STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41758 Based on observation, interview, and record review the facility failed to follow their incontinence care policy for one resident who was identified as dependent on staff for assistance with toileting. This failure resulted in R3 being cold, wet, and uncomfortable in urine. This affected one of three residents reviewed for incontinence care. Findings Include: R3 has the diagnosis of vascular dementia, hemiplegia and hemiparesis following cerebral infarction affection left dominant side. Brief interview for mental status dated 4/5/24 documents a score of fifteen which indicate cognitively intact. Section GG (functional abilities) documents: R3 was dependent for toileting hygiene (helper does all the effort) resident does none of the effort to complete activity. R3's care plan dated 3/17/22 documents: he has bowel and bladder incontinence. Check and change per facility protocol and assist with toileting as needed. On 6/7/24 at 9:59am, R3 who was assessed to be alert and orient to person, place and time said, the last time he was provided incontinence care was on the night shift. R3 said, he has not been provided any care for the day shift. R3 said, he was wet, and the adult brief was cold and uncomfortable on his genitals. On 6/7/24 at 10:01am, V26 (Certified Nursing Assistant) said, she has not provided any care for R3. V26 said, she usually changes R3 after breakfast, but she hasn't gotten to R3 yet. R3 has a history of refusing. R3 did not refused care today. R3 normally will tell staff when he wants to be changed. On 6/11/24 at 1:52pm, V2 (Director of Nursing) said, incontinence care should be provided every two to three hours. Point of care bowel and bladder documentation dated 6/7/24 documents: Care was provided at 02:47 (2:47AM). Incontinence care policy dated 11/28/12 documents: To prevent excoriation and skin breakdown, discomfort and maintain dignity.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow physician orders by not drawing weekly Keppra levels and failed to follow pharmacy recommendations for administrating Keppra tablets by crushing the tablets for one (R6) of three residents reviewed for medications and physician orders. Findings include: R6 was admitted to the facility on [DATE] with a diagnosis of seizures. R6's laboratory result for Keppra was documented on 4/19/24 with a level of 4.67. A level of 4.6 is considered nontherapeutic. Reference range is 10-40. Review of R6's medical record does not document any other Keppra levels. On 6/11/24 at 11:06AM, V42 (Medical Doctor) said R6's seizure medication (Keppra) levels are being monitored weekly. I would expect them to be done weekly as ordered to ensure the level is therapeutic. If the result is subtherapeutic, we would increase the dose and recheck the level to ensure it is therapeutic because she is at risk for seizures and an abnormal low result may result in seizures. V42 said she saw R6 a few days ago and saw the order for Keppra level weekly. V42 was asked if she reviewed the results of those labs and said she believed they were not available. V42 was asked if Keppra was ok to be crushed if pharmacy recommends not to crush. V42 said she would follow the pharmacy recommendation and unsure if crushing the medication would affect the medication or absorption of medication. V42 said R6 has not had any recent seizures. R6's physician order sheet dated 3/22/22 documents active order: weekly Keppra level every Wednesday. R6's Keppra medication card with a delivery date of 5/18/24 documents: Give 1500mg by mouth every 12 hours related to seizures. Do not crush. May cause drowsiness or dizziness. Avoid. On 6/11/24 at 2:28PM, V12 (Nurse) was R6's assigned nurse that shift said she administered R6's medication that morning. V12 said she crushed all R6's medication and gave it applesauce. R6 has liquid Ativan and R6 can swallow that medication. On 6/12/24 at 11:30AM, V33 (Nurse) was R6's assigned nurse that shift said she administered R6's medication that morning. V33 said she crushed all R6's medication that morning. On 6/12/24 at 10: 02AM, V30 (Pharmacist) said R6's seizure medication is recommended not to be crushed. V30 said it does not specify rationale, but it will usually affect the absorption of the medication. The medication may be released all at once and not work properly. The medication may lose its potency prior to being absorbed if crushed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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 0689 Level of Harm - Actual harm Residents Affected - Few	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** 41758 Failures at this level required more than one deficient practice statements. I. Based on interview and record review, the facility failed to monitor and supervise a resident with cognitive impairment, identified as high fall risk with a history of falls and decreased safety awareness. This affected one of three residents (R4) reviewed for falls and supervision. This failure resulted in R4 having two