

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Marseilles		STREET ADDRESS, CITY, STATE, ZIP CODE 578 West Commercial Street Marseilles, IL 61341	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>33973</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered per the physician's order and facility policy for two (R1 and R5) of nine residents reviewed during medication administration and two (R2 and R4) of four residents reviewed for medications in a sample of five.</p> <p>Findings include:</p> <p>The facility's undated Medication Administration General Guidelines policy documents Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration.) This policy continues to state, Administration: 2. Medications are administered in accordance with written orders of the prescriber. 3. When medications are administered by mobile cart and taken to the resident's location (room, dining area, etc.), medications are administered at the time they are prepared. Medications are not pre-pured either in advance of the med pass or for more than one resident at a time.</p> <p>1. On 9/12/24 at 2:30 pm, during medication administration, this writer noted three pre-filled medicine cups in the top drawer of the medication cart from which V3 Licensed Practical Nurse/LPN was passing medications. At this time, V3 stated that the pre-filled medications were for V3's four o'clock med (medication) pass because I wasn't sure if I would have time to get them ready.</p> <p>On 9/12/24 at 4:00 p.m., during medication administration, V3 LPN opened the top drawer of the medication cart and pulled one of the three pre-filled medicine cups marked with R5's initials on it. As V3 proceeded to approach R5, V3 stopped to re-examine R5's medications and was unable to correctly identify all the medications in the medicine cup.</p> <p>On 9/12/24 at 4:15 p.m., the V2 Director of Nursing/DON confirmed that nurses are not to pre-fill medicine cups prior to medication pass.</p> <p>2. On 9/13/24 at 7:57 a.m., during medication administration, V4 LPN entered R1's room with her medications in a medicine cup. R1 counted her medications with V4. R1 stated that one pill was missing in addition to a pain pill she requested. V4 returned to the medication cart with R1's medications and reviewed R1's electronic Medication Administration Record/MAR. V4 determined and confirmed that the missing pill from R1's medicine cup was Lasix 20mg.</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/13/24 at 8:25am, R1 stated Do you see what I go through? They mess up my pills several times every week, and it is not only agency staff, but their regular staff does too!</p> <p>R1's September MAR includes the following medications scheduled for 8:00 pm: Lamictal 150mg (milligrams) one tablet two times per day related to Bipolar Disorder, Unspecified; Hydroxychloroquine Sulfate 200mg (milligrams) one tablet two times per day; Atorvastatin Calcium 20mg one at bedtime; Amitriptyline HCl (Hydrochloride) 50mg at bedtime related to Bipolar Disorder, Unspecified; Senna Plus 50-8.6mg one two times per day; Aspirin 81mg one two times per day; Midodrine HCl 5mg three times per day; MiraLAX powder 17gm (grams) per scoop one scoop two times per day; and Quetiapine Fumarate 50mg 1.5 tablets at bedtime related to Hallucinations, Unspecified and Bipolar Disorder. This same MAR documents R1 received these physician-prescribed 8 pm medications between 10:07pm-10:14pm on 9/8/24 and between 10:24pm-10:27pm on 9/9/24.</p> <p>On 9/12/24 at 1:30pm, R1 stated that (R1) has had meetings with the facility about not getting her medications on time or correctly, So that my psych meds aren't a mess .I go by the count. If I don't have the right number of pills, then I don't know what's missing and if it is what regulates my Bipolar. I can't have them come late. I get extremely agitated and confused when this happens.</p> <p>On 9/12/24, at 4:15 p.m., V2 Director of Nursing/DON stated, Some residents have complained of their medications being late, and (R1) has said hers are incorrect at times. We put a checklist in place for that reason.</p> <p>3. On 9/13/24 at 11:58 am, R2 sat at a dining room table. R2 stated, Sometimes my psych and seizure medications are late - like as late as 12:30 or one am. You don't even want to know what I'm like when I get them late. Sometimes, I have to go see the nurse and go out to the hospital when I get them too late.