

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 305 N.W. 11th Street Fairfield, IL 62837	

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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44492</b></p> <p>Based on interview and record review, the facility failed to administer regularly scheduled ordered pain medication for 1 (R1) of 5 residents reviewed for pain management. This failure resulted in R1 experiencing loss of sleep and significant pain to R1's shoulders, back, and knees due to missing R1's 2/5/24 pm dose of her regularly scheduled pain medication. This past noncompliance occurred between 2/05/2024 - 2/09/2024.</p> <p>Findings:</p> <p>R1's face sheet documents an admission to the facility on [DATE] with diagnoses of Chronic Kidney disease, Stage 3 Unspecified, Malignant neoplasm of uterus, part unspecified, other intervertebral disc degeneration, lumbar region, unspecified osteoarthritis, unspecified site, other sleep apnea.</p> <p>R1's Minimum Data Set (MDS) dated [DATE], documents R1 has a Brief Interview for Mental Status (BIMS) score of 13, indicating she is cognitively intact. R1's MDS Section J, Pain Management, documents she has a scheduled pain medication regimen.</p> <p>R1's Care Plan documents a Focus of: R1 has chronic pain; Goal: R1 will not have an interruption in normal activities due to pain through the review date; Interventions: Administer analgesia per orders; Evaluate the effectiveness of pain interventions; Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition; Monitor/document for side effects of pain medication; Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician.</p> <p>R1's Physician's Orders dated 4/20/2023 documents Pain Assessment every day and night shift; 4/19/2023 documents Acetaminophen 500mg (milligrams) (2 tabs) every 4 hours as needed for pain; 4/21/2023 documents Percocet 5/325mg three times a day for pain (Unspecified Osteoarthritis, Unspecified site; Other Intervertebral disc degeneration, lumbar region); 2/6/2024 documents Hydrocodone 5/325mg every 8 hours as needed for pain (may substitute if Percocet is unavailable).</p> <p>R1's Medication Administration Record (MAR) dated February 1 - 29, 2024 does not document Percocet 5/325mg was given on 2/5/2024 (9:00 PM); 2/6/2024 (5:00 AM, 1:00 PM, 9:00 PM) and 2/07/2024 (1:00 AM).</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:  146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE  305 N.W. 11th Street Fairfield, IL 62837	

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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's MAR dated February 1-29, 2024 documents pain assessment every day and night shift completed with pain rating on 2/5/2024 to be 6 and on 2/6/2024 to be 7. No alternative medication was ordered until 2/6/2024 and first dose was given at 5:37 PM.</p> <p>R1's Narcotic Administration Sheet for Percocet 5/325mg documents last dose given on 2/5/2024 at 1:00 PM and documentation of Percocet 5/325mg received on 2/7/2024 (30 tabs) with the next dose given on 2/7/2024 at 12:30 PM.</p> <p>R1's Progress Notes dated 2/06/2024, 6:00 PM (Late Entry) by V4 (Quality Assurance/Licensed Practical Nurse/LPN) documents in part .R1 came to this nurse and spoke about being out of her pain pills .asked R1 if she was having pain and R1 stated she was and had been to a doctor's appointment .told R1 a nurse sent a script to V20 (Primary Nurse Practitioner/NP), Monday (2/5/2024) to get signed .it came back Tuesday morning (2/6/2024) that it didn't have quantity amount or DEA (Drug Enforcement Administration) number on it .so V20 was going to escribe it to pharmacy .told R1 that hopefully it would come in on the delivery we would get Tuesday night .When pharmacy delivered Tuesday evening around 10:30 PM, did not have R1's pain medication.</p> <p>R1's Progress Notes dated 2/07/2024, 11:58 AM, documents in part .med delivery guy had been there and delivered R1's pain medications.</p> <p>On 2/14/2024, at 12:30 PM, R1 stated Last week either Sunday or Monday evening, the nurse came in and told me that I was out of my regular pain medication. R1 stated they told her a new nurse forgot to reorder it. R1 stated that the nurse told her that it probably wouldn't be here until tomorrow night and R1 stated that she was not offered any other type of pain medication until the following day. R1 stated that she has arthritis in her shoulders, back, and has had multiple knee replacements. R1 stated that she didn't get any sleep for three nights after missing her regularly scheduled pain medication and her pain was unbearable in her shoulders, back, and knees. R1 stated that she has been on scheduled Percocet for over twenty years and that is the only medication that helps to relieve her pain.