STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145758	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Glenwood	19330 South Cottage Grove Glenwood, IL 60425

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40065 Based on interview and record review the facility failed to developed a resident specific care plan with interventions to address a residents drug use history. This failure resulted in R1 being found unresponsive, non-breathing and was pronounced dead at the hospital. This failure affected R1 out of 8 residents reviewed for comprehensive care plan. Findings include: R1 was [AGE] years old, was admitted to the facility on [DATE] with diagnosis of but not limited to: Anoxic brain damage, Poisoning by unspecified drugs and functional quadriplegia. R1's BIMS Score (Cognition test) was 14 meaning R1 was cognitively intact. R1's (,d+[DATE]) admission paperwork from the hospital document in part: Anoxic brain damage secondary to drug overdose. R1's ([DATE] at 2:05 pm) progress note documents in part: Resident is a [AGE] year old, male, Caucasian newly admitted to the facility on [DATE]. Resident is alert x3 and he can make his needs known. Resident was diagnosed with anoxic brain injury due to drug overdose. Resident also has protein calorie malnutrition and dysphagia. R1's ([DATE]) death certificate documents cause of death: drug overdose, due to toxic effects of Fentanyl and Cocaine. R1's ([DATE] at 10:48 am) progress note documents: Upon rounding by staff, resident observed unresponsive and non-breathing. Resident a full code, code blue called, 911 emergency services contacted and CPR (cardio pulmonary resuscitation) initiated with crash cart present. Resident last observed alert and sleeping at approximately 7:50am. CPR continued until Emergency services arrived to facility and transferred resident to the hospital. Nurse Practitioner made aware. Family contacted and made 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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:10 am V10 (Certified Nursing Assistant) said, she is on staff at the facility and has been here little over a year. She remembers R1, was keeping to himself, had an electric wheelchair and spoke to some residents. R1 needed help with putting on clothes, he was smoking cigarettes when it was time for smoke breaks, she did not have a clue or did not see signs of drug use, if she would suspect drug use she would let the nurse on duty and V2 (Director Of Nursing) and V1 (Administrator) know. V10 said, V16 was assigned to him but she was duty on that wing also. V10 asked V16 if if R1 wanted his breakfast tray, sometimes he didn't want anything. V10 said, V16 told her she just checked on him earlier and he was sleeping but if V10 could check on R1 because R1 didn't look right. V10 said, she went into R1's room and she went over by the window (R1's bed was by the window) and he didn't respond, he slept with pillow on his face usually, she got closer and noticed his fingertips were purple and it freaked her out because his eyes were open and she never seen anything like that. V10 said, she ran towards nurses station and she yelled called blue and everyone started running, even from different wings to help. On [DATE] at 9:28 am R8 said she was a friend of R1 and they were close. R8 said, she knew something of his history of drug use however she did not suspect R1 to do drugs. R8 said, she never saw R1 doing drugs or talk about drugs. R8 did not know R1 was struggling with drugs. R8 said, she never saw residents doing drugs. R8 said, he passed on Monday morning and the last time she saw him was Saturday evening and he was his normal self. R8 said, she was supposed to see R1 on Sunday but he never come over to her room. On [DATE] at 10:13 AM with V1 (Administrator), V2 (Director of Nursing) and V12 (Social Service Director) were present for the interview. V1 said, she was here at the facility, little after 9 am, code blue was called, she went there with V17 (ADON), as she was headed down there the nurse started CPR, 911 was called and staff continued CPR, paramedics were doing CPR also even as leaving the facility, Narcan was given but unsure if it was the paramedics or the facility that gave the Narcan. V15 (RN) was R1's assigned nurse. V1 said, she was not aware of R1 cause of death until she was informed by the surveyor. V12 (Social Service Director) said R1 had history of drug use. V2 said, one of R1's diagnosis were Poisoning by unspecified drugs and it could be drug are pharmaceutical and recreational. V12 was asked what facility had in place for R1 with known history of drug use, V12 said, R1 came with history of drugs and was in no condition to inject any drugs, he was not alert and oriented on admission, he became more oriented with time, R1 made improvements in functional abilities and was able to do more by himself, and he got physical therapy and got stronger. V12 said facility monitors residents and also does constant monitoring, for unusual behavior as needed. V12 said, he believes R1 was care planned for drug use (V12 was provided copy of R1's care plan and asked by surveyor to show where the care plan documents interventions for history of drug use). V12 said, he is not seeing R1 was care planned for drug use, and in hindsight R1 should have been care planned for drug use. V12 said, resident monitoring is based on observation and staff would document if something is observed and increased monitoring if required. V1 said, R1 never presented with active drug use and never facility found any drugs on him. V12 said, R1 had his own phone that he was using. V2 said, is someone comes in and they want to leave something for a resident, it goes first to social service and it is inspected and inventoried. V1 said, if (online food delivery platform system) is delivered or dropped off the facility does not inspect/open residents food, like staff will not open the actual wrapper but will look in the bag. V1 said, if packages come thru the mail they are inventoried so facility can keep track of resident belongings and social service inspects them first. R1's care plan does not document intervention in place for history of drug use. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	R1's ([DATE]) community assessment documents R1 does not appear to be capable of unsupervised outside pass privileges at this time. Facility's (,d+[DATE], revXXX,d+[DATE]) Comphrensive Care Plan policy documents in part: Facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.