STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145522	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Hill	2400 South Finley Road Lombard, IL 60148

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview and record review, the facility failed to ensure medications were obtained in a timely manner to prevent residents from missing medication doses as ordered by the provider. This applies to 1 of 3 residents (R1) reviewed for improper nursing care in the area of missing medication doses in the sample of 4. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including lumbosacral spinal fusion, lumbar spine stenosis, anxiety, and breast cancer. R1's MDS (Minimum Data Set) dated June 13, 2025, showed R1 was cognitively intact. R1's Order Summary Report dated June 24, 2025, showed an order dated June 13, 2025, for Temazepam capsule 7.5 mg (milligrams), give one capsule by mouth at bedtime for insomnia. On June 23, 2025, at 2:46 PM, R1 said while she was residing at the facility, she was not able to sleep. R1 said she spoke with a provider and was told temazepam was ordered for her to sleep. R1 said she never received a dose of temazepam. R1's June 2025 MAR (Medication Administration Record) showed R1 did not receive temazepam as ordered on June 13 and June 14, 2025. A progress note dated June 13, 2025, at 10:17 PM, by V12 (RN/Registered Nurse) showed Temazepam capsule 7.5 mg, give one capsule by mouth at bedtime for insomnia. Not available. Order on progress. Physician and resident aware. A progress note dated June 14, 2025, at 9:47 PM, by V12 showed Temazepam capsule 7.5 mg, give one capsule by mouth at bedtime for insomnia. Not available. Order on progress. Physician aware. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 25, 2025, at 1:21 PM, V12 said on June 13, 2025, R1 had an order for temazepam, but since the temazepam is a controlled substance, a script is required for pharmacy to fill the prescription. V12 continued to say V14 (Psychiatric Nurse Practitioner) is the provider who ordered the temazepam but V12 did not have a way to contact V14 regarding a script. V12 continued to say on June 13, V12 notified V17 (R1's Doctor) that a script was required in order for pharmacy to fill the temazepam order. V12 said she did not receive a script from V17. V12 continued to say she did not notify a provider on June 14, 2025, when the temazepam was still unavailable. On June 25, 2025, at 12:11 PM, V11 (Pharmacy Account Manager) said temazepam is not listed on R1's medication profile for the pharmacy. V11 said since the temazepam is not on R1's profile it means the pharmacy did not receive a script for the medication. On June 25, 2025, at 1:56 PM, V1 (Administrator) said it should not have taken over 24 hours for R1's temazepam to be available to be administered.