

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145877	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Aperion Care Dolton		STREET ADDRESS, CITY, STATE, ZIP CODE  14325 South Blackstone Dolton, IL 60419	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34490</p> <p>Based on interview and record review the facility failed to securely store a resident's injectable medication for 1 of 3 residents (R1) reviewed for medication storage in the sample of 3.</p> <p>The findings include:</p> <p>R1's Face Sheet shows a diagnosis of acute transverse myelitis in demyelinating disease of central nervous system.</p> <p>On 2/21/25 at 10:50 AM, V6 (R1's Family Member) said that she delivered three doses of R1's Enspryng injection that she had delivered to her home from a specialty pharmacy to the facility. V6 said that she received a call from the nurse on 2/7/25 and the nurse said that they could not find her third dose of the injection. V6 said that R1 was sent to the emergency room but was not able to receive the medication but they re-ordered the medication for her and the resident received the dose on 2/12/25.</p> <p>R1's Medication Administration Record (MAR) for January and February shows an order for: Enspryng Subcutaneous Solution Prefilled syringe 120 mg (milligrams)/ML (milliliter)-Inject 120 mg/ml subcutaneously in the afternoon every 2 weeks on Friday for neuromyelitis for 6 weeks. R1's January MAR shows that she received a dose on 1/10/25 and 1/24/25. R1's February MAR shows that she was supposed to get a dose on 2/7/25 but received it on 2/12/25.</p> <p>R1's Nursing Note dated 1/10/25 shows, Approached by [V6] in facility regarding order for Enspryng Three available injections in frig (refrigerator) as per [V6] she brought 3 injections</p> <p>R1's Nursing Note dated 2/7/25 shows, Reached out to [V6] regarding need for Enspryng Subcutaneous Solution Prefilled Syringe. Patient is due for administration this afternoon. None available. Per pharmacy is a specialty medication. Daughter provided last doses. She was made aware of need for medication at this time.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/25 at 10:39 AM, V3 (Licensed Practical Nurse) said that she was R1's nurse on the day that she needed her third injection. V3 stated that V6 had brought three doses of the injection, and they were put in the medication room refrigerator. V3 stated that they were in separate boxes and had R1's name on them. V3 stated that she administered R1's first and second dose of the medication but the day that her third injection was due, she could not find it in the fridge. V3 stated that she notified V6, V2 (Director of Nursing) and R1's Nurse Practitioner.</p> <p>On 2/21/25 at 12:38 PM, V2 (Director of Nursing) said that she was notified by V3 that she could not find R1's Enspryng injection. V2 stated that she searched the medication room and facility and could not find the injection. V2 stated that she then called V6 and told her that she thinks that the medication got thrown out in error.</p> <p>A Concern Form dated 2/7/25 for R1 shows, Staff reached out to family that a dose of Enspryng injection is missing for [R1] Summary of Pertinent Findings: Substantiated Facility was searched not able to locate. Pt (patient) monitored, sent out to hospital. No adverse reaction. Physician notified</p> <p>On 2/21/25 at 1:59 PM, V1 (Administrator) stated that the facility does not have a policy for when family brings in medications for the resident.</p> <p>The facility's undated Storage of Medication Policy shows, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.</p>		