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APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

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S 000	Initial Comments Complaint Investigation 2493579/IL172847	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.610c)2) 300.1010b) 300.1030a)4) 300.1030c) 300.1210a) 300.1210b) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. c) The written policies shall include, at a minimum the following provisions: 2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary	S9999		

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services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray)

Section 300.1010 Medical Care Policies

b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee.

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).

c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section.

Section 300.1210 General Requirements for Nursing and Personal Care

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S9999	Continued From page 2 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 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999		

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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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to have a written policy to address the response to an opioid overdose and failed to ensure that staff were trained and competent in monitoring of a resident after administration of Narcan medication. The facility also failed to follow recommendations from SAMHSA (Substance Abuse and Mental Health Services Administration) for the administration and monitoring of a resident assessed to be at risk for substance abuse and who received Narcan medication for a suspected overdose. This failure affects one of one (R11) resident reviewed for overdose treatment. These failures resulted in R11 not being monitored in accordance with SAMHSA recommendations after receiving Narcan while in the facility for a suspected overdose.

Findings include:

R11 is a 45-year-old female originally admitted to the facility on 4/17/23. R11's medical diagnoses include Schizoaffective Disorder, Bipolar Type, Blindness One Eye, Anxiety Disorder, Personal History of Traumatic Brain Injury, Tobacco Use, Bipolar Disorder, Current episode depressed, Severe w/out, psychotic features, Cannabis abuse, Drug Induced Subacute Dyskinesia, and

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hyperlipidemia.

R11's MDS (Minimum Data Set) assessment dated 04/16/24, documents that R11 has a BIMS (Brief Interview of Mental Status) score of 09 (moderate cognitive impairment) and uses a wheelchair.

R11's Abuse/Neglect Screening effective date 3/15/24 documents that R11 is at moderate risk for abuse/neglect, with a risk measure score of 3 - Screening indicators include: (yes) Factors that increase the resident's vulnerability (e.g., confusion, disorientation, poor insight/poor judgement, history of being exploited, etc ...); (yes) history of substance abuse; (yes) diagnosis of depression and/or history of depressive illness.

R11's current care plans document the following:

- Abuse focus (initiated 12/15/23) documents that R11 is observed/monitored to mitigate potential risk towards becoming a recipient or perpetrator of abuse/neglect or further trauma; given R11's poor and compromised health/mental health status, cognitive issues, physical decline and need for 24-hour care, the interdisciplinary team (IDT) recognizes that I am considered a vulnerable adult.
- Supervised access to the community (initiated 10/25/23).
- History of substance abuse focus (cocaine, marijuana) (initiated 10/25/23) related to rigid personality traits and ineffective coping and at risk for further episodes of illicit substance abuse as well as adverse side effects/complications that may result from it.
- History of persistent substance use/abuse and resultant medical complications from this harmful behavior. I am now living in a skilled

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facility at a younger age. I have used: marijuana, tobacco, and cocaine (initiated 12/6/23); intervention includes restricted independent pass privileges and requires supervision when accessing the community; there are no noted updates or revisions to R11's care plan after this incident on 5/6/24 until 6/20/24.
- Impaired cognition focus (initiated 12/15/23) documents that R11 has impaired cognition/thought process related to diagnosis of mental illness and traumatic brain injury. Symptoms are manifested by poor temporal orientation & difficulty with recall.

R11 Nurse Progress Note(s) written by V32 Licensed Practical Nurse (LPN) document:

- 5/6/2024 22:03 "Note Text: At around 9PM, resident observed sleeping on wheelchair in front of resident's room, resident was hard to arouse, VS (vital signs) are normal BP (blood pressure): 122/74 P (pulse): 78, o2 (Oxygen Saturation): 95% RA (room air), responded to chest rubs, Narcan (Opiate Antagonist) administered r/t (related to) unknown substance intoxication. Resident responded to stimuli after Narcan administration. Resident stated she is fine. NP (Nurse Practitioner) (V33). Awaiting for response."

