STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Elgin	134 North McLean Boulevard Elgin, IL 60121

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to assess residents for self-administration and storage of medication, as well as notifying and ordering medications for residents who were self-administering. The facility also failed to ensure residents took their medications during medication pass. This applies to 4 of 4 residents (R12, R25, R34, R71) reviewed for administration and storage of medications in a sample of 26. The findings include: 1. On April 30, 2024 at 10:40 AM, R25 had a 245-milliliter bottle of generic day time severe cold and cough medicine which contained acetaminophen, dextromethorphan hydrobromide, and phenylephrine hydrochloride on the bedside table. R25's bottle of cough medicine appeared half empty. R25 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease, abnormalities of gait and mobility, chronic respiratory failure, chronic pulmonary edema, hyperlipidemia, and muscle wasting. R25's MDS (Minimum Data Set) dated April 18, 2024 showed R25 was cognitively intact. R25 required supervision for eating and moderate assistance from staff for oral hygiene, upper body dressing, and personal hygiene. R25 required maximal assistance from staff for showering/bathing, and was dependent on staff for toileting hygiene, lower body dressing, and putting on/taking off footwear. R25's POS (Physician Order Sheet) did not show an order for the generic day time severe cold and cough medicine. R25's care plan was reviewed, and there were no care plans prior to the beginning of the survey showing R25 was allowed to self-administer or store medications at bedside. 2. On April 30, 2024 at 11:08 AM, during initial tour, R71's bedside table and boxes had several bottles of medications. R71 had one bottle of iron 28 mg (Milligrams), one bottle of Vitamin C 500 mg, one bottle of fish oil 1000 mg, one bottle of apple cider vinegar tablets, and three bottles of pineal XT gold. R71 said he took his medications every day but did not consistently take fish oil. V71 said when he does remember to take the fish oil, he would take three of them. (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 - Some	R71 was admitted to the facility with diagnoses including congestive heart failure, hypothyroidism, hypertension, alcohol abuse, nicotine dependence, bipolar disorder, and anxiety disorder. R71's MDS dated [DATE] showed R71 was cognitively intact. R71 required supervision for all activities of daily living. R71's POS was reviewed, and no orders were found for self-administration of medications. R71's POS did not have any orders for the medications found at bedside. R71's care plan was reviewed, and a care plan was initiated on May 1, 2024 (during the survey) regarding self-administration of medications. 3. On April 30, 2024 at 10:15 AM, R34 had a medicine cup with 20 ml (Milliliters) of red liquid. R34 said the medicine was there since last night and she was supposed to have drank it as it was for wound healing. R34 was admitted to the facility with diagnoses including rhabdomyolysis, multiple sclerosis, seizures, peripheral vertigo, pressure ulcers of the sacral region and right heel, osteoporosis, and neuromuscular dysfunction of the bladder. R34's MDS dated [DATE] showed R34 had moderate cognitive impairment. R34 required supervision for eating, moderate assistance from staff for upper body dressing, maximal assistance from staff for oral hygiene and personal hygiene, and was dependent on staff for toileting hygiene, shower/bathing, lower body dressing, and putting on/taking off footwear. R34's POS did not show an order to self-administer medications. R34's care plan was reviewed, and a care plan was initiated on May 1, 2024 (during the survey) regarding self-administration of medications. On May 1, 2024 at 04:28 PM, V2 (DON/Director of Nursing) said there was only one resident who was allowed to self-administer medications, and R25, R71, and R34 were not supposed to self-administer. V2 said if a resident wanted to self-administer medications, they should be cognitively intact and alert. V2 said there would be an assessment completed and it would go into their medical record and a care plan would be initiated. V2 said the doctor would be notified and the medications should be ordered so they can be tracked upon administration. V2 said if a resident was cleared to self-administer, they would need to tell their nurse when they took their medicine, and the nurses should also be asking when they round. V2 said the medications should be stored in a locked space in the resident's room for safety, as there were other residents around. V2 also said the nurses should be watching the residents take their medications prior to leaving the room. 46380 4. On 4/30/2024 at 1:27 PM, a full bottle of Milk of Magnesia was noted on top of R12's drawer. The medication had no labels. R12 said she takes Milk of Magnesia when she feels constipated. She said she follows the instructions on the bottle. R12 said she buys the medication from the store. On 5/1/2024 at 9:05 AM, unlabeled bottle of Milk of Magnesia was still on top of R12's drawers. On 5/2/2024 at 12:13 PM, V2 (DON-Director of Nursing) said only one resident has an order to self-administer medication in the facility. V2 said medications should be labeled and come from the pharmacy. For medications from outside, she expects the nurses to take the medication from the resident, inform the physician and obtain order to administer. She said if resident is able, the resident will be assessed for self-administration, educate on medication administration, do return demonstration, and obtain order for self-administration. