 call on 5/23/25. Z1 stated "I was dispatched to the facility and was told the patient (E6) may have low blood sugar. When I arrived, (E6) was in the medication room sitting in a chair. He was diaphoretic, shaking and not responding to questions. Almost catatonic like. His blood sugar was 157. Upon assessment, I noted he had poinpointed pupils. I asked if he had ingested anything and he denied taking anything. His respirations were normal and he was acting strange. He said "I feel like I'm hallucinating right now." He had strong indications of narcotic use. We took him to the hospital via ambulance and during hand-off report, I suggested to the nurse they should giving him narcan for a possible narcotic overdose. Even though he was showing signs of narcotic intoxication, I couldn't give him narcan because he didn't meet all the parameters for me to give it. His respirations were not shallow or in distress." On 5/30/25 at 10:14 am, E2, Director of Nursing, stated "(E1) called me that night (5/23) and told me that (E6) was sent to the ER and I needed to come in and finish the medication pass. I haven't really talked to him about it. (E6) told me it was medical issue and I left it at that." On 5/30/25 at 10:45 AM, during review of the narcotic count sheet for the memory care unit and the resident's medicaiton adminstraion record (MAR) for prescribed narcotics from 5/23-5/24, it was discovered that R4's Lorazepam count has 2 pills that are unaccounted for. R4's narcotic count sheet dated 5/23/25 at 7:03 am, documents a count of 17.5 tablets of Lorazepam. R4's narcotic count sheet dated 5/24/25 at 7:03 pm, documents a count of 131 tablets of Lorazepam aftert the pharmacy delivered 120 tablets of Lorazepam.	A6000		

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A6000	Continued From page 13	A6000		

R4's MAR dated 5/23 to 5/24 documents R4 was given his scheduled 1.5 tablets of Lorazepam and 3 PRN (As Needed) tablets of Lorazepam. The ending count on 5/24/25 at 7:03 PM, documents 131 tablets instead of 133 tablets. On 5/23 beging count: 17.5 tablets - (1.5 tablets + 3 PRNs tablets) = 13 tablets + 120 tablets received = 133 tablets remaining. The ending count was 131 tablets leaving 2 tablets of Lorazepam unacounted for.

R4's medical record documents the following:
Lorazepam 0.5mg Take 1 1/2 tables by mouth three times a day.
Lorazepam 0.5mg Take 1 tablet by mouth every six hours as needed for anxiety

On 5/30/25 at 11:10 AM, E2, Wellness Director, and this surveyor did a physical narcotic count reconciliation of the memory care unit's narcotic medication. R4's Lorazepam shows he had 120 Lorrazepam delivered on 5/24/25 bringing the total count to 137.5 Lorazepam. E2 was given R4's MAR dated 5/23-5/24 and confirmed R4 was given the following beteween narcotic count - 5/23 1.5 scheduled tab, 5/23 1 PRN tab, 5/24 1 PRN tab and 5/24 1 PRN tab. According to the count, there should be 133 Lorazepam tablets left. The narcotic count shown 131 tablets. There are 2 Lorazepam tablets unaccounted for. E2 stated he was unaware there are 2 pills missing and stated "There was an issue where the nurses were giving (R4)'s PRN medication for his scheduled dose. They were popping 2 Lorazepam, cutting one in 1/2 and putting the 1/2 back and taping the bubble pack. I assumed the missing lorazepam were from them doing that. E2 was asked when he addressed this with the nurses and he stated "I talked to (E6) that day about not cutting the PRN tablets in 1/2 and told

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A6000	Continued From page 14	A6000		

them they can't be doing that. They would have to order the scheduled lorazepam. That's why the MAR has the circle around and it says not available. It was pointed out to E2, that the count prior to him talking to E6 was reconciled at 17.5 tablets with 1.5 given before the nurse documented the medication as not given. The nurses did not administer the scheduled medication after that. E2 stated "I'm not sure why there's 2 missing. I'll have to look into it. I just assumed the 2 missing were from the PRNs being cut in 1/2."

On 5/30/25 at 11:50 AM, E6 was asked about the 2 missing Lorazepam. E6 stated E2 told them not to give the scheduled medication out of the PRN card and that's why they were documented as not given. E6 confirmed through the MAR and Narc count sheet that he only administered R4 the 1.5 scheduled Lorazepam and the 1 PRN Lorazepam prior to him being sent to the ER.

On 5/30/25 at 3:24 PM, E7, LPN, was asked about the 2 Lorazepam that are unaccounted for. E7 stated "I texted (E2) after I completed the narc count the moring of 5/24 letting him know that (R4) has 2 Lorazepam missing. I texted him at (pulling up her phone to look text messages) 7:14am letting him know that (R4)'s Lorazepam count was 13 and the count should be 15." E7 stated E2 came into the facility and cleared the count thinking the mistake was from the PRN administration issue."

