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 03/18/2022

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APERION CARE WEST RIDGE	6450 NORTH RIDGE BLVD CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation:#2281500/IL00143902	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1220b)2) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, includin 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These Requirements were Not Met evidenced by: Based on observations, interviews and record reviews, the facility failed to monitor and supervise 2 of 2 residents (R8 and R11) reviewed for illicit substance use out of 7 residents (R8, R12, R13, R14, R15, R16, R17) reviewed for substance abuse history. This failure resulted in R8 being found unresponsive, Narcan given and R8 being transferred to the hospital for drug overdose, R8 leaving the facility without authorization and R11 going into cardiac arrest, transferred to the hospital, and intubated related to drug overdose. Findings include:	S9999		

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S9999	Continued From page 2 1. According to a face sheet, R8 is a 60-year resident admitted to the facility on 06/29/2021. R8's Minimum Date Set assignment dated 01/05/2022 indicated R11 has a Brief Interview for Mental Status (BIMS) score of 14, which indicates resident has intact cognitive response. R8's care plan dated 01/06/2022 indicated resident has a history of alcohol and cocaine abuse and resident last relapse occurrence was on 8/3/21 and 11/30/21. R8's Nursing Progress Note (dated 01/27/2022 11:54pm) documents: "11.15pm resident came to report to the nurse that R8 was not breathing. Nurse entered the room resident noted in bed lethargic, non-responsive to verbal or tactile stimulation. Call placed to 911. 11.30pm Emergency crew arrived resident transferred to the closest hospital. R8's Nursing Progress Note (dated 01/28/2022 12:42pm) documents: "Resident admitted to hospital with dx of drug overdose." R8's Hospital Records (dated 01/28/2022) documents: "Patient brought from nursing home with complaint of drug overdose, found unresponsive and Narcan was administered. Patient states he had a bag of drugs that was supposed to be cocaine, but thinks dealer gave him heroin instead." R8's Social service note (dated 01/31/2022) documents R8 was involved with an illegal transaction regarding drugs, with peers witnessing R8 conducted the transaction in which co peers was involved with as well.	S9999		

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S9999	Continued From page 3 The facility failed to put R8 on 1 to 1 supervision immediately after the surveyor notified the administrator R8 admitted to leaving the facility without authorization using the back door, R8 was not placed on 1 to 1 supervision unit 6:11pm. R8 progress note (dated 3/9/2022 18:11) documents: R8 continues to leave the facility unauthorized, counseling implemented but the resident refuses teaching by staff. On 03/09/2022 at 1:50pm, R8 stated "I was given crack cocaine. On 01/27/22 I used crack cocaine. On 01/27/2022, I didn't leave the facility and another resident from this facility brought me the drugs to my room. There are a lot of residents here that use drugs, so another resident gave me the phone number for a drug dealer, and I contacted the drug dealer recommended by the resident. I won't tell you who told me the name and phone number of the drug dealer. There are a lot of residents here who are using drugs. I know for a fact that there are a lot of residents who do drugs here because we smoked crack-cocaine together here in this facility on many occasions, that's how I know that these residents here take drugs. We get together with some of the residents here and we use drugs together. If I cannot go out into the community because they take my community pass away from me, and I am not able to meet up with the drug dealer to buy the crack-cocaine, then another resident will meet with the dealer and bring me the drugs to my room. I cannot go out right now because they took my pass away, so yesterday (03/08/2022), I used the basement back door to sneak out of the facility and I went to the gas station and drank a 6 pack of beer, and I came back through the front door, and nobody	S9999		

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noticed that I was out. There is a back door that I use to leave the facility whenever I want, especially when they refuse to give me the pass to go out into the facility. R11 is my roommate, and R11 saw me do drugs many times. R11 knows that I do drugs and R11 saw me do it many times. I did not give R11 drugs, so R11 must have gotten the drugs from another resident."

On 03/09/2022 at 9:30am, V3 (Assistant Director of Nursing) stated, "On 01/17/2022, we found R8 unresponsive, we did not know what was happening to R8, so we sent R8 to the hospital. The hospital confirmed R8 overdosed. R8 has been a resident of our facility for a while and has had a problem with substance abuse in the past. R8 is here back from the hospital. R8 has community pass privileges currently revoked. We did not do an investigation on this incident because it was a medical emergency so there was nothing to investigate.

On 03/09/2022 at 10:48am V2 (Director of Nursing/DON) stated, "When I looked at R8's hospital records, the records stated R8 only has a history of drug overdose. It did not state R8 overdosed on 01/27/2022."