</p> <p>On 2/14/2024, at 1:10 PM, V2 (Director of Nursing/DON) stated that R1's Percocet medication is not in the facility's emergency medication kit (E-Kit). V2 stated that it is the expectation of her nurses to have any medication that needs to be refilled, to be refilled in a timely manner before the medication runs out. V2 stated that it is the expectation of the nurses to call the primary physician when a medication runs out and get it refilled as soon as possible or get another order for an alternative medication to be given. V2 stated that R1 did get offered an alternative medication on 2/6/2024 and on 2/7/2024.</p> <p>On 2/14/2024, at 1:25 PM, V6 (Ombudsman) stated that V19 (Family) contacted her and told her that R1 ran out of her pain medication. V6 stated that she called R1 and R1 stated to her that she had not received her pain medication for 24 hours. V6 stated that R1 told her that she had been on regularly scheduled Percocet for over [AGE] years and that is the only pain medication that works for her. V6 stated that she offered R1 a grievance form to fill out. V6 stated that she spoke with V1 (Administrator) and was told R1 was offered an alternative medication but that she refused. V6 stated that V1 verified to her that R1's Percocet was not in the facility's emergency medication kit. V6 stated that V1 verified to her that R1 had missed 5-6 doses of her Percocet medication. V6 stated that V1 told her that R1's Percocet did arrive on 2/7/2024 and that the facility is monitoring to make sure this doesn't happen again.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE  305 N.W. 11th Street Fairfield, IL 62837	
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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/14/2024, at 1:40 PM, V1 (Administrator) stated that he spoke with V6 (Ombudsman) and told her that R1 ran out of her pain medication and that a back-up alternative was offered and given. V1 stated that R1's Percocet was ordered on 2/5/24 &amp; 2/6/24 and received on 2/7/2024.</p> <p>On 2/14/2024 at 2:00 PM, the emergency medication kit was observed to have no Percocet available. There was hydrocodone 5/325mg available in the emergency medication kit.</p> <p>On 2/14/2024 at 3:05 PM, V9 (Registered Nurse/RN) stated that she works 6:00 AM - 6:00 PM regularly and she worked on 2/5/2024, day shift. V9 stated that she was told in report by V5 (RN) that R1 had one Percocet pill left and that it would need to be reordered. V9 stated that she called V20 (Primary Nurse Practitioner) and told her that we needed a new script for R1's Percocet medication. V9 stated that she gave R1 her last dose of Percocet at 1:00 PM on 2/5/2024. V9 stated that she told V5 (RN) in report that R1's Percocet medication was supposed to come in that evening.</p> <p>On 2/14/2024 at 3:10 PM, V5 (RN) stated that she worked Sunday night, 2/4/2024, and noticed that R1 only had one dose of Percocet left after she gave R1 her regularly scheduled 5:00 AM dose. V5 stated that she did not notify the primary physician at that time, just told V9 (RN) that R1 only had one dose of Percocet left and it needed to be reordered.</p> <p>On 2/20/2024 at 8:10 AM, V10 (RN) stated that she worked on 2/6/2024 and R1 was out of her Percocet medication. V10 stated that she called V20 (Primary Nurse Practitioner) and got an alternative medication (Hydrocodone 5/325mg) ordered for her until the Percocet would come in from the pharmacy. V10 stated that she offered Tylenol to R1 but R1 refused stating, That will not work for me and V10 stated she offered the hydrocodone to her and R1 refused the first time, stating, Those will not work for me, I threw 120 tablets away because that medication would not work for me. V10 stated that she talked to R1 and explained to her that hydrocodone was equivalent to Percocet and R1 finally agreed to take a dose of it. V10 stated that R1 was experiencing more pain than usual that day. V10 stated that R1's Percocet was supposed to arrive from pharmacy later that evening.