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	04/24/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49572 Based on interview and record review, the facility failed to accurately complete Fall Assessments for one resident (R1). This failure affects one resident (R1) in a sample of 4 residents reviewed for falls. Findings include: R1's face sheet documents R1 was admitted to the facility on [DATE]. R1's face sheet documents diagnoses that include but are not limited to repeated falls, dementia, schizophrenia, anxiety disorder, and major depressive disorder. R1's care plan, revised date 10/27/22, documents, I (R1) am at risk for falls r/t (related to) convulsion, dementia, anxiety and MDD (major depressive disorder) with interventions that document, in part, Ensure resident wearing non-skid footwear . Frequent rounding to ensure resident is wearing nonskid socks . R1's care plan, date initiated 5/6/23, documents, WANDERING/ELOPEMENT: (R1) has been observed to be disoriented to place, have impaired safety awareness, wander aimlessly throughout the facility, and have a history of attempting to exit the facility without supervision r/t dementia. It has been determined by the outcome of the elopement assessment that the resident is included in the elopement prevention program. R1's care plan, revised date 7/9/24, documents, I (R1) have an ADL (activities of daily living) and functional ability for self-care and mobility performance/deficit r/t (related to) dementia, schizophrenia, anxiety disorder, MDD (major depressive disorder), and convulsion with interventions that document, in part, BED MOBILITY: The resident requires supervision from staff for repositioning and turning in bed . TRANSFER: The resident requires partial assistance from staff to move between surfaces . R1's care plan, revised date 8/25/24, documents, I (R1) require assistance with walking r/t (related to): dementia. R1's Fall Risk Assessment, dated 2/12/25, documents, Not at Risk for Falls . Ambulation/Elimination status chair bound . Gait/Balance N/A - not able to perform function. (continued on next page)

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
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) score of 00, which indicates R1's cognition is severely impaired. Section GG documents, Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space requires partial/moderate assistance. R1's Order Summary Report, order date 4/7/25, documents, Send resident to (Name of Hospital) Hospital for medical evaluation due to unwitnessed fall. R1's Initial FRI (Facility Reported Incident), documents, Date of Occurrence 4/7/25 . On 4/7 /25 at approximately 0545AM, the resident (R1) sustained a fall and was observed with an open area on his left eyebrow. Full body assessment performed. First aid interventions were administered to stop bleeding. He (R1) denied pain. Neurochecks initiated. Sent to (Hospital) ER (emergency room) for further evaluation and treatment per MD (medical doctor) orders. At around 6PM, he (R1) was sent back to the facility with 3 sutures on L (left) eyebrow . On 4/20/25 at 10:45am, R1 was sitting on the side of R1's bed, swaying back and forth, attempting to stand up. R1 was barefoot, with a pair of red nonskid footwear/socks under R1's bed. R1 asked, Can you help me? I'm (R1) trying to get up. R1 was asked about R1's call light that was attached to R1's bottom sheet of R1's bed, and R1 replied, My call light for the nurse is over there (R1 pointed to the towards the door of R1's bedroom). Surveyor pointed to R1's call light that was next to R1, and was attached to R1's bottom sheet of R1's bed, and R1 replied, What's that string for? R1 was oriented only to person. When asked about R1's fall that occurred on 4/7/25, R1 replied, I didn't fall. What do you mean? On 4/22/25 at 10:48am, V2 (Assistant Director of Nursing/ADON) said, Yes, I expect fall assessments to be completed accurately. On 4/22/25 at 1:44 pm, V14 (MDS Coordinator/Licensed Practical Nurse (Prior Restorative Nurse) said, Yes, (R1's) Fall Risk Assessment on 2/12/25 was not accurately completed. On 4/23/25 at 12:43pm, V20 (Director of Nursing/DON) said, Fall assessments should be completed to be correctly. If assessments are not filled out properly we (staff) cannot identify the most appropriate interventions. If we fail to identify the need, it can potentially result to a fall that could have been prevented. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled, Fall Prevention Program, revised date 11/21/17, 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 interventions to provide necessary supervision and assistive devices are utilized as necessary . The Fall Prevention Program includes the following components: . Care plan incorporates: Identification of all risk/issue; Addresses each fall; Interventions are changed with each fall, as appropriate; Preventative measures. Standards: A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines; A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident; Safety interventions will be implemented for each resident identified at risk; The admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained; Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions; The Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations. In addition, Director of Nursing is responsible for informing the Administrator of program analysis. Fall/safety interventions may include but are not limited to: Direct care staff will be oriented and trained in the Fall Prevention Program; Footwear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid. Facility policy titled, Resident Rights, reviewed 1/4/19, documents, To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability . Facility presented pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life . Your facility must provide equal access to quality care regardless of diagnosis . You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually . Your facility must be safe, clean, comfortable, and homelike . You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices . You should receive the services and/or items included in the plan of care . Facility job description titled, Director of Nursing, documents, The primary purpose of the Director of Nursing position is to plan, organize, develop and direct the overall operation of our