STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146143	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Hanover Park	2000 West Lake Street Hanover Park, IL 60133

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46409 Based on observation, interview, and record review, the facility failed to assess residents to self-administer medications. This applies to 2 of 2 residents (R27, R84) reviewed for self-administration of medications in a sample of 23. The findings include: 1. On April 1, 2025 at 11:19 AM, R27 pulled out an albuterol sulfate inhaler and took a puff of the inhaler as she was short of breath. R27 said she was given the inhaler from the facility. On April 2, 2025 at 12:13 PM, R27 said she had chronic obstructive pulmonary disease, and she used the inhaler twice on April 1, 2025 when she was going to the doctor's office. R27's face sheet showed she was admitted to the facility with diagnoses including chronic obstructive pulmonary disease. R27's POS (Physician Order Sheet) showed an order for Albuterol Sulfate Inhalation Aerosol Powder breath activated 108 (90 base). R27's POS did not show orders for R27 to self-administer medications or to store medications at her bedside. The facility was unable to provide a self-administration assessment. R27's care plan did not show she was able to self-administer medication. 2. On April 1, 2025 at 10:53 AM, R84's room had a bottle of bismuth subsalicylate 525 MG (Milligrams), which was half empty, sitting on the side table in her room. The bottle contained 473 ML (Milliliters) of medication. R84 said she took the medication when she had heartburn. R84 said she brought the medication from home. R84's face sheet showed she was admitted to the facility with diagnoses including difficulty in walking, need for assistance with personal care, cognitive communication deficit, hypothyroidism, hypertension, and acute kidney failure. R84's POS did not show an order for bismuth subsalicylate 525 MG or for her to self-medicate. The facility was unable to provide a self-administer assessment. R84's care plan did not show she was able to self-administer medication. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 3, 2025 at 11:20 AM, V15 (LPN/Licensed Practical Nurse) said none of the residents were allowed to take medications on their own. V15 said the residents needed an assessment to make sure they understand the use of the medication and the side effects to be able to take the medication themselves. V15 said if she saw medications at the bedside, she would remove the medications. V15 said R27 and R84 were not allowed to have medications at their bedside. V15 said it was a risk to keep medications at the bedside as there were other residents who could walk into the rooms and take the medications left at the bedside. On April 3, 2025 at 11:34 AM, V5 (RN/Registered Nurse) said the residents were not allowed to have medications at the bedside unless the doctor prescribed it and there was an assessment completed. V5 said the assessment would determine if they were safe to self-administer medications. V5 said the managers would also need to be notified. V5 said R27 and R84 were not allowed to have medications at their bedside. V5 said if she saw medications kept at the bedside, she would remove it from their room. On April 3, 2025 at 1:59 PM, V2 (DON/Director of Nursing) said residents who wanted to self-administer-medication needed an assessment and orders should be placed by the doctor. The facility's Self Administration of Medications and Treatments policy dated November 2018 showed Self administration of medications and treatments is determined by physician order after determining that the resident is able to self administer. Medications and treatments for self administration are kept in a locked drawer in the resident room. All medications and treatments that are self-administered are signed out in the eMAR (Electronic Medical Administration Record) or eTAR (Electronic Treatment Administration Record) with the nurses initials. If it is determined by a member of the interdisciplinary team, or if the resident requests to self administer, it is documented in the chart and the physician is called for an order to self administer medications, and keep the medications at bedside. Assessment of the ability to self-administer medications will be done by nursing using the tool Assessment for Self-Administration of Medications. The assessment will review if the resident is fully capable, able with assist, or unable to perform assessment criteria.