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	01/27/2025

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 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** 35432 Based on interview and record review, the facility failed to have fall interventions in place to prevent a resident from serious injury. This failure affects one (R1) of three residents reviewed for falls in a total sample of four residents. The failure resulted in R1 sustaining two cervical (neck) fractures and be subjected to excruciating pain while awaiting surgery to fix the injuries. Findings include: R1 is a [AGE] year-old male. R1's diagnoses are, but not limited to: displaced fracture of first cervical vertebra, displaced fracture of second cervical vertebra, anterior displaced dens fracture, Parkinson's disease, dementia, schizoaffective disorder bipolar type, schizophrenia, bipolar disorder, major depressive disorder, anxiety disorder, cognitive communication deficit, and high blood pressure. R1's BIMS (Brief Interview for Mental Status), dated 1/10/2025, notes R1 is alert. R1's care plan notes R1 requires the use of a neck brace due to fracture of the first and second cervical vertebrae. R1 has had a fall due to Parkinson's disease, dementia, abnormal gait and mobility, anxiety disorder, and a history of falls. R1 is at risk for falls. R1 has had an actual fall due to Parkinson's disease, dementia, abnormal gait and mobility, anxiety disorder, and history of falls. R1's care plan goals are not sustaining serious injury through the review date, provide (sticky pad to prevent resident from sliding out from the wheelchair) to the wheelchair, and re-educate R1 to lock the wheelchair before sitting down or when stationary. R1 fall risk assessments, dated 11/22/2024, 12/09/2024, and 12/19/2024, note R1 has had 1-4 falls in the past three months, is chair bound, requires the use of assistive devices, and takes medications such as antiseizure, narcotics, psychotropics and/or sedatives/hypnotics. Facility final report, dated 12/23/2024, notes R1 is alert, able to verbalize his needs, uses a wheelchair as primary locomotion but forgetful, impulsive and needs persistent redirection/education for safety awareness. On 12/19/2024, a loud noise was heard and R1 was observed on the floor. R1 reported he was attempting to pick up something off the floor and he fell forward. R1 had a small skin cut on his forehead. R1 was sent to the hospital and admitted with cervical fracture now pending surgical procedure per hospital nurse. Currently, R1 wears a neck brace around the clock. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nurse's note, dated 12/19/2024, notes, around 12:00 PM, this writer heard a noise coming from (R1's) room. Writer immediately went to (R1's) room; (R1) calling for help. When in the room, the writer observed (R1) lying on his left side facing the room's door, and blood coming from his forehead. A head-to-toe assessment was done. (R1) was observed with laceration about 3 centimeters long and 0.5 centimeters deep. (R1) complained of a headache and a pain level of 8/10, on the pain scale. At 5:22 PM, writer called local hospital emergency department and spoke to hospital staff. (R1) was be admitted with the diagnoses of cervical spine fracture. Fall Occurrence Report, dated 12/19/2024, notes R1 had an un-witnessed fall on 12/19/2024 in his room. R1 was lying on his left side, facing the door, and bleeding from his forehead. R1 stated, While sitting on my wheelchair, I was trying to pick up something from the floor. I lost my balance, fell to the floor, and hit my head on the door. Cervical Spine X-ray, dated 12/20/2024, notes R1 has an acute transverse fracture through the base of the dens type II. Acute type II odontoid fracture with mild posterior displacement of odontoid process. There is a communicated fracture of C1 with fractures involving the anterior arch and the posterior arches bilaterally. IDT (Interdisplinary Team) Note, dated 12/23/2024, notes R1 was asked what he was trying to do prior to fall. R1 stated he was sitting in his wheelchair and tried to pick up something on the floor. R1 lost control of his upper trunk fell face forward. On 1/25/2025, at 9:40 AM, R1 was lying flat in bed. R1 had a C-collar (medical device used to support and immobilize a person's neck). On 1/25/2025, at 9:42 AM, R1 stated, I do not know what happened. I have a lot of pain in my neck. I do not remember if I could walk around. I can get out of bed by myself, but they do not want me to. I can