Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015333	A. BUILDING: ______ B. WING ______	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

(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 #2398485/IL165393	S 000		
S9999	Final Observations Statement of Licensure Violations 300.690b) 300.690c) 300.695c)1) 300.695c)3) 300.1030a)4) 300.1210a) 300.1210b) 300.1210d)6) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.695 Contacting Local Law Enforcement

c) The facility shall develop and implement a policy concerning local law enforcement notification, including:

1) Ensuring the safety of residents in situations requiring local law enforcement notification;

3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure;

Section 300.1030 Medical Emergencies

a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:

4) Toxicologic emergencies (for example, untoward drug reactions and overdoses).

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This REQUIREMENT was not met as evidenced by:

Based on interview and record review the facility

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failed to prevent the overdose of illicit drugs at the facility for 5 of 12 residents (R1, R2, R3, R12, and R9) reviewed for substance abuse on the sample list of 13.

1. R1's face sheet showed he was admitted to the facility on 12/27/2019 with diagnoses to include paraplegia, Diabetes Mellitus, morbid obesity, chronic pain syndrome, overactive bladder, hyperglycemia, and nicotine dependence. On 7/11/23 an additional diagnoses was added to R1's record of "Poisoning by other opioids, accidental (unintentional).

R1's facility assessment dated 7/28/23 showed he has no cognitive impairment and requires extensive assistance from staff for most cares.

R1's care plan initiated 7/12/23 showed, "I have a history of opioid abuse. At risk for withdrawal symptoms. I will be free of withdrawal symptoms and be kept comfortable as possibly by next review date. Interventions: Call light within reach while in room. Monitor for safety. Notify MD (medical doctor) of changes as needed. Observe effectiveness of medications. Psych consult as needed."

R1's 7/8/23 Nurses Note entered at 11:23 PM showed, "Resident was found unresponsive, rapid response was initiated. 911 was called, EMTs (Emergency Medical Technicians) arrived and resident was taken to [acute care hospital] ..."

R1's 7/9/23 Nurses Note entered at 2:15 AM showed, "Spoke to ER (emergency room) Nurse of [acute care hospital] resident admitted with Dx (diagnosis) Opioid Overdose."

R1's acute care hospital documents from 7/8/23

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through 7/11/23 showed, " ... Chief Complaint: Overdose ... History of Present Illness: ... presents to ED (Emergency Department) via EMS (Emergency Medical Services) from [long term care facility] due to overdose. Per EMS SNF (skilled nursing facility) staff found patient and his roommate unresponsive. Unknown down time. EMS gave 10 mg Narcan with some response ... On arrival to the ED patient was minimally responsive with pinpoint pupils, requiring bagging. Patient was given 2 mg (milligrams) intranasal Narcan followed by 4 mg IV (intravenous) Narcan. Patient became more responsive, answering some questions and following some commands. At that time, patient denied taking anything, denied alcohol use, denied intentional overdose. Then stopped answering questions. Patient's roommate reportedly responded to Narcan as well ... During interview patient stated he did not remember coming to the hospital or remember what happened prior to coming to the hospital ... Urine Drug Screen pending ..." Results of urine drug screen requested and not received.

R1's 7/12/23 Nurse Practitioner Note showed, " ... Patient was brought to the ED for unresponsiveness and was admitted for opioid overdose. Was treated and transferred back to [long term care facility] on 7/11/23 where he resides as a long term care patient ..."

R1's 7/12/23 Social Service Note showed, "Writer spoke to resident to explain that he will be on restriction for 30 days due to previous behavior. Resident was receptive to information. Writer will continue to follow up as needed."

R1's 7/12/23 Social Service Note entered at 2:31 PM by V39 (Social Services Director) showed, "Writer spoke to resident who presents to be alert

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and oriented x 3 and can make his needs known. Writer informed resident he would be placed on a temporary restriction for 30 days due to incident that occurred. Resident was receptive to information stating he does not go out anyway ..."

R1's 7/28/23 Abuse/Neglect Screening showed R1 to have no history of substance abuse. (20 days after hospitalization for substance abuse overdose)

R1's 9/15/23 Social Service Note showed, "Writer met with resident who presents to be alert and oriented x 3. Gave Fentanyl information to resident with known substance use. The information talks about Fentanyl and what it can be found in because of resident substance use history. Resident respectfully declined receiving the information on Fentanyl. Writer will continue to follow up."

On 10/21/23 at 4:13 PM, V6 RN (Registered Nurse) said, "We sent out [R1] and [R2]. I was on break and they called me. By the time I was there all nurses were already in the room doing interventions ... They found [R2] unresponsive, they started performing CPR (cardiopulmonary resuscitation) and gave Narcan ... they were just unresponsive. We did not know why they were unresponsive. Technically Narcan would be for overdose ... I can't remember. I don't know how they got the drugs or what they were. I think after that incident they made new rules to check and monitor some people that would usually have something like that. .. I don't know of any drug use that occurs between the residents ..."

On 10/25/23 at 10:11 AM, V37 (Restorative Aide) said R1 has had residents from other room overdose in his room. V37 said he has seen R1

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with wads of money and flashing it around. V37 said the problem is residents are allowed by Administration to come and go as they please.