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview, and record review, the facility failed to utilize assistive devices to prevent furthering worsening of contractures. This applies to 1 of 3 residents (R10) reviewed for restorative care in a sample of 23. The findings include: On 4/01/25 at 10:22 AM, during initial tour, surveyor went to R10's room. R10 was sleeping in bed. Both of R10's hands were contracted. R10 did not have a carrot splint type device used to prevent contractures placed in between her hands. On 4/02/25 at10:14 AM, R10 was in bed, and she did have a carrot in her hands. R10 stated, They never put it on me or give me exercises on my hands. On 4/03/25 at 8:45 AM, R10 was in bed. There was no carrot in her hands. During all three days of the survey, surveyor did not see carrots on R10, on her bedside table, or on her bed. On 4/03/25 at 9:00 AM, V14 (LPN-Licensed Practical Nurse/Restorative Nurse) stated R10 was already contracted when I came in the building. It's almost 3 years since I have been here. The CNA's (Certified Nursing Assistants) are supposed to give restorative care and PROM (Passive Range of Motion). They are also supposed to put carrots in R10's hands to prevent further contraction of hands. It should be left on for a few hours in the morning and taken off during ADL (Activities of Daily Living). It is removed in the evening. R10 puts wash clothes in her hand after he comes back from work. It should be the carrots that are orange colored that should be placed in her hands. R10's face sheet shows diagnoses of other seizures, multiple sclerosis, depression, encounter for palliative care, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R10's MDS (Minimum Data Set) dated 2/26/25 shows a BIMS (Brief Interview for Mental Status) score of 9, which means moderate cognitive impairment. Section GG-Functional Abilities shows she was assessed as a 2 in upper extremity which means she has impairment in both sides. R10's March 2025 POS (Physician Order Sheet) shows an order (10/9/24) for the following: May wear carrot hand splint in the morning for 8 hours a day. Inspect skin integrity before and after splinting. If skin breakdown is being caused by splints, please hold off on wearing schedule. R10's restorative assessment dated [DATE] shows she has impairments on both sides of her upper extremity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Uploaded into R10's electronic medical chart was a document that shows: Daily wearing schedule recommended. May wear for up to a 8 hour duration. Instructions: Please inspect skin integrity before and after splinting. Questions, please contact occupational therapy. Updated on 6/12/24. As per V14, this was document was from occupational therapy. On the taskbar on the electronic program that the CNA's use, it documents: Task: Nursing Rehab: Passive ROM: (R10) to perform 5-7 reps of PROM exercises to BLE/BUE (Bilateral Lower Extremities/Bilateral Upper Extremities) for 15 minutes a day for 6-7 days a week until next review. (R10) requires use of splint, bilateral carrot splints in hands for contracture management. R10's care plan dated 7/9/24 shows the following: Focus: Splint/Brace: (R10) requires the use of splint, bilateral carrot splints in hands for contracture management. Goal: (R10) will not experience contracture progression by continued ability to wear current splint comfortably and without complication. Interventions: May wear for up to 8 hour duration. Facility's policy titled Restorative Nursing Program (9/14/25) shows: Purpose: The facility promotes restorative nursing to attain or maintain the highest practicable physical, mental, and psychosocial well being. Increased independence fosters self worth and dignity as well as promotes a quality of life for resident, families, and staff. Type: Contracture Prevention and Management-Components: Passive ROM, Active ROM, positioning, and tone reduction. ADL programs-teaching of compensatory strategies and use of assistive devices. Facility's policy titled Appliance Protection Policy (11/2018) shows: 4. The nurse shall contact the unit director of any delinquency in practice of appliance care and of any lost appliance within 24 hours of being made aware of lost appliances.