</p> <p>On 2/20/2024 at 8:20 AM, V11 (Licensed Practical Nurse/LPN) stated that she worked on 2/6/2024, the night shift and was told in report that R1 was out of her Percocet medication and that hydrocodone could be given as needed until her Percocet medication could be delivered from pharmacy. V11 stated that R1's Percocet medication was supposed to arrive to the facility on [DATE] but did not show up that evening. V11 stated that she called the pharmacy and they told her that it would arrive on the next pharmacy delivery, which would be in the morning. V11 stated that she administered the hydrocodone as ordered for R1 when she was able to have it.</p> <p>On 2/20/2024, at 8:40 AM, V20 (Primary Nurse Practitioner) stated that she was notified on 2/5/2024 that R1 needed her Percocet re-ordered. V20 stated that she reordered R1's Percocet that day but it was sent to the wrong pharmacy. V20 stated that she received another phone call on 2/6/2024 regarding R1 needing her Percocet reordered. V20 stated that when she went into the computer to order it again on 2/6/2024, she noticed she had sent the initial Percocet order to the wrong pharmacy. V20 stated that she reordered the Percocet again as well as ordered an alternative pain medication, hydrocodone 5/325mg that could be given as needed until the Percocet became available. V20 stated that it is her expectation for the nurses to notify her in a timely manner to refill medications and not wait until residents run out of medications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE  305 N.W. 11th Street Fairfield, IL 62837	
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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Pain Management policy dated 7/6/2018 documents in part .Purpose: To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness.</p> <p>The facility's concern/compliment form dated 2/7/2024 documents being filled out by R1 stating: I have to have my pain med regularly; I got my evening med and the nurse told me we were out of percocet and she would check to see if they were ordered; I didn't get my pain med until 2/7/2024 at noon; A very painful 2 days and nights.</p> <p>On 2/15/2024, at 10:30 AM, V1 (Administrator) stated that the facility had a Quality Assurance (QA) meeting on 2/9/2024 to discuss narcotic medications and medication refills. V1 stated the following people attended the QA meeting: V1 (Administrator), V2 (Director of Nursing), V4 (Quality Assurance/LPN), V16 (LPN/MDS/Care Plan Coordinator). V1 stated the measure put in place to ensure that deficient practice does not recur are: V2 (DON) and V4 (QA/LPN) will be checking narcotic books weekly (Tuesday) to see if the facility needs to get any scripts for narcotic medication refills to ensure that they don't run out of any narcotic medications.</p> <p>On 2/14/2024, V1 (Administrator) provided their QAPI (Quality Assurance Performance Improvement) Ad Hoc Form outlining the actions taken by the facility prior to the survey date to correct the noncompliance.</p> <p>Prior to the survey date, the facility took the following actions to correct the non-compliance:</p> <ol style="list-style-type: none"> <li>1. A Quality Assurance and Performance Improvement meeting was held on 2/09/2024. In attendance - V1, V2, V4, and V16.</li> <li>2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents who receive narcotic medication have the potential to be impacted.</li> <li>3. Measures put into place/systematic changes to ensure the deficient practice does not recur: V2 and V4 provided in-service training on 2/9/2024 to nursing staff, (narcotic medications and medications refill).</li> <li>4. Plan to monitor performance to ensure solutions are sustained: Narcotic medication audits to be conducted weekly x 4 weeks by V2 &amp; V4. The first complete facility audit was completed on 2/13/2024.</li> </ol>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE  305 N.W. 11th Street Fairfield, IL 62837	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44492</b></p> <p>Based on interview and record review, the facility failed to ensure ordered pain medication was refilled in a timely manner for 1 (R1) of 3 residents reviewed for pharmacy services. This past noncompliance occurred between 2/05/2024 - 2/09/2024.