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R12's POS (Physician Order Sheet) shows she has no order for medication at bedside and has no order for Milk of Magnesia. There was no order to self-administer medication. There is no assessment for self-administration of medication in R12's EHR (Electronic Health Record). Facility's Policy on Self Administration of Medication dated 04/2014 stated the following: General Guidelines: 1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on observation, interview, and record review, the facility failed to assess and care plan residents that smoke per facility policy. The facility also failed to ensure smoking materials were kept in the designated secure location. This applies to 5 of 9 residents (R46, R62, R71, R74, and R387) reviewed for safe smoking in the sample of 26. The Findings Include: 1. R46 is a [AGE] year-old male admitted on [DATE] with moderately impaired cognition as per the Minimum Data Set (MDS) dated [DATE]. R46 was observed on 4/30/24 at 10:45 AM in his room with an opened pack of cigarettes and matches on the bedside table. R46 stated, I have cigarettes and matches with me to go for smoking. I may go for a smoke after lunch. Record review on smoking safety risk assessment for R46 dated 1/15/24 document: All smoking materials will be kept locked in the facility designated area. A review of the care plan documents that R46 was care planned for smoking non-compliance with interventions, including smoking materials, will be in the social service office and distributed to him during designated smoking times. 2. R74 is a [AGE] year-old male admitted on [DATE] with cognition intact as per the MDS dated [DATE]. R74 stated during interview of 4/30/24 that, I smoke cigarettes, and I have my cigarette and lighter in my pocket. 3. On 4/30/2024 at 11:35 AM, R62 was observed to have cigarette and lighter in the drawer of his nightstand. The nightstand had a keyhole but was not locked. R62 said the drawer could not be locked because the facility did not give him keys. R62's Smoking Safety Risk assessment dated [DATE] stated R62's smoking materials will be kept locked in facility designated area. 4. R71 was observed on April 30, 2024 at 11:08AM in his room. A carton of cigarettes was noted on R71's bedside table. R71 was admitted to the facility with diagnoses including congestive heart failure, hypothyroidism, hypertension, alcohol abuse, nicotine dependence, bipolar disorder, and anxiety disorder. R71's MDS (Minimum Data Set) dated February 6, 2024 showed R71 was cognitively intact. R71 required supervision for all activities of daily living. R71's care plan was reviewed, and there were no care plans addressing R71 being a smoker, level of assistance needed, and whether R71 was allowed to store his smoking material in his room. R71's Smoking Safety Risk assessment dated [DATE] showed R71 was both an independent smoker and resident is able to go out in the court yard with supervision. R71 did not have any quarterly assessments completed from June 5, 2023 until May 2, 2024 (during the survey). (continued on next page)

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	145740	A. Building B. Wing	05/03/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On April 30, 2024 at 11:03 AM, R387 was asleep in bed with the door partially open. R387 had a carton of cigarettes on her bedside table. At 02:58 PM, R387 was observed with her cigarettes on the bedside table, visible upon entry to her room. On May 1, 2024 at 12:13 PM, R387 was sleeping in bed with the door slightly ajar. R387's cigarettes and lighter were on the dresser table next to the doorway. R387 was admitted to the facility with diagnoses including major depressive disorder, abnormalities of gait and mobility, generalized anxiety disorder, polyneuropathy, hypertension, gout, polyarthritis, and acute kidney failure. R387's MDS dated [DATE], showed R387 was cognitively intact and required supervision for all activities of daily living. R387's record lacked a smoking assessment and smoking care plan. R387 was noted with smoking material in the room. On May 2, 2024, at 10:03 AM, V7 (Social Services Director) stated that if a resident wanted to smoke or vape, a safe smoking assessment and a care plan were completed. V7 added that the residents are expected to put smoking materials in their bedside table drawer. V7 continued and stated that she had to remind residents to place the smoking materials in their drawers and not leave them out on top of the tables. V7 said residents who smoke should have a yearly smoking assessment, as well as quarterly assessments to review whether they still have the skills to smoke independently. V7 said there should also be a smoking care plan in place, which should address whether they are allowed to have their smoking materials in their room or not.