2. R2's face sheet showed he was admitted to the facility on 7/21/22 with diagnoses to include vitamin B12 deficiency anemia, alcohol abuse, polyneuropathy, hypertension, acute post hemorrhagic anemia, and chest pain. On 7/10/23 diagnoses were added to R2's record including cocaine abuse, cannabis abuse, and poisoning by other opioids, accidental (unintentional).

R2's facility assessment dated 7/15/23 showed he has no cognitive impairment and requires supervision for most cares.

R2's June 2023 Physician Order Sheet showed an order started 3/13/23 for "Narcan Nasal Liquid 4 MG ... 1 application in nostril as needed for overdose ..."

R2's care plan initiated 3/13/23 showed, "I have a history of drug abuse ... I will not show signs and symptoms of distress related to no drug use ... Interventions: Allow resident to voice feelings of frustration related to situation, no alcohol use, etc. Encourage resident drink lots of fluids and rest when needed. Give reassurance, redirection, allow resident to vent, offer snack, drink, walk, to call and speak to family etc."

R2's 7/8/23 Nurses Note entered at 9:16 PM showed, "Resident was found unresponsive, rapid response was initiated. 911 was called, EMTs arrived and resident was taken to [acute care hospital] ..."

R2's acute care hospital documents from his admission 7/8/23 through 7/1023 showed, " ...

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Chief complaint: Drug Problem, Patient was found unresponsive at nursing home. Patient denies drug or ETOH (alcohol), and patient responded to 2 mg of Narcan ... male with medical history as noted below who presents with vomiting brown vomitus ... unresponsive episode at home at nursing home after drinking. Denied opioid use but did respond to Narcan given by ems. States last drink at 5:00 PM. Drinks heavily and regularly ... Patient is currently residing at a nursing home ... Upon my evaluation, patient provides additional history. He had experienced 2 episodes of bright red blood per rectum at around 5 PM. Thereafter he had some shots of vodka and ½ can of natural ice beer. He also smoked a joint. Then he went and took a nap and woke up diaphoretic as he was being transported to our facility via EMS. Upon arrival to our ER he had 2 episodes of nausea and vomiting ... He adds that he drinks couple of beers once a week; no history of withdrawals; did have an episode of passing out when he had smoked a joint previously and was dehydrated as it was hot outside ... Urine Drug Screen: ... cocaine metabolite: detected; ... Marijuana/THC (tetrahydrocannabinol): Detected ..."

R2's 7/10/23 Nurses Note entered at 6:47 PM showed, "Resident arrived back to the facility from [acute care hospital] alert and stable."

R2's 7/12/23 Social Services Note showed, "Writer spoke to resident to explain that he will be on restriction for 30 days due to previous behavior. Resident was receptive to information. Writer will continue to follow up as needed."

R2's 7/15/23 Elopement Risk & Community Survival Skills Assessment showed R2 was assessed for supervised pass in the community

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only.

On 10/23/23 at 12:40 PM, V36 LPN (Licensed Practical Nurse) said, "We did a code for [R2], got him stabilized, took vitals and probably gave him Narcan ... We know to consider Narcan is the resident is unresponsive to pain. The resident's usually have friends that alert us if they have been using substances that day... specifically [R2] we monitor. Friends say he is out smoking and don't know what he was smoking ..."

3. R3's face sheet showed he was admitted to the facility on 10/25/22 with diagnoses to include peripheral vascular disease, chronic obstructive pulmonary disease, paraplegia, stage 4 pressure ulcer of sacral region, acquired absence of left and right leg above knee, stage 4 pressure ulcer of left hip, osteoarthritis, hyperlipidemia, major depressive disorder, myelitis, chronic kidney disease, and colostomy.

R3's facility assessment dated 6/30/23 showed R3 has no cognitive impairment and required extensive to total assist from staff for most cares.

R3's care plan initiated 3/4/23 showed, "Resident presents with behavior concerns as evidenced by abusing drugs in the facility ... Resident will decrease behaviors throughout next review ... Encourage resident to participate in facility activities, Staff to complete room search to confiscate any drugs.

R3's care plan initiated 3/4/23 showed, " ...have a history of substance use/abuse related to mental illness and maladaptive coping ... I will not show signs and symptoms of distress related to no drug use ... Implement increasingly restrictive interventions in an effort to help me break my

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addictive cycle including supervision while I am in the community, restricting independent pass privileges, and implementation of money guidance and budget controls to reduce/prevent access to substances... 7/25/23: Make sure that I am aware of rules prohibiting use of alcohol, illicit substances, and intoxication ..."

R3's 7/9/23 at 1:15 PM progress note showed, "It was reported to writer that patient was found incoherent out on the patio and may have used an outside controlled substance. Writer went to speak with the patient, patient was responsive but still appeared to be 'out of it'. Patient was given a cool towel and was put in bed. Writer reported incident to doctor."

R3's 7/9/23 at 1:22 PM progress note showed, "Writer spoke to [Nurse Practitioner] and was instructed to give resident Narcan. Narcan was administered at approximately 1:40 PM..."