</p> <p>Findings:</p> <p>R1's face sheet documents a facility admitted [DATE] with diagnoses of Chronic Kidney disease, Stage 3 Unspecified, Malignant neoplasm of uterus, part unspecified, other intervertebral disc degeneration, lumbar region, unspecified osteoarthritis, unspecified site, other sleep apnea. R1's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 13, indicating R1 is cognitively intact; Section J, Pain Management, documents R1 has a scheduled pain medication regimen.</p> <p>R1's Physician's Orders dated 4/19/2023 documents Acetaminophen 500mg (2 tabs) every 4 hours as needed for pain; 4/21/2023 documents Percocet 5/325mg three times a day for pain (Unspecified Osteoarthritis, Unspecified site; Other Intervertebral disc degeneration, lumbar region); 2/6/2024 documents Hydrocodone 5/325mg every 8 hours as needed for pain (may substitute if Percocet is unavailable).</p> <p>R1's Medication Administration Record (MAR) dated February 1 - 29, 2024 documents Percocet 5/325mg not given on 2/5/2024 (9:00 PM); 2/6/2024 (5:00 AM, 1:00 PM, 9:00 PM) and 2/07/2024 (1:00 AM).</p> <p>R1's Narcotic Administration Sheet for Percocet 5/325mg documents last dose given on 2/5/2024 at 1:00 PM and documentation of Percocet 5/325mg received on 2/7/2024 (30 tabs) and next dose given on 2/7/2024 at 12:30 PM.</p> <p>R1's Progress Notes dated 2/06/2024, 6:00 PM (Late Entry) by V4 (Quality Assurance/Licensed Practical Nurse/LPN) documents in part .R1 came to this nurse and spoke about being out of her pain pills .asked R1 if she was having pain and R1 stated she was and had been to a doctor's appointment .told R1 a nurse sent a script to V20 (Primary NP), Monday (2/5/2024) to get signed .it came back Tuesday morning (2/6/2024) that it didn't have quantity amount or DEA (Drug Enforcement Administration) number on it .so V20 was going to escribe it to pharmacy .I told R1 that hopefully it would come in on the delivery we would get Tuesday night . When pharmacy delivered Tuesday evening around 10:30 PM, did not have R1's pain medication.</p> <p>R1's Progress Notes dated 2/07/2024, 11:58 AM, document in part .med delivery guy had been there and delivered R1's pain medications.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE  305 N.W. 11th Street Fairfield, IL 62837	
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 2/14/2024 at 12:30 PM, R1 stated last week either Sunday or Monday evening, the nurse came in and told me that I was out of my regular pain medication. R1 stated they told her a new nurse forgot to reorder it. R1 stated that the nurse told her that it probably wouldn't be here until tomorrow night. R1 stated that she was not offered any other type of pain medication until the following day. R1 stated that she has arthritis in her shoulders, back, and has had multiple knee replacements. R1 stated that she didn't get any sleep for three nights after missing her regularly scheduled pain medication and her pain was unbearable in her shoulders, back, and knees. R1 stated that she has been on scheduled Percocet for over twenty years and that is the only medication that helps to relieve her pain.</p> <p>On 2/14/2024, at 1:10 PM, V2 (Director of Nursing/DON) stated that R1's Percocet medication is not in the facility's emergency medication kit (E-Kit). V2 stated that it is the expectation of her nurses to have any medication that needs to be refilled, to be refilled in a timely manner before the medication runs out. V2 stated that it is the expectation of the nurses to call the primary physician when a medication runs out and get it refilled as soon as possible or get another order for an alternative medication to be given. V2 stated that R1 did get offered an alternative medication on 2/6/2024 and on 2/7/2024. V2 stated that an in-service training for all the nurses on narcotic medications and medication refills was given on 2/9/2024. V2 stated that she and V4 (Quality Assurance/LPN) are completing weekly audits to see if they need to get any scripts for narcotic medications refilled.</p> <p>On 2/14/2024, at 1:25 PM, V6 (Ombudsman) stated that V19 (Family) contacted her and told her that R1 ran out of her pain medication. V6 stated that she called R1 and R1 stated to her that she had not received her pain medication for 24 hours. V6 stated that R1 told her that she had been on regularly scheduled Percocet for over [AGE] years and that is the only pain medication that works for her. V6 stated that she offered R1 a grievance form to fill out. V6 stated that she spoke with V1 (Administrator) and was told R1 was offered an alternative medication but that she refused. V6 stated that V1 verified to her that R1's Percocet was not in the facility's emergency medication kit. V6 stated that V1 verified to her that R1 had missed 5-6 doses of her Percocet medication. V6 stated that V1 told her that R1's Percocet did arrive on 2/7/2024 and that the facility is monitoring to make sure this doesn't happen again.