On 03/09/2022 at 11:36am, V1 stated, "All I know is on 01/27/2022, R8's nurse went into R8's room and found R8 on the bed unresponsive. R8's nurse called 911 and the paramedics arrived and decided to administer Narcan to R8. After the paramedics administered the Narcan, they transported R8 to the hospital. I asked R8's nurse if there were any injuries and R8's nurse said that R8 did not have any injuries. We sent R8 to the hospital for a medical emergency, and I did not do an incident report or an investigation of the

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S9999	Continued From page 5 overdose because R8 had a medical emergency because there was nothing to investigate. 2. According to a face sheet, R11 is a 54-year resident admitted to the facility on 07/23/2019. According to physician note dated 02/11/2022, R11 has a history of Diabetes Mellitus type II, GERD, Osteoarthritis Arthritis, COPD, Dyslipidemia, cigarette smoking addiction, Obesity. Class II. R11's Minimum Date Set assignment dated 01/25/2022 indicated R11 has a Brief Interview for Mental Status (BIMS) score of 13, which indicates resident has intact cognitive response. R11's care plan dated 01/04/2022 indicated resident has a history of depression and scores a 14 out of 27 on the PHQ9 (Patient Health Questionnaire) which is indicative of the presence of mood symptoms and alteration in mood state which is evident in the areas of psychosocial well-being, adjustment and coping challenges, increased dependency, energy, and emotional distress R11's Nursing Progress Note (dated 02/18/2022 4:56am) documents: "At 1.40 AM, NOD (Nurse On Duty) noted this resident sitting on the chair on the Hallway sleeping, having difficulty in breathing, Non responsive to Calls and other Stimuli. Breathing very shallow with Oxygen Saturation at 57% HR 103. At 1.44 am, Code Blue announced and 911 team called. Oxygen at 5L administered via Nasal Cannula. At 1.53 am,911 arrived and continued with resuscitation. Administered Narcan injection to this resident and R11 answered his name but remain very weak and Lethargic. At 2.02 am, resident was picked up by 911 ambulance to the hospital. ADON made aware of this situation."	S9999		

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S9999	Continued From page 6 R11's Nursing Progress Note (dated 02/18/2022 at 7:44am) documents: "At 7.28 am, NOD placed call to the hospital and confirmed this Resident admitted into the ICU with DX of Drug overdose." R11's Hospital Discharge Summary (dated 02/22/2022) documents that R11 presented to the emergency room with possible drug overdose from nursing home after R11 took unknown pill. R11 was found to have pinpoint pupil and was given Narcan and became more alert afterwards. R11 was intubated. R11's admitting diagnosis is accidental drug overdose." On 03/09/2022 at 1:39pm, V6 (Certified Nursing Assistant/CNA) stated, "R11 does not go out to the facility independently. R11 goes outside to smoke and returns back into the facility. R11 only visitor comes to visit R11 is R11"s mom. I don't know how R11 got access to drugs. I don't know how R11 got drugs because on 02/17, R11 did not go out on pass. I know we have new residents in the building, but I don't know how R11 got access to illegal drugs." On 03/11/2022 at 12:17pm, V11 (Licensed Practical Nurse/LPN) stated, "On 02/18/2022, R11 had a doctor's appointment during the day and was back in the facility. When I came in in the evening shift, R11 was in a chair, and I heard R11 snoring loud. I called R11 name and attempted to wake R11 up, but R11 was not responding to any stimuli. I called a code and checked R11's vitals. R11's oxygen was in the 60's. R11 was slumped over and drooling. We called 911 and they asked me what time I saw R11 last, which I explained that I start my shift at 11:30pm and I just basically started my shift, so I saw the resident close to 11:30pm. R11 was	S9999		

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S9999	Continued From page 7 found slummed over and unresponsive at 1:40am. The paramedics administered Narcan and R11 responded to the Narcan right away, and then the paramedics took R11 to the hospital because R11 became unresponsive again." On 03/11/2022 at 12:40pm, V12 (Registered Nurse) stated, "On 01/27/2022, I sent R8 to the hospital because R8 was lethargic and non-responsive. The last time I saw R8 was at 9 pm when R8 came to me to get R8's bedtime medication, so that was the last time I saw R8. Around 11pm, R8's friend came and notified me that something is wrong with R8. I went to R8's room and saw R8 on R8's bed and R8 was unresponsive, so I called a code, and we applied oxygen to R8 and we called 911. The paramedics came and I am not sure if Narcan was given because other staff was there but shortly after the paramedics took R8 to the hospital." On 03/11/2022 at 2:21pm, V15 (R11's Nurse Practitioner) stated, "R11 does not have a drug use history. Narcan is given in an emergency during a narcotic episode. It is used in an emergency during a drug overdose situation. It is given during a drug overdose." 3. Staff interviews were conducted related to R8 and R11 and revealed the following: On 03/09/2022 at 9:20am, surveyor requested facility drug overdose incident report and investigation for R8 and R11. V3 (Assistant Director of Nursing/ADON) and V1(Administrator) informed the surveyor that no indecent report and investigation was done because this was a medical emergency and did not require an investigation and reporting.	S9999		

