

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 03/18/2025
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)
F 0580 Level of Harm - Actual harm Residents Affected - Few	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on observations, interviews, and record reviews, the facility failed to follow its physician - family notification - change in condition policy and notify the attending physician/nurse practitioner of a resident having severe hypoglycemia and obtain emergent treatment orders. This failure affected one resident (R1) out of three residents reviewed for diabetes management in a sample of 4. On 2/21/25, R1 was nonresponsive and with a blood sugar level of 29; no treatment initiated prior to EMS (emergency medical services) 911 arrived and transported R1 to the hospital emergently.</p> <p>Findings include:</p> <p>On 3/2/25 at 7:49 PM, V7 LPN (licensed practical nurse) stated that V7 does recall R1. V7 stated that V7 was about to leave facility at end of shift on 2/21/25 when the CNA (certified nurse aide) told her that R1 did not look right. V7 went to R1's room and checked R1's blood sugar and it was low. V7 stated that R1 was non-responsive. V7 stated that V7 was alone on nursing unit as the rest of the evening shift staff left. V7 stated that another nurse came to assist her, but does not recall the nurse's name. V7 stated that V7 last saw R1 during evening medication pass. V7 stated that R1 did not have any oral diabetic medications and R1 was not receiving insulin. When questioned if V7 administered any medication to R1 to treat low blood sugar, V7 did not respond.</p> <p>On 3/3/25 at 11:34 AM, V8 ADON (assistant director of nursing) stated that staff are expected to try nursing interventions, call NP (nurse practitioner) on call and follow the orders given. V8 stated that if the resident is alert, give hard candy or a packet of sugar. V8 stated that if the resident is not alert, there is glucose in the crash cart and emergency kit. V8 stated that there is a crash cart and emergency kit located at the nurses' station on each nursing unit. V8 stated that V12 (nursing supervisor) works 10:00 PM until 6:00 AM and should have been called to assist V7 with R1.</p> <p>On 3/3/25 at 11:40 AM, this surveyor and V8 ADON checked emergency box located in medication room on R1's nursing unit. The kit contained two doses of baqsimi (nasal glucagon) nasal spray for treatment of severe hypoglycemia. V8 stated that when a medication is used from emergency kit, the nurse documents on the sign out sheet, so medication can be replaced. V8 stated that on 2/21/25 baqsimi medication was not removed from the emergency kit.</p> <p>On 3/3/25 at 11:50 AM, V8 ADON stated that V8 reviewed R1's progress notes. V8 stated that V7 documented R1's blood sugar was 29, notified V10 NP, and sent R1 out via EMS (emergency medical services) 911. V8 stated that staff are expected to know what is in the emergency kit. V8 stated that after reviewing the policy, V7 LPN did not give R1 anything to treat hypoglycemia.</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 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/3/25 at 12:20 PM, V12 (nursing supervisor) stated that V12 worked on 2/21/25. V12 stated that V12 did not receive any calls for a resident with low blood sugar. V12 stated that V12 heard about this event a few days later when staff were talking about it. V12 stated that if V12 had been made aware V12 would have instructed V7 to administer baqsimi nasal spray from the emergency kit and would have gone to R1's bedside to assist.</p> <p>On 3/3/25 at 12:46 PM, V10 NP (nurse practitioner) stated that V10 was not notified by nursing that R1's blood sugar was 29 and R1 was nonresponsive. V10 stated that if a resident has a blood sugar of 29 and is nonresponsive, V10 would expect the nurse to administer medication to treat hypoglycemia while waiting for EMS 911.