On 5/31/25 at 7:00 AM, review of E6's report, documents E6 was treated in the emergency room on 5/23/25 for an acute narcotic intoxication. The report documents the follwing: Admission Type: Emergency Point of Origin: Transfer From Skilled Nursing Facility by

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A6000	Continued From page 15 Ambulance. Patient works at (Facility) house. He was seen by coworkers in the medication room on the ground, slow to respond,possible brief loss of consciousness. Per EMS, there were many pills of hydrocodone next to him. Patient absolutely denies taking any of these. He does admit to taking 2 Ativan (Lorazepam), that apparently belong to patients at (Facility) house. He does not give me a particular reason for why he took them, other than for recreation. On 5/31/25 at 9:20 am, E1 stated "When there's narcotics missing, (E2) is required to do an investigation going back to the previous correct narcotic count, who all had access to the narcotics during that time frame and what was administered to the resident and then report it to me. I wasn't aware there were missing narcotics until you told me yesterday."	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: General Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the	A6010		

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A6010	Continued From page 16 Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. These requirements were not met as evidence by: Based on observation, interveiw and record review, the facility failed to investigate and report R4's missing narcotics when notified by the nurse. Findings include: On 5/30/25 at 9:42 AM, E6, LPN, was asked to give details of the incident that happened on 5/23. E6 stated "On 5/23, I was in (Memory Care Unit) med around 6pm. I was bending down to pull medications out of the med cart, got dizzy and passed out. I don't remember anything. The only thing I remember was waking up in the ER (emergency room)." E6 pulled the toxicology report from his 5/23/25 ER visit up on his phone and showed it to this surveyor. E6's toxicology report shows he tested positive for narcotics at 11:32 PM on 5/23/25. E6 confirmed he was sent to the ER around 7:00 PM and was treatd with Narcan upon arrival for a possible narcotic overdose. E6 was asked if he has any prescriptions that would show a positive narcotic	A6010		

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A6010	Continued From page 17	A6010		

result on a toxicology screen. E6 stated he isn't on any prescribed medications for narcotics.

On 5/30/25 at 9:59 AM, E1, Executive Director, stated "I was the one that called 911. I was still in the building and one of the caregivers came up to me and said there was something wrong with (E6). When I got to the memory care unit, (E6) was leaning over the med cart, he was very sweaty and his scrub top was soaked from sweat. He said he hadn't eaten and his blood sugar was probably low. So I sat him down in the chair and got him a grilled cheese and some orange juice. After finishing it, he said "That's not it". That's when the EMTs arrived and took over."

On 5/30/25 at 10:08 AM, Z1, EMT/Firefighter stated that he responded to the 911 call on 5/23/25. Z1 stated "I was dispatched to the facility and was told the patient (E6) may have low blood sugar. When I arrived, (E6) was in the medication room sitting in a chair. He was diaphoretic, shaking and not responding to questions. Almost catatonic like. His blood sugar was 157. Upon assessment, I noted he had poinpointed pupils. I aksed if he had ingested anything and he denied taking anything. His respirations were normal and he was acting strange. He said "I feel like I'm hallucinating right now." He had strong indications of narcotic use. We took him to the hospital via ambulance and during hand-off report, I suggested to the nurse they should giving him narcan for a possible narcotic overdose. Even though he was showing signs of narcotic intoxication, I couldn't give him narcan because he didn't meet all the parameters for me to give it. His respirations were not shallow or in distress."

On 5/30/25 at 10:14 am, E2, Director of Nursing, stated "(E1) called me that night (5/23) and told

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A6010	Continued From page 18	A6010		

me that (E6) was sent to the ER and I needed to come in and finish the medication pass. I haven't really talked to him about it. (E6) told me it was medical issue and I left it at that."

On 5/30/25 at 10:45 AM, during review of the narcotic count sheet for the memory care unit and the resident's medicaiton adminstraion record (MAR) for prescribed narcotics from 5/23-5/24, it was discovered that R4's Lorazepam count has 2 pills that are unaccounted for. R4's narcotic count sheet dated 5/23/25 at 7:03 am, documents a count of 17.5 tablets of Lorazepam. R4's narcotic count sheet dated 5/24/25 at 7:03 pm, documents a count of 131 tablets of Lorazepam aftert the pharmacy delivered 120 tablets of Lorazepam. R4's MAR dated 5/23 to 5/24 documents R4 was given his scheduled 1.5 tablets of Lorazepam and 3 PRN (As Needed) tablets of Lorazepam. The ending count on 5/24/25 at 7:03 PM, documents 131 tablets instead of 133 tablets. On 5/23 beging count: 17.5 tablets - (1.5 tablets + 3 PRNs tablets) = 13 tablets + 120 tablets received = 133 tablets remaining. The ending count was 131 tablets leaving 2 tablets of Lorazepam unacounted for.