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On 03/09/2022 at 9:30am, V3 stated, "R11 was sent to the hospital on 02/18/2022 because of a medical emergency so we did not do an investigation."

On 03/09/2022 at 10:48am V2 (Director of Nursing/DON) stated, "When I looked at R8's hospital records, the records stated R8 only has a history of drug overdose. It did not stated R8 overdosed on 01/27/2022."
On 03/09/2022 at 11:36am, V1 stated, "There was no incident report or investigation done for R8 and R11 because these two residents were sent to the hospital due to change of status. The only documentation we have for both R8 and R11 is the nursing progress note, that's all. R8 and R11 was sent out because of a medical change of condition."

On 03/09/2022 at 11:36am, V1 stated, "On 02/17/2022, R11 did not overdose on drugs. On 02/17/2022, we sent R11 to the hospital for a medical emergency. R11's admitting diagnosis was respiratory failure. R11 did not overdose on drugs. I did not know that R11 was administered Narcan at our facility. There was progress note made on R11's condition and that we sent R11 to the hospital. I did not do an incident report nor an investigation because R11 had a medical emergency, so there was nothing to investigate.

4. On 03/09/2022 at 2:20pm, the surveyor made V1 (administrator) aware R8 informed the surveyor, R8 sneaks out of the facility using the back ramp ambulance entrance to go to the gas station and buy beer. The surveyor accompanied V1 to observe the back door used by R8 to leave the facility unauthorized. V1 stated, the facility will change the security code on all doors. V1 informed that R8 stated that other residents bring

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S9999	Continued From page 9 drugs into the building on regular basis. On 03/10/2022 at 11:13am V8 (Maintenance Director) stated, "If the facility administrator tells me the facility security access codes need to be changed because it is compromised so what I do is I call the company and they come out and change the codes. What happened is we have two security systems on the back ambulance ramp door. One alarm alerts the front desk which that alarm is always active. If anyone leaves out that door without putting in the security code, it will alert the front desk. The second alarm is a magnetic lock with a siren. That magnetic lock w2as disabled and the company Hollow point was called couple of weeks ago to come and do maintenance on it and fix it. They have not come out to fix it. Yesterday, on 03/10/2022, I called the security company again and followed up with them to come out and fix the other security system. So the reason why the resident, R8, was able to go out the back door was because the second security system was not working at all. I called the company, and I am waiting for them to come and fix it, they are supposed to come and fix it today. So basically, we only change the security codes when there is a need such as the codes have been compromised. I was aware that the magnetic lock was not working, and I have called the company a couple of weeks ago. Because the magnetic lock has not been working for weeks, the residents are able to leave through the back door, but they cannot come back through the back door, but they are able to leave through the back door. The alarm will sound, and it will alert the front receptionist that someone without the code opened the door and they are supposed to come to the back door immediately when they hear the back door alarm."	S9999		

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S9999	Continued From page 10 Door Alarm Inspection Record (dated 02/18/2022) documents that the northwest ramp exit door used by R8 to leave the facility on multiple occasions without authorization was identified as failing inspection and not sealing the door properly on 02/16/2022. Email Communication to the security company (dated 02/16/2022) documents, "V8 (maintenance director) notifying the security company that the Northwest Ramp Exit Door used by R8 to leave the facility on multiple occasions without authorization failed the inspection and the security feature was not sealing the door properly. 5. On 03/10/2022 at 12:25pm, V9 (Social Service Director) stated, "Currently, we have 7 residents (R8, R12, R13, R14, R15, R16, R17) with history of substance abuse. Some of the residents with the substance abuse history are placed on the 3rd floor, that's how we monitor them. On 03/09/2022, when the back door alarm went off, which is after the state surveyor made facility aware of R8's unauthorized leave, the staff saw R8 leaving on camera and the staff ran out after R8 and followed R8 for a while, and finally R8 returned back. Currently, R8 has a restriction on community pass privileges. R8 had community pass privileges revoked before, due to alcohol, because R8 returned into the facility intoxicated, so we revoked R8's pass and we moved R8 to the 3rd floor in the past. We had a big problem before with a lot of residents using drugs inside the facility. R8 escaped 3 times through the back door on 03/09/2022, after the surveyor made the administrator aware that the back door is breached and residents can escape, R8 escaped a total of 3 times, and after R8's 3rd elopement attempt, R8 was placed on 1 to 1 supervision.	S9999		