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46380 Based on observation, interview and record review, the facility failed to provide timely incontinence care to a resident dependent on toileting and failed to keep indwelling catheter drainage bag off the floor. This applies to 2 out of 2 residents (R46 and R48) observed for incontinence care and indwelling catheter care in a sample of 26. 1. On 4/30/2024 at 11:29 PM, R48 had a strong smell of urine. On 4/30/2024 at 11:32 AM, skin check with V13 (CNA-Certified Nurse Assistant) showed R48's incontinent brief was soaked with urine. R48's shirt and bed pad were soaked with urine. R48's coccyx was observed to be red. V13 provided incontinence care but did not apply barrier cream. On 5/2/2024 at 11:22 AM, V2 (DON-Director of Nursing) said she expects staff to check for incontinence care frequently at least every two hours. She said she expects staff to provide timely incontinence care to prevent skin breakdown and infection. R48 was admitted to the facility on [DATE]. MDS (Minimum Data Sheet) dated 3/27/2024 documents R49 has moderately impaired cognitive functions, dependent for toileting hygiene and is frequently incontinent of bladder and always incontinent of bowel. Review of R48's EHR (Electronic Health Record) shows he had a urinary tract infection on 10/27/2023. R48's care plan dated shows he has an ADL (Activity of Daily Living) deficit and one of the interventions documents the following: TOILET USE: Check frequently for incontinence. Provide peri-care after each incontinence episode. Provide barrier as needed/ordered. Facility's Incontinence Care Policy dated 11/28/2012 and revised on 1/16/2018 states the following: Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity.Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or every two hours and provided perineal and genital care after each episode. 34410 2. R46 is a [AGE] year-old male admitted on [DATE] with moderately impaired cognition as per the Minimum Data Set (MDS) dated [DATE]. On 4/30/24 at 10:45 AM, R46 was observed on his bed with his indwelling catheter bag on the floor with no privacy bag to contain. On 4/30/24 at 10:45 AM, V12 (Licensed Practical Nurse/LPN) stated, The indwelling catheter bag shouldn't be on the floor. The facility provided urinary catheter care policy revised on 2/14/19 documents the following: .7. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly. May place drainage bag and excess tubing in a secondary vinyl bag or other similar device to prevent primary contact with floor or other surfaces.

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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 its oxygen and respiratory equipment changing/cleaning policy by not changing respiratory tubing and humidifier on weekly basis and not storing nasal cannula and nebulizer mask in a plastic bag with zip loc. This applies to 3 of 3 residents reviewed (R10, R40, R46) for respiratory care in a sample of 26. The Findings Include: 1. R46 is a [AGE] year-old male admitted on [DATE] with moderately impaired cognition as per the Minimum Data Set (MDS) dated [DATE]. On 4/30/24 at 10:45 AM, R46 was observed on his bed with his nasal cannula on the floor with no date/label. The humidifier was observed to be dirty and had no date/label. On 4/30/24 at 10:45 AM, R46 stated, They don't care about the tubing change. I filled the humidifier water chamber a couple of times. 04/30/24 at 10:51 AM, V4 (Licensed Practical Nurse/LPN), The night shift is supposed to change tubing, date, and label tubing, and fill the water reservoir. Oxygen tubing should be contained in a plastic bag. Record review on R46's current Physician Order Sheet (POS) documents that R46 is on oxygen therapy with a nasal cannula at 3 liters per minute (L/M) as needed. 2. R40 is a [AGE] year-old female admitted on [DATE] with cognition intact as per the MDS dated [DATE]. On 04/30/24 at 11:11 AM, R40 was observed on her bed with a nasal cannula hanging from the drawer knob at her bedside. On 4/30/24 at 11:11 AM, R40 stated, I am the one who hung it on my drawer knob. They didn't give me a plastic bag to keep my nasal cannula in. Record review on R40's current POS documented that R40 is on oxygen therapy with a nasal cannula at 2 L/M as needed for shortness of breath (SOB). 3. R10 is a [AGE] year-old female admitted on [DATE] with mild cognitive impairment as per the MDS dated [DATE]. On 4/30/24 at 11:03 AM, R10 was observed in her bed with a nebulizer mask on the floor. On 04/30/24 at 11:20 AM, V12 (Licensed Practical Nurse/LPN) stated, The residents should be getting a plastic bag to keep their nebulizer mask in. The nebulizer mask shouldn't be on the floor. The machine and mask should be inside the drawer. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on R10's current POS document that R10 is on Ipratropium/Albuterol nebulizer treatment every 8 hours as needed for SOB. The facility presented the Oxygen and Respiratory Equipment -Changing/Cleaning policy revised on 1/7/19 document: Procedure: 1. Hand Held Nebulizer (HHN) and Mask a.The handheld nebulizer should be changed weekly and as needed (PRN). b. A clean plastic bag with a zip-loc or drawstring, etc, will be provided with each new setup and will be marked with the date the setup was changed. 2. Nasal Cannula a. Nasal Cannulas are to be changed once a week, as well as PRN. c. A clean plastic bag with a zip loc or draw string, etc will be provided to store the cannula when it is not in use. It will be dated with the date the tubing was changed. 4. Oxygen Humidifier. a. The oxygen humidifier should be changed weekly or as needed and will be dated when it is changed.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review, the facility failed to monitor and document behaviors; and failed to develop and update plan of cares with interventions for residents (R1 and R61) with known behaviors related to mental disorders. This applies to 2 out of 2 residents (R1, R61) reviewed for behaviors in a sample of 26. Findings include: 1. R61's Electronic Medical Record (EMR) showed R61 admitted to the facility on [DATE]. R61's EMR showed multiple diagnoses including psychosis, paranoid delusions, and dementia. R61's MDS (Minimum Data Set) dated 3/20/2024 showed R61 was cognitively intact. R61's MDS continued to show R61 did not show any behaviors of potential indicators of psychosis, including delusions. On 4/30/2024 at 10:34 AM, R61 was in his room and his privacy curtain was pulled. R61 had an untouched old meal tray with a ham sandwich, brussels sprouts, potatoes, a carton of milk, and a Rice Krispie treat on his bedside table. R61 said the facility staff was trying to poison him by putting chemicals in his food and he was refusing to eat yesterday's lunch. R61 continued to say the facility was spying on him because he believed there were cameras and devices transmitting information in his room. R61 continued to exhibit disorganized speech patterns with accelerated speech during the interview. On 5/01/2024 at 3:15 PM, V4 (Licensed Practical Nurse/LPN) said he was familiar with R61. V4 said R61 has behaviors including believing he is being poisoned and refusal of care. V4 said nurses document behavior episodes in the resident's EMR Behavioral/Mood Charting assessment forms. V4 searched in R61's EMR system and said the last Behavior/Mood Charting assessment completed was on 12/06/2023 for verbal aggression. On 5/02/2024 at 9:47 AM, V1 (Administrator) said R61 had intense paranoia of being poisoned and aggressive behaviors towards staff. V1 said R61 was recently transferred to an inpatient psychiatric hospital for behavior management. V1 said he believed R61 was not aware he had a paranoid schizophrenia condition. R61's inpatient psychiatric hospital discharge report dated 9/22/2023 showed he received treatment for aggressive behavior. The report showed a new problem with MDD (Major Depressive Disorder), and the discharge care plan goal said, stabilize mood and behaviors; maintain focus on reality. The report also included discharge instructions/education on schizophrenia and psychosis. R61's Care Plan dated 5/02/2024 showed multiple focuses for behavioral symptoms with interventions to Observe for behavior episodes, if observed, document appropriately. If possible, attempt to determine underlying cause/reason for behavior .Report to MD any changes or frequencies in behaviors. R61's Care Plan did not include the intervention of maintaining focus on reality as recommended nor focus problems for his diagnosis of MDD or schizoaffective disorder. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R1's EMR showed R1 admitted to the facility on [DATE]. R1's EMR showed multiple diagnoses including schizoaffective disorder bipolar type, insomnia, generalized anxiety disorder, and vascular dementia with behaviors. R1's MDS dated [DATE] showed R1 was severely cognitively impaired. R1's MDS continued to show R1 did not show any behaviors such as screaming, or throwing or smearing food or bodily wastes. On 4/30/2024 at 10:07 AM, R1 was in bed with his pants unzipped and partially exposed. The room had a strong foul urine smell. R1's roommate said R1 frequently urinated on the floor. R1 was unable to engage in the interview. On 5/01/2024 at 3:10 PM, V6 (Registered Nurse/RN) said he was familiar with R1. V6 said R1 had behaviors related to his schizophrenia diagnosis. V6 said R1 screamed a lot all the time. V6 said nurses document behavior episodes in the resident's EMR Behavioral/Mood Charting assessment forms. V6 searched in R1's EMR system and said he was unable to find any assessment documentation for behaviors. R1's Care Plan dated 5/02/2024 showed multiple focuses for behavioral symptoms with interventions to Monitor/record occurrence of any mood/behavior changes . R1's Care Plan did not include a focus problem for the behavior of urinating on the floor. On 5/01/2024 at 3:30 PM, V2 (Director of Nursing/DON) said she expected nurses to document resident behavior episodes in the resident's EMR progress notes or complete a Behavioral/Mood Charting assessment form. On 5/02/2024 at 11:16 AM, V2 (DON) said the facility did not have a policy for behavioral monitoring, V2 said she confirmed with the facility's corporate staff. V2 said residents with behaviors should have an order for behavior monitoring every shift and behavioral occurrence episodes should be documented in the residents' EMAR (Electronic Medical Administration Record). R1's and R61's EMRs did not show an order for behavior monitoring every shift and their progress notes for the past 30 days did not show nursing documentation for any behaviors.