unwitnessed falls which resulted in a small subdural hematoma and a hematoma to right side of forehead. R4's diagnosis includes Vascular Dementia and Altered Mental Status. Brief interview for mental status dated 4/11/24 documents a score of five which indicates severe cognitive impairment. Fall risk assessment dated [DATE] documents: at risk for falls. Care plan dated 2/9/24 documents: R4 had an activity of daily living (ADL) self-care/mobility performance (functional abilities) deficits that may fluctuate with activity throughout the day related to activity intolerance, impaired balance, limited mobility/range of motion, shortness of breath and impaired cognition. Interventions documents: R4 requires substantial/maximal assistance with chair/bed to chair transfer, lying to sitting on side of bed and toilet transfer. Fall occurrence dated 11/16/23 documents: R4 had an unwitnessed fall in resident's room. Upon rounding staff, observed R4 lying on the floor on her right side next to her bed and wheelchair. R4 statement documents: she was trying to get into her wheelchair and her legs got weak, she fell to the floor and hit her head. New injury: hematoma to right side of forehead (bleeding under the skin). On 6/7/24 at 11:03AM, R7 (R4's roommate) who was assessed to be alerted and oriented to person, place, and time, said R4 went to the bathroom without staff assistance and fell . R7 said, she asked R4 to wait for staff but R4 did not. R4 is forgetful. On 6/7/24 at 12:23PM, V5 (Nurse) said, R4 needs assistance with transfers. R4 has episodes of confusion and requires reminders. On 6/7/24 at 12:48PM, V6 (Nurse) said, R4 was able to make her needs known. R4 required one-person physical assist with transfers and ambulation. R4 is forgetful and needs reminders. On 6/7/24 at 1:42PM, V2 (Director of Nursing/DON) said, R4 self-transferred from bed to wheelchair. R4 went to the bathroom. R4 loss her balance. R4 fell on to the floor. R4 required assistance with toileting. R4 will attempt to toilet self. R4 has intermittent confusion. On 6/12/24 at 11:15AM, R4 who was assessed to be alert to name and situation, said she went to the bathroom by herself, fell and hit her head. R4 could not recall what she hit her head on. R4 was apologetic and said, she was sorry she could not remember. R4 said, she forgets a lot. R4 was asked if she could use the call light, R4 replied, no she forgets. R4 said, she can call 911 but doesn't have a phone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/12/24 at 12:55PM, V34 (Director of Rehab) said, R4's cognition is not consistent. R4 can follow step by step instructions when given prompts. R4 requires redirections. R4 was on physical therapy before she fell . R4's care plan initiated on 09/16/2019 documents: At risk for falls and injury related to falls. Risk factors: requires assistance with ADLs, possible medications side effects, urinary incontinence, weakness, impaired cognition, not used to being dependent to staff. Intervention: assess for altered cognition, decline in safety awareness, assist with ADL's. Anticipate and meet the resident's needs, assist with toileting upon awakening, before and after meals, during rounds, before bedtime as needed (PRN), ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Physical therapy evaluation and plan of treatment dated 3/7/2024 documents: R4 readmitted and presents with a continued functional decline in all areas of mobility placing R4 at risk for further decline and a high risk for falls. Precaution: history of falls. Indoor Mobility (ambulation): needed some help. Functional cognition: needed some help, has patient fallen in past year: yes, does patient feel unsteady when walking: yes, does patient worry about falling: yes, reason for therapy: R4 presents with balance deficits, decreased safety awareness, safety awareness deficits, strength impairments and tremors. Assessment summary: follows one -step directions usually with prompts/cues. Diagnosis: lack of coordination and unsteadiness on feet. Nursing note dated 3/30/2024 documents: Called doctor about R4's unwitnessed fall. No new orders. Provide schedules toileting assistance. Call light in reach. Nurse Practitioner note dated 4/1/2024 documents: per nurse on duty. Dementia: alert and orient times 1-2: forgetful. History of fall. Fall/safety precaution: 1:1 transfer assistance. Urge R4 to call for assistance when transferring. Fall IDT (Intra Disciplinary Team) note dated 4/1/24 documents: R4 was transferring from the toilet to the wheelchair, while reaching (for) the wheelchair to sit (down) she slid down, she denies hitting her head. IDT fall committee meeting note dated 4/1/24 documents: root cause-attempting to transfer without assistance. New interventions and/or changes suggested by the IDT at this time: continue to encourage to ask for assistance. Hospital paperwork dated 4/2/2024 documents: R4 was seen for confusion as well as falls. R4 also had a CT of head which showed a small subdural hematoma (pool of blood between the brain and it outermost covering.) Fall prevention program dated 11/28/12 documents: to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate intervention to provide necessary supervision and assistive devices are utilized as necessary. Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and as addressed on the plan of care. 39340 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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 0689 Level of Harm - Actual harm Residents Affected - Few	II. Based on interview and record review, the facility failed to monitor and prevent one resident with a diagnosis of Alzheimer's disease with a history of exit seeking behaviors and wandering from eloping from the facility. This affected one of three residents (R1) reviewed for supervision. This failure resulted in R1 exiting the facility unauthorized and being found outside by emergency services a mile away from the facility in a yard confused with only a t-shirt and shorts in the month of January. Findings Include: R1 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease, type II diabetes, chronic obstructive pulmonary disease, hypertension, heart disease, post-traumatic stress disorder, delirium, delusional disorders, and cocaine use. Resident brief interview for mental status sated 1/19/24 documents a score of 2/15 which indicates severe cognitive impairment. R1's referral paperwork dated 1/15/24 documents: Sitter discontinued 1/10/24. Patient at doorway when approached room today. Easily redirected. Per nurse wandered x1 last night. Patient requires 24/7 supervision for safety precautions. R1's initial elopement risk dated 1/16/24 documents: at risk for elopement and should be placed on the elopement risk protocol. R1's social service progress note dated 1/17/24 documents: social service spoke to Nurse Practitioner while visiting resident. Stated recommends for resident to be in a locked Alzheimer unit due to inability to redirect resident. R1's physician progress notes dated 1/22/24 documents under history: Resident with vascular dementia, post-traumatic stress disorder, delusional disorder, and previous cocaine use. He has been very delusional, confused, and aggressive. He is attempting to elope to meet his girlfriend and engage in previous activities. R1's police report dated 1/29/24 call received at 12:22PM from local citizen for well-being check. Address documented on the police report and where R1 was located is approximately one mile from nursing facility. (According to goggle maps, approximately a 25-minute walk from the facility) Under notes: Male in t-shirt and shorts sitting by garage/seems lost. Cold exposure. Subject transferred to local hospital. R1's ambulance report dated 1/29/24 documents under impression: confusion/delirium; under complaint Patient confused and slow to answer questions; under mental status; Patient is alert but slow at answering questions, patient unable to tell crew address, president, time or what he is doing outside in the cold. Under narrative: dispatched to above location for the male patient who seems confused. On arrival crew found patient standing outside with bystanders at his side. Bystanders stated they found this man wandering their yard and have no clue who he is. Bystanders stated patient looks like he's freezing and unsure how long he has been outside. Crew asked patient what was going on. Patient was alert but slow at answering questions. Patient could not give crew his home address or phone number and had no idea how he got to his location. Patient stated he left his house and just started walking and ended up here. Patient had no complaints besides being cold and just looking to go back home but patient could not tell crew or police his address. Patient had no phone or wallet to call family or get further information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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 0689 Level of Harm - Actual harm Residents Affected - Few	R1's hospital record dated 1/24/24 at 1:05PM documents under chief complainant: Altered mental status. Patient was found outside in a t-shirt and shorts and unable to identify himself. Patient is confused and unable to provide any history. Resident physician spoke with nursing home who reported that they have been looking for patient. Under history: Patient was brought in by emergency medical services when found wondering in someone's yard. Patient eloped today and was unable to be stopped by staff. According to Accuweather (weather application), weather in Oak Lawn on 1/29/24 was a low of 31 degrees and high of 40 degrees. On 6/7/24 at 12:28PM, V6 (Nurse) who was identified as the nurse assigned to R1 on 1/29/24 at time of elopement. V6 said that was her first time working with R1. V6 said she wasn't familiar with R1, and staff reported R1 was combative, but they did not report he was at risk for elopement. V6 said R1 was with her most of morning following her as she did her morning medication pass between [PHONE NUMBER]AM. V6 said she last observed R1 sitting at the nursing station but unable to recall what time that