</p> <p>R2's August Medication Administration Record/MAR includes the following physician prescribed medications scheduled for 8:00 pm: Tylenol 325mg, two tablets four times per day; Clonazepam 1mg at bedtime for convulsions; Atorvastatin Calcium 40mg at bedtime; Trazodone HCl (Hydrochloride) 50mg at bedtime; Quetiapine Fumarate 400mg at bedtime for Schizophrenia; Metformin HCl 500mg two times per day for Diabetes; Lantus insulin 100 units/ml (millimeter) inject 12 units subcutaneously two times per day for Diabetes; Oxybutynin Chloride ER (Extended Release) 24 hour 10mg at bedtime; Phenytoin 50mg two tablets two times per day for seizure; Baclofen 5mg two tablets two times per day; scheduled for 10:00 pm: Carbamazepine 200mg three tablets three times per day for convulsions; Meclizine HCl 25mg three times per day and Gabapentin 300mg one three times per day. This same MAR documents these medications were ordered for their 8 pm and 10 pm times on 8/3/24, and R2 received them between 11:49 pm-11:54 pm on 8/4/24, and R2 received them the next day on 8/5/24 between 2:44 am-2:45am; on 8/15/24 and R2 received them between 11:18pm-11:27pm; on 8/19/24 and R2 received them between 11:00pm-11:04pm; and on 8/18/24 and R2 received them between 10:57 pm-11:30pm.</p> <p>R2's September Medication Administration Record/MAR includes the following physician-prescribed medications scheduled for 8:00 p.m.: Clonazepam 1mg at bedtime for convulsions; Atorvastatin Calcium 40mg at bedtime; Trazodone HCl (Hydrochloride) 50mg at bedtime; Quetiapine Fumarate 400mg at bedtime for Schizophrenia; and Phenytoin 50mg two tablets two times per day for seizures. This same MAR documents that these medications were ordered at 8:00 p.m., and R2 received them between 9:54 p.m. and 9:55 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R2's September MAR documents Carbamazepine 200mg, three tablets three times a day for convulsions, was ordered to be given at 10:00 pm on 9/8/24, and R2 received the medication on 9/9/24 at 12:38am.</p> <p>4. R4's August Medication Administration Record/MAR includes the following physician prescribed medications scheduled for 8:00 pm: Protonix Delayed-Release 40mg one two times per day; Melatonin ER (Extended Release) 3mg two tablets at bedtime; Ipratropium-Albuterol solution 0.5-2.5 (3) mg/3ml (millimeters) one inhalation every 12 hours for SOB (Shortness of Breath) related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation; scheduled for 9:00 pm: Atorvastatin Calcium 10mg one at bedtime; and scheduled for 10:00 pm Alprazolam 0.5mg one three times per day related to Anxiety Disorder due to known physiological condition. This same MAR documents that these medications were ordered for their designated times on 8/5/24, and R4 received them the next day on 8/6/24, between 1:59 am-2:00 am.</p> <p>R4's August MAR documents that R4's physician prescribed Alprazolam 0.5mg to be given at 10:00 p.m. on 8/16/24, 8/18/24, 8/21/24, and 8/22/24; R4's Alprazolam was administered the day after at 5:04 a.m. on 8/17/24, 2:57 a.m. on 8/19/24, 4:08 a.m. on 8/22/24, and 2:45 a.m. on 8/23/24.</p> <p>R4's August MAR documents the following physician prescribed medications scheduled for 8:00 pm: Docusate Sodium 200 mg two times per day; Protonix Delayed Release 40mg one two times per day; Melatonin ER (Extended Release) 3mg two tablets at bedtime; Ipratropium-Albuterol solution 0.5-2.5 (3) mg/3ml (millimeters) one inhalation every 12 hours for SOB (Shortness of Breath) related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation; Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5mcg (micrograms)/ACT (actuation) two puffs inhale orally two times per day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation; and scheduled for 9:00 pm: Atorvastatin Calcium 10mg one at bedtime. This same MAR documents that these medications were ordered for their designated times, and R4 received them between 11:06 pm and 11:08 pm.</p> <p>R4's September MAR documents that R4's physician prescribed Alprazolam 0.5mg to be given at 10:00 p.m. on 9/5/24 and 9/6/24; R4's Alprazolam was administered at 11:33 p.m. and 11:24 p.m., respectively.</p> <p>R4's September MAR documents the following physician prescribed medications scheduled for 8:00 pm: Ipratropium-Albuterol solution 0.5-2.5 (3) mg/3ml (millimeters) one inhalation every 12 hours for SOB (Shortness of Breath) related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation; Protonix Delayed-Release 40mg one two times per day; Melatonin ER (Extended Release) 3mg two tablets at bedtime; and Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5mcg (micrograms)/ACT (actuation) two puffs inhale orally two times per day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation. This same MAR documents that these medications were ordered at 8:00 p.m., and R4 received them between 10:49 p.m. and 10:50 p.m.</p> <p>On 9/13/24, at 3:45 p.m., R4 was in bed utilizing oxygen and stated that all her evening medications come as late as midnight or after. R4 stated, The cholesterol medication is supposed to be taken in the evening. Some of them are to help me sleep, so I am just awake and waiting. I have to wait for them to be able to fall asleep. It is upsetting to have to wait.</p> <p>On 9/13/24, at 2:56 p.m., the V1 Administrator stated that V1 is aware of medications being administered late and considers late meds (medications) an error that the facility does not document on any form.</p>		