</p> <p>On 3/3/25 at 1:05 PM, V14 (EMS paramedic) stated that when V14 arrived at R1's bedside V14 and crew were informed that the night shift nurse was making rounds and found R1 nonresponsive. V14 stated that the crew was informed that the evening shift nurse had already left facility. V14 stated that the crew quickly got R1 in to the ambulance to start treatment while in route to the hospital. V14 stated that the crew was informed that no treatment was initiated by the nurse prior to their arrival. V14 stated that the crew checked R1's continuous blood glucose system receiver. V14 stated that R1's blood sugar bottomed out at 7:30 PM and remained that way until their arrival at 11:34 PM.</p> <p>R1's EMS (emergency medical services) run sheet, dated 2/21/2025, notes EMS crew was dispatched to the facility at 11:27 PM for a resident with a diabetic problem. The crew arrived at R1's bedside at 11:34 PM. Upon arrival R1 was in the room with a CNA, unresponsive, diaphoretic, with a GCS (glasgow coma score) of 3. The CNA advised the crew that R1 had low blood sugar. V7 LPN just checked it, but I don't know what it is. R1's continuous blood glucose system receiver just says 'LOW'. The crew looked at R1's continuous blood glucose system receiver and the trends it showed was: blood glucose at a normal level around 3:00 PM with it dropping to LOW around 3:30 PM and continuously being at LOW until the crew's arrival at 11:34 PM. R1 was loaded on to the stretcher and brought down to the ambulance. R1's vital signs were taken, and all were within normal limits with the exception of her blood glucose level which was at 31. Two intravenous catheter insertion attempts were made, one in each forearm but were unsuccessful. IO (intraosseous) equipment was set up, the hospital was called to clear the IO insertion. An IO was established in R1's left tibia. R1 was administered dextrose 10% at a keep open rate. R1's oxygen saturation level was starting to decrease in route. A nasal cannula was placed on R1 and oxygen was delivered at 4 liters.</p> <p>The facility's physician orders-entering and processing policy, revised 1/31/2028, notes if the medication is needed immediately, it will be removed from the emergency drug kit. All appropriate paperwork will be filled out when a drug is removed from the emergency drug kit.</p> <p>The facility's physician - family notification - change in condition policy, revised 11/13/2018, notes the facility will consult with the resident's physician or NP when there is a significant change in the resident's physical, mental, and psychosocial status (deterioration in health, life threatening condition).</p> <p>The facility's hypoglycemia guidelines, undated, notes contact physician if blood sugar is below 60. Take vital signs. Repeat finger stick in 15 minutes after intervention. If unable to swallow notify the physician and prepare glucagon from the emergency drug kit for administration as ordered. Document findings, interventions, and physician contact in resident's clinical record.</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interviews and record reviews, the facility to provide quality care and services in accordance with professional standards of practice for blood sugar monitoring, insulin administration, recognizing the signs and symptoms of hypoglycemia, and implementing interventions to treat hypoglycemia for one resident (R1) out of three residents reviewed for diabetes management in a sample of 4. This failure resulted in R1 receiving intermediate-acting insulin on 2/21/25 at 11:31 AM and 12:19 PM leading to severe hypoglycemia with a blood sugar level of 29.</p> <p>Findings include:</p> <p>On 3/2/25 at 7:49 PM, V7 LPN (licensed practical nurse) stated that V7 does recall R1. V7 stated that V7 was about to leave facility at end of shift on 2/21/25 when the CNA (certified nurse aide) told her that R1 did not look right. V7 went to R1's room and checked R1's blood sugar and it was low. V7 stated that R1 was non-responsive. V7 stated that V7 was alone on nursing unit as the rest of the evening shift staff left. V7 stated that another nurse came to assist her, but does not recall the nurse's name. V7 stated that V7 last saw R1 during evening medication pass. V7 stated that R1 did not have any oral diabetic medications and R1 was not receiving insulin. When questioned if V7 administered any medication to R1 to treat low blood sugar, V7 did not respond.</p> <p>V13 CNA (agency certified nurse aide) worked 3:00 PM - 11:00 PM shift on 2/21/25. V13 was unavailable for interview during this survey.