STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Westchester	2901 South Wolf Road Westchester, IL 60154

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on interview and record review the facility failed to report an allegation of abuse for one of two residents (R73) reviewed for abuse in a total sample of 47. Findings include: R73 is a [AGE] year-old resident admitted to facility on 11/22/2021 with medical diagnoses including but not limited to: vascular dementia, major depressive disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R73 has a Brief interview mental status (BIMS) score of 03 dated 08/12/2024 which suggests severe cognitive impairment. Minimum Data Set (MDS) assessment dated [DATE] documents GG0130 Self - care: R73 is dependent for toileting hygiene, shower/bathe self, and putting on and taking off footwear. R73 requires substantial/maximal assistance with lower body dressing. R73 requires partial/moderate assistance with eating, oral hygiene, upper body dressing and personal hygiene. On 08/25/24 at 11:45 AM R73 - I have lived here 3 years. I don't like it here. R73 made the choking sign. Surveyor asked resident if someone choked him, and he replied yes. When asked who choked him, he responded with first name of V8 Certified Nursing Assistant (CNA). V8 here choked me. When asked when this happened R73 replied, it happened three weeks ago. It was a Saturday. When asked about what time, he stated about 10 am. He choked me and pinched me. I am sick of it here. I had enough. They know I want to leave. When asked if they are working to get him moved out of here, he states, I don't know. When asked if V8 is a CNA, he states yes, I think so. I have not seen him since. Resident has some trouble getting out some words. He also uses his hands to make signs such as choking sign. He can verbally answer simple questions. Resident did use curse words. On 08/26/24 at 11:14 AM R73 - I am not doing good. I have had enough. I can't stand it here. R73 says V8's first name and then makes choking sign. Take me home. I am sick and tired of it man. I can't stand it. R73 did use curse words. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 11:38 AM V19 (CNA) - Regarding R73, I have heard that he accused somebody of choking him. I don't know how true it was. I did not report that to anyone because it was supposed to be reported. He did not tell me I heard it from a coworker. If he would have reported it to me, I would have reported it. On 08/26/24 at 11:47 AM V1 Administrator - Surveyor asked Have you been made aware of any choking incident by any staff of a resident. V1 replies I have not, just right now social service department told me you were asking about this. Surveyor informed administrator that R73 reported being choked by V8 (CNA). Administrator also made aware that R73 stated he reported to V1 by name. V1 states R73 just curses us out but he never told me about this incident. That is something anyone would have told me. Do you know when. Surveyor replied yes on or about 8/3/2024 at about 10 am R73 alleges V8 choked him and pinched his side. V1 continues, R73 has been here three years. If R73 is not flicking you off his he is saying curse words to you. I have not had any allegations of abuse for V8 he is an as needed staff member and works once or twice a month. Surveyor asked V1 what would happen if a resident would report this to staff. Administrator stated that staff would notify me immediately or notify their immediate supervisor. If they notified their immediate supervisor, then that supervisor would notify me. I just got back from FMLA. I came back that week of 08/03/2024 that Monday or Tuesday. If I was not here staff would notify V21. V21 did not inform me of any incidents reported to him of V8 choking R73. I am sure R73 did not report anything to me. The V10 family member did report to me that week that R73 did not want male staff and just his regular staff to help him. It was that first week I was back that the V10 reported that to me. V10 said he was grumpy and wanted me to make sure the staff caring for him was people that know him. I will go talk to R73 now. On 08/27/24 at 11:25 AM V18 Licensed Practical Nurse (LPN) - Regarding R73 behaviors, he fights, curses, refuses care/medications and tries to hit people. We attempt to redirect. There are some people he just does not like. If we can get another person to help, we will do that, or we will try again later. I did hear