R3's 7/9/23 Order Administration Note entered at 1:24 PM showed, "Writer did not administer due to OD (overdose) ordeal." This note did not indicate what medication was not administered.

R3's 7/9/23 at 7:43 PM progress note showed, "Resident was sent out to [acute care hospital] via lifeline ambulance for further evaluation related to incident which transpired on AM (morning) shift..."

R3's 7/9/23 Nurses Note entered at 10:39 PM showed, "Resident returned from [acute care hospital] via stretcher with NNO (no new orders) in a stable condition ..."

R3's 7/9/23 Acute Hospital Documents showed he arrived at the ED at approximately 5:44 PM. These same documents showed, "Diagnoses:

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S9999	Continued From page 10 Fever in adult, Urinary tract infection... heroin abuse... Patient arrived via EMS (emergency medical services) from [long term care facility] after receiving two rounds of Narcan at noon from a drug overdose... At noon he was found unresponsive on the facility patio. After receiving 2nd round of Narcan he was awake and alert. Patient was then transported back to his room.... Patient initially denied any illicit drug use but states he did receive his Norco and gabapentin at 6AM and 8 AM. After later questioning patient endorsed having $20 worth of heroin around noon." R3's 7/10/23 Nursing Note entered at 3:19 PM showed, "Spoke with resident regarding drug use, resident reports he has a history of heroin use and that he got the heroin in the city while out on pass on Thursday prior to the weekend - he reports he did not take any until Sunday, and he snorted it Sunday around noon. Resident did report that he would be accepting of seeking help for substance abuse, resident informed he is not allowed to leave facility at this time unsupervised that due to substance abuse he needs supervision while out of the facility, he was accepting of this. Asked resident if we could search his person and room, he was agreeable-found bag of powdered substance with a white paper rolled into shape of joint filled with substance in fanny pack. Resident admitted it was heroin..." R3's 7/10/23 Nurse Practitioner Note showed, "... On 7/9 he was found to be incoherent, lethargic, with suspicion of using illicit substance; was given Narcan at facility then transferred to ER for evaluation; where he admitted to using heroin..." R3's 7/10/23 Nurses Note showed, "TORB	S9999		

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(telephone order read back) MD transfer to [acute care hospital] for evaluation and detoxification ..."

R3's 7/13/23 Social Service Note entered at 4:01 PM by V5 (Social Services Assistant) showed, "Writer spoke to resident to explain that he will be on restriction for 30 days due to previous behavior resident was receptive to the information. Writer will continue to follow up as needed."

R3's 7/16/23 Nurse Practitioner Note showed, "... (Referencing R3's 7/9/23 incident) He was found to be incoherent, lethargic; with suspicion of using illicit substance; was given Narcan at facility then transferred to the ER (emergency room) for evaluation; where he admitted to using heroin; he went back and was admitted for detox; now back here for further care... Assessment/Plan: ... AMS (altered mental status) due to heroin use - resolved... Has Narcan in the event. Social Service is following the incident..."

R3's 8/8/23 Social Services Note entered by V5 at 12:30 PM showed, "Writer was notified by staff that resident went out on pass during 30 day restriction. Writer will follow up when resident returns."

R3's 8/8/23 Social Service Note entered by V5 (Social Service Assistant) showed, "Writer spoke to resident who presents to be alert and oriented x 3 and can make his needs known. Writer spoke to resident to explain that 30 day restriction was not up yet due to previous behavior ..."

The facility's resident sign in and sign out log showed R3 signed himself out of the facility on 8/8/23 at 12:20 PM and returned to the facility at 3:40 PM. Additionally, R3 was signed out of the

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facility on 8/16/23 at 11:17 AM, 8/17/23 at 11:25 AM, 8/21/23 at 11:26 AM, 8/23/23 at 11:53 AM, 8/20/23 at 10:17 AM, 8/22/23 at 2:44 PM, 8/25/23 at 10:51 AM, and 9/5/23 at 10:27 AM.

R3's 8/16/23 Nurses Note showed, "Resident currently out in community. No distress or discomfort noted upon departure."

R3's Social Services Note dated 9/5/23 entered at 3:41 PM by V5 (Social Services Assistant) showed, "Writer was instructed to do a random search in resident room. Writer spoke to resident who presents to be alert and oriented x 3 and can make his needs known and consented to the search. Resident was noted with some white powder substance in his possession. An order to discontinue the patient from going outside was given per Social Service. Resident was told that he could no longer go outside, resident stated that he is grown and he will go outside when he wants to. Staff will continue to redirect and follow up as needed."

R3's 9/5/23 Elopement Risk & Community Survival Skills Assessment completed by V39 Social Services Director (This assessment was not signed as completed until 9/13/23.) showed R3 to not have a history of illicit drugs while in the community for the previous 3 months. This same assessment showed R3 to require supervision when out in the community on pass.

R3's 9/6/23 Nurse Practitioner Note showed, "... Recent AMS (altered mental status) due to heroin use - resolved. Had detox at hospital. Has Narcan in the event. Advised on avoidance of illicit substances..."