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V10 (Behavioral Aide) was placed on 1 to 1 to monitor R8, but R8 was able to escape away from V10 (behavior aide) because V10 walked away from R8, did not have R8 in visual field to go get a chair, and R8 took advantage of the fact that V10 (behavior aide) walked away to escape again, and we had to run outside after R8. I attempted to place R8 to the 3rd floor, but R8 refused for us to place R8 to the 3rd floor. We cannot force R8 to go to the 3rd floor. I talked to R8 on several occasions, I did not talk to R8's physician and inform R8 that R8 is using drugs and attempting to elope to get drunk. I don't know what R8 is on parole for. I did not ask what R8 is on parole for, because I did not want to be in R8's business. On 03/08/2022, R8 told me that R8 told the parole office and R8 did drugs and will continue to do drugs. After R8 told me that R8 admitted to the parole office that R8 does drugs, I was trying to change rooms for R8, to put R8 from the first floor to the 3rd floor, but R8 refused, and I can't force R8. I did not petition R8 and send R8 out. R11 does have community pass privileges and only goes to get some fast food and comes right back. I don't believe that R11 overdosed. I know that the progress notes and the hospital record say that, but I don't believe that R11 uses drugs, R11 did not have any drug use history prior to this incident."

On 03/10/2022 at 2:49pm V1 (administrator) stated, "When we have a resident in the building on parole, we are required to know what the resident is on parole for. I do not know what R8 is on parole for. I am not sure; I would have to go and check. If they are on parole, we do the background check and we have a process in place for monitoring R8. The social service director and the social service team is responsible for knowing what the resident, R8, is

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S9999	Continued From page 12	S9999		

on parole for, so that we don't put vulnerable residents in place. It is the responsibility of the social service director and social service staff to know what R8 and other residents on parole are on parole. Not knowing what residents are on parole for, poses a significant threat to vulnerable residents and other residents in the facility, especially because the resident on parole can cause harm to other residents. Not knowing the reason why residents are on parole, can have a big significant harm to the residents in the facility. I don't know what if there are other residents in the building that are on parole. After I was notified by you (state surveyor) that R8 elopes from the facility using the back door, I got in touch with maintenance director, and notified the maintenance that R8 has access to the codes or that there is a possibility that R8 knows the codes, and asked maintenance to change the codes. About 10 minutes after I was notified that R8 escapes I would say about 2:40pm, I asked V2 (ADON) to have the resident placed on 1 to 1 observation due to the elopement. Approximately around 3:30pm, V2 (ADON) told me R8 was placed on 1 to 1 and the 1 to 1 was assigned to V10 (behavior aide)."

On 03/11/2022 at 2:40pm, V10 (Behavioral Aide) stated, "They asked me to provide 1 to 1 supervision for R8 around 8pm on 03/09/2022. They asked me to watch R8 because R8 was attempting to leave the facility unauthorized after several attempts. So around 8pm I started to watch R8 for 1 to 1 supervision. R8 ran out the back door and went out of the facility unauthorized, and I followed R8 out of the facility and brought R8 back. I heard the alarm and saw R8 leaving through the camera, I followed R8 and brought R8 back into the facility. I was providing 1 to 1 until the ambulance arrived which was

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 03/18/2022

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

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S9999	Continued From page 13 around 9pm. The ambulance arrived around 9pm and took R8 to the hospital." The facility's Security, Supervision & Safety Policy (undated) states: Acute or sustained visual monitoring or 1:1 observation on a time limited basis is provided as necessary for residents demonstrating an increase in psychiatric symptoms or aggressive behaviors. The facility routinely identifies hazards and risks; evaluates and analyzes hazards and risks; implements interventions to reduce hazards/risks. On 03/11/2022 at 1:13pm, V14 (Nurse Practitioner) stated, "I am familiar with R8 using drugs and alcohol. I was notified R8 was transferred to the hospital due to drug overdose. I believe the social worker was helping R8 with R8's substance abuse problem. Narcan is for people who overdose on drugs and is used to resuscitate a person and bring back." The facility's Behavior Management Contract (undated) lists using non-prescribed drugs and alcohol as inappropriate and unacceptable behaviors. (A)	S9999		