- 5/6/2024 22:23 "Note Text: No new orders from (V33 - Nurse Practitioner)."

R11 was interviewed on 6/20/24 at approximately 6:30PM. R11 was asked if she remembered getting Narcan last month and she said that she had no memory of that event. R11 said the administrator told her about it but she didn't believe it ever happened because she had no memory of it. Surveyor asked if she ever

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remember getting a nasal spray (medication) and R11 said no, I don't remember that ever. Surveyor asked R11 if she ever took any illicit substances like opioids or marijuana and R11 denied any drug use and added that she only smokes cigarettes. Surveyor asked if she ever gets cigarettes from people outside and R11 said yes, she does and it's possible that someone put something in her cigarette without her permission. Surveyor asked if she remembered being very sleepy in the hall and hard to arouse. R11 denied any recollection of such event. R11 was asked if she is normally a heavy sleeper and difficult to wake up and she said she is a heavy sleeper but will usually wake up easily if someone tries to wake her up. R11 could not provide any other details or information about the incident on 5/6/24.

On 6/17/24 at 4:44PM V32 (LPN) said, R11 is alert and knows what's going on. She goes down to smoke independently. She can transfer and eat independently and would say that she needs limited assistance. (On 5/6/24) I remember that day, when I came back from break the other nurse working told me that R11 was difficult to arouse. She was in the hallway in her wheelchair. Vitals were within normal limits. I did a chest rub and she said it hurt. She had pinpoint pupils. I asked staff where she had been and they said her usual, outside. I used my judgement and administered Narcan. I gave her one dose and she became more responsive to stimuli ...She looked high that night, but I've never seen that behavior with her. I asked her but she denied taking anything. I was checking on her all through that time. After 40 minutes she was back to herself. She then got annoyed and told me to remove the ice I had put behind her neck. We (other staff and I) stayed in the room for 15

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minutes and then I went back and forth finishing med pass. I waited more than an hour and then I let her be. Her vitals and respiratory rate were fine. I notified the administrator and nurse practitioner, who gave no new orders, but the administrator told me to do the urine screen. The urine screen was not done during my shift because R11 said she didn't have to urinate, so I endorsed it to the next nurse. I don't know if they did the test. I didn't call 911 because she responded ...I don't remember if the nurse practitioner told me to monitor her, but I would do it regardless because she is under my care ...I guess I would monitor for at least an hour. There were no new orders and no restrictions afterwards. What I do now (on my own) is that I watch her when she comes up from smoking. I did get training on administering Narcan. They said only send the resident out if they are unresponsive; give another dose, if they wake up good, if not, then call 911. If they don't respond after two doses, call 911, doctor, administrator, and family. V32 said, I pulled the Narcan from the convenience box. I don't remember if I put it in her chart, but I should have put it in as a one-time order.

Review of staffing for 5/6/24 documented that V23 (RN) was the oncoming nurse, after V32's shift.

6/17/24 at 10:40PM V23 Registered Nurse (RN) said, the (previous) nurse endorsed to me about the incident and she told me what happened with R11; she told me to monitor the resident's vitals. During my shift, the resident had good vitals and she asked me to give her some water. In the morning she asked me for an Ensure. I checked her vitals when I first arrived, then I came back about 30 minutes later and checked her again.

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She was responding. I asked her to press the call light if she needed anything and she agreed. I checked on her around 2am and she told me not to wake her again until the morning. I think it was around 4am when I was back in her room, and she told me she was okay. It's normal for her to fall asleep in the wheelchair and then I usually wake her up to tell her to sleep in her bed. Usually, she is in the morning in the bed. It usually takes her one to two minutes before she wakes up. The evening nurse had endorsed to me to do the drug test, but I was not able to do it during my shift. First, the kit was not in the nursing station or med room, and I didn't know where it was. I think it was somewhere in the office, so we had to wait for someone to arrive, so I just endorsed it to the oncoming morning nurse. I had training during orientation on how to respond to overdose. Procedure is to spray it in the nostril and if they are not responding then we call 911. After you give it, you wait 5-10 minutes and then call 911. I would give another dose while I am waiting for 911. If the person responds, then you monitor them closely. You have to check on them every 30 minutes until they come back to their normal self. If the person responds, then you don't have to send them to the hospital. This was new to me, and she never has this behavior.

