

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Forest Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 West Roosevelt Road Forest Park, IL 60130	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32115</p> <p>Based on observation, interview, and record review the facility failed to ensure a supply of resident medication was available as prescribed by the physician for 2 of 4 residents (R1, R14) reviewed for medications in the sample of 14.</p> <p>Findings include:</p> <p>1. R1's Admission Profile printed 6/9/24 shows diagnoses to include chronic pain syndrome, paraplegia, and morbid obesity. R1's 4/15/24 facility assessment shows he is cognitively intact, required as needed (PRN) pain medication, had occasional pain, and occasionally had pain that made it difficult for him to sleep. R1's Pain assessment dated [DATE] shows his pain was distressing, that he takes norco (narcotic) 10/325, and medication is what is used to relieve it.</p> <p>R1's care plan initiated 8/15/20, and revised on 4/25/24, shows he has potential alteration in comfort related to chronic pain syndrome and paraplegia. This care plan shows an intervention to administer analgesia as ordered.</p> <p>R1's Physician Orders printed 6/9/24 shows an order for Norco 10/325mg (milligrams) (narcotic pain medication) one tablet by mouth one time a day for pain, started on 4/29/24. This order summary shows a second order, Norco 10/325, give 1 tablet every 4 hours as needed for moderate-severe pain, started on 10/28/23.</p> <p>R1's June Medication Administration Record (MAR) shows Norco 10/325mg give one tab by mouth every day at 9:00AM. This MAR does not show any dose given on 6/3/24, and on 6/4/24, it shows 5 hold, see progress note. R1's medication administration note on 6/4/24 shows waiting for pharmacy to deliver.</p> <p>On 6/9/24 at 9:35AM, R1 was in bed with an air mattress in place, and both side rails in the raised position. R1 was wearing a gown, and was resting on his side. R1 said he recently had to wait three days to get his pain medication because the facility ran out. R1 said he has chronic pain to the back of his neck and his back. R1 said no they didn't give him anything else, he just had to go through the pain. It was kind of vicious, he stayed in bed and tried not to move. R1 said it was real tight around his waist, and rated the pain at that time as an 8 out 10. He said they ran out last Sunday and he didn't get it until Wednesday.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Forest Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 West Roosevelt Road Forest Park, IL 60130	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/9/24 at 9:45AM V10 (Licensed Practical Nurse-LPN) said the nurses are responsible for reordering resident medications. V10 said it is on the EMAR (electronic medication administration record) when the medication was last ordered. V10 said they also know when to reorder the medication based off the supply of the medication. Usually when there is less than 1/2 of the doses left, we reorder it.</p> <p>On 6/9/24 at 10:20AM V31 (Registered Nurse-RN) said the nurses are responsible for ordering medication from the pharmacy. The medication card tells you when to re-order. V31 said when there are 7 or less medications left, you reorder them from the pharmacy. V31 said some medications require signed scripts from the providers. Once the script is sent to pharmacy, they will send the medication right away.</p> <p>On 6/9/24 at 1:42PM, V3 (Director or Nursing) reviewed R1's electronic medical record (EMR). V3 said the nurse is responsible for reordering medications from pharmacy when the supply is low. When they get to the last row of medication in the supply card, they should reorder the medication. V3 said there is also an estimated refill date ([NAME]) on the medication card which alerts the nurse to reorder the medication. V3 reviewed R1's progress note for 6/4/24 and said yes, the medication (norco) was not available, they were waiting for delivery.</p> <p>On 6/9/24 at 2:17PM, V10 said R1 has moderate to severe chronic pain. V10 said R1 takes pain medication regularly for it. He is alert and oriented, and will request pain medication when he needs it.</p> <p>On 6/10/24 at 12:24PM, V34 (Nurse Practitioner) said R1 has a history of chronic pain and takes norco regularly. V34 verified R1 has a scheduled dose (norco 10/325) every morning and can have it every 4 hours as needed. V34 said the facility is expected to have a daily supply of medication available for the residents. V34 said she thinks the protocol is usually, when there is a three day supply left, the nurse is to reorder the medication from pharmacy. In this situation, they would need to get the provider to either call the pharmacy or come to the facility and get a signed script because it is a controlled substance. R1 did not get his medication because he ran out on a Sunday, Monday was a holiday, and she did not get to the facility until Tuesday (6/4/24). On Tuesday she sent the script to another NP who holds a DEA license to reorder the medication. V34 said R1 should not have gone without his pain med, and the facility should have a supply available.