of an allegation of abuse for him about 3-4 days after it allegedly happened. R73 said somebody choked him. I asked R73 if he told anyone. I asked him if he told the V1 and he said yes. When surveyor asked if V18 reported the allegation, she said no because I asked V1 if she was aware that R73 reported someone choked him and V1 said it was already reported to her. She did not say who reported it to her. I think we have abuse training yearly. I do not remember when the last one was. It is usually an in-person training. On 08/27/24 at 12:00 PM Interview with V18 LPN and V1 Administrator together - V18 was re-read her statement and she stated, I did say that. V18 stated, I actually did not report it to V1, I spoke to R73 and since he replied that he did report it, I did not report it. I assumed it was reported. V1 stated this was not reported to me by anyone until surveyor reported to me specifically. V18 stated, once he told me he reported it, I assumed it was reported. When surveyor asked how often abuse training is provided V18 stated, We have abuse training yearly. V1 stated V18 should have reported it and followed up with what she heard. Abuse Prevention and Reporting Illinois Policy dated 11/28/2016 documents: Internal Reporting Requirements and Identification of Allegations: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act as an administrator in the administrator's absence. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for Urinary Catheter Care by not ensuring a catheter urinary drainage bag was emptied timely for a resident with a history of UTI's (Urinary Tract Infections). This failure applies to one of one residents (R86) reviewed for catheters and UTI's (Urinary Tract Infections). Findings include: R86 is a [AGE] year-old male with a diagnoses history of UTI's Neuromuscular Bladder Dysfunction, Pseudomonas Bacteria as the Cause of Other Diseases, Acute and Chronic Congestive Heart Failure, Presence of Coronary Artery Graft (Transplanted Blood Vessels), and Pressure Ulcers who was admitted to the facility 03/30/2024. On 08/25/24 from 10:18 AM - 10:30 AM Observed R86's catheter (urinary drainage) bag extremely full. R86 stated if his catheter (urinary drainage) bag is full and it backs up, It could mess me up. R86 stated they constantly forget to empty his catheter (urinary drainage) bag. R86 informed the surveyor he wanted his catheter (urinary drainage) bag to be emptied. On 08/26/24 at 9:01 AM Observed R86's catheter (urinary drainage) bag full. R86 stated he wanted his catheter (urinary drainage) bag to be emptied. On 08/26/24 at 01:24 PM R86 stated many times he has a real bad burning sensation and heavy pressure in his penis. R86 stated he has complained to the CNA (Certified Nursing Assistant) and V22 (Family Member) has also complained to someone about his catheter (urinary drainage) bag not being emptied timely but it's still happening. On 08/27/24 at 10:57 AM V22 (Family Member) stated she has complained multiple times about R86's catheter (urinary drainage) bag not being emptied timely and has had to make staff empty R86's catheter (urinary drainage) bag. On 08/27/24 at 04:55 PM V2 (Director of Nursing) stated a catheter (urinary drainage) bag should be emptied before being completely full because it could back up and cause infection. V2 stated a catheter (urinary drainage) bag should be changed as often as needed. V2 stated all nursing staff are responsible for emptying catheter (urinary drainage) bags. The facility's Urinary Catheter Care Policy received and reviewed on 08/28/2024 states: The purpose of the policy is to establish guidelines to reduce the risk of or prevent infections in resident with an indwelling catheter. Catheter drainage bags will be emptied as needed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on observation, interview, and record review, the facility failed to administer medications as ordered; failed to ensure medication is available during medication administration; and failed to follow manufacturer's guidelines in insulin pen administration. There were 27 opportunities with eight errors resulting in a 29.63% medication error rate. The errors involved four (R46, R63, R82 and R86) of 10 residents in the sample of 47 reviewed for medication administration. Findings include: R63 is a [AGE] year-old, female, admitted in the facility on 03/20/23 with diagnosis of Type 2 Diabetes Mellitus without Complications. POS (Physician Order Sheet) dated 