Nursing Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49572 Based on observation, interview, and record review, the facility failed to implement a resident's (R1) care plan, who was assessed at risk for fall and has a history of falls. This affects 1 resident (R1) out of 4 residents reviewed for care plans. Findings include: R1's face sheet documents R1 was admitted to the facility on [DATE]. R1's face sheet documents diagnoses that include but are not limited to repeated falls, dementia, schizophrenia, anxiety disorder, and major depressive disorder. R1's care plan, revised date 10/27/22, documents, I (R1) am at risk for falls r/t (related to) convulsion, dementia, anxiety and MDD (major depressive disorder) with interventions that document, in part, Ensure resident wearing non-skid footwear . Frequent rounding to ensure resident is wearing nonskid socks . R1's care plan, date initiated 5/6/23, documents, WANDERING/ELOPEMENT: (R1) has been observed to be disoriented to place, have impaired safety awareness, wander aimlessly throughout the facility, and have a history of attempting to exit the facility without supervision r/t dementia. It has been determined by the outcome of the elopement assessment that the resident is included in the elopement prevention program. R1's care plan, revised date 7/9/24, documents, I (R1) have an ADL (activities of daily living) and functional ability for self-care and mobility performance/deficit r/t (related to) dementia, schizophrenia, anxiety disorder, MDD (major depressive disorder), and convulsion with interventions that document, in part, BED MOBILITY: The resident requires supervision from staff for repositioning and turning in bed . TRANSFER: The resident requires partial assistance from staff to move between surfaces . R1's care plan, revised date 8/25/24, documents, I (R1) require assistance with walking r/t (related to): dementia. R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) score of 00, which indicates R1's cognition is severely impaired. R1's Minimum Data Set (MDS) section GG, dated 2/06/25, documents R1 requires partial/moderate assistance for sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed; partial/moderate assistance chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair); and partial/moderate assistance for ambulating 10 feet. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's FALL- INITIAL OCCURRENCE NOTE, dated 10/29/24, documents, . Unwitnessed Fall . This writer was at the Nurses station charting when a sound of something falling was heard. Room was checked with CNA (certified nursing assistant) and observed resident kneeling down trying to get back up. This writer asked resident to remain seated to be assessed, resident was non-compliant and got back up by himself. R1's FALL- INITIAL OCCURRENCE NOTE, dated 11/11/24, documents, . Witnessed Fall . reported that resident stood up from the chair and lost balance and fell on his buttocks without hitting his head. R1's FALL- INITIAL OCCURRENCE NOTE, dated 4/7/25, documents, . Unwitnessed Fall . Resident walked out of his room with blood noted on the left eyebrow . Unable to give statement due to been delirious. On 4/20/25 at 10:45am, R1 was sitting on the side of R1's bed, swaying back and forth, appearing as if R1 was attempting to stand up. R1 was barefoot, with a pair of red nonskid footwear/socks under R1's bed. R1 asked, Can you help me? I'm trying to get up. Surveyor inquired about R1's call light that was attached to R1's bottom sheet of R1's bed, and R1 replied, My call light for the nurse is over there (R1 pointed to the towards the door of R1's bedroom). Surveyor pointed to R1's call light that was next to R1, and was attached to R1's bottom sheet of R1's bed, and R1 replied, What's that string for? R1 was oriented only to person. When asked about R1's fall that occurred on 4/7/25, R1 replied, I didn't fall. What do you mean? On 4/21/25 at 10:51am, V6 (Licensed Practical Nurse/LPN) said, (R1) is a fall risk. When asked if the pair of red non-skid socks under R1's bed should be on R1, V6 replied, Yeah. They (nonskid socks) are to prevent falls, but he kicks them off. When asked if there is staff at the nurse's station at all times monitoring R1, V6 replied, Well . not all the time, but most of the time. On 4/22/25 at 9:51am, V7 (Registered Nurse/RN) said, (R1) can walk. He goes to the bathroom by himself sometimes. He's a dementia resident. Gait is not steady. That's why they put a diaper on him, so he won't get up. Bed is always lower, lowest setting. Yes, he is supposed to have nonskid socks on. I'm not sure if he had his skid socks on. The nonskid socks help if resident gets up, if there was water on the floor, they are not gonna (sic) fall. I'm not sure if he had his nonskid socks on cause (sic) he was in bed with cover on during my shift. On 4/22/25 at 10:31am, V10 (Licensed Practical Nurse/LPN) said, Since I've been here, he walks but with an unsteady gait, and kinda (sic) zig zags when he walks . Most times. He can walk on his own. His bed is always in lowest position, call light by side, rounds every 2 hours, and (R1's) room is opposite nurse's station so eyes are always on him . He should have nonskid footwear all the time because he is impulsive, and he has some shoes too. On 4/22/25 at 10:48am, V2 (Assistant Director of Nursing/ADON) said, Yes, in a general I'm familiar with (R1). Since I've been here, he's ambulated with some assistance from staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 1:44 pm, V14 (MDS Coordinator/Licensed Practical Nurse (Prior Restorative Nurse) said, Yes, I know (R1). He is ambulatory, but there were days when we had to sit him in the wheelchair. He would refuse to get up and walk. He has dementia. When he is ambulatory, would walk on his own. His gait is not steady. I mean he would be wobbly sometimes when walking, sit in his wheelchair sometimes, and other days he would be walking on his own fine. We weren't encouraging him to walk on his own but were kinda (sic) redirecting him. Interventions in place to prevent from falling was nonskid socks, but I'm not familiar with other interventions. For his 10/29 (10/29/24) fall, we (facility) had frequent rounding and staff encouraged (R1) to have nonskid socks on. On 4/23/25 at 10:42am, V9 (Licensed Practical Nurse/LPN) said, Yes, he's my patient. A little bit about (R1) is that he walks