</p> <p>On 2/14/2024 at 1:40 PM, V1 (Administrator) stated that he spoke with V6 (Ombudsman) and told her that R1 ran out of her pain medication and that a back-up alternative was offered and given. V1 stated that R1's Percocet was ordered on 2/5/24 &amp; 2/6/24 and received on 2/7/2024. V1 stated that an in-service for all nurses on narcotic medications and medication refills was given on 2/9/2024. V1 stated that V2 (DON) and V4 (Quality Assurance/LPN) are completing weekly audits to see if they need to get any scripts for narcotic medications refilled.</p> <p>On 2/14/2024 at 2:00 PM, the emergency medication kit was observed to have no Percocet available. There was hydrocodone 5/325mg available in the emergency medication kit.</p> <p>On 2/14/2024 at 3:05 PM, V9 (Registered Nurse/RN) stated that she works 6:00 AM - 6:00 PM regularly and she worked on 2/5/2024, day shift. V9 stated that she was told in report by V5 (RN) that R1 had one Percocet pill left and that it would need to be reordered. V9 stated that she called V20 (Primary Nurse Practitioner) and told her that a new script was needed for R1's Percocet medication. V9 stated that she gave R1 her last dose of Percocet at 1:00 PM on 2/5/2024. V9 stated that she told V5 (RN) in report that R1's Percocet medication was supposed to come in that evening.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE  305 N.W. 11th Street Fairfield, IL 62837	
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 2/14/2024 at 3:10 PM, V5 (RN) stated that she worked Sunday night, 2/4/2024, and noticed that R1 only had one dose of Percocet left after she gave R1 her regularly scheduled 5:00 AM dose. V5 stated that she did not notify the primary physician at that time, just told V9 (RN) that R1 only had one dose of Percocet left and it needed to be reordered. V5 stated that she has been in-serviced on medication refills and has been closely monitoring when medications need to be reordered and refilled.</p> <p>On 2/15/2024 at 10:00 AM, V2 (DON) and V4 (Quality Assurance/LPN) both stated that they are doing weekly audits on checking the narcotic book weekly to see if any new scripts for narcotic medications need to be reordered. Both stated that the nursing staff have been in-serviced, (2/9/2024), on medication refills and that all the nurses know how to use the (name of medication dispensing system). Both stated that the first weekly audit for narcotic medication refill was completed on 2/13/2024 with no concerns noted. Both stated that the facility is trying to implement different pain medications to be added to the (name of medication dispensing system) as well.</p> <p>On 2/20/2024 at 8:10 AM, V10 (RN) stated that she worked on 2/6/2024 and R1 was out of her Percocet medication. V10 stated that she called V20 (Primary Nurse Practitioner/NP) and got an alternative medication (Hydrocodone 5/325mg) ordered for her until the Percocet would come in from the pharmacy. V10 stated that she offered Tylenol to R1 but R1 refused stating, That will not work for me and V10 stated she offered the hydrocodone to her and R1 refused the first time, stating, Those will not work for me, I threw 120 tablets away because that medication would not work for me. V10 stated that she talked to R1 and explained to her that hydrocodone was equivalent to Percocet and R1 finally agreed to take a dose of it. V10 stated that R1 was experiencing more pain than usual that day. V10 stated that R1's Percocet was supposed to arrive from pharmacy later that evening. V10 stated that she has been in-serviced on medication refills and she has been closely monitoring when medications need to be reordered.</p> <p>On 2/20/2024 at 8:20 AM, V11 (LPN) stated that she worked on 2/6/2024, the night shift and was told in report that R1 was out of her Percocet medication and that hydrocodone could be given as needed until her Percocet medication could be delivered from pharmacy. V11 stated that R1's Percocet medication was supposed to arrive to the facility on [DATE] but did not show up that evening. V11 stated that she called the pharmacy and they told her that it would arrive on the next pharmacy delivery, which would be in the morning. V11 stated that she administered the hydrocodone as ordered for R1 when she was able to have it. V11 stated that she has been in-serviced on medication refills and has been monitoring closely when medications need reordered.