R3's 9/13/23 nursing note entered at 11:18 PM

Illinois Department of Public Health

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S9999	Continued From page 13 showed, "Obtained clean catch urine sample for drug test." R3's 9/15/23 Social Service Note showed, "Write met with resident who presents to be alert and oriented x 3, gave Fentanyl information to resident with known substance use ..." 4. R12's face sheet showed he was admitted to the facility on 5/13/22 with diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Type 2 Diabetes Mellitus without complications, Chronic Obstructive Pulmonary Disease, gastrostomy, heart failure, schizoaffective disorder, dysphagia, hypertension, major depressive disorder, hyperlipidemia, and tobacco use. R12's 7/24/23 facility assessment dated 7/24/23 showed he is mildly cognitively impaired and required extensive assistance from staff for most cares. This same assessment showed R12 requires supervision of 1 staff member for locomotion off the unit. R12's current Physician Order Sheet showed an order dated 7/10/23 for Naloxone HCl (Hydrochloride) 4 mg... as needed." R12's 8/7/23 nursing note entered at 11:14 AM by V3 DON (Director of Nursing) showed, "Writer received report from social service staff that resident was noted with some white powder substance in his possession. Staff immediately took substance and gave substance to the administrator. Staff instructed to notify provider and ask is drug toxicity is needed." R12's 8/7/23 Elopement Risk & Community Survival Skills Assessment completed by V5	S9999		

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(Social Service Assistant at 3:31 PM (6 hours after a white substance was found in R12's room that was believed to be an illegal substance.) showed R12 to have no history of self-harm, alcohol, and/or illicit drugs while in the community and is able to avoid persons who constitute a bad influence, and is able to practice 'harm reduction' strategies and verbalizes to ability and has no recent violations in the last 30 days of adhering to pass privilege policies including adhering to local laws. This assessment showed, "Resident appears to be capable of outside independent and or supervised pass privileges..."

R12's 8/7/23 nursing note entered at 3:46 PM by V7 LPN (Licensed Practical Nurse) showed "Around 9:30 AM social service staff reported to this writer that they found a small bag with marijuana in it. Social staff stated they returned it to the administrator. This writer called the on call NP to make aware. Order to discontinue patient from going outside was given per Social Service. Resident was told that he could no longer go outside, resident stated that he is grown that he will go outside when he want to."

R12's 8/7/23 Social Service Note entered at 4:34 PM by V5 (Social Services Assistant) showed, "Writer received report at 8:15 AM from Restorative staff that while resident was sleeping there was some white powder substance at bed side. Writer immediately took substance and gave substance to the administrator. Writer notify family and nursing provider and ask if drug toxicity is needed. Writer will continue to follow up."

R12's 8/8/23 Nurse Practitioner Visit Note showed, "... Nurse reported he was very sleepy... Nurse reported to me he was very sleepy

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yesterday, found some white substances next to him with suspect cannabis. He woke up without incident and continues to be his usual self today... Assessment/Plan: Somnolence due to unknown substance, likely cannabis-resolved... Spoke with him today, he denies using any substances, stated that it was "nothing", Advised on avoiding illicit substances due to adverse reactions... asked if we can check his urine to rule out other causes; he does not want, Monitor for now..."

R12's 8/17/23 Nurse Practitioner Visit Note showed, "... Previously seen for lethargy/somnolence, found some white substances next to him with suspect cannabis... Assessment/Plan: ... Somnolence due to unknown substance - resolved... previously denied using illicit substances and did not want his urine checked... Order Narcan PRN (as needed) in the event. Monitor..."

R12's 8/24/23 nursing note entered at 4:02 PM showed, "Resident roommate alerted writer resident was not responding, upon assessment, resident noted sitting up in wheelchair in bathroom, alert, non-verbal... pupils dilated, breathing was shallow, resident was lowered to floor and CPR was initiated, 911 called, will continue to monitor. (blood pressure) 196/88, (pulse) 62, (respirations) 12..."

R12's 8/24/23 acute care hospital records showed, "... Brought in by [emergency medical services], was found down on the floor by NH (nursing home) staff. Was given unknown amount of Narcan by NH staff. Arrives alert and oriented x 4, reports taking Heroin today. Spo2 (oxygen saturation) found to be 88% on RA (room air)... Patient presents for overdose from snorting heroin. Resident at [long term care facility] for last

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9 months. Responded and awakened after Narcan... ED (Emergency Department) Diagnosis and Impressions: 1. Accidental overdose of heroin..."

R12's 8/24/23 nursing note entered at 5:15 PM showed, "Resident status post emergency care, resident was given CPR (cardiopulmonary resuscitation) after he was noted unresponsive, resident was transferred to [acute care hospital] via 911..."

R12's 8/25/23 Social Service Note entered at 11:15 AM by V5 (Social Services Assistant) showed, "Write did a wellbeing check on resident this morning. Resident stated that he is fine. Writer asked do you feel safe in the environment, resident stated "yes". Writer explain to resident I will be doing a room search, resident gave me permission to do the room search. Writer did not find anything in resident's room. Writer expressed that he is NOT allowed any visitors at this time or access to the community. Writer will continue to follow up as needed."