around with redirection and with no assistance, other than cuing and observing with constant monitoring. (R1's) gait is unsteady. His room is across the nurse's station because he is a fall risk patient. We (staff) check him every 15 minutes throw a side-eye and look at him from the nurse's station. He always has non-skid socks on. He sleeps with them (non-skid socks). (R1) always has to have them (non-skid socks) on even when sleeping. (R1) will not wear shoes. On 4/23/25 at 12:43pm, V20 (Director of Nursing/DON) said, Yes, staff should implement interventions in care plan. Supervise him when walking. Complicated residents like him like the inability to call for help, his impulsiveness. They (residents) have the tendency to fall again. Staff is aware of increase supervision. Staff knows. There are certain residents that need increased supervision. Very impulsive. Doesn't call for staff. It's part of the supervision issue. Already in place. We (facility) cannot do 1:1. Staffing, we have enough for supervision. Facility policy titled, Comprehensive Care Plan, revised date 11/17/17, documents, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled, Fall Prevention Program, revised date 11/21/17, 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 interventions to provide necessary supervision and assistive devices are utilized as necessary . The Fall Prevention Program includes the following components: . Care plan incorporates: Identification of all risk/issue; Addresses each fall; Interventions are changed with each fall, as appropriate; Preventative measures. Standards: A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines; A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident; Safety interventions will be implemented for each resident identified at risk; The admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained; Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions; The Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations. In addition, Director of Nursing is responsible for informing the Administrator of program analysis. Fall/safety interventions may include but are not limited to: Direct care staff will be oriented and trained in the Fall Prevention Program; Footwear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid. Facility policy titled, Resident Rights, reviewed 1/4/19, documents, To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability . Facility presented pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life . Your facility must provide equal access to quality care regardless of diagnosis . You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually . Your facility must be safe, clean, comfortable, and homelike . You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices . You should receive the services and/or items included in the plan of care .

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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** 49572 Based on interview and record review, the facility failed to have one (R1) resident assessed by Physical Therapy in a timely manner. This affects 1 resident (R1) out of 4 residents reviewed for quality of care. Findings include: R1's face sheet documents R1 was admitted to the facility on [DATE]. R1's face sheet documents diagnoses that include but are not limited to repeated falls, dementia, schizophrenia, anxiety disorder, and major depressive disorder. R1's care plan, revised date 10/27/22, documents, I (R1) am at risk for falls r/t (related to) convulsion, dementia, anxiety and MDD (major depressive disorder) with interventions that document, in part, Ensure resident wearing non-skid footwear . Frequent rounding to ensure resident is wearing nonskid socks . R1's care plan, date initiated 5/6/23, documents, WANDERING/ELOPEMENT: (R1) has been observed to be disoriented to place, have impaired safety awareness, wander aimlessly throughout the facility, and have a history of attempting to exit the facility without supervision r/t dementia. It has been determined by the outcome of the elopement assessment that the resident is included in the elopement prevention program. R1's care plan, revised date 7/9/24, documents, I (R1) have an ADL (activities of daily living) and functional ability for self-care and mobility performance/deficit r/t (related to) dementia, schizophrenia, anxiety disorder, MDD (major depressive disorder), and convulsion with interventions that document, in part, BED MOBILITY: The resident requires supervision from staff for repositioning and turning in bed . TRANSFER: The resident requires partial assistance from staff to move between surfaces . R1's care plan, revised date 8/25/24, documents, I (R1) require assistance with walking r/t (related to): dementia. R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) score of 00, which indicates R1's cognition is severely impaired. R1's FALL- INITIAL OCCURRENCE NOTE, dated 10/29/24, documents, . Unwitnessed Fall . This writer was at the Nurses station charting when a sound of something falling was heard. Room was checked with CNA (certified nursing assistant) and observed resident kneeling down trying to get back up. This writer asked resident to remain seated to be assessed, resident was non-compliant and got back up by himself. R1's FALL- INITIAL OCCURRENCE NOTE, dated 11/11/24, documents, . Witnessed Fall . reported that resident stood up from the chair and lost balance and fell on his buttocks without hitting his head. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's FALL- INITIAL OCCURRENCE NOTE, dated 4/7/25, documents, . Unwitnessed Fall . Resident walked out of his room with blood noted on the left eyebrow . Unable to give statement due to been delirious. R1's IDT (Interdisciplinary Team) FALL COMMITTEE MEETING NOTE, dated 4/8/25, documents, PT (Physical Therapy) eval (evaluation) for assistive device. R1's Order Summary Report, ordered date 4/11/25, documents, Refer for PT (Physical Therapy) evaluation and treatment for gait imbalance and use of assistive device. R1's PT (Physical therapy & (and) Plan of Treatment, dated 4/17/25, documents R1 was assessed by Physical Therapy for an assistive device on 4/17/25. Physical therapy did not assess R1 until 10 days after R1's fall; Physical Therapy did not assess R1 until 9 days after IDT's recommendation; and Physical Therapy did not assess R1 until 6 days after the physical therapy order was placed. On 4/20/25 at 10:45am, R1 was sitting on the side of R1's bed, swaying back and forth, appearing as if R1 was attempting to stand up. R1 was barefoot, with a pair of red nonskid footwear/socks under R1's bed. R1 asked, Can you help me? I'm trying to get up. Surveyor inquired about R1's call light that was attached to R1's bottom sheet of R1's bed, and R1 replied, My call light for the nurse is over there (R1 pointed to the towards the door of R1's bedroom). Surveyor pointed to R1's call light that was next to R1, and was attached to R1's bottom sheet of R1's bed, and R1 replied, What's that string for? R1 was oriented only to person. When asked about R1's fall that occurred on 4/7/25, R1 replied, I didn't fall. What do you mean? On 4/23/25 at 11:50 am, V17 (Physical Therapy Director) said, Yes, we (Physical Therapy) evaluated him last week for Physical Therapy. Physical Therapy should complete evaluations ASAP (as soon as possible) so the resident can be seen. I was verbally told on 4/15 (415/25) or 4/16 (4/16/25) for the fall on 4/7. They (staff) notify by paper, verbal, or e-mail. It was the DON (Director of Nursing) that notified me of the 4/7 fall, but a lot of people can notify us. I mean if he had that fall then, yes he should have been seen earlier. On 4/23/25 at 12:43pm, V20 (Director of Nursing/DON) said, Notification of Physical Therapy is done when we (staff) have morning meetings. Physical Therapy should be notified ASAP (as soon as possible) when they are needed. We review the 24 hour report and then we notify PT verbally or through e-amil. Any supervisor/nurse manager can send out the notification when they (physical therapy/nurse manager) see the referral order from the staff. Sometimes when we do the IDT (interdisciplinary) meetings, fall referrals for therapy are discussed and we notify them. As soon as we get the referral we notify them. If there was a 10 day gap, that wouldn't be a timely manner. Special circumstances may cause a delay. Delay can be the result not getting the order immediately. Maybe there was an oversight. (continued on next page)

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Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled, Fall Prevention Program, revised date 11/21/17, 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 interventions to provide necessary supervision and assistive devices are utilized as necessary . The Fall Prevention Program includes the following components: . Care plan incorporates: Identification of all risk/issue; Addresses each fall; Interventions are changed with each fall, as appropriate; Preventative measures. Standards: A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines; A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident; Safety interventions will be implemented for each resident identified at risk; The admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained; Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions; The Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations. In addition, Director of Nursing is responsible for informing the Administrator of program analysis. Fall/safety interventions may include but are not limited to: Direct care staff will be oriented and trained in the Fall Prevention Program; Footwear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid. Facility policy titled, Resident Rights, reviewed 1/4/19, documents, To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability . Facility presented pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life . Your facility must provide equal access to quality care regardless of diagnosis . You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually . Your facility must be safe, clean, comfortable, and homelike . You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices . You should receive the services and/or items included in the plan of care . Facility presented document titled, Job Title: Physical Therapist, dated 2/2024, documents, Responsible for overall supervision of department, oversees daily operations and therapist performance. Ensure all discipline programs are running smoothly . Ensure proper utilization to meet patient needs . Ensure all policies and procedures are being implemented, followed and staff are compliant with company policies . Ensure all MD orders, signatures and certifications are compliant . Ensure claims on review are submitted accurately and timely. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility job description titled Director of Nursing, documents, The primary purpose of the Director of Nursing position is to plan, organize, develop and direct the overall operation of our Nursing Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 51772 Based on observation, interview, and record review, the facility failed to prevent the development of pressure ulcers; failed to ensure a resident's wound dressing is intact as ordered by the physician; and failed to complete skin assessments accurately. This failure caused 1 resident (R2) to develop a 25x10 cm unstageable pressure ulcer to the sacrum and sustain severe pain (7/10). This failure affects 1 resident (R2) in a sample of 4 residents reviewed for pressure ulcers. Findings Include: R2's Face sheet, dated 4/21/2025, documents a diagnosis of but is not limited to Failure to thrive, Dysphagia, Major Depressive Disorder. Review of R2's Weekly Skin Assessments documents, on 3/12/2025 R2's skin was intact with no concerns. On 3/19/25, documents an unstageable pressure ulcer to R2's coccyx. On 3/24/2025, R2's skin was assessed and documented skin was intact with no concerns (incongruent with current unhealed pressure ulcer). No weekly skin observation was completed in R2's electronic health record since 3/24/25. Record review of document titled, Facility Acquired Worsening Wound Investigation Report, dated 3/19/24, documents R2 had predisposing risk factors including hypertension, anemia, poor appetite, bowel incontinence, and urinary incontinence. 27 other risk factors were not noted, including malnutrition. At the time the wound was developed turning and repositioning, and preventative skin products were in place. 