6/18/24 at 5:37PM V33 (Nurse Practitioner) said, I don't recall the incident with R11. There's no general protocol; we go based off the nurse's judgement. If they take opioids for chronic pain and there is a change in status, then we would treat giving Narcan to see if that would improve the situation or not. I would have them sent to the hospital for the evaluation but again it depends on the nurse's assessment. Let's say you give the medicine, and the patient improves, then we also based the facility's judgment as well. If it is a

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medical emergency, then we would send to the hospital. I do recommend the rapid drug test if we suspect the patient is using something that they are not supposed too. Surveyor presented information provided from V1 (Administrator), that after administering Narcan, facility staff should do a rapid drug urine screen and send the resident to the hospital if the screen comes back positive but if the test comes back negative, they don't have to transfer resident to the hospital; surveyor then asked V33 if this seemed like a reasonable practice to follow. V33 said, assuming the patient is stable after getting Narcan and improves, I would say that that is reasonable to follow that protocol. I don't recall the nurse contacting me at all for the results. I may have ordered drug test (for R11). I have seen R11 and followed up with her in person after the incident and there should be Progress Notes. There are no specific guidelines that I follow. Monitoring is just nursing 101 for any clinical issue - any acute mental status change. You always monitor after applying treatment. There's nothing specific that I know that the facility does for suspected overdose. I am not aware of any protocol that the facility follows.

6/17/24 at 5:43PM, V36 (RN) was asked about facility protocol for administering and monitoring residents after being administered Narcan for suspected overdose. V36 said, call 911 five minutes after giving one dose, then give a second dose if resident doesn't respond after 15 minutes. Constantly stimulate and assess the resident. If the resident perks up, then reassess, take vitals, call the doctor. If the doctor gives orders to send the resident to the hospital, then we will transfer them. If they do not give orders to transfer to the hospital, then we would just monitor them in the facility for 72 hours; taking vitals once a shift. If the doctor orders it, then we will do a drug test.

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6/18/24 at 4:33PM V14 Director of Nursing (DON) was interviewed about the incident with R11 on 5/6/24. V14 said, when a resident needs Narcan, we administer it, notify the physician, and wait for further orders. We may or may not send them out at the discretion of the provider. I would like to be notified so that we can investigate further as to what happened. It's a case-by-case basis on whether we do the rapid drug test or not, depending on the provider. It's all at the providers discretion. We do monitor as a standard given - for no specific amount of time, just monitor closely and make sure they're at their baseline. I was not the DON at that time, and I am not familiar with the situation. Surveyor asked if there is a written policy or protocol to follow after administering Narcan and V14 said, it's standard practice as a nurse to notify the provider for any change of condition.

6/17/24 at 6:05PM V1 (Administrator) said, there is no specific monitoring (after overdose) because my nurses are not trained for that. They call me and I make the call; I take the decision making out of their hands at that point. If the rapid drug test comes back positive, they're going to the hospital. That's why we have them do the rapid drug test and if it comes back positive, they go out. The nurse did call me (for R11), and I told her to do the drug test. It was done and came back negative, so she didn't get sent out. Surveyor asked when and who completed the rapid drug test since it was not documented and both nurses that worked with R11 immediately after the incident confirmed that they did not conduct the drug test and V1 said, I will find out who did the drug test. Surveyor then asked if the drug test should be part of R11's medical record and V1 said, yes, I suppose the drug test should

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be part of the medical record. I ask R11 all the time to do a drug test for me and she agrees because she hangs out with "the boys;" some guys that live next door and they hang out by the side of the building. I don't know if I assume guilt by association. She always comes back negative.