</p> <p>On 3/3/25 at 5:00 PM, V10 NP (nurse practitioner) stated that R1 had an order for insulin 70/30 subcutaneous daily. V10 was not made aware that R1's insulin was changed to three times a day. V10 stated that V10 would not have changed R1's insulin to be given three times daily. V10 stated that insulin should not be administered intramuscularly. V10 stated that insulin should be administered within 30 minutes of when blood sugar is checked. V10 stated that insulin 70/30 is an intermediate-acting insulin and should not be given two doses close together.</p> <p>On 3/3/25 at 1:05 PM, V14 (EMS paramedic) stated that when V14 arrived at R1's bedside V14 and crew were informed that the night shift nurse was making rounds and found R1 nonresponsive. V14 stated that the crew was informed that the evening shift nurse had already left facility. V14 stated that the crew quickly got R1 in to the ambulance to start treatment while in route to the hospital. V14 stated that the crew was informed that no treatment was initiated by the nurse prior to their arrival. V14 stated that the crew checked R1's continuous blood glucose system receiver. V14 stated that R1's blood sugar bottomed out at 7:30 PM and remained that way until their arrival at 11:34 PM.</p> <p>On 3/4/25 at 9:13 AM, V8 ADON (assistant director of nursing) stated that the nurse is expected to review discharge paperwork sent with new admission from the hospital. V8 stated that if there is a question regarding any physician order, the nurse is expected to clarify the order prior to implementing it. When questioned why insulin administration was changed from subcutaneous to intramuscular, V8 stated that V8 will have to look into this. When questioned reason insulin 70/30 was changed from daily to three times a day, V8 stated that she will have to look into this as well. V8 stated that the nurse is expected to know when insulin peaks and duration of its action.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's POS (physician order sheet), dated 2/18/25, notes an order for novolin 70/30 insulin, administer 20 units subcutaneously once a day. On 2/19/25 at 00:50 AM, the insulin order was changed to 20 units intramuscularly three times a day.</p> <p>V15 LPN (licensed practical nurse) created the order changing R1's insulin from subcutaneous to intramuscular and from daily to three times daily. V15 was unavailable for interview during this survey.</p> <p>R1's MAR (medication administration record), dated February 2025, notes six nurses administered insulin 70/30 intramuscularly. R1 received a total of 9 doses intramuscularly. It also notes on 2/21/25 the 9:00 AM scheduled dose of novolin 70/30 insulin was administered at 11:31 AM by V11 LPN (licensed practical nurse) and the 12:00 PM scheduled dose was administered at 12:19 PM by V11.</p> <p>R1's EMS (emergency medical services) run sheet, dated 2/21/2025, notes EMS crew was dispatched to the facility at 11:27 PM for a resident with a diabetic problem. The crew arrived at R1's bedside at 11:34 PM. Upon arrival R1 was in the room with a CNA, unresponsive, diaphoretic, with a GCS (glasgow coma score) of 3. The CNA advised the crew that R1 had low blood sugar. V7 LPN just checked it, but I don't know what it is. R1's continuous blood glucose system receiver just says 'LOW'. The crew looked at R1's continuous blood glucose system receiver and the trends it showed was: blood glucose at a normal level around 3:00 PM with it dropping to LOW around 3:30 PM and continuously being at LOW until the crew's arrival at 11:34 PM. R1 was loaded on to the stretcher and brought down to the ambulance. R1's vital signs were taken, and all were within normal limits with the exception of her blood glucose level which was at 31. Two intravenous catheter insertion attempts were made, one in each forearm but were unsuccessful. IO (intraosseous) equipment was set up, the hospital was called to clear the IO insertion. An IO was established in R1's left tibia. R1 was administered dextrose 10% at a keep open rate. R1's oxygen saturation level was starting to decrease in route. A nasal cannula was placed on R1 and oxygen was delivered at 4 liters.