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 verify the counting logs accuracy for residents with controlled medications (R28, R47, and R52) and failed to dispose of controlled medications (R43) per facility policy. This applies to 4 out of 4 (R28, R47, R43, and R52) residents in a sample of 26. Findings include: 1. On 4/30/2024 at 2:45 PM, R28's Pregabalin 100 mg (milligrams) medication punch card was observed with #27 through #30 pill slots punched out with no medications. R28's Control Drug Administration Record sheet did not show any entries for medication removal. V4 (Licensed Practical Nurse/LPN) was present during the observation and said he was not sure why the medications removed were not logged in R28's sign-off sheet. R28's Medication Review Report (MRR) dated 5/01/2024 did not show an order for Pregabalin. 2. On 4/30/2024 at 2:46 PM, R43's Hydrocodone-APAP 5-325 mg medication punch card was observed with the #3 through #6 pill slots punched open, with tape over them with a pill inside each slot. V4 (LPN) was present during the observation and said they tape pill slots when there are tears in the punch card slots. R43's MRR dated 5/01/2024 showed an order for HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for pain. 3. On 4/30/2024 at 2:44 PM, R52's filled Lorazepam Oral Concentrate 2mg/mL (milliliter) bottle was in the East Hall medication room refrigerator. R52's Lorazepam Controlled Drug Administration Record sheet was wrapped around the medication (not in the unit's narcotic control counting log binder). R52's MRR dated 5/01/2024 did not show an order for Lorazepam. 4. On 4/30/2024 at 3:12 PM, R47's filled Lorazepam 2 mg/ml Oral Solution bottle was opened in the [NAME] Hall medication room refrigerator. R47's Lorazepam Individual Controlled Substance Record sheet was wrapped around the medication (not in the unit's narcotic control counting log binder). R47's MRR showed an order for LORazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml by mouth every 4 hours as needed for agitation and restlessness. V3 (Registered Nurse/RN) was present during R52 and R47's observations. V3 said he was not sure why the controlled medication sheets were not in the units' narcotic control counting binders for counting. (continued on next page)

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	145740	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Elgin	134 North McLean Boulevard Elgin, IL 60121

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/01/2024 at 10:48 AM, V2 (Director of Nursing/DON) said she expected all individually controlled administration sheets to be kept in each medication cart's narcotic control sign-off binder and for nurses to verify the correct count for controlled medications during the change of shifts to prevent any discrepancies. V2 continued to say nurses should sign off the residents' individual controlled administration sheets when removing medications to maintain the accuracy of controlled medications and controlled medications should be disposed of accordingly if discontinued and not be placed back into the punch card slots with tape. The facility's policy titled Narcotic/Controlled Substances-Counting with a revised date of 11/26/2017 showed Purpose: 1. To count controlled substances with a partner and to verify the accuracy of the log sheets. 2. Knowledge of correct response should an error be discovered in the controlled substance count. General Guidelines: 1. Always participate in the counting of the controlled substances at the beginning and ending of your shift .2. Always note the integrity of any liquid form of controlled substance to ensure that the bottle has NOT been tampered .3. When observing the cards of medication, make certain and visually scan the entire card for any medication that may be popped out, out of order .Also, look at the back of each card to ensure the card has not been tampered with. Be observant for use of tape to cover an area where a pill has been popped out, replaced with another type of pill, and then re-taped for closure .General Procedure for Counting Controlled Substances .9. Observe the appearance of the pills to identify if they are correct and ensure there has been no tampering or substitution of medications. 10. Determine amount of liquid medication, if appropriate .25. Report the incorrect count to nursing supervisor, Director of Nursing, or administrative staff present.