11 other potential interventions were not noted. The document also indicates the wound was unavoidable based on: Resident advanced disease process, but also unavoidable due to, goals of care review, review of clinical record, collaboration with PCP, visual examination of the wound, discussion with wound care nurse R2's physician orders document an active order (4/10/2025) for Wound: Coccyx: cleanse with Dakin's, apply silver calcium alginate cover with foam dressing daily every shift for wound care. R2's wound summary (4/21/25) documents an unstageable pressure ulcer was first assessed on R2's coccyx on 3/17/2025 with dimensions of 25 cm x 10 cm, and was last assessed on 4/17/2025 as unstageable. On 4/21/2025 at 11:14 am, R2 stated R2 has a pressure ulcer to R2's bottom (sacrum). R2 explained the pressure ulcer was caused, from my diaper. R2 affirmed the pain from the pressure ulcer is about 7/10. On 4/21/2025 at 11:28am, V18 (Wound Care Nurse, Licensed Practical nurse) stated V18 was unsure when R2's sacral pressure ulcer was discovered. V18 stated when the ulcer was discovered, the pressure ulcer was unstageable. On 4/21/2025 at 11:36 am, R2's sacral wound was observed and appeared open, reddened, with wound edges intact. No dressing was noted covering the wound. V18 affirmed there should be a dressing on R2's pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/21/2025 at 12:45pm, R2's sacrum was observed, and no dressing was noted on the wound. V18 stated the purpose of dressing changes is to help heal the wound and for infection control measures. V18 stated when staff notice the dressing is not present on a wound, the staff member should notify the nurse or wound care nurse to reapply the dressing. On 4/22/25 at 11:10 am, V11 (Wound Care Coordinator) stated V11 was notified R2 had a wound to her coccyx on 3/17/2025 that measured 25x10 cm. V11 stated R2's wound to the coccyx was unstageable due to slough being present when the wound was first assessed. V11 stated the nurses do conduct skin checks weekly. V11 affirmed V11 was assessed on 3/12/24 with skin intact. V11 stated V13 (Nurse Practitioner) was notified of the wound and V13 was involved in determining that the pressure ulcer is unavoidable. On 4/22/2025 at 12:21 pm, V13 (Nurse Practitioner) affirmed V13 is the primary care provider for R2. V13 affirmed pressure ulcers are usually preventable, and caused by prolonged pressure to bony areas. V13 explained R2's pressure ulcer was caused by poor oral intake. V13 recalled R2 used to be up walking around the facility, then had a change in condition and became weaker, developing malnutrition. V13 stated R2's pressure ulcer couldn't have developed in a week. On 4/23/25 at 10:53 am, V9 (Licensed Practical Nurse) stated V9 is familiar with R2. V9 recalled assessing R2's skin on 3/12/2025 while R2 was receiving continent care, and affirmed R2's skin was intact. V9 stated the wound was later discovered over the weekend, and V9 was not sure which nurse discovered the wound. V9 stated pressure ulcers can be caused by incontinence, poor hydration/nutrition, friction/sheering, incontinence and prolonged pressure to an area. V9 affirmed R2 was incontinent, had poor nutrition, and was bedbound because whenever we (staff) put (R2) in the wheelchair, she would slide down. V9 stated the facility expectation is that resident's skin is assessed weekly by the nurse. V9 stated V9 was unsure why no weekly skin observation was completed for R2 since 3/24/25. V9 stated V9 has not been assigned to care for R2 since before 3/24/25. On 4/23/2025 at 12:50 pm, V20 (Director of Nursing) stated the expectation is that a weekly skin assessment is completed on every resident weekly by the nurses. V20 stated, I don't know why the last weekly skin assessment was completed on 3/24/2025. Every shift the CNA (Certified Nursing Assistant) is to report any skin changes to the nurse or the wound care nurse. This wound didn't develop in one shift, but probably over 24 hours. V20 verified the weekly skin Assessment completed on 3/24/25 that the skin is intact. V20 affirmed the weekly skin assessment on 3/24/25 is incorrect, and should document a coccyx wound with a description of the wound. V20 stated pressure ulcers are caused by pressure to bony prominences. V20 stated, It is possible an unstageable pressure ulcer measuring at 25x10 cm, if we consider other things. V20 affirmed the form titled Facility Acquired/Worsening Wound Investigation Report that the form doesn't quite make sense, and needs to be revised. Part of this form needs to be reviewed more. V20 affirmed malnutrition is not checked on the unavoidable wound care assessment. V20 affirmed every nurse should be able to apply a temporary dressing if the dressing is removed during continent care. On 4/23/24 at 2:03 PM, V21 (Wound Care Physician) affirmed V21 is the Wound Care physician for R2. V21 believed R2's wound was primarily caused by malnutrition, incontinence, and immobility. V21stated a resident could have developed an unstageable pressure ulcer in an 8-hour shift if the resident was lying on a hard surface without proper pressure relief, like a deflated mattress. It only takes a few hours for damage to occur in vulnerable areas in these situations. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facilities Pressure Ulcer Policy with a revision date of 1/15/2018 documents: Purpose: To prevent and treat pressure sores/ pressure injury. Guidelines: 1. Maintain clean/dry skin during daily hygiene measures. 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. May use lotion on dry skin. 3. Change bed linen per schedule and whenever soiled with urine, feces or other material. 4. Keep bottom sheet dry and tightly stretched and free of wrinkles. 5. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. 6. Employ active and passive range of motion exercises to improve circulation as indicated (in accordance with physician order and plan of care) 7. Whenever possible, encourage resident to change position at regular intervals as able to promote circulation. Wheelchair residents may be instructed to shift weight from one buttock to the other. 8. If redness does not disappear within 30 minutes the turning schedule may be shortened to 1 hour. 9. Pressure reducing (foam) mattresses are used for all residents unless otherwise indicated. Specialty mattresses such as low air loss, alternating pressure, etc. may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple Stage 2 wounds or one or more Stage 3 or Stage 4 wounds.

