STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145877	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE DOLTON	**14325 SOUTH BLACKSTONE DOLTON, IL 60419**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** Based on observation and interview, the facility failed to have drawers accessible at a height that a resident can access and failed to accommodate enough space for a resident to move around in his room while using their required assistive devices. This failure applies to one (R3) of one resident reviewed for resident rights. Findings include: On 3/3/20 at 11:20 am, R3 was sitting in the hallway outside his room with legs extended out straight in front of him. R3 stated that he does not like to spend a lot of time in his room because it is too congested with the other residents and their wheelchairs. It is a 4-person room and 3 other residents use wheelchairs. R3 propelled self into his room toward his bed. R4 sat in his wheelchair and tried to move up against his bed to allow R3 to get near his bed and his belongings. R4 stated that it is really tight when he is in his room and R3 comes in the room with his wheelchair. R3 made several attempts to turn his wheelchair around and tried to back in towards his bed. R3 and R4's wheels were hitting each other and butted up against one another. R3 was not able to move self to the side of his bed due to his legs extended straight and inability to bend them. R3 stated, See; there is not enough room. R3 had to stop at the foot of his bed as he could not get through to the side of his bed with his wheelchair with his legs extended. R3 stated, I am unable to bend my legs. R3 stated he uses the bathroom down the hall and does not like to go into his room much due to the lack of space. R3 was out of his room from 11:20 am until after 2:50pm, at times sitting in wheelchair outside of room in the hallway. On 3/4/20 at 1:35pm, R3 stated and it was observed that R3 cannot reach the lower drawer of his dresser where clothes and papers are in. R3 stated, Even with my reacher, the drawer is too heavy to pull it open. Sometimes I have to wait until someone comes in here to get something out for me. On 3/4/20 at 11:26am, V2 (Social Service Director) stated, We typically keep in mind how much equipment a resident has and their mobility when placing them in a room. On 3/5/20 at 10:34 am, V12 (Restorative Nurse) stated, R3 has a walker he can use from time to time but his main mode of transportation is his wheelchair. R3's functional status dated 2/7/20 notes he has impairment in both lower extremities and uses a wheelchair and walker.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide scheduled medication as ordered and failed to reorder medication timely; the facility also failed to have written policies and procedure that outlined who is responsible for assuring timely delivery of medication, who to notify when a delay in medication administration occurs and to identify what to do when a delay in medication administration occurs. This failure applies to 1 (R3) of one resident reviewed for medication. Findings include: On 3/3/20 at 11:20 am, R3 stated, The [MEDICATION NAME] for the pain in my legs is still not here. They stated it has to be ordered but it has already been ordered. On 3/3/20 at 1:35pm, V5 (Licensed Practical Nurse/LPN) stated, The [MEDICATION NAME] for his leg pain is not available. I think he needs a new script. It is ordered 3 times a day. On 3/3/20 at 3:15pm, V1 (Administrator) stated, I was not aware that R3's [MEDICATION NAME] has not been available. I called the pharmacy and they will send it today. On 3/3/20 at 3:38 pm, V6 (Pharmacist) stated, [MEDICATION NAME] is dispensed in a 14-day supply and the facility nurse should request a refill with the pharmacy when it needs to be reordered. There was a call to pharmacy on 2/25/20 asking about the refill of [MEDICATION NAME] and the nurse was instructed a new script was needed. We did not receive a new script or a request until 3/3/20. Before that, the medication was refilled last on 2/7/20 with 14 days (42 tabs) dispensed and is ordered to be given 3 times a day for [MEDICAL CONDITION] pain. This would have needed to be refilled again on 2/21/20. On 3/3/20 at 6:32pm, V6 stated, I have checked every avenue that nurses request medication refills; there was not a request to refill it ([MEDICATION NAME]) until today (3/3/30). This medication is given to diabetic patients with [MEDICAL CONDITION] (nerve) pain in hands and legs. The facility requests a refill be sent, it just does not get dispensed automatically. On 3/4/20 at 8:44am V1 stated, The pharmacy usually keeps track of new prescriptions and they follow up with the physician if it is not signed. I spoke to the nurses last evening and they stated they called pharmacy and were told it was coming. The next day they would call and a different pharmacist said they needed a new script. They were told something different each time. There is a broken part of the system somewhere. I am supposed to be notified if the medication was not available from pharmacy, but I was not. I would have followed up with the pharmacist. On 3/4/20 at 10:04 am, V3 (LPN) stated, I did call the pharmacy on multiple occasions and was told the medication was coming. We are supposed to reorder the medication from pharmacy when it is running low. I cannot remember if I was the one who did that or not, but I also endorse it to the next shift. After several days, I should have followed the chain of command and informed the supervisor the medication was not available for days, but I did not. On 3/4/20 at 2:50pm, V1 stated, The nurses are to inform the supervisor if the medication is not available and the physician. We do not have a policy and procedure with pharmacy regarding following up with medication if there is a delay. We have a policy if the medication is unavailable due to manufactures shortage or the drug is no longer being made, which states to inform the doctor. I will educate the nurses to inform their supervisor and the physician. R3's physician orders [REDACTED]. R3's Medication Administration Record [REDACTED]. R3's progress notes dated 2/25/20 to 3/3/30 note medication is on order, unavailable, awaiting from pharmacy or needs new prescription.

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

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.