08/16/24 recorded: Humalog Kwikpen Subcutaneous Solution Pen Injector 100 unit/ml (milliliter) Insulin Lispro inject 5 units subcutaneous with meals for diabetes. On 08/25/24 at 12:03 PM, V4 (Licensed Practical Nurse, LPN) was preparing the Humalog Kwikpen to R63. V4 took the Humalog Kwikpen from the cart, wiped the needle port with alcohol wipes, and pushed the needle onto the pen. She (V4) then turned the dose knob to 5 units and injected the insulin to R63's right lower quadrant for 2 seconds. V4 did not prime the insulin pen prior to injection. Also, the order for Humalog is to be administered with meals. R63 was not eating meals at the time of Humalog administration. Her (R63) lunch was served at 12:25 PM and started eating thereafter. R86 is a [AGE] year-old, male, admitted in the facility on 03/30/24 with diagnosis of Acute on Chronic Systolic (Congestive) Heart Failure and Paroxysmal Atrial Fibrillation. POS dated 03/30/24 documented: Midodrine HCl tablet 5 mg (milligrams) give 1 tablet by mouth three times a day for low blood pressure. On 08/25/24 at 3:50 PM, V5 (Registered Nurse, RN) was observed passing medications to R86. V5 stated that his Midodrine medication is not available and will have to reorder from Pharmacy. R82 is an [AGE] year-old, male admitted in the facility on 05/14/24 with diagnoses of Hypertensive Urgency and Essential (Primary) Hypertension. During medication administration on 08/25/24 at 3:58 PM, V5 mentioned that his Hydralazine 50 mg is not available and needs to be reordered. Per POS dated 05/14/24, R82 has an order of Hydralazine HCl (hydrochloride) oral tablet 50 mg 1 tablet by mouth every 8 hours. R46 is a [AGE] year-old, male, initially admitted in the facility on 10/22/21 with diagnoses of Unspecified Atrial Fibrillation and Essential (Primary) Hypertension. Per POS dated 04/25/24, R46 has an order of Metoprolol Tartrate tablet 25mg, give 25 mg by mouth two times a day. R46's Metoprolol tablet was also not available during medication pass. V5 was asked regarding medication reordering. V5 stated, If I order now, it will come tonight or early morning. Nurses on each shift should order medications if it is 8 pills and below remaining in the medication cards. It's easy, we go to electronic health record, click Summary, and click order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/25/24 at 4:10PM, V6 (RN) was observed preparing R63's Humalog Kwikpen. R63 has an order of Humalog Kwikpen 100 u/ml solution pen injector, inject as per sliding scale, subcutaneously before meals for diabetes, subcutaneously three times a day per POS dated 12/27/23. Her blood sugar level was 267mg/dl (milligrams per deciliter). The sliding scale recorded 251- 300 = 4 units. V6 stated that since R63 has another order of Humalog Kwikpen subcutaneous solution pen injector 100 unit/ml (insulin lispro) inject 5 units subcutaneously with meals, he will give the 5 units now, and will give a total of 9 units. V6 took the Humalog Kwikpen, pushed the needle onto the pen, turned the dose knob to 9 units, and administered 9 units to R63's left deltoid area. When V6 prepared the Humalog kwikpen, he did not prime the insulin pen prior to administration. R63's sliding scale is to be given before meals and should only be 4 units. Her (R63) Humalog 5 units is to be given with meals. R63 was not eating meals/dinner at the time of insulin administration. Per V6, dinner is served at about 4:30 PM. Per R63, sometimes dinner is served at 5:15 PM. On 08/26/24 at 2:08 PM, V2 (Director of Nursing) was interviewed regarding medication administration on residents. V2 replied, Nurses check the 5R's before administering medications: right patient; dose; drug; time; route. If medication is not available, we have a cubex (emergency portable pharmacy), nurses look if the medication is available there. If medication is not available, notify me or the doctor and document. Medications should be readily available prior to medication administration. We have cubex to check if medication is available for resident's use. Nurses are the ones responsible for restocking the medications in the med cart. Restocking is done before it runs out. We have to follow medication orders from physicians. We have to follow manufacturer's guidelines in administering Humalog kwikpen. Facility's policy titled Ordering and Receiving Non-Controlled Medications, undated, stated in part but not limited to the following: Procedures: Ordering