R12's care plan initiated 8/27/23 showed, "Community Access Supervised.... require the support, care, and services of a long-term care facility and has been determine by community access assessment to be able to access the community with supervision... I am on supervised access to the community. Obtain a physician's order for outside pass privilege. Inform me of any restrictions placed by my physician..."

R12's 9/5/23 Elopement Risk & Community Survival Skills Assessment completed by V39 (Social Service Director) at 4:35 PM (This assessment was not signed as completed until 9/13/23. (6 days after R12 experienced a second

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overdose requiring emergency medical services.) showed R12 to have no history of self-harm, alcohol, and/or illicit drugs while in the community and is able to avoid persons who constitute a bad influence, and is able to practice 'harm reduction' strategies and verbalizes to ability and has no recent violations in the last 30 days of adhering to pass privilege policies including adhering to local laws. This assessment noted "The resident appears to be capable of outside supervised pass privileges only..."

R12's 9/7/23 Nursing Note entered by V7 LPN at 2:37 PM showed, "Resident is alert and oriented to self. Around 1:30 PM in front of the nurses station resident observed staring at the ceiling, blank stare, eyes and pupil dilated. Resident did not respond to touch or sound. Resident assisted back to his room, resident continue to stare at the ceiling, appear to be under the influence of unknown substance. Narcan 4 mg administered via nostril. Resident started to respond to sound and touch two minutes after the administration of Narcan. Drug screen done which also showed resident was positive... MD (doctor) called new order to send resident out to hospital for evaluation..."

R12's 9/7/23 Acute Care Hospital documentation showed, " ... Chief Complaint: Overdose, Patient overdosed on heroin, found unresponsive by staff. Given Narcan at 1:30 PM. EMS (Emergency Medical Services) just called to patient NH for transport... Patient overdosed on heroin, found unresponsive by staff. Given Narcan at 1:30 PM... Nursing home staff reports that the patient was reported found in an unresponsive state sitting in his wheelchair. No evidence of trauma or paraphernalia noted when found. Patient was given 4 mg intranasal Narcan with appropriate

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response. Sent to the emergency department afterwards for evaluation. Urine drug screen performed afterward showing positive opiates. Patient reports... was snorted from a friend who gave it to him... Does not know if it was laced with other medications."

R12's 9/8/23 Incident Note entered by V3 DON (Director of Nursing) at 10:30 AM showed, "... Resident noted with change of mental status. Lethargic. Slow to arouse. Resident appeared to be under the influence of an illegal substance. Narcan given. Root Cause of the incident: Resident ingested an illegal substance.

R12's 9/8/23 Social Service Note entered by V5 (Social Services Assistant) at 12:46 PM showed, "Writer met with resident for a well-being checkup. Resident presented in a pleasant mood. Writer asked resident did they have any questions of concerns. Resident stated he did not. Writer asked resident does he feel safe in his environment. Resident stated "yes" Writer encouraged resident to seek staff assistance when needed. Resident was receptive to information. Care plans have been updated. Staff will continue to follow up as needed."

R12's 9/8/23 nursing note entered at 2:47 PM showed, "Patient refused to give urine sample and to straight cath during AM shift. Will endorse to next shift nurse."

R12's care plan initiated 9/8/23 (15 days after R12's second overdose incident) showed, "Substance Abuse, Implement increasingly restrictive interventions in an effort to help me break my addictive cycle including supervision while I am in the community, restricted independent pass privileges and implementation

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of money guidance and budget controls to reduce/prevent access to substances..."

R12's 9/11/23 Social Service Note entered at 4:24 PM by V5 (Social Services Assistant) showed, "Writer was instructed to do a random room search in resident room. Writer spoke to resident who presents to be alert and oriented x 3 and can make his needs known and consented to the search. Nothing was found during room search. Writer and staff will continue to redirect resident and follow up as needed."

R12's 9/13/23 Psychiatric Nurse Practitioner Note showed, "... Patient did admit to taking illegal substance, "I know I shouldn't have done that. It will never happen again. My family got angry at me."

R12's 9/15/23 Social Service Note entered at 4:09 PM by V5 (Social Services Assistant) showed, "Writer met with resident who presents to be alert and oriented x 3, gave Fentanyl information to resident with known substance abuse. The information talks about Fentanyl and what it can be found in because of resident substance abuse history."

On 10/24/23 at 11:14 AM, V37 (Restorative Aide) said he was notified by someone in housekeeping that R12 had a small baggie of a white substance on his table. V37 said he notified V5 (Social Services Aide) about the baggie and she handled the situation after that.

On 10/21/23 at 10:50 AM, V7 LPN (Licensed Practical Nurse) said he had to administer Narcan to R12. V7 said R12 was sitting in his motorized wheelchair in front of the nurse's station starting off. V7 said R12 did not respond

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to touch and his pupils were dilated. V7 said when R12 did not respond to a sternal rub he knew it was time for Narcan. V7 said he considered Narcan because R12 was one of the residents who had been out smoking. V7 said R12 responded to Narcan and he knows his urine drug screen was positive. . V7 said sometimes when the residents are out smoking they have symptoms of potentially overdosing. V7 said when they smell marijuana room checks are done by social services. The DON (Director of Nursing) and Administrator gave us a protocol that even if residents respond to Narcan we are having to send them to the ER. V7 said he has been lucky and has never had to give more than one dose of Narcan for the patient to respond. V7 said they treat the resident like a change of condition, bring them back to revival, take vitals, make notifications, and send them to the hospital.