</p> <p>R1's hospital record, dated 2/22/25, was unavailable for review during this survey.</p> <p>The facility's hypoglycemia guidelines, undated, notes contact physician if blood sugar is below 60. Take vital signs. Repeat finger stick in 15 minutes after intervention. If unable to swallow notify the physician and prepare glucagon from the emergency drug kit for administration as ordered. Document findings, interventions, and physician contact in resident's clinical record.</p> <p>Per the National Library of Medicine, insulin is absorbed faster after intramuscular injection compared to subcutaneous injection. Intramuscular injections should be avoided as they increase the risk of hypoglycemia.</p> <p>Per the FDA (Food and Drug Administration), novolin insulin 70/30 is an intermediate-acting insulin. The effects of Novolin 70/30 start working 30 minutes after injection. The greatest blood sugar lowering effect is between 2 and 12 hours after the injection. This blood sugar lowering may last up to 24 hours. Symptoms of hypoglycemia may include, but not limited to: sweating, confusion, shakiness. Severe hypoglycemia can cause unconsciousness, seizures, and death.</p> <p>(continued on next page)</p>		

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F 0658 Level of Harm - Actual harm Residents Affected - Few	The Centers for Medicare & Medicaid Services requires nurses to verify specific information prior to the administration of medication to avoid errors, referred to as verifying the rights of medication administration. These rights of medication administration are the vital last safety check by nurses to prevent errors in the chain of medication administration that includes the prescribing provider, the pharmacist, the nurse, and the patient. The nurse ensures the route of administration is appropriate for the specific medication and also for the patient. Some medications can only be given safely via one route. Nurses must administer medications via the route indicated in the order. If a nurse discovers an error in the order or believes the route is unsafe for a particular patient, the route must be clarified with the prescribing provider before administration.		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow its physician orders policy and hypoglycemia guidelines and administer emergency medication to treat a resident exhibiting signs and symptoms of severe hypoglycemia (low blood sugar level) for one resident (R1) out of three residents reviewed for diabetes management in a sample of 4. On 2/21/25, R1 was nonresponsive and with a blood sugar level of 29; no treatment initiated prior to EMS (emergency medical services) 911 arrived and transported R1 to the hospital emergently.</p> <p>The immediate jeopardy began on 2/21/25 when R1 was found unresponsive and with a blood glucose level of 29. V1 and V2 were notified of the immediate jeopardy on 03/13/2025 at 9:35 AM. The surveyor confirmed by onsite observations, interviews, and record reviews that the immediacy was removed on 3/13/2025, but remains at level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>Findings include:</p> <p>On 3/2/25 at 7:49 PM, V7 LPN (licensed practical nurse) stated that V7 does recall R1. V7 stated that V7 was about to leave facility at end of shift on 2/21/25 when the CNA (certified nurse aide) told her that R1 did not look right. V7 went to R1's room and checked R1's blood sugar and it was low. V7 stated that R1 was non-responsive. V7 stated that V7 was alone on nursing unit as the rest of the evening shift staff left. V7 stated that another nurse came to assist her, but does not recall the nurse's name. V7 stated that V7 last saw R1 during evening medication pass. V7 stated that R1 did not have any oral diabetic medications and R1 was not receiving insulin. When questioned if V7 administered any medication to R1 to treat low blood sugar, V7 did not respond.</p> <p>V13 CNA (agency certified nurse aide) worked 3:00 PM - 11:00 PM shift on 2/21/25. V13 was unavailable for interview during this survey.