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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 25 opportunities with 3 errors resulting in a 12% error rate. This applies to 2 out of 2 (R29, R77) residents in a sample of 26. Findings include: 1. On 5/01/2024 at 8:10 AM during medication administration, V5 (Licensed Practical Nurse/LPN) said R77 had scheduled 11 units of Aspart (insulin). V5 turned R77's Aspart FlexPen dose knob to 11 units then administered it on R77's right arm and quickly removed the pen from the injection area. R77's Medication Review Report (MRR) dated 5/01/2024 showed an order for Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 11 unit subcutaneously with meals for DM2. 2. On 5/01/2024 at 8:38 AM during medication administration, V5 said R29 had scheduled 12 units of Humalog (insulin). V5 turned R29's Humalog Kwikpen dose knob to 12 units then administered it to R29's right mid abdominal area and quickly removed the pen from the injection area. 3. Then V5 continued to say R29 had 2 units of Lymjev (insulin) ordered per sliding scale. V5 turned R29's Lymjev Kwikpen dose knob to 2 units then administered it on R29's right lower abdominal area and quickly removed the pen from the injection area. R29's MRR dated 5/01/2024 showed orders for HumaLOG KwikPen 100 UNIT/ML Solution pen-injector Inject 12 units subcutaneously with meals related to type 2 diabetes mellitus and Lyumjev KwikPen 100 UNIT/ML Solution pen-injector Inject as per sliding scale. V5 did not prime R77 and R29's insulin pens before administering their scheduled doses of insulin and did not continue to press down the pens after injecting the administered doses before removing the needles. Insulin pen injection manufacture instructions document with revised date 8/2023 showed Priming your Pen Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensure that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin Step 6: To prime your Pen, turn the Dose Knob to select 2 units .Step 11: Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48944 Based on observation, interview, and record review, the facility failed to administer the correct doses of insulin medications to residents (R29 and R77) and scheduled pain medication to a resident (R26). This applies to 3 out of 3 (R26, R29, R77) residents in a sample of 26. Findings include: 1. On 4/30/2024 at 2:46 PM during medication cart check, V4 (Licensed Practical Nurse/LPN) said he signed off R26's scheduled 9 AM Tramadol medication in the MAR (Medication Administration Record) but forgot to administer it that morning. R26's Tramadol 50 MG TAB medication punch card showed R26's 9 AM scheduled dose for 4/30/2024 was not removed. R26's Medication Review Report (MRR) dated 5/01/2024 showed an order for Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth one time a day for Chronic pain. 2. On 5/01/2024 at 8:10 AM during medication administration, V5 (LPN) said R77 had scheduled 11 units of Aspart (insulin). V5 turned R77's Aspart FlexPen dose knob to 11 units then administered it on R77's right arm and quickly removed the pen from the injection area. R77's MRR dated 5/01/2024 showed an order for Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 11 units subcutaneously with meals for DM2. 3. On 5/01/2024 at 8:38 AM during medication administration V5 said R29 had scheduled 12 units of Humalog (insulin). V5 turned R29's Humalog Kwikpen dose knob to 12 units then administered it to R29's right mid abdominal area and quickly removed the pen from the injection area. V5 continued to say R29 had scheduled 2 units of Lymjev (insulin) ordered per sliding scale. V5 turned R29's Lymjev Kwikpen dose knob to 2 units then administered it to R29's right lower abdominal area and quickly removed the pen from the injection area. R29's MRR dated 5/01/2024 showed orders for HumaLOG KwikPen 100 UNIT/ML Solution pen-injector Inject 12 units subcutaneously with meals related to type 2 diabetes mellitus and Lyumjev KwikPen 100 UNIT/ML Solution pen-injector Inject as per sliding scale. V5 did not prime R77 and R29's insulin pens before administering their scheduled doses of insulin and did not continue to press down the pens after injecting the administered doses before removing the needles. On 5/01/2024 at 10:48 AM, V2 (Director of Nursing/DON) said nurses administering insulin with the use of an insulin pen should prime the pen before administering and slowly remove the pen once administered to assure the resident received the