5. R9's face sheet showed he was admitted to the facility on 4/8/21 with diagnoses to include paraplegia, atherosclerotic heart disease, neuromuscular dysfunction, polyneuropathy, cerebral infarction, and acute kidney failure.

R9's facility assessment dated 9/18/23 showed he has mild cognitive impairment and was dependent with all cares.

R9's care plan initiated 9/8/23 which showed, "Substance Abuse, I have a history of substance use/abuse/chemical dependency (marijuana and cocaine) related to rigid personality traits and ineffective coping. Despite education/support to assist with sobriety, I do not exhibit self-awareness and motivation to change...Interventions: Implement increasingly restrictive interventions in an effort to help me break my addictive cycle including supervision

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S9999	Continued From page 21 while I am in the community, restricted independent pass privileges and implementation of money guidance and budget controls to reduce/prevent access to substances. Meet with my interdisciplinary team to discuss the extent of my illness. Refer to the psychiatrist and clinical psychologist, as indicated. My physician my write an order restricting my outside pass privileges. Provide information related to treatment services/programs. Assist with referral process, as consented to. Provide me with a psychiatric and psychological evaluation, supportive mental health intervention, and treatment recommendations. R9's October 2023 Physician Order Sheet printed 10/25/23 showed no orders for Naloxone. R9's August 2023 eMAR (electronic Medication Administration Record) showed no Naloxone on order or administered. R9's September 2023 eMAR showed an order started on 9/4/23 for Naloxone HCl Liquid 4 mg as needed. The Naloxone order was discontinued on 10/23/23. This MAR showed no doses of Naloxone given. R9's September 2023 MAR did show on 9/2/23 and 9/6/23 "Drug Panel 9 Test one time only for suspected OD (overdose). R9's Social Services Assessment for Abuse and Neglect dated 7/17/23, 9/18/23 and 10/17/23 completed by V5 (Social Services Assistant) showed R9 was assessed as having no history of substance abuse. On 8/31 23 at 8:00 PM, V43 LPN (Licensed Practical Nurse) entered a nursing progress note which showed, "Resident noted in lobby lethargic and somewhat unresponsive but responds	S9999		

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S9999	Continued From page 22 minimally when name is called. Resident suspected to be under the influence of some substance after visiting with other residents. Resident was in a motorized wheelchair which had to be operated by staff in order to get resident back to his room. Sternal rub was done and resident was given Narcan 4 mg in left nostril. After approximately 2 minutes resident began to look around. Supervisor on duty (V18 LPN) made aware, writer was instructed to call 911. 911 was called, resident was put back to bed via (mechanical lift) lift..." On 9/1/23 at 1:29 PM, V5 (Social Services Assistant) completed a social service note for R9 which showed, "... No history of substance abuse noted... Yes current use of smoking products. Cannot determine hazardous behavior with smoking products..." On 9/6/23 at 12:39 AM, V18 (LPN) entered a note in R9's medical record that showed, "Resident assisted to bed x 3 person, complete body assessment, resident became responsive after 2 Narcan administration. Resident stated I'm okay. Urine collected, positive for opioid substance. NP aware, TORB (telephone order read back) Transfer to (acute care hospital) for evaluation..." On 9/6/23 at 7:32 PM, R9's nursing note entered by V3 DON (Director of Nursing) showed, "Writer overheard commotion regarding someone was passed out on the patio, writer went to patio and noted resident alert but drowsy and slow to respond. Sternal rub done. Resident noted more alert. Nurse on duty came to patio and assisted resident back to unit via his motorized wheelchair driven by nurse. Resident unable to operate as independently done. Writer went to unit and was informed 2 doses of Narcan given because	S9999		

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resident was slow to respond."

On 9/7/23 at 11:26 AM, V5 (Social Services Assistant) documented, "Writer met with resident for a well-being check. Resident presented in a pleasant mood. Writer asked resident did they have any questions or concerns. Resident stated he did not. Writer asked resident if he feels safe in his environment. Resident stated "yes". Writer encouraged resident to seek staff assistance when needed. Writer encouraged resident to participate in in-house activities..."

On 9/15/23 at 4:09 PM, V5 (Social Services Assistant) documented, "Writer met with resident who presents to be alert and oriented x 3. Gave Fentanyl information to resident with known substance use. The information talks about Fentanyl and what it can be found in because of resident substance use history."

On 9/19/23 at 2:10 PM, V2 documented a room search conducted of R9's room without yielding any illegal drugs or alcohol. (This is the first room check documented for R9's room.)

On 10/21/23 at 2:06 PM, R9 said he has never been offered any drugs in the facility but that his old roommate overdosed on heroin while he was in the room with him. R9 said they had to give him roommate Narcan in his nose. R9 said he does not do anything like that and does not know where the drugs came from.