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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** 49572 Based on interview and record review, the facility failed to provide adequate supervision to prevent a fall of a resident (R1), who was assessed at risk for fall and has a history of falls. These failures affect 1 resident in a sample of 4 residents reviewed for falls. As a result, R1 fell and sustained a head injury with a laceration, requiring R1 to be sent to the hospital. R1 received sutures to close the laceration. Findings include: R1's face sheet documents, R1 was admitted to the facility on [DATE]. R1's face sheet documents diagnoses that include but are not limited to repeated falls, dementia, schizophrenia, anxiety disorder, and major depressive disorder. R1's care plan, revised date 10/27/22, documents, I (R1) am at risk for falls r/t (related to) convulsion, dementia, anxiety and MDD (major depressive disorder) with interventions that document, in part, Ensure resident wearing non-skid footwear . Frequent rounding to ensure resident is wearing nonskid socks . R1's care plan, date initiated 5/6/23, documents, WANDERING/ELOPEMENT: (R1) has been observed to be disoriented to place, have impaired safety awareness, wander aimlessly throughout the facility, and have a history of attempting to exit the facility without supervision r/t dementia. It has been determined by the outcome of the elopement assessment that the resident is included in the elopement prevention program. R1's care plan, revised date 7/9/24, documents, I (R1) have an ADL (activities of daily living) and functional ability for self-care and mobility performance/deficit r/t (related to) dementia, schizophrenia, anxiety disorder, MDD (major depressive disorder), and convulsion with interventions that document, in part, BED MOBILITY: The resident requires supervision from staff for repositioning and turning in bed . TRANSFER: The resident requires partial assistance from staff to move between surfaces . R1's care plan, revised date 8/25/24, documents, I (R1) require assistance with walking r/t (related to): dementia. R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) score of 00, which indicates R1's cognition is severely impaired. R1's Minimum Data Set (MDS) section GG, dated 2/06/25, documents R1 requires partial/moderate assistance for sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed; partial/moderate assistance chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair); and partial/moderate assistance for ambulating 10 feet. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's FALL- INITIAL OCCURRENCE NOTE, dated 10/29/24, documents, . Unwitnessed Fall . This writer was at the Nurses station charting when a sound of something falling was heard. Room was checked with CNA (certified nursing assistant) and observed resident kneeling down trying to get back up. This writer asked resident to remain seated to be assessed, resident was non-compliant and got back up by himself. R1's FALL- INITIAL OCCURRENCE NOTE, dated 11/11/24, documents, . Witnessed Fall . reported that resident stood up from the chair and lost balance and fell on his buttocks without hitting his head. R1's FALL- INITIAL OCCURRENCE NOTE, dated 4/7/25, documents, . Unwitnessed Fall . Resident walked out of his room with blood noted on the left eyebrow . Unable to give statement due to been delirious. R1's Order Summary Report, order date 4/7/25, documents, Send resident to (Name of Hospital) Hospital for medical evaluation due to unwitnessed fall. R1's Order Summary Report, ordered date 4/17/25, documents, Wound Left eyebrow, suture site, cleanse with antimicrobial wound cleanser apply bacitracin and LOTA (leave open to air) everyday shift for wound care for 7 Days. R1's progress note, dated 4/7/2025 at 7:15am, V7 (Registered Nurse/RN), documents, Resident had an unwitnessed fall 04/07/2025 5:45 AM. Location of Fall: Resident room. Resident walked out of his room with blood noted on the left eyebrow on 04/07/2025 5:45 AM . Assessment: Unwitnessed fall . New injury observed. Laceration to the left eyebrow . R1's progress note, dated 4/7/2025 2:50pm, V9 (Licensed Practical Nurse/LPN), documents, Resident was received at 7:05 AM with endorsement of awaiting ambulance to be sent to (hospital) ER (emergency room) for evaluation post fall. Resident transported to (hospital) by . ambulance at 8:10am. Follow Up call made at 1: 30pm and resident was still under evaluation. Another call made at 3:05pm and resident is awaiting discharge. (Hospital) ER will call for report . Will endorse for next shift to follow up return. R1's progress note, dated 4/7/2025 5:31pm, V10 (Licensed Practical Nurse/LPN), documents, The resident is brought back to the facility by two paramedics from (Hospital)on a stretcher. He presents with a left eyebrow laceration, sutured with three stitches, opened to air without s/s (signs and symptoms) of infection noted . On 4/20/25 at 10:45am, R1 was sitting on the side of R1's bed, swaying back and forth, appearing as if R1 was attempting to stand up. R1 was barefoot, with a pair of red nonskid footwear/socks under R1's bed. Surveyor introduced self and R1 replied, Can you help me? I'm trying to get up. Surveyor inquired about R1's call light that was attached to R1's bottom sheet of R1's bed, and R1 replied, My call light for the nurse is over there (R1 pointed to the towards the door of R1's bedroom). Surveyor pointed to R1's call light that was next to R1, and was attached to R1's bottom sheet of R1's bed, and R1 replied, What's that string for? R1 was oriented only to person. When asked about R1's fall that occurred on 4/7/25, R1 replied, I didn't fall. What do you mean? (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/21/25 at 10:51am, V6 (Licensed Practical Nurse/LPN) said, (R1) is a fall risk. There is a sticker of a leaf by his name by his bedroom door that indicates he's a fall risk. I do not know anything about his recent fall. For fall risk residents, the bed is in the low position, call light within reach. And for (R1), (R1) is by the nurse's station so the CNAs (Certified Nursing Assistants) can watch him. And plus, we (staff) do frequent rounds. When asked if the pair of red non-skid socks under R1's bed should be on R1, V6 replied, Yeah. They (nonskid socks) are to prevent falls, but he kicks them off. When asked if there is staff at the nurse's station at all times monitoring R1, V6 replied, Well . not all the time, but most of the time. On 4/22/25 at 9:51am, V7 (Registered Nurse/RN) said, I know him. I had him that day (4/7/25 fall). I am also the supervisor. At 5:30, I was doing rounds, and a CNA said she found a resident on the floor. (R1) had a cut on forehead that was bleeding. I gave him first aid, cleaned it, and applied gauze. I called the physician. I called the ambulance and ambulance picked him up before I left there. Later, I saw that he got stitches to the laceration. (R1) can walk. He goes to the bathroom by himself sometimes. He's a