</p> <p>On 3/3/25 at 11:34 AM, V8 ADON (assistant director of nursing) stated that staff are expected to try nursing interventions, call NP (nurse practitioner) on call and follow the orders given. V8 stated that if the resident is alert, give hard candy or a packet of sugar. V8 stated that if the resident is not alert, there is glucose in the crash cart and emergency kit. V8 stated that there is a crash cart and emergency kit located at the nurses' station on each nursing unit. V8 stated that V12 (nursing supervisor) works 10:00 PM until 6:00 AM and should have been called to assist V7 with R1.</p> <p>On 3/3/25 at 11:40 AM, this surveyor and V8 ADON checked emergency box located in medication room on R1's nursing unit. The kit contained two doses of baqsimi (nasal glucagon) nasal spray for treatment of severe hypoglycemia. V8 stated that when a medication is used from emergency kit, the nurse documents on the sign out sheet, so medication can be replaced. V8 stated that on 2/21/25 baqsimi medication was not removed from the emergency kit.</p> <p>On 3/3/25 at 11:50 AM, V8 ADON stated that V8 reviewed R1's progress notes. V8 stated that V7 documented R1's blood sugar was 29, notified V10 NP, and sent R1 out via EMS (emergency medical services) 911. V8 stated that staff are expected to know what is in the emergency kit. V8 stated that after reviewing the policy, V7 LPN did not give R1 anything to treat hypoglycemia.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 3/3/25 at 12:20 PM, V12 (nursing supervisor) stated that V12 worked on 2/21/25. V12 stated that V12 did not receive any calls for a resident with low blood sugar. V12 stated that V12 heard about this event a few days later when staff were talking about it. V12 stated that if V12 had been made aware V12 would have instructed V7 to administer baqsimi nasal spray from the emergency kit and would have gone to R1's bedside to assist.</p> <p>On 3/3/25 at 12:46 PM, V10 NP (nurse practitioner) stated that V10 was not notified by nursing that R1's blood sugar was 29 and R1 was nonresponsive. V10 stated that if a resident has a blood sugar of 29 and is nonresponsive, V10 would expect the nurse to administer medication to treat hypoglycemia while waiting for EMS 911.</p> <p>On 3/3/25 at 1:05 PM, V14 (EMS paramedic) stated that when V14 arrived at R1's bedside V14 and crew were informed that the night shift nurse was making rounds and found R1 nonresponsive. V14 stated that the crew was informed that the evening shift nurse had already left facility. V14 stated that the crew quickly got R1 in to the ambulance to start treatment while in route to the hospital. V14 stated that the crew was informed that no treatment was initiated by the nurse prior to their arrival. V14 stated that the crew checked R1's continuous blood glucose system receiver. V14 stated that R1's blood sugar bottomed out at 7:30 PM and remained that way until their arrival at 11:34 PM.</p> <p>R1's hospital discharge instructions, dated [DATE], notes insulin 70/30, administer 20 units subcutaneously daily in the morning.</p> <p>R1's POS (physician order sheet), dated 2/18/25, notes continuous blood glucose system sensor and receiver. It also notes an order for insulin 70/30 suspension pen-injector, inject 20 units subcutaneously one time a day for high blood sugar.</p> <p>R1's POS, dated 2/19/25 at 00:50 AM, notes an order for insulin 70/30 suspension pen-injector, inject 20 unit intramuscularly three times a day for high blood sugar.</p> <p>V15 LPN (licensed practical nurse) created the order changing R1's insulin from subcutaneous to intramuscular and from daily to three times daily. V15 was unavailable for interview during this survey.</p> <p>R1's medical record, dated 2/19/25, V10 NP noted R1's hospital stay notable for hypoglycemia from poor oral intake. R1's diabetes is stable. Blood sugar level 115 this morning. On insulin 70/30 daily, order blood sugar testing before meals and at bedtime. Baqsimi nasal spray as needed.</p> <p>On 2/21/25 at 11:47 PM, V8 LPN noted CNA (certified nurse aide) notified V8 of R1 not being responsive. V8 observed R1 unresponsive. V8 than obtained vital signs, and blood sugar, pulse 60 beats/minute, respirations 20/minute, oxygen saturation level 90% on room air, and blood sugar 29. R1 transferred to the hospital via stretcher.</p> <p>On 2/22, R1 has been admitted for Hypoglycemia.