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46003 Based on observation, interview and record review the facility failed to implement safety measure for a resident with a history of falls with injury. This applies to 1 of 3 residents (R294) reviewed for accidents in a sample of 23. Findings include: R294 admitted to the facility from the hospital with a traumatic brain injury. R294's diagnosis includes pneumonia, difficulty walking, lack of coordination, chronic obstructive pulmonary disease, type 2 diabetes, congestive heart failure, hypertension, and kidney failure. On 04/01/25 at 11:55 AM, V19 (Family Member) stated R294 had a fall in the facility on 3/31/25. V19 stated R294 was admitted to the facility from the hospital after suffering a fall at home that resulted in a brain bleed. V19 stated she wished the facility had more safety devices in place to protect R294. V19 stated R294 can communicate, but he does not comprehend well, and his legs are weak. V19 stated the nurse that called her stated he was found on the floor. V19 stated the facility has not put any intervention in place that she can see to protect R294 from falls even though she had asked for them. V19 stated the facility did not send R294 to the hospital for evaluation after his fall. On 04/01/25 at 03:34 PM, V17 RN (Registered Nurse) stated she had seen R294 at 7am, 8am and 12pm. V17 RN stated R294 had fallen on 3/31/25 and no new fall interventions had been put in place since the fall. On 04/03/25 at 10:02 AM, R294's bed was in an elevated position and his feet were hanging off the right side of his bed. On 04/03/25 at 10:05 AM, V16 CNA (Certified Nursing Assistant) was called to R294's bed side to lower his bed and reposition him to safe position in bed. V16 stated R294 had sat up for breakfast and put himself back in bed without assistance. V16 stated she checks the residents as often as she can. They are checked every hour alternating check with the nurse. V16 stated she was unaware of any new fall interventions added after R294's fall. V16 stated there was no care card in R294's room to reference for his safety interventions so she got the information from the off going shift and the nurse. On 04/03/25 at 12:09 PM, V2 (DON) stated R294's fall prior to admission should have been included in his initial fall risk assessment. Fall Interventions that had been put in place for R294 were to place bed in a low position, assure bed breaks are locked, non-skid foot ware, anticipate needs and meet needs, physical and occupational therapy consult. After his fall the care plan was updated to include offer patient to get back in bed after dinner to avoid trying to transfer self in bed. V2 stated they should offer to place him back to bed after all meals. If R294's bed was elevated the staff should have lowered it to a safe position before leaving the room. If he falls from the bed while it is in an elevated position the impact from an injury maybe greater. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/25 at 01:35 PM, V18 (RN) stated R294 fell from his wheelchair around 10pm on 3/31. V18 stated he had been placed in his wheelchair because he kept trying to stand up. V18 did not know how long R294 had been up in the wheelchair. V18 stated she did not recall what fall interventions were in place for R294, but the prior nurse cautioned her to be careful because he had fallen before. V18 stated she did a fall risk assessment but did not know the meaning of the fall risk score, what R294's fall risk score was or if it changed. V18 stated she did not add or change or add any new fall interventions. V18 stated she did not endorse to the on coming nurse to update the fall interventions. R294's care plan prior to fall states the resident will remain free from injury relate to falls through the review period. Interventions include anticipate and meet the resident's needs, bed in low position when in bed, review information on past falls and attempt to determine cause of falls. Record possible root causes. After and or remove any potential causes if possible. Educate resident/ family/ caregivers / IDT as to causes. The facility policy Incidents - Accidents dated 05/2023 states the facility will monitor the effectiveness of the interventions including adequate supervision consistent with the resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of accident. The facility policy Fall Prevention dated 05/2024 states Every resident will be assessed for the causal risk factor for falling at the time of admission, upon return from a health care facility and after every fall in the facility. Every team member is responsible for checking the care plan of residents who are at risk for falls when beginning each day and throughout the assigned shift.