get up and go to the bathroom by myself, but they do not let me. On 1/25/2025, at 9:48 AM, V2 (Certified Nursing Assistant) stated, (R1) is alert and oriented. I must help him go to the bathroom. I always must tell him to push the call light if he needs something. But he is not compliant. He wants to get up and do things by himself, but he cannot. He has always been this way. He cannot walk by himself. I was here when he had the fall. I was with another resident helping them change. I came out of the room. I heard my name. It was a nurse that called me. We went there but there was someone in the room. Everyone came up. It was a fall. It was (V10, Certified Nursing Assistant). He was the first one in the room. When I got there, care was already being rendered. On 1/25/2025, at 9:55 AM, V3 (Licensed Practical Nurse) stated, I was (R1's) nurse the day he fell . I sent him out. I was at the nurse's station. It was almost at the end of my shift. I heard a noise. It sounded like a big thump. I ran with (V11, Nurse). The bathroom door was blocking us from entering. (R1) stated he was alright. He stated he was trying to get something from the closet, and he fell forward out of the wheelchair. It looks like he got up from the wheelchair. He cannot walk by himself, and he is wheelchair bound. He shakes a lot possibly due to his Parkinson's. (V11) called for help. I asked (R1) if he could push backwards so I could get in. I got in the room and assessed him. He was bleeding from the forehead. He was at his baseline. He denied hitting his head. I sent him out because he could have hit his head. He was alert and oriented and just complained of pain from his head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/25/2025, at 1:08 PM, V10 stated, I was the Restorative Aide that day. After I finished my round, I started my charting. I heard one of the nurses yelling. The door was halfway open. I was slim enough to rescue (R1). I opened the door so staff could get in. I saw the resident on his side on the floor. He was bleeding a little. To my knowledge he was not complaining of anything. The wheelchair was close to him, but it was not locked. He can lock and unlock himself. He had shoes on, and his bed was low. He does not always fall. He is cautious. He does a lot of things by himself. He cannot walk by himself. He uses his wheelchair to move around. On 1/26/2025, at 10:12 AM, V12 (Fall Coordinator/Nurse) stated, Before the 12/19/2024 fall, he was a high risk for falls due to his fall risk assessments. The fall on 12/19/2024, resulted in first and the second cervical fractures. The interventions in place before this fall was call light in reach to use when needed, remind him of his center of gravity when reaching for things on the floor, educate to call staff for assistance, dycem to the wheelchair, and re-educate to lock his wheelchair when he is stationary. (Wheelchair pad) is a sticky mat that helps the residents not to slip out of the wheelchair. He is alert enough to understand the education pertaining to locking his wheelchair. I believe he is alert and oriented. The root cause of this fall is he was picking up an item on the floor. He lost his balance and fell forward. The resident was able to verbalize this. The new interventions in place were to provide him with a reacher and grabber. The nurse on the floor told me the (wheelchair pad) was in place. (V3) stated it was in place. I cannot find in my documentation if his wheelchair was locked. If the wheelchair was not locked and he fell forward, this could contribute to his injuries. On 1/26/2025, at 11:30 AM, V3 stated, I saw the wheelchair locked and I saw the (wheelchair pad). It is a pad, and it attaches. Staff put it in the wheelchair. It is used for support for him not to slide. Per his statement he got up to get something and he was far from his call light. On 1/26/2025, at 12:25 PM, V13 (Medical Physician) stated, I am his physician. I was notified of his fall. I was aware of his significant injuries. I think he hit his forehead, and it caused a fracture. A forehead injury can cause a fracture. Review of R1's medical record and fall documents do not note if R1's wheelchair was locked to prevent R1 from falling out of his wheelchair. Facility policy titled Fall Prevention Program, dated 11/21/2017, notes 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 interventions to provide necessary supervision and assistive devices are utilized as necessary. Safety interventions will be implemented for each resident identified at risk.