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's EMS (emergency medical services) run sheet, dated 2/21/2025, notes EMS crew was dispatched to the facility at 11:27 PM for a resident with a diabetic problem. The crew arrived at R1's bedside at 11:34 PM. Upon arrival R1 was in the room with a CNA, unresponsive, diaphoretic, with a GCS (glasgow coma score) of 3. The CNA advised the crew that R1 had low blood sugar. V7 LPN just checked it, but I don't know what it is. R1's continuous blood glucose system receiver just says 'LOW'. The crew looked at R1's continuous blood glucose system receiver and the trends it showed was: blood glucose at a normal level around 3:00 PM with it dropping to LOW around 3:30 PM and continuously being at LOW until the crew's arrival at 11:34 PM. R1 was loaded on to the stretcher and brought down to the ambulance. R1's vital signs were taken, and all were within normal limits with the exception of her blood glucose level which was at 31. Two intravenous catheter insertion attempts were made, one in each forearm but were unsuccessful. IO (intraosseous) equipment was set up, the hospital was called to clear the IO insertion. An IO was established in R1's left tibia. R1 was administered dextrose 10% at a keep open rate. R1's oxygen saturation level was starting to decrease in route. A nasal cannula was placed on R1 and oxygen was delivered at 4 liters.</p> <p>R1's hospital record, dated 2/22/25, was unavailable for review during this survey.</p> <p>R1's care plan, dated 2/19/25, notes R1 is an insulin dependent diabetic. Interventions include, but not limited to, diabetes medication as ordered by physician. Monitor/document for side effects and effectiveness.</p> <p>The facility's physician orders-entering and processing policy, revised 1/31/2024, notes if the medication is needed immediately, it will be removed from the emergency drug kit. All appropriate paperwork will be filled out when a drug is removed from the emergency drug kit.</p> <p>The facility's hypoglycemia guidelines, undated, notes contact physician if blood sugar is below 60. Take vital signs. Repeat finger stick in 15 minutes after intervention. If unable to swallow notify the physician and prepare glucagon from the emergency drug kit for administration as ordered. Document findings, interventions, and physician contact in resident's clinical record.</p> <p>The Immediate Jeopardy that began on 02.21.25 was removed on 03.13.25 when the facility took to remove the Immediacy.</p> <p>Removal Plan:</p> <p>Action Steps Responsible Person(s)</p> <p>Target Date:</p> <p>Change of condition assessment done as soon as change Nurse managers</p> <p>Ongoing</p> <p>is noticed to monitor condition</p> <p>Daily clinical meeting</p> <p>IDT</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ongoing</p> <p>Nursing Huddle/CNA</p> <p>DON/ADON</p> <p>Ongoing</p> <p>Change of condition NP / Dr notified</p> <p>Admin/DON/Nurses</p> <p>Ongoing</p> <p>All department Heads to read 24-hour report daily before DON/ADON</p> <p>Ongoing</p> <p>Morning meeting at 9:30am</p> <p>Guardian Angel rounds and sheets to be completed daily DON/ADON</p> <p>Ongoing</p> <p>and turned into and reviewed daily at standdown, don't just report issues, correct as you go.</p> <p>New insulin orders will be discussed daily in morning meeting</p> <p>Weekly insulin Orders checked and verified orders for the last week</p> <p>Nursing</p> <p>3/4/2025</p> <p>Nurses including agency inserviced on verifying with repeat DON</p> <p>3/5/2025</p> <p>back to NP/physicians when taking orders. All nurses not already inserved they will be inserviced prior to next scheduled shift.</p> <p>Nurses including agency inserviced on following Dr orders DON</p> <p>3/5/2025 Completed 3/13/25 for agency staff</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 03/18/2025
NAME OF PROVIDER OR SUPPLIER Aperion Care Forest Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 West Roosevelt Road Forest Park, IL 60130	

