

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145660	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2025
NAME OF PROVIDER OR SUPPLIER  Aperion Care Westchester		STREET ADDRESS, CITY, STATE, ZIP CODE  2901 South Wolf Road Westchester, IL 60154	

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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to follow its Medication Administration Policy by failing to administer medications in a timely manner. This applies to four of 15 residents (R2, R7, R4 and R5) reviewed for medication administration in a sample of 15. The Findings include: On 9/23/25 at 10:12 AM, V6 (Licensed Practical Nurse/LPN) was passing medication and stated, I have 10 more residents (R2, R3, R4, R7, R8, R9, R10, R11, R14, and R15) to pass the morning medications, which were supposed to be administered at 8:00 AM. We are supposed to administer medications within 2-hour window (one hour before and one hour after) around the scheduled time. I would be able to finish by 10:45 AM. R2 is an [AGE] year-old female with moderate cognitive impairment as per MDS dated [DATE]. On 9/24/25 at 12:30 PM, R2 stated (with Spanish interpreter V8/Housekeeping), I don't know what time I received my medications today. I would like to get my medications on time. A review of the R2's POS and MAR indicates that R2 was scheduled to get the prescribed medications at 8:00 AM including Amlodipine 10 milligram (mg) daily, Aspirin 81 mg daily, Losartan Potassium 25 mg daily, Eliquis 5 mg twice per day (BID), Metoprolol 100 mg daily, Lasix 80 mg BID, and Gabapentin 300 mg three times a day (TID). R7 is a [AGE] year-old male with intact cognition, as per the MDS dated [DATE]. On 9/23/25 at 12:40 PM, R7 stated, The morning medication should come around 8:00 AM, and I got it around 10:30 AM today. I would like to get my medications on time. Today it was late by two and a half hours. A review of the R7's POS and MAR indicates that R7 was scheduled to get the prescribed medications at 8:00 AM, including Amlodipine 10 mg daily, Hydrochlorothiazide 12.5 mg daily, Lisinopril 40 mg daily, and Gabapentin 300 mg three times a day (TID). R4 is an [AGE] year-old male having intact cognition as per the MDS dated [DATE]. On 9/23/25 at 12:45 PM, R4 stated, The morning medications were delayed today, not all the time. I prefer to get my medication on time. A review of the R4's POS and MAR indicates that R4 was scheduled to get the prescribed medications at 8:00 AM, including Amlodipine 7.5 mg daily. On 9/23/25 at 10:20 AM, V7 (Registered Nurse/RN) was passing morning medications and stated, I have three more residents (R5, R12, and R13) to pass 8:00 AM medications. I am sorry, I am late today, because one of my residents was getting shortness of breath and stomachache. R5 is a [AGE] year-old male admitted with mild cognitive impairment as per the MDS dated [DATE]. On 9/23/25 at 12:50 PM, R5 stated, I would prefer to get my medications on time. It was delayed today. A review of the R5's POS and MAR indicates that R5 was scheduled to get the prescribed medications at 8:00 AM, including Ferrous Sulfate Elixir 220 mg (Fe 44)/5milliliter(ml) (Give 7.5 ml) daily, Potassium Chloride 20 milliequivalent (mEq) daily, and Terazosin 2mg daily. On 9/23/25 at 10:25 AM, V5 (LPN) was passing morning medications and stated, I have one more resident (R6) to give 8:00 AM medications. I have residents going out for appointments, and I must prepare them. That's the way I got delayed. A review of the facility's Medication Administration policy, dated September 2018, reveals that, at a minimum, the 5 rights - right patient, right drug, right dose, right route, and right time - should be applied to all medication administration. On 9/24/25 at 9:39 AM, V2 (Director of Nursing) stated, Our staff supposed to follow the five rights of medication administration, including right patient, right drug, right dose, right route, and right time. On 9/23/25 at 11:00 AM, V2 added, Our staff is supposed to pass medications within a two-hour window around the scheduled time (one hour before and one hour after the scheduled time). We will in-service all our nurses and change the administration time from 8:00 AM to 9:00 AM.</p>		