occurred. V6 said she noticed R1 was gone right before lunch. V6 said she asked the staff and walked the facility and was unable to find the resident. V6 said she called the code and staff began looking for R1. V6 said she did recall hearing any alarms at time of incident. On 6/11/24 at 9:24AM, V13 (Social service director) was asked about her documentation on 1/17/24 in relation to R1 needed a locked unit. V13 said the facility is not considered a locked unit but the all the doors have alarms. V13 said they were attempting to find R1 another facility. V13 was asked what interventions were in place for R1 being at risk for elopement. V13 said making sure staff is aware R1 has a bracelet in place to trigger alarm doors upon attempting to exit. V13 was unaware of monitoring or rounding on the resident and said that would be a nursing intervention. V13 was unable to provide any documentation of the monitoring of R1's location, wandering behavior, and attempts diversional interventions in behavior log. On 6/11/24 at 10:41AM, V2 (DON) said R1 was asked about interventions R1 had in place for being on elopement risk prior to elopement. V2 said R1 had a bracelet in place to trigger alarm doors upon attempting to exit. V2 said she was unaware of the interventions (monitoring location every 15/30/60 and documenting wander behavior and identify patterns of wandering) and would not be the responsibility of nursing staff to document that information and unsure who would be responsible. V2 unable to provide any documentation of monitoring location, wandering behavior or patterns of wandering. On 6/11/24 at 11:58am, V25 (Front Desk) said V6 (nurse) called a code pink and reported R1 was missing. V25 said she received a call from local hospital if the facility was missing any residents and gave R1's description which matched and reported he would be returning to the facility. V25 said she did not hear any alarm day of elopement and said there is no system that alerts her when any door alarms. V25 said you cannot hear all the door alarms from each exit door. On 6/11/24 at 9:54AM, V10 (Certified Nursing Assistant/CNA) who was working on 1/29/24, said she did not hear any alarms that day. On 6/11/24 at 1:17pm, V27 (CNA) said staff told her R1 was missing around lunch time. V27 said she does not recall hearing any alarms. V27 said sometimes it's hard to hear the door alarms if you are in a room or another hallway. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/7/24 at 1:19PM, V8 (Maintenance Director) reviewed door check list tool log and said doors are checked daily. V8 was unable to locate the door checklist for the week of January 28th- January 31st. V8 said the northwest door by the oxygen room has a device that alarms when a resident wearing a bracelet is close to the doors attempting to exit. The door also has an alarm that is activated when the door is pushed with a 15 second delay prior to the door opening. The second door that leads outside does not have any alarm. On 6/11/24 5:05PM, V8 said there were no changes to the door after R1's elopement. R1's care plan for elopement documents: R1 deemed to be at risk for elopement as evidence by assessment and reassessment elopement review of risk/wanderer, unable to find what I am seeking, pacing, or roaming repeatedly. Responds poorly to staff redirection, impaired cognition. Risk factors Alzheimer's disease, delusion, on wander guard date initiated 1/23/24 revision 3/8/24. Disguise exits, cover door knobs and tape floor distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; identify patterns of wandering, intervene as appropriate; monitor for fatigue; monitor location every 15/30/60 min (no time was documented) document wandering behavior and attempts diversional interventions in behavior log; wander alert right wrist initiated on 1/23/24 revised 3/8/24. Facility code pink policy reviewed 11/25/18 documents under should an employee discover that a resident is missing from the facility, they should: report missing person to nursing supervisor; review orders to determine if resident out on pass; alert staff by announcing code pink; inform staff the name and picture of resident that is missing if available; make a thorough search of the building and premises; notify administrator and director of nursing immediately if resident not found after search; administrator and director of nursing will evaluate the situation develop a plan of action based on individual resident; the following steps should occur: Nurse should notify the attending physician; notify resident legal guardian; notify the police department; provide search team with resident information; increase search by more extensive search of surrounding area, remain in contact with hospitals; complete incident report and notify the state agency according to reporting guidelines, document appropriate notifications in the medical record. Facility elopement device policy revised 9-13-19 documents: The elopement alert exit door device will be inspected for proper working daily by maintenance and manger on duty.