</p> <p>On 6/10/24 at 3:09 PM, V3 said she looked at R3's medication, narcotic log, and administration record. V3 said R1 did not get his medication (6/3/24 and 6/4/24) because it was not ordered in time from the pharmacy.</p> <p>2. R14's Admission Record printed 6/9/24 shows diagnoses to include major depressive disorder-recurrent-moderate, generalized anxiety disorder, and insomnia.</p> <p>R14's Physician Orders shows lorazepam 2mg by mouth every 8 hours for generalized anxiety, started on 5/2/24.</p> <p>R14's April MAR shows Lorazepam 2 mg by mouth at 12:00AM, 8:00AM, and 4:00PM. This MAR shows a 9, other see progress notes indicating the dose was not given on 4/27/24 at 4:00PM and 4/28/24 at 12:00AM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Forest Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 West Roosevelt Road Forest Park, IL 60130	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R14's 4/29/24 psycho-therapy note shows His nurse states that there was a pharmacy delay for his Ativan yesterday and he stated he was [going to check himself into the ER] to get a dose.</p> <p>R14's administration note dated 4/27/24 shows the medication was not administered, waiting for pharmacy to deliver, not available in (medication delivery storage machine).</p> <p>R14's June MAR shows Lorazepam 2 mg by mouth at 12:00AM, 8:00AM, and 4:00PM. This MAR shows a 9, other see progress notes indicating the dose was not given on 6/4/24 for the 12:00AM and 4:00PM doses.</p> <p>R14's 6/3/24 psycho-therapy note shows R14 is frustrated that pharmacy does not have his medication in stock. This note shows anxiety: Moderate /chronic, inquiring if his medications can be increased or changed to the highest dose and if anything is new (which is baseline). This note also shows Initial visit: He has been on Ativan 2mg TID [3 times per day] for [AGE] years, if he runs out or misses a dose he ends up in the ER .</p> <p>R14's administration note dated 6/5/24 at 5:01AM shows lorazepam 2mg will be delivered from pharmacy this morning. R14's administration note dated 6/4/24 at 0001 (12:01AM) shows waiting for delivery from pharmacy.</p> <p>On 6/9/24 at 1:42PM, V3 (DON) said R14 is constantly seeking for ativan (lorazepam). R14 get's upset when the medication is not available. The only time the medication would not be available is if we are waiting on delivery from pharmacy. V3 reviewed R14's MAR and said according to the MAR he was not given his lorazepam on 4/27/24 and 4/28/24. V3 reviewed R14's progress notes, and said the notes show it was not available, and it was not available in the (facility stock). V3 said it appears on 6/4/24 he did not receive his scheduled dose at 12:00AM, and 4:00PM. V3 verified the progress note entered on 6/5/24 at 5:00AM shows they were waiting on delivery [from pharmacy]. V3 said R14 becomes agitated when he knows he doesn't have his medication. V3 said yes, if the medication was reordered on time, they should be able to get the refill before he runs out. That is the standard for all medications.</p> <p>On 6/9/24 at 2:10PM, V31 (RN) said R14 has behaviors of being verbally abusive to others. R14 has anxiety, shakes a lot, and has tremors. V31 said the day R14 did not have his lorazepam, he thought I was lying, and I had to actually show him the script after I got it. V31 said it may have been an agency nurse that tried to reorder the medication from the pharmacy without a script. He was anxious and agitated that day, and upset the medication wasn't available. He called me names. He did not go to the hospital, he waited for the medication to be delivered from the pharmacy.</p> <p>On 6/10/24 at 12:24PM, V34 (NP) said R14 has a history of anxiety and takes lorazepam. V34 said there are some medications the facility has a stock supply of but generally, psychotropic and narcotic medications are not part of this supply. V34 said the facility is expected to have prescribed daily medications available.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Forest Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 West Roosevelt Road Forest Park, IL 60130	