dementia resident. Gait is not steady. That's why they put a diaper on him, so he won't get up. Bed is always lower, lowest setting. Yes, he is supposed to have nonskid socks on. I'm not sure if he had his skid socks on. The nonskid socks help if resident gets up, if there was water on the floor, they are not gonna (sic) fall. I'm not sure if he had his nonskid socks on cause (sic) he was in bed with cover on during my shift. On 4/22/25 at 10:31am, V10 (Licensed Practical Nurse/LPN) said, I've been here 4 months. Yes, I work with (R1) sometimes .I mean once in a while. On April 7th, I had (R1). He came back from the hospital and was stable. He was okay. There wasn't anything different about him other than the left eyebrow. He had a cut there because he fell . I can't remember what the hospital did. He did have sutures. Since I've been here, he walks but with an unsteady gait and kinda (sic) zig zags when he walks . Most times. He can walk on his own. His bed is always in lowest position, call light by side, rounds every 2 hours, and (R1's) room is opposite nurse's station so eyes are always on him. He should have nonskid footwear all the time because he is impulsive, and he has some shoes too. No other falls that I am aware of. On 4/22/25 at 10:48am, V2 (Assistant Director of Nursing/ADON) said, Yes, in a general, I'm familiar with (R1). Since I've been here, he's ambulated with some assistance from staff. If a fall assessment was completed incorrectly, I don't know if anything extra would have been done. Yes, I expect fall assessments to be completed accurately. not sure if he had a fall plan. Restorative would know. It (Fall Assessments) might trigger a care plan for someone to be at risk for falls. I know what happened with his most recent fall (4/7/25 fall), but I wasn't here. I believe the fall took place in (R1's) room. He came out of the room, had a cut to one of the eyebrows, and was sent to the hospital. The hospital didn't admit (R1), just placed sutures and he came back. Fall requiring sutures is an injury that needs to be reported to you (IDPH). I didn't see him, so I don't know if it hurt him. I'd have to look at his chart to see if fall precautions were in place. On 4/22/25 at 12:08pm, V12 (Medical Director) said, A fall with sutures can cause harm to the resident. It is an injury. That is the harm, he got sutures, so that has harm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/22/25 at 1:44 pm, V14 (MDS Coordinator/Licensed Practical Nurse (Prior Restorative Nurse) said, Yes, know (R1). He is ambulatory, but there were days when we had to sit him in the wheelchair. He would refuse to get up and walk. He has dementia. When he is ambulatory, (R1) would walk on his own. His gait is not steady. I mean he would be wobbly sometimes when walking, sit in his wheelchair sometimes, and other days he would be walking on his own fine. We weren't encouraging him to walk on his own, but were kinda (sic) redirecting him. Interventions in place to prevent (R1) from falling was nonskid socks, but I'm not familiar with other interventions. For the 4/7 fall: evaluate for assistive device was the recommendation. (R1) never used an assistive device prior to his falls. He wasn't as unsteady, and we (facility) didn't want to take away his independence. Restorative couldn't get him to use a walker. No 1:1 for supervision interventions. Yes, (R1's) Fall Risk Assessment on 2/12/25 was not accurately completed. I'm not sure if it (accurately completing R1's 2/12/25 Fall Assessment) would have changed anything. On 4/23/25 at 10:42am, V9 (Licensed Practical Nurse/LPN) said, Yes, he's my patient. A little bit about (R1) is that he walks around with redirection, and with no assistance, other than cuing and observing with constat monitoring. (R1's) gait is unsteady. His room is across the nurse's station because he is a fall risk patient. We (staff) check him (R1) every 15 minutes throw a side-eye and look at (R1) from the nurse's station. He always has non-skid socks on. He sleeps with them (non-skid socks). (R1) always has to have them (non-skid socks) on even when sleeping. (R1) will not wear shoes. On 4/7, the nurse before endorsed to me that (R1) fell and he called hospital, and the ambulance is on its way. I continued monitoring (R1) until the ambulance picked him up. He did not return for me. On 4/23/25 at 11:50 am, V17 (Physical Therapy Director) said, Yes, we (Physical Therapy) evaluated him last week for Physical Therapy. (R1) was evaluated for an assistive device but (R1) is not suitable for an assistive device. (R1) is partial monitor assistance for bed mobility and staff assistance while ambulating. On 4/23/25 at 12:43pm, V20 (Director of Nursing/DON) said, Yes, staff should implement interventions in care plan. Supervise him when walking. Complicated residents like him like the inability to call for help, his impulsiveness. They (residents) have the tendency to fall again. There are certain residents that need increased supervision. Very impulsive . Doesn't call for staff. It's part of the supervision issue that already in place. We (facility) cannot do 1:1. There's a lot of dementia patients and a lot of redirection. Staff are doing their best. During daytime they (residents) have a lot of activities to involve and engage in. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled, Fall Prevention Program, revised date 11/21/17, 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 interventions to provide necessary supervision and assistive devices are utilized as necessary . The Fall Prevention Program includes the following components: . Care plan incorporates: Identification of all risk/issue; Addresses each fall; Interventions are changed with each fall, as appropriate; Preventative measures. Standards: A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines; A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident; Safety interventions will be implemented for each resident identified at risk; The admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained; Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions; The Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations. In addition, Director of Nursing is responsible for informing the Administrator of program analysis. Fall/safety interventions may include but are not limited to: Direct care staff will be oriented and trained in the Fall Prevention Program; Footwear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid. Facility policy titled, Resident Rights, reviewed 1/4/19, documents, To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability . Facility presented pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life . Your facility must provide equal access to quality care regardless of diagnosis . You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually . Your facility must be safe, clean, comfortable, and homelike . You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices . You should receive the services and/or items included in the plan of care .