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46409 Based on interview and record review, the facility failed to provide nutritional supplements for a resident who was losing weight. This applies to 1 of 3 residents (R67) reviewed for weight loss in a sample of 23. The findings include: On April 3, 2025 at 11:15 AM, R67 said he did not get the ensure supplement on his meal trays. At 11:28 AM, R67 said he had not gotten his nutritional supplement in the morning. R67 said the nurse must have forgotten. R67 said he had not received his nutritional supplement for more than a month and was not aware he was supposed to have them daily. On April 3, 2025 at 11:20 AM, V15 (LPN/Licensed Practical Nurse) said R67 was losing weight because he was more mobile than when he was first admitted to the facility. V15 said R67 liked the vanilla supplement but sometimes the facility ran out of the flavor R67 preferred. V15 said she had not given R67 his supplement that morning. On April 3, 2025 at 11:34 AM, V5 (RN/Registered Nurse) said she did not remember giving R67 his supplement yesterday. V5 said she used to give him the ensure supplement a long time ago. On April 3, 2025 at 12:33 PM, V22 (Registered Dietitian) said R67 had a 26-pound weight loss over the last six months, which was a 13.3% weight loss. V22 said R67's weights had stabilized, and she had started him on supplements twice daily beginning on February 25, 2025. V22 said R67 was supposed to get the supplement twice daily. V22 said the supplement was supposed to supplement his oral intake for meals to help stabilize his weights and meet his nutritional needs. V22 said if R67 was deficient in calories, it could lead to continued weight loss. On April 3, 2025 at 1:59 PM, V2 (DON/Director of Nursing) said the staff should provide the house supplement to the residents who have the supplement ordered for them. V2 said the staff should not sign off the MAR (Medication Administration Record) without providing the supplement to him. R67's face sheet showed he was admitted to the facility with diagnoses which included unspecified severe protein-calorie malnutrition. R67's MDS (Minimum Data Set) dated March 14, 2025 showed R67 was cognitively intact. R67's MDS showed R67 was independent with eating. R67's POS (Physician Order Sheet) showed House Supplement two times a day for Nutritional supplementation House supplement/Ensure/Boost 1 carton/Bottle po (Oral) BID (Twice Daily), starting February 25, 2025. R67's April 2025 MAR (Medication Administration Record) showed the staff were signing off on R67 receiving the ensure supplement, including V15 and V5. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R67's care plan dated February 17, 2025 showed R67 has the potential for alterations in nutrition and hydration r/t (Related To) spinal infarction, protein calorie malnutrition, paraplegia, CKDII (Stage 2 Chronic Kidney Disease), neurogenic bowel, neurogenic bladder, [Congestive Heart Failure], [Hypertension], [Atrial Fibrillation], [Obstructive Sleep Apnea], [Coronary Artery Disease], depression with interventions including Provide and serve supplements as ordered. 2/25/25: House supplement BID. R67's progress notes dated March 20, 2025 at 5:09 PM showed a note by V22 which showed the following, House supplement BID .Nutritional supplementation is in place. The facility's Weight policy dated November 2018 showed Once the reweighs have occurred any resident with an unexplained significant to insidious weight loss will have a weight loss investigation completed. Residents identified with a significant weight loss will be communicated to the provider and registered dietician, and additional nutritional and/or pharmacologic interventions recommended and initiated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on observation, interview, and record review, the facility failed to follow physician orders and care plan interventions to administer oxygen therapy. The facility also failed to provide humidification with oxygen therapy by using an empty humidifier bottle with oxygen therapy. This applies to 1 of 2 residents (R60) reviewed for respiratory care in a sample of 23. The findings include: R60 is an [AGE] year-old female admitted with an admitting diagnosis, including transient ischemic attack and brain aneurism. On 04/01/25 at 10:14 AM, R60 was observed in her bed with oxygen therapy, a nasal cannula at 5 L/M (Liters/Minute), and an empty humidifier bottle connected to the nasal cannula. On 4/1/25 at 10:14 AM, V11 (Certified Nursing Assistant/CNA) said she would inform the nurse about the empty humidifier. On 4/1/25 at 10:37 AM, V12 (Licensed Practical Nurse/LPN) stated, The oxygen tubing and humidifier bottles need to be replaced every Saturday. The humidifier should be filled up with distilled water. It will help residents from drying up the nares. A review of the facility provided policy on oxygen administration revised on 05/2024 document: 3. Disposable tubing and prefilled humidifiers will be changed weekly. On 4/3/25 at 10:05 AM, R60 was observed