Reviewed R11's EMR (electronic medical record); there is no documentation that R11 was "closely" monitored after administration of Narcan; there is only one set of vitals documented in progress notes for 5/6/24 (during incident) and respiratory rate is not documented; no other vitals noted to be taken on 5/6/24 or 5/7/24.

Review of R11's MAR (medication administration record) does not show that R11 was administered any opioid type of medication or that R11 was administered Narcan on 5/6/24.

Review of physician orders does not include any orders or results of drug screen for R11.

6/17/24 at 4:27PM V37 (Pharmacist) was asked if they provide the facility with any instructions on monitoring after administration of Narcan and V37 said, We don't include the package insert or anything when we dispense it. The facility will have a specific policy. We only send it if they ask. I can provide the manufacturer insert.

Review of Narcan Nasal Spray Package Insert (manufacturer) includes the following:
- Risk of Cardiovascular (CV) Effects: ...Monitor these patients closely in an appropriate healthcare setting after use of naloxone hydrochloride.
- WARNINGS AND PRECAUTIONS - Risk of Recurrent Respiratory and Central Nervous System Depression, The duration of action of

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most opioids may exceed that of NARCAN Nasal Spray resulting in a return of respiratory and/or central nervous system depression after an initial improvement in symptoms. Therefore, it is necessary to seek emergency medical assistance immediately after administration of the first dose of NARCAN Nasal Spray and to keep the patient under continued surveillance. Administer additional doses of NARCAN Nasal Spray if the patient is not adequately responding or responds and then relapses back into respiratory depression, as necessary [see Dosage and Administration (2.2)]. Additional supportive and/or resuscitative measures may be helpful while awaiting emergency medical assistance.
- Precipitation of Severe Opioid Withdrawal - The use of NARCAN Nasal Spray in patients who are opioid-dependent may precipitate opioid withdrawal characterized by the following signs and symptoms: body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure ...Abrupt postoperative reversal of opioid depression after using naloxone hydrochloride may result in nausea, vomiting, sweating, tremulousness, tachycardia, hypotension, hypertension, seizures, ventricular tachycardia and fibrillation, pulmonary edema, and cardiac arrest.
- Administration Instructions ... Monitor patients and re-administer NARCAN Nasal Spray using a new NARCAN Nasal Spray every 2 to 3 minutes, if the patient is not responding or responds and then relapses back into respiratory depression ...

Surveyor asked facility administration for written policy to address overdose several times

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 06/23/2024

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
S9999	Continued From page 13	S9999		

throughout the course of this survey, and none was provided. Surveyor was provided with Narcan Instructions for Use (manufacturer) and with Physician-Family Notification-Change in Condition Policy; neither of which specified a protocol for the treatment/monitoring of overdose.

On 6/20/24 at 2:45PM surveyor was provided facility Substance Use Disorder Guidelines (Reviewed: 10/25/23) - it is to be noted that review of policy did not include specific written policy to address overdose. This concern was shared with facility administration at this time.

SAMHSA Opioid Overdose Prevention Toolkit - Five Essential Steps for First Responders document includes: Step 5: Monitor The Person's Response ... All people should be monitored for recurrence of signs and symptoms of opioid toxicity for at least 4 hours from the last dose of naloxone or discontinuation of the naloxone infusion. People who have overdosed on long-acting opioids should have more prolonged monitoring. [2,5,6]
Most people respond by returning to spontaneous breathing. The response generally occurs within 2 to 3 minutes of naloxone administration. (Continue resuscitation while waiting for the naloxone to take effect.) [2,5]
Because naloxone has a relatively short duration of effect, overdose symptoms may return. [2,5,6] Therefore, it is essential to get the person to an emergency department or other source of medical care as quickly as possible, even if the person revives after the initial dose of naloxone and seems to feel better.

(B)