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	04/24/2025

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 51772 Based on observation, interview, and record review, the facility failed to ensure the correct diet was served in accordance to physician orders and Dietician recommendations. This failure affects 1 resident (R2) out of 4 residents reviewed for diet orders. Findings include: R2's Face sheet, dated 4/21/202,5 documents a diagnosis of but is not limited to Failure to thrive, Dysphagia, Major Depressive Disorder. R2's Minimum Data Set Section C documents a Brief Interview Mental Status of 14, which indicates R2 is cognitively intact. R2's Physician order sheet documents an active diet order, dated 3/14/2025 at 12:31pm, for General Diet Pureed in texture; regular/thin consistency, super cereal at breakfast (x2), whole milk with meals, ice cream lunch and dinner, pudding with meals. On 4/21/2025 at 12:04 pm, V23 (Certified Nurses Aid) passed R2's dietary tray, and exited R2's room. R2's dietary slip served with R2's lunch (4/21/24) documents, Diet: Regular; Texture: Mechanical Soft; Beverages: Lemonade-1 cup; Notes: Shake on Tray, add cream soup with lunch and dinner tray. On 4/21/2025 at 12:09 pm, R2's tray contained mechanical soft chicken, mashed potatoes with gravy, a cup of fruit, and a cup of lemonade. R2's dietary tray contained a mechanical soft diet, and there was no whole milk, ice cream, or pudding was on R2's tray. On 4/21/2025 at 12:11 pm, V15, Licensed Practical Nurse/LPN affirmed R2 has a dietary order for General diet Pureed in consistence with thin liquids. On 4/21/2025 at 12:41 PM, V19 (Dietary Manager) affirmed the tray and meal ticket should reflect R2's current diet and other foods added. V19 stated R2 should have had ice cream, whole milk, and pudding with meals. V19 did not know why these were not on the meal ticket and were not given to R2 during the meal pass. On 4/22/25 at 1:37pm, V22 (Registered Dietician) stated V22 comes to the facility a few times a month and is familiar with R2. V22 affirmed R2 has a diagnosis of Failure To Thrive and supplements were put in place, which included R2's food choices. V22 stated V22 calls the Dietary Manager for dietary texture orders. V22 stated when the physician orders a new diet, the nurses will complete a dietary order slip and send it to the kitchen. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/2025 at 12:54 pm, V20, Director of Nursing/DON, stated a meal ticket is filled out by nurses, and they forward it to the kitchen so the diet can be updated to the Dietary Manager. V20 state the Speech Therapist collaborates with nurse managers and the doctor regarding the diet. V20 verified R2's Physician Order Sheet dated 3/14/2025 at 12:31pm documents a General Diet Pureed in texture; regular/thin consistency, super cereal at breakfast (x2), whole milk with meals, ice cream lunch and dinner, pudding with meals. V20 stated the facility should be following the active diet orders that the physician orders. Facilities Policy undated Dining Services Manager Roles and Responsibilities are as follows: Dining Services Manager Roles and Responsibilities Guideline & Procedure Manual (C)2020 DiningRD.com | Health Technologies, Inc. Guideline: Under the direction of the Dining Services Manager, all activities of the Dining Services Department shall occur to meet the specified purposes and functions as follows. Procedure: 1. To ensure all residents have an exceptional dining experience that enhances their quality of life and provides attention to the individual resident plan of care, food preferences, and dining wishes. 2. To provide a nutritious and well-balanced meals that meet the daily nutritional needs of residents. 3. To comply with physician diet orders for all residents, including those on therapeutic diets and those with special nutritional needs. 4. To store, prepare, and serve foods in a clean and sanitary manner, in compliance with local, state, and federal regulations. 5. To operate the Dining Services Department in a cost effective manner by budgeting and controlling the costs of food, labor, and other related supplies. 6. To comply with current public health and safety standards in all phases of (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	department operation. 7. To provide orientation, training, supervision, and evaluation of all dining services staff. 8. To coordinate with all other department activities relative to nutrition care and dining services. 9. To accomplish the above within the specific goals and guidelines established by this community.