R4's medical record documents the following:
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On 5/30/25 at 11:10 AM, E2, Wellness Director, and this surveyor did a physical narcotic count reconciliation of the memory care unit's narcotic medication. R4's Lorazepam shows he had 120 Lorrazepam delivered on 5/24/25 bringing the total count to 137.5 Lorazepam. E2 was given R4's MAR dated 5/23-5/24 and confirmed R4 was

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A6010	Continued From page 19	A6010		

given the following beteween narcotic count - 5/23 1.5 scheduled tab, 5/23 1 PRN tab, 5/24 1 PRN tab and 5/24 1 PRN tab. According to the count, there should be 133 Lorazepam tablets left. The narcotic count shown 131 tablets. There are 2 Lorazepam tablets unaccounted for. E2 stated he was unaware there are 2 pills missing and stated "There was an issue where the nurses were giving (R4)'s PRN medication for his scheduled dose. There were popping 2 Lorazepam, cutting one in 1/2 and putting the 1/2 back and taping the bubble pack. I assumed the missing lorazepam were from them doing that. E2 was asked when he addressed this with the nurses and he stated "I talked to (E6) that day about not cutting the PRN tablets in 1/2 and told them they can't be doing that. They would have to order the scheduled lorazepam. That's why the MAR has the circle around and it says not available. It was pointed out to E2, that the count prior to him talking to E6 was reconciled at 17.5 tablets with 1.5 given before the nurse documented the medication as not given. The nurses did not administer the scheduled medication after that. E2 stated "I'm not sure why there's 2 missing. I'll have to look into it. I just assumed the 2 missing were from the PRNs being cut in 1/2."

On 5/30/25 at 3:24 PM, E7, LPN, was asked about the 2 Lorazepam that are unaccounted for. E7 stated "I texted (E2) after I completed the narc count the moring of 5/24 letting him know that (R4) has 2 Lorazepam missing. I texted him at (pulling up her phone to look text messages) 7:14am letting him know that (R4)'s Lorazepam count was 13 and the count should be 15." E7 stated E2 came into the facility and cleared the count thinking the mistake was from the PRN administration issue."

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A6010	Continued From page 20 On 5/31/25 at 9:20 am, E1 stated "When there's narcotics missing, (E2) is required to do an investigation going back to the previous correct narcotic count, who all had access to the narcotics during that time frame and what was administered to the resident and then report it to me. I wasn't aware there were missing narcotics until you told me yesterday." On 5/31/25 at 3:00 PM, E2 confirmed he did not start an investigation or report the missing narcotics and stated "Like I said, I just assumed it was from the nurses cutting the pills in 1/2. Looking back at it now, I should have looked into it, but I wasn't thinking it was theft at the time."	A6010		
A7000	Secton 295.7000 Resident Records This Regulation is not met as evidenced by: General Violation Section 295.7000 Resident Records b) An establishment shall maintain a resident's record that contains at least the following: 9) Notation of known accidents, incidents or injuries; 10) Documentation of any significant change in a resident's behavior or physical, cognitive, or functional condition that would trigger an assessment or evaluation, and action taken by employees to address the resident's changing needs;	A7000		

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A7000	Continued From page 21 These requirements were not met as evidence by: On 5/30/25 at 11:05 AM, This surveyor and E2, Wellness Director, entered the memory care unit to conduct a narcotic reconciliation count. Upon approaching the medication room, E9, CNA, was observed wiping blood from R2's hand. E2 asked what happened and E9 stated R2 stood up from her wheelchair, fell and cut herself. E2 then proceeded to address the cut and assess R2. As of 5/31/25 at 4:00 PM, R2's medical record does not document a fall or laceration that occured on 5/30/25 at 11:00am. On 5/31/25 at 4:02 PM, E1, was infomred that R2's medical record does not contian the residents fall incident on 5/30/25. E1 stated she will have to get with E2 about it.	A7000		
A9040	Section 295.9040 Environmental Requirements This Regulation is not met as evidenced by: General Violation Section 295.9040 Environmental Requirements a) The establishment shall be kept in a clean, safe and orderly condition and in good repair. b) The establishment shall be free of odors. These requirements are not met as evidence by:	A9040		

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A9040	Continued From page 22 On 5/30/25 at 7:05 AM, upon entry of the memory care (MC) unit, a strong urine like odor was detected. This surveyor walked all the halls of the MC unit and could not locate where the smell was coming from. During the walk through, it was noted the carpet has a gold ball sized hole in it, next to the dining room. There are several dark spots on the carpet scattered throughout the unit. There is some type of dried pink substance ground into the carpet in 2 different locations next to the dining room. While walking through the dining room, the entire dining room floor is sticky. On 5/30/25 at at 7:27 AM, E5, Caregiver, agreed the MC unit has a strong urine odor and stated "It's the whole unit. I think it's the carpet. They need get it professionally cleaned or replace it." On 5/30/25 at 11:00 AM, 5/31 at 8:00m, 10:15 am and 3:15 pm, upon entry of MC unit, a strong unrine like smell could be detected. On 5/31/25 at 3:15 PM, E1, Excutive Director, entered the MC unit with this surveyor and confirmed the urine like smell. This surveyor then pointed out the several dark stains throughout the unit, the pink substance on the carpet and the hole in the carpet to E1. On 6/6/25 at 1:30 PM, E1 stated "We had the carpet cleaned, but the pink stuff didn't come out. I think it's paint. I also have maintenace addressing the hole."	A9040		