</p> <p>On 2/20/2024 at 8:40 AM, V20 (Primary Nurse Practitioner) stated that she was notified on 2/5/2024 that R1 needed her Percocet re-ordered. V20 stated that she reordered R1's Percocet that day but it was sent to the wrong pharmacy. V20 stated that she received another phone call on 2/6/2024 regarding R1 needing her Percocet reordered. V20 stated that when she went into the computer to order it again on 2/6/2024, she noticed she had sent the initial Percocet order to the wrong pharmacy. V20 stated that she reordered the Percocet again as well as ordered an alternative pain medication, hydrocodone 5/325mg that could be given as needed until the Percocet became available. V20 stated that it is her expectation for the nurses to notify her in a timely manner to refill medications and not wait until residents run out of medications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE  305 N.W. 11th Street Fairfield, IL 62837	

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>The facility's pharmacy policy dated 8/2020 documents in part .Procedures: Elements of Controlled Substance Prescription: 6. Quantity Prescribed; 11. Name, address, and DEA registration number of the prescriber .Ordering medications from the pharmacy: 2. Repeat medications (refills) are written on a medication reorder form or by peeling the reorder tab from the prescription label and placing it in the appropriate area on the medication reorder form provided by the pharmacy for that purpose, or requested via the facility's electronic health record (EHR) system and ordered as follows: a. Reorder medications based on the estimated refill date ([NAME]), on the pharmacy Rx label, or at least three days in advance, to ensure an adequate supply is on hand. When ordering medication that requires special processing, order at least seven days in advance of need; b. The refill order is called in, faxed, sent electronically, or otherwise transmitted to the pharmacy. When available and legible, the pharmacy label (including bar code) is pulled and transmitted to the pharmacy.</p> <p>The facility's concern/compliment form dated 2/7/2024 documents being filled out by R1 stating: I have to have my pain med regularly; I got my evening med and the nurse told me we were out of percocet and she would check to see if they were ordered; I didn't get my pain med until 2/7/2024 at noon; A very painful 2 days and nights.</p> <p>On 2/15/2024, at 10:30 AM, V1 (Administrator) stated that the facility had a Quality Assurance (QA) meeting on 2/9/2024 to discuss narcotic medications and medication refills. V1 stated the following people attended the QA meeting: V1 (Administrator), V2 (Director of Nursing), V4 (Quality Assurance/LPN), V16 (LPN/MDS/Care Plan Coordinator). V1 stated the measure put in place to ensure that deficient practice does not recur are: V2 (DON) and V4 (QA/LPN) will be checking narcotic books weekly (Tuesday) to see if the facility needs to get any scripts for narcotic medication refills to ensure that they don't run out of any narcotic medications.</p> <p>On 2/14/2024, V1 (Administrator) provided their QAPI (Quality Assurance Performance Improvement) Ad Hoc Form outlining the actions taken by the facility prior to the survey date to correct the noncompliance.</p> <p>Prior to the survey date, the facility took the following actions to correct the non-compliance:</p> <ol style="list-style-type: none"> <li>1. A Quality Assurance and Performance Improvement meeting was held on 2/09/2024. In attendance - V1, V2, V4, and V16.</li> <li>2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents who receive narcotic medication have the potential to be impacted.</li> <li>3. Measures put into place/systematic changes to ensure the deficient practice does not recur: V2 and V4 provided in-service training on 2/9/2024 to nursing staff, (narcotic medications and medications refill).</li> <li>4. Plan to monitor performance to ensure solutions are sustained: Narcotic medication audits to be conducted weekly x 4 weeks by V2 &amp; V4. The first complete facility audit was completed on 2/13/2024.</li> </ol>