again on oxygen therapy with a nasal cannula at 5 L/M. On 4/3/25 at 10:07 AM, V5 (Registered Nurse) verified that R60 was getting oxygen at 5 L/M, and she did not know who set it at 5 L/M when the physician's order says 2 L/M. A review of R60's physician order sheet (POS) dated 3/22/24 documented the administration of oxygen at 2 L/M to maintain an oxygen level greater than 92%. A review of the care plan documenting intervention to administer oxygen at 2 L/M to maintain an oxygen level of 92% or greater as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48944 Based on observation, interview, and record review, the facility failed to reorder residents' prescribed medications. This applies to 3 out of 4 (R15, R27, and R13) reviewed for pharmacy services in a sample of 23. The findings include: 1. On 4/02/2025 at 11:00 AM, V5 (Registered Nurse/RN) was asked to check for the availability of R27's prescribed medications. V5 proceeded to reconcile R27's Order Summary Report with her available prescribed medications. V5 said R27's ordered DuoNeb and Hydrocodone-Acetaminophen medications were not available. R27' Order Summary Report dated 4/02/2025 showed active orders for DuoNeb Solution 0.5-2.5 MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally three times a day and Hydrocodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for Pain. 2. R15's EMAR (Electronic Medication Administration Record) dated 4/02/2025 showed R15's scheduled 9 AM dose of Flonase nasal spray was omitted. On 4/02/2025 at 11:15 AM, V6 (RN) was asked to check for the availability of R15's prescribed medications. V6 proceeded to reconcile R15's Order Summary Report with her available prescribed medications. V6 said R15's ordered Flonase, Midodrine, Nystatin, and Triamcinolone Acetonide medications were not available. R15's Order Summary Report dated 4/02/2025 showed active orders for Flonase Suspension 50 MCG/ACT (Fluticasone Propionate) 1 spray in both nostrils every 12 hours, Midodrine HCl Tablet 10 MG Give 1 tablet by mouth every 24 hours as needed, Nystatin Cream 100000 UNIT/GM Apply to inner thigh topically every 12 hours, and Triamcinolone Acetonide External Cream 0.1% (Triamcinolone Acetonide (Topical)) Apply to ABDOMEN topically every day shift. 3. On 4/02/2025 at 12:15 PM, V9 (RN) was asked to check for the availability of R13's prescribed medications. V9 proceeded to reconcile R13's Order Summary Report with her available prescribed medications. V9 said R13's ordered Diclofenac, DuoNeb, Guaifenesin-Codeine, and Aspart Insulin medications were not available. R13's Order Summary Report dated 4/02/2025 showed active orders for Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical)) Apply to right thoracic topically every 12 hours as needed, DuoNeb Solution 0.5-2.5 MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally every 4 hours, Gualatussin AC Oral Syrup 100-10 MG/5ML (Guaifenesin-Codeine) Give 10 ml by mouth every 6 hours as needed, and Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously with every meals for DM give if blood sugar more than 120. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/02/2025 at 3:45 PM, V2 (Director of Nursing/DON) said nurses were expected to reorder medications from the pharmacy prior to the medications being depleted to ensure they were available for administration as prescribed. The facility's policy titled Medication Availability with a revision date 04/2024 said General: To provide a strategy for the facility to ensure that drug storages and/or medications that are with limited supply from manufacturers are given .1. Facility is to inform Pharmacy when there is a shortage and limited supply of medications.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48944 Based on observation, interview, and record review, the facility failed to administer medications as ordered. There were 38 opportunities with 4 errors resulting in a 10.53% error rate. This applies to 3 out of 4 (R15, R90, and R27) residents observed in the medication pass in a sample of 23. Findings include: 1. On 4/02/2025 at 8:00 AM, during R15's scheduled medication administration V6 (Registered Nurse/RN) said she had administered all of R15's medications as ordered. At 10:50 AM, V6 said she did not administer R15's Flonase scheduled at 9 AM because it was unavailable. R15's Order Summary Report dated 4/02/2025 was reconciled and showed an active order for Flonase Suspension 50 MCG/ACT (Fluticasone Proplonate) 1 spray in both nostrils every 12 hours for allergic nasal symptoms. R15's EMAR (Electronic Medication Administration Record) dated 4/02/2025 showed R15's scheduled 9 AM dose of Flonase nasal spray was omitted. 