On 10/23/23 at 12:03 PM, V32 CNA (Certified Nursing Assistant) said, "I don't know but sometimes the hallways smell like weed..."

On 10/23/23 at 12:08 PM, V33 CNA (Certified Nursing Assistant) said, "I just know one day I

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came in to work and we were in-serviced about 3 residents overdosing. They asked if we have seen the residents buying drugs. They also talked about notifying the nurse if there is a change in behavior."

On 10/24/23 at 10:45 AM, V5 (Social Service Aide) said residents are assessed for their ability to go out on community pass. V5 said their ability to go out on pass is mainly dependent on their BIMS (Brief Interview Mental Screening) score. If they score a 13 or higher on their assessment they are able to have community pass ... If a resident is having behaviors we would restrict their access until their behavior has changed. Drug abuse behaviors we would monitor for change by checking in on the residents well-being. Social services basically just would talk to them about it and see what is driving them to do the behavior ..."

On 10/24/23 at 11:14 AM, V37 (Restorative Aide) said, "There are drugs everywhere, a lot of residents have them. They always smell of marijuana. One day a paralyzed resident was in his bed smoking a joint. Someone had to give that to him." V37 said he saw a resident in a motorized wheelchair drop a bag of marijuana off his lap onto the floor. V37 said he just rolled his wheelchair over it to hide it and another resident picked it up and gave it back to him. V37 said there are a lot of residents that go out in front of the building to smoke and he sees cars pull up to them and get out, they will only be there a couple minutes then leave. I haven't seen a transaction but it's odd. I've reported to the administrator. The nurses have started carrying Narcan in their pocket.

On 10/24/23 at 12:44 PM, V1 (Administrator)

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S9999	Continued From page 25 said, "At first we didn't know we had a Fentanyl problem. I thought maybe they were nervous and everyone that was 'out of it' (unresponsive) so they were just giving them Narcan too. When we looked into it and [R12] was positive for cocaine I started looking at Fentanyl. That's when I got a kit, not a urine test. It was a substance test kit. I got the substances to test from a room search. If you go online, it won't let you buy the Fentanyl test kits because of weird political or probably money reasons. In Illinois you can't buy Fentanyl test kits but at 333 State St, in downtown Chicago they have a box on the 3rd floor in the Chicago Department of Public Health office where you can take as many Fentanyl test strips and Narcan as you want. They are there for the drug users who don't want to die from Fentanyl so they can test their own product. I've reached out and I'm getting 500 Fentanyl test strips that I can distribute to other facilities and family members. We have a CNA whose dad used recreational drugs and he died from Fentanyl. You can smoke it. I said we gotta get ahead of this so we put an action plan together for people who even smoke a little pot and become unresponsive. I know weight wise it's good to put it (Fentanyl) in heroin but why put it in marijuana. The drug dealers who are cutting the marijuana, the heroin, or the cocaine are using the same surfaces, it's a cross contamination issue. Two people told me that, one was a coordinator we were talking to about NA (Narcotics Anonymous) meetings for our facility and also Dr. Google (internet serach engine). When we were using Narcan like nobody's business, we assessed all residents for a history of substance abuse and updated a list. One of the people were non-responsive on the patio but our staff monitor that, but that's one set of eyes. If they wheel somebody to the elevator and back that's not a problem they don't have to	S9999		

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	IL6015333	A. BUILDING: ______ B. WING ______	C 10/27/2023

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S9999	Continued From page 26 necessarily be out there. So we set up a camera. We did do training on nurses for drug overdose and responding and Narcan usage. We reviewed care plans ... We did start to do some searches of bags and personal things, nothing super harsh because we know if someone wants to sneak something in they can. We initiated random room searches. We did a resident council meeting because I wanted to do a harm reduction meeting. I told them if they are smoking pot and they are feeling out of it they should let the nurses know because it could be Fentanyl ...we have a new company that will be working with our active substance users to look at other underlying mental health issues such as anxiety and depression that could be contributing to their substance use ... We did also reach out to [a local company] and they are willing to come in and meet with the residents to discuss overdosing. They are a harm reduction group. They will go over the signs of OD and what they should do ... [R12] is going to NA meetings because he is somebody that when he is out in the community he goes immediately to get cocaine, like a moth to a flame. I don't want that life for him ... This is their home but we also don't want them to die. Something I still don't know is where the Fentanyl was coming from. Too many different people in and out of the facility. They had to have been getting it from someone. We talked to everybody, I looked at probably 30 hours of video checking to see if staff were going in and out of rooms more frequently ... Just because you have community access and are found with drugs on you it doesn't mean that you are sharing. We haven't used Narcan in months (last documented Narcan usage found in resident sample was 9/7/23.) That good considering how often we were using it. These guys were all like a group, always together. A couple pops of marijuana with	S9999		