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>and the five rights of medication and Hypoglycemia protocol</p> <p>(see policy) All nurses not already inserved they will be inserved prior to next scheduled shift.</p> <p>Facility wide audit completed for residents on Insulin to ensure correct DON /RNC</p> <p>3/4/2025</p> <p>orders in place and orders for hypoglycemic treatment</p> <p>Emergency QAPI completed with Medical Director Admin/DON/Medical Director 3/13/2025</p> <p>Orders written for residents on insulin to monitor for signs DON/RNC</p> <p>3/13/25</p> <p>and symptoms of hypoglycemia</p> <p>Facility policy reviewed and revised to include emergency CCO</p> <p>3/13/25</p> <p>response and directions for use of baqsimi</p> <p>Pharmacy consultant to review all insulin orders monthly during</p> <p>On going</p> <p>monthly facility visits for 6 months to verify that dose is appropriate</p> <p>Red emergency drug kits will be checked weekly to verify all</p> <p>DON / ADON</p> <p>On going</p> <p>medications are available.</p>

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(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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interviews and record reviews, the facility failed to follow professional standards of nursing care and clarify with the physician the frequency and route of administration of insulin 70/30 prior to administering the medication. This failure affected one resident (R1) out of three reviewed for significant medication errors in a sample of 4. Prior to admission, 20 units of insulin 70/30 was administer to R1 subcutaneously once a day. The order was changed on 2/19/25 at 00:50 AM to insulin 70/30, administer 20 units intramuscularly three times a day. This resulted in R1 having severe hypoglycemia with a blood sugar level of 29 and being nonresponsive for unknown length of time.</p> <p>The immediate jeopardy began on 2/21/25 when R1 was found unresponsive and with a blood glucose level of 29. V1 and V2 were notified of the immediate jeopardy on 03/13/2025 at 9:35 AM. The surveyor confirmed by onsite observations, interviews, and record reviews that the immediacy was removed on 3/13/25, but remains at level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>Findings include:</p> <p>On 3/3/25 at 5:00 PM, V10 NP (nurse practitioner) stated that R1 had an order for insulin 70/30 subcutaneous daily. V10 was not made aware that R1's insulin was changed to three times a day. V10 stated that V10 would not have changed R1's insulin to be given three times daily. V10 stated that insulin should not be administered intramuscularly. V10 stated that insulin should be administered within 30 minutes of when blood sugar is checked. V10 stated that insulin 70/30 is an intermediate-acting insulin and should not be given two doses close together.</p> <p>On 3/4/25 at 9:13 AM, V8 ADON (assistant director of nursing) stated that the nurse is expected to review discharge paperwork sent with new admission from the hospital. V8 stated that if there is a question regarding any physician order, the nurse is expected to clarify the order prior to implementing it. When questioned why insulin administration was changed from subcutaneous to intramuscular, V8 stated that V8 will have to look into this. When questioned reason insulin 70/30 was changed from daily to three times a day, V8 stated that she will have to look into this as well. V8 stated that the nurse is expected to know when insulin peaks and duration of its action.</p> <p>R1's POS (physician order sheet), dated 2/18/25, notes an order for novolin 70/30 insulin, administer 20 units subcutaneously once a day. On 2/19/25 at 00:50 AM, the insulin order was changed to 20 units intramuscularly three times a day.</p> <p>V15 LPN (licensed practical nurse) created the order changing R1's insulin from subcutaneous to intramuscular and from daily to three times daily. V15 was unavailable for interview during this survey.</p> <p>R1's MAR (medication administration record), dated February 2025, notes six nurses administered insulin 70/30 intramuscularly. R1 received a total of 9 doses intramuscularly. It also notes on 2/21/25 the 9:00 AM scheduled dose of novolin 70/30 insulin was administered at 11:31 AM by V11 LPN (licensed practical nurse) and the 12:00 PM scheduled dose was administered at 12:19 PM by V11.