2. On 4/02/2025 at 8:20 AM, during R27's scheduled medication administration V5 (RN) administered Calcium Carbonate 500 mg (milligrams) 1 tablet. V5 then administered Breyna (aerosol inhaler) 2 inhalations without instructing R27 to rinse her mouth afterward as instructed in the package. At 11:00 AM V5 said she reviewed R27's EMAR which showed she was to receive Calcium Carbonate 600 mg 1 tablet. V5 said she also reviewed R27's Breyna inhaler package and failed to follow the instructions to have R27 rinse her mouth afterward. R27's Order Summary Report dated 4/02/2025 showed an active order for Calcium Carbonate Tablet 600 MG Give 1 tablet by mouth one time a day for supplementation. The facility's document titled Breyna Instructions for Use undated said 12. After you finish taking BREYNA (2 puffs), rinse your mouth with water. Spit out the water. Do not swallow it .BREYNA may cause serious side effects, including .Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using BREYNA to help reduce your chance of getting thrush. 3. On 4/02/2025 at 8:45 AM, during R90's scheduled medication administration V5 (RN) administered Amlodipine 5 mg (antihypertensive) without checking R90's blood pressure prior to administration. At 11:00 AM V5 said she did not check R90's prior to administering her scheduled antihypertensive as ordered. V5 said R90's last recorded blood pressure was obtained at the beginning of her shift at 7:30 AM. R90's Order Summary Report dated 4/02/2025 showed an active order for AmLODIPine Besylate Tablet 5 MG Give 1 tablet by mouth one time a day for HTN HOLD FOR SBP <90. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146143	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Hanover Park	2000 West Lake Street Hanover Park, IL 60133

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/02/2025 at 3:45 PM, V2 (Director of Nursing/DON) said nurses were expected to follow physician orders and instructions when administering medications to ensure safety. The facility's policy titled Administration of Medications dated 02/2018 said All medications are administered safely and appropriately to aide residents to and help in overcome illness, relieve and prevent symptoms and help in diagnosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146143	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48944 Based on observation, interview, and record review, the facility failed to label residents' medications when opened. This applies to 4 out of 4 (R78, R91, R13, and R27) residents reviewed for medications in a sample of 23. The findings include: 1. On 4/01/2025 at 3:50 PM, the facility's third-floor North medication cart was checked with V8 (Licensed Practical Nurse/LPN). R78's Advair and Albuterol inhalers were open and not labeled with open or discarded dates. R91's Trelegy and Breyna inhalers were also open and not labeled with open or discarded dates. V8 checked R78 and R91's inhalers and packages. V8 said the inhalers were open and their open-date labels were unlabeled. R78's Order Summary Report dated 4/02/2025 showed active orders for Advair Diskus Inhalation Aerosol Powder Breath Activate 500-50 MCG/ACT and ALBUTEROL HFA 90 MCG INHALER. 2. R91's Order Summary Report dated 4/02/2025 showed active orders for Trelegy Ellipta Inhalation Aerosol Powder Breath Activate 100-62.5-25 MCG/ACT and Symbicort Aerosol 160-4.5 MCG/ACT (Breyna). 3. On 4/01/2025 at 4:15 PM, the facility's third-floor East medication cart was checked with V7 (Registered Nurse/RN). R13's Albuterol and Trelegy inhalers were open and not labeled with open or discard dates. V7 checked R13's inhalers and packages. V7 said the inhalers were open and their open date labels were unlabeled. R13's Order Summary Report dated 4/02/2025 showed active orders for Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90Base) MCG/ACT and Trelegy Ellipta Inhalation Aerosol Powder Breath Activate 100-62.5-25 MCG/ACT. 4. On 4/02/2025 at 11:00 AM, the facility's second-floor East medication cart was checked with V5 (RN). R27's Breyna inhaler was opened and the open date label was unlabeled. R27's Oder Summary Report dated 4/02/2025 showed an active order for Budesonide-Formoterol Fumarate Inhalation Aerosol 80-4.5 MCG/ACT (Breyna). On 4/02/2025 at 3:45 PM, V2 (Director of Nursing/DON) said nurses were expected to label medications including inhalers with open dates as indicated to ensure safe storage and use. The facility's policy titled Medication Storage in the Facility dated 12/31/2022 said Medications and biological are stored safely, securely, and properly following the manufacturer or supplier recommendations.