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S9999	Continued From page 27 a little Fentanyl in it and you are drooling. I tested the drugs myself. [R3] was actually honest about it. Until we Narcan' d him, we didn't even know he had a heroin issue. He told us he was using heroin every day. Now all of a sudden he is out (unresponsive). So when we tested it and found it had Fentanyl in it, he was really upset about it. He said he would get on the bus and go back into the neighborhood or somewhere to get it but that doesn't mean he is being honest. I believe we actually looked at who had a substance abuse history between nursing consultants and our social services team. They did the assessments. (A document was provided by the Administrator with some steps taken by the facility, all undated, all marked 'completed'.) It shows 'completed' but it was varying dates. At one point we sat down and said 'We are outgunned here.' After that multiple Narcan usages. I would say the education started in September. At first we were like 'hmm [R2] just got really drunk or someone overdosed on something they were taking. Maybe it's an isolated incident.' The two residents would have been isolated verses widespread. Then in September is when we realized we had a pattern. It was shocking to me because [R2] is no newbie when it comes to using substances so how in the world are they overdosing. Especially [R3] too. We were absolutely playing defense. Narcan was being given and the resident perked up and they (the nurses) were like 'oh he is good' and let them just go back to their rooms. They would have to send them out to get looked at and verified. That's why we had to do the education. I flushed the drugs. I did not call the police. I did not report to (State Survey Agency) ... I don't know what the reasoning would be to report it... We look at harm .... Thank God no one was ... We were actually expecting (State Survey Agency) to come out earlier because a lot residents were freaking out I	S9999		

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S9999	Continued From page 28	S9999		

figured someone would call in. We were well expecting you guys. The reality is Fentanyl is a problem ... This in uncharted territory and I guarantee you we did some things wrong. There hasn't been any more Narcan use 'knock on wood' but we are putting things into place where residents are educated and are smarter now. We were going to bring drug sniffing dogs in, not the police though because the police don't want to do it. I called the Chicago police to see if they take their dogs in to facilities and they said 'If a resident has a bag of heroin and he is in a wheelchair with no legs, we don't want to be on the news 'perp walking' them out of the facility. It's bad PR (Public Relations)' Documentation of the room checks would be in the progress notes only.

On 10/24/23 at 12:14 PM, V41 (Medical Director) said, "I was made aware of the issue of overdosing in the facility several weeks into the situation. It was actually brought to my attention by one of my Nurse Practitioners that they had used Narcan on some of our residents. I called the Administrator and he said they were working on it through education ... He said they traced it back to just one resident and he was transferred out. I would think the police would have been involved too ... Of course I would have expected to have been notified right away. I would have been able to help with the situation, reach out to an addict team, Notify IDPH, Treat medically whoever was in need, and ensure the regulatory stuff would have been followed through. This is a bizarre situation that looks like someone is bringing drugs in ..."

The facility's Substance Use Disorder Guidelines with effective date of 10/24/22 showed, "Substance use disorder is defined as recurrent use of alcohol and/or drugs that causes clinically

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S9999	Continued From page 29 and functionally significant impairment, such as health problems or disability. Providing health care and supportive services is an integral part of the person-centered environment. This involved an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Staff should be prepared to address emergencies related to substance use by providing increased monitoring, maintaining and having knowledge of administering opioid reversal agents like Naloxone, initiating CPR as appropriate and contacting emergency medical services as soon as possible...Safety: Residents with a history of substance use disorder may be at increased risk for leaving the facility without notification and/or for illegal or prescription drug overdose if the resident continues using substances while residing in the nursing home. Resident with a history of substance use disorder should be assessed for these risks, and care plan interventions should be implemented to ensure the safety of all residents. For example, residents with substance use disorder may leave the facility to satisfy an addiction to alcohol, prescription drugs or illegal substances. Care planning interventions should address this risk by providing appropriate diversions for residents and encouraging residents to seek out facility staff to discuss their plan of care, including discharge planning, rather than leaving to seek out substances that could endanger the resident's health and/or safety The facility should advise residents of the risks of leaving the facility to seek out substances and/or early, unplanned discharge, and provide appropriate referrals and discharge instructions whenever possible... Risk Assessment: Facility staff should assess the resident for risk for substance use in the facility and have knowledge of signs and symptoms of	S9999		

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S9999	Continued From page 30 possible substance use, such as: frequent leaves of absence with or without facility knowledge; odors (i.e., etc.)... changes in resident behavior such as unexplained drowsiness, slurred speech, lack of coordination, and mood change, particularly after interaction with visitors or absences from the facility... If illegal substance use is suspected, the staff may ask residents who appear to have used an illegal substance (e.g. cocaine, hallucinogens, heroin), whether they possess or have used an illegal substance... To protect the health and safety of residents, the staff may need to provide additional monitoring and supervision while awaiting the arrival of law enforcement..." The facility's policy and procedure with effective date of 11/28/12 showed, "Community Pass Guidelines... To define the facility and the resident's responsibility when a resident leaves the facility with the consent of the facility... The resident has the right to community access with the consent of the facility and the residents' cooperation with the standards described within. If the resident refuses to adhere to the standards, he or she may be restricted from independent pass privileges... 3. Residents returning from passes that are suspected to be under the influence of alcohol, or illegal drugs will agree to drug testing and/or treatment programming. They are also subject of pass restriction..." (A)	S9999		