STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510218	A. BUILDING: _____ B. WING _____	C 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON SQUARE LC LOMBARD, LLC	555 FOXWORTH BLVD LOMBARD, IL 60148

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A 000	Initial Comment Entity Reported Incident Investigation IL184971- Substantiated, no deficiency cited IL183665- Substantiated, 295.5000, 295.6000 cited.	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 2 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 2) Storing and controlling medication; 5) Recording of medication assistance provided to residents and maintenance of medication records. h) Any medication stored by the establishment shall meet the following requirements: 1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents; These requirements are not met as evidenced by:	A5000		

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A5000	Continued From page 1 Based on observation, interview and record review the establishment failed to follow their policy and procedure on controlled medication. This deficient practice affected four (R16, R17, R18, R19) of four residents reviewed for controlled substance. Findings include: On 2/4/25 at 12:01pm, R16's narcotic lock box was stored inside R16's apartment's refrigerator. The lock box contained a bottle of Morphine containing 29.75 milliliter(ml). On 2/4/25 at 12:12pm, R18's narcotic lock box was stored in R18's apartment's refrigerator. The lock box contained Morphine 20mg (milligram)/ml bottle. On 2/4/25 at 12:19pm, R19's narcotic lock box was stored in R19's apartment's refrigerator. The lock box contained 2 bottles of Morphine. The narcotic lock boxes of these residents were locked. Each lock box can be opened using a code. They were stored in the resident's refrigerator located in the resident's apartment. The refrigerator had no lock. There was no issue with the narcotic count according to the narcotic sheet. Although the lockboxes were secured, it was small enough to fit in a regular size tote bag. The resident's refrigerator was not locked, it can be opened by anyone who has access to the apartment including housekeepers, and visitors etc. According to establishment's document titled "Incident Investigation", on 12/31/24 R16's hospice comfort kit containing Morphine and Lorazepam bottles were missing significant	A5000		

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A5000	Continued From page 2	A5000		

amount. As part of the investigation, R17's comfort kit was also inspected, R17's Morphine bottle although sealed was empty. There was a miniscule hole in the seal of the bottle, it was presumed that the medication was emptied though the hole. There was no evidence of medication spillage. R17's Morphine narcotic sheet was missing. This incident was reported to the police.

On 2/4/25 at 12:07pm, R17's lock box was in the nursing station. It was locked and contained Lorazepam 30 ml bottle.

According to R16's document titled, "Individual Controlled Substance Record", R16 was missing 28.75 ml of Morphine Sulfate (20mg/ml). The last administered dose of this medication was on 6/17/23. R16 was also missing Lorazepam 19.25ml of Lorazepam concentrate 2mg/ml. The last dose was administered on 3/18/24. These missing medications were discovered on 12/31/24.

On 2/4/25 at 11:29am, E3 (Director of Assisted Living and Memory Care) said R17 was missing 30 ml of Morphine (20mg/ml). E3 said some of resident's comfort kit, which contained the narcotics are stored in resident's refrigerator located in the resident's apartment. When asked why, E3 said it is for home like environment.

On 2/4/25 at 12:58pm, E4 (Nurse) said the shift to shift count for narcotics are done for the narcotics in the medication cart. The narcotics in the resident's comfort kit are only counted by Hospice nurse. The Hospice nurse, however, do not count the medications every time they visit.

The lack of incoming and outgoing (shift to shift)

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A5000	Continued From page 3 count of the narcotic medications led to the delayed discovery of the missing controlled substance. Establishment's Policy and Procedure titled 1.4 Controlled medications in ALZ/AL with revision date of 5/17 stated in part; Policy: The licensed healthcare professional and the consultant pharmacist shall insure that controlled medications (schedule II, III, IV, and V) are ordered, received, stored and administered in a manner that reduces the potential for substance abuse, protects the health and wellbeing of residents, and maintains compliance with federal and state laws and regulations. Storage 1.6.4 Schedule II though IV controlled medications shall be stored in a locked medication cart, a lock box inside a locked medication cabinet, or a locked medication refrigerator within a locked medication room. Administering Controlled Medications 1.6.8 The licensed health professional administering controlled medications verifies the count on the declining inventory record provided by the pharmacy ... COMMONLY PRESCRIBED CONTROLLED MEDICATIONS SCHEDULE II: Morphine .... SCHEDULE IV Lorazepam	A5000		

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A6000	Continued From page 4	A6000		
A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
Type 2 Violation
Section 295.6000 Resident Rights

a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights
13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor.

This requirement is not met as evidenced by:

Based on observation, interview and record review the establishment failed to prevent controlled medications paid for by residents from misappropriation. This deficient practice affected two (R16, R17) residents reviewed for resident rights.

Findings include:

According to establishment's document titled "Incident Investigation", on 12/31/24, R16's hospice comfort kit containing Morphine and Lorazepam bottles were missing significant amount. As part of the investigation, R17's comfort kit was also inspected, R17's Morphine bottle although sealed was empty. There was a miniscule hole in the seal of the bottle, it was presumed that the medication was emptied through the hole. R17's Morphine narcotic sheet was also missing. There was no evidence of

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A6000	Continued From page 5	A6000		

medication spillage. This incident was reported to the police, and an investigation was completed. As of 2/4/25 onsite visit, the establishment cannot identify who took the medications.

According to R16's document titled, "Individual Controlled Substance Record", R16 was missing 28.75 ml of Morphine Sulfate (20mg/ml). The last administered dose of this medication was on 6/17/23. R16 was also missing 19.25ml of Lorazepam concentrate 2mg/ml. The last dose was administered on 3/18/24. These missing medications were discovered on 12/31/24.

On 2/4/25 at 12:01pm, R16's narcotic lock box was stored inside R16's apartment's refrigerator. There was a bottle of Morphine containing 29.75 milliliter(ml). Although the lockbox was secured, the refrigerator containing it was not locked.

On 2/4/25 at 11:29am, E3 (Director of Assisted Living and Memory Care) said R17 was missing 30 ml of Morphine (20mg/ml). E3 said some of resident's comfort kit, which contained the narcotics are stored in resident's refrigerator located in the resident's apartment. When asked why, E3 said it is for home like environment.

On 2/4/25 at 12:58pm, E4 (Nurse) said on the day of discovery R16 was in pain and needed Morphine for pain. When she went to R16 comfort kit the medication was empty. E4 said she had to give R16 Tylenol to relieve the pain. Usually, Morphine would give faster relief while Tylenol takes 2 hours for full relief. E4 said, R16 would not eat when in pain. E4 also said the shift to shift count are done for the narcotics in the medication cart. The narcotics in the resident's comfort kit are only counted by Hospice nurse. The Hospice nurse, however, do not count the

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A6000	Continued From page 6 medications every time they visit. Establishment's Policy and Procedure titled 1.4 Controlled medications in ALZ/AL with revision dated of 5/17 stated in part; Storage 1.6.4 Schedule II though IV controlled medications shall be stored in a locked medication cart, a lock box inside a locked medication cabinet, or a locked medication refrigerator within a locked medication room. The establishment is not following their policy and procedure for storing controlled medication. The establishment also was not completing a shift to shift count of all controlled substances to ensure each medication is accounted for in the beginning and end of shift.	A6000		