correct dose of insulin as ordered. V2 continued to say that the facility did not have a medication administration policy, but she expected the nurse to administer medications as ordered and sign them off in MAR (Medication Administration Record) once completed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Insulin pen injection manufacture instructions document with revised date 8/2023 showed Priming your Pen Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensure that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin Step 6: To prime your Pen, turn the Dose Knob to select 2 units .Step 11: Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 dispose of expired medications. This applies to 2 of 2 (R34, R47) residents in a sample of 26. Findings include: 1. On 4/30/2024 at 3:12 PM, the medication storage task was done with V3 (Registered Nurse/RN) in the facility's [NAME] Hall medication room. The medication storage refrigerator had multiple medications stored including two bottles of R34's Vancomycin liquid solution with liquid solutions inside with expiration labels date of 4/01/2024. The Vancomycin bottle's labels said Use this bottle for dispensing after reconstitution. Contents MUST be used within 14 days, discard if hazy. R34's Medication Record Report (MRR) dated 5/01/2024 did not show an order for Vancomycin. 2. The medication storage refrigerator also had an opened hospice kit box with R47's medications. R47's box kit had one bottle of Lorazepam oral solution with liquid solution inside and an expiration label date of 3/02/2024, two needless syringes of Scopolamine gel with solution inside and they had an expiration label date of 3/01/2024, and a bottle of Vancomycin liquid solution with liquid solution and an expiration label date of 12/31/2023. The Vancomycin bottle label said, Discard remainder after 10 days. R47's MRR dated 5/01/2024 showed an order for LORazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml by mouth every 4 hours as needed for agitation and restlessness. The MRR did not show an order for Scopolamine and Vancomycin. On 5/01/2024 at 10:48 AM, V2 (Director of Nursing/DON) said expired and discontinued medications should be removed from the medication storage room and returned to the pharmacy for disposal. The facility's policy titled Medication Storage with a revision date of 7/02/2019 showed Purpose: To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes and needles.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on observation, interview, and record review, the facility failed to discard expired food items from the dry storage. The facility also failed to follow its dishwashing machine operation guidelines by not checking the dishwashing machine before its first use to ensure sanitization. This applies to all 87 residents consuming food from the kitchen. The Findings Include: On [DATE] at 10:12 AM, during an initial tour of the kitchen, the kitchen dry storage was observed with two one-gallon Worcestershire sauces used by the date of [DATE]. On [DATE] at 10:15 AM, V11 (Dietary Manager) stated that the expired sauce shouldn't be there and that he would discard it. The facility presented food storage guidelines and procedural Manual (2020) document: c. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing it under proper refrigeration. On [DATE] at 9:48 AM, the kitchen was observed with V10 (Dietary Aide) running the dish machine after breakfast. As per the surveyor's request, V10 reran the machine with a test strip, and the test strip was not sanitizing, with no color change with the test strip. On [DATE] at 10:00 AM, V11 reran the dish machine, and the test strip was again with no color change. On [DATE] at 10:07 AM, V11 stated, We have a low-temperature machine with a chlorine-based sanitization agent. Apparently, I have a white test strip after running it through the dish machine with no color change. It should be between 50 and 100 parts per million (ppm). I am trying to figure out why it is not sanitizing. On [DATE] at 10:07 AM, the surveyor observed the dishwashing sanitization log with no entry for [DATE]. The facility presented Guidelines and Procedural Manual (2020) document: 2. Check the dishwashing machine before first use. If the dishwashing machine has not been used for several hours. 3. Record log documents twice daily for either final rinse temperature (High-temperature dishwashing machine) or sanitizer concentration (Low-temperature dishwashing machine with chemical sanitizer).