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's EMS (emergency medical services) run sheet, dated 2/21/2025, notes EMS crew was dispatched to the facility at 11:27 PM for a resident with a diabetic problem. The crew arrived at R1's bedside at 11:34 PM. Upon arrival R1 was in the room with a CNA, unresponsive, diaphoretic, with a GCS (glasgow coma score) of 3. The CNA advised the crew that R1 had low blood sugar. V7 LPN just checked it, but I don't know what it is. R1's continuous blood glucose system receiver just says 'LOW'. The crew looked at R1's continuous blood glucose system receiver and the trends it showed was: blood glucose at a normal level around 3:00 PM with it dropping to LOW around 3:30 PM and continuously being at LOW until the crew's arrival at 11:34 PM. R1 was loaded on to the stretcher and brought down to the ambulance. R1's vital signs were taken, and all were within normal limits with the exception of her blood glucose level which was at 31. Two intravenous catheter insertion attempts were made, one in each forearm but were unsuccessful. IO (intraosseous) equipment was set up, the hospital was called to clear the IO insertion. An IO was established in R1's left tibia. R1 was administered dextrose 10% at a keep open rate. R1's oxygen saturation level was starting to decrease in route. A nasal cannula was placed on R1 and oxygen was delivered at 4 liters.</p> <p>Per the National Library of Medicine, insulin is absorbed faster after intramuscular injection compared to subcutaneous injection. Intramuscular injections should be avoided as they increase the risk of hypoglycemia.</p> <p>Per the FDA (Food and Drug Administration), novolin insulin 70/30 is an intermediate-acting insulin. The effects of Novolin 70/30 start working 30 minutes after injection. The greatest blood sugar lowering effect is between 2 and 12 hours after the injection. This blood sugar lowering may last up to 24 hours. Symptoms of hypoglycemia may include, but not limited to: sweating, confusion, shakiness. Severe hypoglycemia can cause unconsciousness, seizures, and death.</p> <p>The Centers for Medicare & Medicaid Services requires nurses to verify specific information prior to the administration of medication to avoid errors, referred to as verifying the rights of medication administration. These rights of medication administration are the vital last safety check by nurses to prevent errors in the chain of medication administration that includes the prescribing provider, the pharmacist, the nurse, and the patient. The nurse ensures the route of administration is appropriate for the specific medication and also for the patient. Some medications can only be given safely via one route. Nurses must administer medications via the route indicated in the order. If a nurse discovers an error in the order or believes the route is unsafe for a particular patient, the route must be clarified with the prescribing provider before administration.</p> <p>The Immediate Jeopardy that began on 02.21.25 was removed on 03.13.25 when the facility took to remove the Immediacy.</p> <p>Removal Plan:</p> <p>Change of condition assessment done as soon as change is noticed to monitor condition</p> <p>Nurse managers</p> <p>Ongoing</p> <p>Daily clinical meeting</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>DON</p> <p>3/5/2025</p> <p>Nurses including agency inserviced on following Dr orders and the five rights of DON 3/5/2025</p> <p>Completed 3/13/25 for agency staff</p> <p>medication and Hypoglycemia protocol (see policy) All nurses not already inserved they will be inserviced prior to next scheduled shift.</p> <p>Facility wide audit completed for residents on Insulin to ensure correct orders in DON 3/4/25 place and orders for hypoglycemic treatment.</p> <p>Emergency QAPI completed with Medical Director Admin/DON/Medical Director 3/13/25</p> <p>Orders written for residents on insulin to monitor for signs and symptoms of DON/RNC 3/13/25</p> <p>hypoglycemia</p> <p>Facility policy reviewed and revised to include emergency response and CCO 3/13/25</p> <p>directions for use of baqsimi</p> <p>Pharmacy consultant to review all insulin orders monthly during monthly</p> <p>On going</p> <p>facility visits for 6 months to verify that dose is appropriate</p> <p>Red emergency drug kits will be checked weekly to verify all medications are available. DON / ADON</p> <p>On going</p>