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 - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32115</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident received their anticonvulsant medication immediately following a hospitalization for status epilepticus (prolonged seizure activity) for 1 of 4 residents (R4) reviewed for medications in the sample of 14.</p> <p>Findings include:</p> <p>R4's Physician Order Summary printed 6/9/24 shows diagnoses to include epilepsy, unspecified, not intractable, with status epilepticus.</p> <p>R4's facility assessment dated [DATE] shows he is cognitively intact.</p> <p>R4's progress notes dated 5/28/24 at 10:55AM shows resident had two active seizures . both 5 seconds lasting .MD notified. The next entry at 11:13AM shows the resident had another active seizure lasting 5 seconds . order to send to the hospital. The 5/28/24 at 2:31PM progress note shows R4 is being admitted to [local hospital] for status epilepticus (a seizure with 5 minutes or more continuous clinical and/or electrographic seizure activity or recurrent seizure activity without recovery between seizures).</p> <p>R4's hospital care notes dated 6/1/24 shows patient presenting with multiple seizure episodes. Reportedly had 3+ seizures at this SNF (skilled nursing facility) this AM. When the patient arrived his glucose was reportedly 37 .In the ED, patient had 2 further seizure episodes and neurology was consulted. Patient had a total of 4 x 1000mg (milligrams) Keppra (levetiracetam) IV (intravenous) . R4's after visit [hospital] summary shows his length of stay was 5/28/24 to 6/3/24.</p> <p>R4's hospital discharge orders dated 6/3/24 shows an order for levetiracetam (Keppra) 500mg take 2 tablets [1000mg] by mouth at bedtime.</p> <p>R4's APN (Advanced Practice Nurse) progress noted dated 6/3/24 shows R4 returned from the hospital with diagnosis of seizures and CHF (congestive heart failure). R4's APN progress note shows Assessment/Plan, Seizures- controlled .continue Keppra (levetiracetam) 1000mg nightly.</p> <p>R4's Care Plan revised on 6/6/24 shows I have a potential for injury related to a seizure disorder. readmitted to the facility post acute hospital stay on 6/3/24, continue interventions. This care plan has an intervention to give seizure medications as ordered by the doctor, and to monitor/document for side effects and effectiveness.</p> <p>R4's Physician Order Summary printed 6/9/24 shows an order date of 6/4/24 for levetiracetam 1000mg give one tablet by mouth at bedtime. The order start date was 6/6/24 (3 days after R4 readmitted from the hospital).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Forest Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 West Roosevelt Road Forest Park, IL 60130	
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 - Few</p>	<p>R4's June Medication Administration Record (MAR) shows levetiracetam 1000mg, give one tablet by mouth at bedtime (9:00PM) with a Discontinue date of 6/3/24. The entry for 6/2/24 shows 6, hospitalized . This MAR shows a new order for levetiracetam 1000mg, give one tablet by mouth at bedtime (9:00PM) with a start date of 6/6/24 at 2100 (9:00PM), three days after R4 readmitted from the hospital. The June MAR does not show any documentation of R4 receiving levetiracetam 1000mg on 6/4/24 and 6/5/24.</p> <p>On 6/9/24 at 9:49AM, R4 was sitting in a wheelchair in the hall outside his room. R4 said the other night he didn't get his seizure meds. He thought Friday night. He said the nurse was agency and couldn't find his meds. This was the second time it's happened. At 12:45PM, R4 said about 2 weeks ago he went to the hospital. During breakfast, he had about 5 seizures. R4 said yes it was after he came back from the hospital that he did not get his night seizure meds. R4 said she [the nurse] wasn't familiar with his medication.</p> <p>On 6/9/24 at 2:17PM, V10 (LPN-Licensed Practical Nurse) said R4 has a history of seizures and is on a daily medication to treat his seizures. V10 said R4 just came back from the hospital about a week ago, and was hospitalized for his seizures. V10 said R4 is alert and oriented, and its is important for him to take his daily medication to prevent seizures.</p> <p>On 6/9/24 at 1:42PM, V3 (Director of Nursing) reviewed R4's electronic record. V3 said R4 had an order for levetiracetam 500mg (2 tabs) at bedtime on return from the hospital. V3 said this order was not entered into the computer until 2 days after R4 returned to the facility from the hospital. V3 said the nurse should have reconciled the hospital discharge orders with R4's provider when R4 returned to the facility. This should be done immediately. The nurse should call the physician on admission and reconcile the medications. V3 said R4 should have received a dose of this medication on 6/4/24 and 6/5/24, but it was not entered into the system.</p> <p>On 6/10/24 at 11:35AM, V33 (Nurse Practitioner) said R4 has a seizure disorder, and a history of seizures. This is a chronic condition that is managed with Keppra (medication). V33 said R4 was recently admitted to the hospital with a break through seizure episode, they found him convulsing. V33 said the hospital gives discharge orders when the resident returns to the facility and we continue those orders. The nurse will call and reconcile the medications. V33 said he was not aware R4 did not receive his Keppra for two days after returning to the facility from the hospital. V33 said he would expect the discharge orders to be carried out and the resident should receive all medications as prescribed.</p>		