STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on interview and record review, the facility failed to ensure residents participated in care planning conferences for 3 (R1, R6, R7) out of 3 residents reviewed. Findings Include: R1's clinical records show an original admitted [DATE]. R1's Quarterly MDS assessment, dated 6/30/24, shows R1 is cognitively intact. R1's clinical records lacked documentation of a care conference for R1. On 8/11/24 at 9:13 AM, R1 stated the facility has not conducted any care plan meeting since R1's admission. R1 stated, They have not given me a care plan meeting. I'm leaving at the end of the month and they still have not done any meeting. I told [V1 Administrator], and V1 said that V1 would schedule one, but there is no point anymore since I'm leaving end of the month. R6's clinical records show an original admitted [DATE]. R6's Quarterly MDS assessment, dated 6/6/24, shows R6 is cognitively intact. R6's clinical records lacked documentation of a care conference for R6. At 9:41 AM, R6 stated the facility has not done any care plan conference since R6's admission. R6 stated, I'd like to. They have not informed me of any schedule for a care plan meeting. When I used to live in a different facility, they would do care plan meetings, but not here. R7's clinical records show an original admitted [DATE]. R7's Quarterly MDS assessment, dated 6/25/24, shows R7 is cognitively intact. R7's clinical records lacked documentation of a care conference for R7. At 9:54 AM, R7was asked if the facility has done a care plan meeting with R7. R7 answered, I don't think they ever did a care plan meeting with me. On 8/11/24 at 10:31 AM, V29 (Psychiatric Rehabilitation Services Coordinator/PRSC) stated V10 (Social Service Director/Psychiatric Services Rehabilitation Director) schedules residents' care plan conferences. (continued on next page)

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
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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/11/24 at 11:14 AM, V10 (Social Service Director/Psychiatric Services Rehabilitation Director) stated the interdisciplinary team (IDT) collaborates in scheduling care plan meeting. V10 stated, We do care plan meetings as requested. I am not sure how they schedule care plan meetings here. As far as I know, as requested by the resident. I am not sure if [R1] had a care plan meeting yet. I am not familiar with [R6]. I'm not sure if [R7] received a care plan meeting. V10 stated V10 has not documented anything in R1, R6, and R7's clinical records regarding care plan meeting minutes. On 8/11/24 at 11:44 AM, a phone interview was conducted with V2 (Director of Nursing). V2 stated V2 participates with care plan meetings. V2 gets invited by V10. V2 stated, There are times that families would reach out to me and they would ask for care plan conference to review. There are times that I coordinate the care conference. But that's more when the families reach out to me directly. Our general practice is the care plan coordinator coordinates those. I don't know the specifics. I believe they do the scheduling. Social service will document the minutes of the care conference. V2 stated V2 has not attended any care plan meeting for R1, R6, and R7. On 8/11/24 at 1:11 PM, V19 (MDS Coordinator/Care Plan Coordinator) stated, Care plan meeting scheduling is done by the Social Services. The meeting schedules are based on the MDS ARD [Minimum Data Set Assessment Reference Date]. It depends on the scheduling of the Social Service. For example, if there is an MDS quarterly assessment, they should schedule a care plan meeting. They have to do a care plan meeting when there is an admission MDS assessment, quarterly, or significant change assessment. Care plan meetings are attended by [V2], [V10], therapy if they are in therapy, Dietary, Activities, and one of the MDS Coordinators. If the resident has been here for 6 months, that resident should have had at least 2 care plan meetings. V19 stated V19 has not attended care plan meetings for R1, R6, and R7. V19 stated care plan meeting minutes should be documented in the residents' clinical records. On 8/11/24 at 2:35 PM, a phone interview conducted with V27 (MDS Coordinator/Care Plan Coordinator) and stated V27 sets the MDS in the resident's electronic health record, and from that, V10 assigns a care plan meeting; then V10 notifies the MDS/Care plan coordinators of the care plan meeting schedule. V27 stated, We attend the meeting, and we sign the attendance sheet. I did not attend [R1, R6, or R7's] care plan meetings. They don't ring a bell. The facility's policy titled; Comprehensive Care Plan, dated 11/17/17, reads: A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. The resident and/or resident representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference (if available) at least quarterly. As a best practice, the interdisciplinary team should attempt to schedule an initial meeting with the resident and/or resident representative within 5 days of admission to review the baseline plan of care and make updates or revisions as indicated based on feedback and input of the resident and/or representative prior to the development of the comprehensive care plan.