STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003453	A. BUILDING: _____ B. WING _____	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WEST RIDGE	6450 NORTH RIDGE BLVD CHICAGO, IL 60626

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2286559/IL00150269	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1) 300.1220b)3) 300.1810g) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	S9999		

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S9999	Continued From page 2 Section 300.1810 Resident Record Requirements g) A medication administration record shall be maintained, which contains the date and time each medication is given, name of drug, dosage, and by whom administered. These requirements were not met as evidenced by: Based on interview and record review the facility failed to 1. Document medication in Medication Administration Record (MAR) per policy; and 2. Follow medication refusal policy for resident with physician order to receive antibiotic and/or insulin medications for 2 out of 3 residents (R1 and R3) reviewed for medication administration. Failures affected R1 who was medically diagnosed for osteomyelitis for not receiving complete dose of antibiotics and caused R3 to be sent to the hospital for hyperglycemia. Findings include: R1 was 34 years old, initially admitted on 8/12/2022 and was transferred to hospital on 8/22/2022, 10 days after admission. R1's medical diagnosis includes acute osteomyelitis on left ankle and foot and diabetes mellitus with hyperglycemia. R1 was ordered multiple antibiotics (Levofloxacin 250 MG, Tygacil Solution Reconstituted 50 MG (Tigecycline) and metroNIDAZOLE Tablet Give 500 mg) and insulins (Insulin Glargine insulin to inject 25, Lantus insulin inject 25 unit and NovoLOG Solution 100 UNIT/ML (Insulin Aspart) Inject 5 unit). The following medications were not signed as given on 8/18/2022: Antibiotics (Tygacil Solution Reconstituted 50 MG (Tigecycline) and metroNIDAZOLE Tablet Give 500 mg) and	S9999		

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S9999	Continued From page 3 Insulins (Lantus insulin 25 unit). R3 was 72 years old, initially admitted on 5/7/2021 with medical diagnosis of diabetes mellitus and hyperglycemia. Review of R3's Medication Administration Record (MAR) for August 2022 documents that R3 was receiving Novolog Insulin 100 unit per ML via sliding scale to determine amount to receive. From 8/22/2022 to 8/26/2022 11:00 AM schedule inclusive dates were not signed as given. And on 8/26/2022 at 7:30 AM, R3's blood sugar result was 523 which is considered as high level of blood sugar. Per R3's progress notes dated 8/26/2022 documented as follows: At 11:00 AM, R3 was observed on the floor in the washroom adjoining to her bedroom responds to verbal cues. R3's blood sugar was 523mg after checking. R3 was sent to the hospital. On 9/8/2022 at 10:35 AM, V3 (Director of Nursing/DON) said, "As to medication administration, nurses should document it. Recording on the MAR (Medication Administration Record) must be done during giving of medications. Yes, R1 was taking antibiotic and insulin medications. I see what you are saying. Nurses need to document it, and because it is not documented. We do not know if it is done or given. I understand that doctors should be informed when resident diagnosed with diabetes and hyperglycemia does not received insulin for 2 to 3 days. And should have been addressed in the care plan. Let me look into the care plan. I know there should be a care plan in place when resident refusing medication. Much more it is insulin, I know resident (R3) blood sugar went up to 523 and she was sent to the hospital. V3 was asked what was or is the plan. Since, R3 was refusing her medications including	S9999		

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S9999	Continued From page 4 insulin. V3 said, "Yes, I understand that there should have been a plan to address this problem. I need to talk to the doctor." After review of R3's full care plan it was documented that R3 has diagnosis for diabetes. With goal is to minimize complication. Included in the intervention is diabetes medication as order and to document and record side effects and effectiveness. But refusal of diabetic or any medication was not addressed as an identified problem. Facility's Medication Administration Policy dared 1/1/2015 in part reads: Documentation of medication administration is recorded on the Medication Administration Record (MAR) includes the date, time and initials of the licensed nurse who administered the medication. Medication and Treatment Refusal Policy not dated in part reads: Under procedure: Should a resident refuse his or her medication, documentation must be recorded concerning the situation. Documentation pertaining to a resident's refusal will include as a minimum (in part): The resident's response or reason(s) for refusal. The date and time that the physician was notified as well as the physician's response. Note: Cardiac, psychotropic, oral glycemic, insulin refusal must be reported to physician each time refused. (B)	S9999		