Medications from the Pharmacy 6. Receiving medications from the Pharmacy A licensed nurse: e) Assures medications are incorporated into the resident's specific allocation prior to the next medication pass. Facility's policy titled, Medication Administration General Guidelines, undated, documented in part but not limited to the following: Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). Procedures Preparation: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. If a medication with a current active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and the facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit. Administration: 2. Medications are administered in accordance with written orders of the prescriber. Humalog Kwikpen U-100 Instructions For Use stated in part but not limited to the following: Humalog KwikPen Insulin Lispro (100 units per ml) Priming your pen Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the needle and repeat priming steps 6 to 8. Small air bubbles are normal and will not affect your dose. Selecting your dose You can give from 1 to 60 units in a single injection. Step 9: Turn the dose knob to select the number of units you need to inject. The dose indicator should line up with your dose. The pen dials 1 unit at a time. The dose knob clicks as you turn it. Step 11: Insert the needle into your skin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observation, interview and record review, the facility failed to follow their policy and procedures for infection control by not ensuring a catheter urinary drainage bag was protected from contaminated surfaces for a resident with a history of UTI's (Urinary Tract Infection); failed to date nasal cannulas and humidifier bottles for residents receiving oxygen; and failed to perform hand hygiene or wear personal protective equipment when providing care to residents on enhanced barrier precautions. This failure applied to five of five residents (R40, R46, R64, R86, and R296) reviewed for infection control. Findings include: R46 is a [AGE] year-old male with a diagnoses history of COPD, Emphysema, Dependence on Supplemental Oxygen, Gastrostomy Status, and Pancytopenia (Abnormally low levels of all blood cell types) who was admitted to the facility 10/22/2021. On 08/25/24 at 12:48 PM Observed R46 's oxygen tubing and humidifier bottle in use and not dated. R86 is a [AGE] year-old male with a diagnoses history of UTI's Neuromuscular Bladder Dysfunction, Pseudomonas Bacteria as the Cause of Other Diseases, Acute and Chronic Congestive Heart Failure, Presence of Coronary Artery Graft (Transplanted Blood Vessels), and Pressure Ulcers who was admitted to the facility 03/30/2024. On 08/25/24 from 10:18 AM - 10:30 AM Observed R86's catheter (urinary drainage) bag uncovered and lying on the floor. R86 stated his catheter (urinary drainage) bag is typically left on the floor. On 08/26/24 at 9:01 AM Observed R86's catheter (urinary drainage) uncovered, and lying on the floor. On 08/26/24 at 01:24 PM R86 stated many times he has a real bad burning sensation and heavy pressure in his penis. R86 stated his catheter (urinary drainage) bag being on the floor causes him to experience burning and it's not a good feeling. On 08/27/24 at 04:55 PM V2 (Director of Nursing) stated a catheter (urinary drainage) bag should never be sitting on the floor because of infection control. R296 is a [AGE] year-old female with a diagnoses history of COPD and Essential Primary Hypertension who was admitted to the facility 08/23/2024. On 08/25/24 at 12:38 Observed R296's oxygen tubing and humidifier bottle being used and not dated. 51084 (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R40 is an [AGE] year-old female, initially admitted to the facility on [DATE], with diagnosis not limited to: Heart Failure, Shortness of breath, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. POS (Physician order sheets) dated 2/1 2023, documented: Oxygen at 2 liters per minute via nasal cannula, every shift for continuous oxygenation. On 08/25/24 at 10:33 AM, R40 was in the bathroom. R40's oxygen tubing/cannula was not labeled with date. The nasal cannula was on the floor. On 08/26/24 at 10:16 AM, R40 was in her room, sitting in a chair, with oxygen tubing/cannula not labeled with date. R64 is a [AGE] year-old male, initially admitted to the facility on [DATE] with diagnosis, not limited to: Acute Respiratory Failure, Traumatic Subarachnoid Hemorrhage Without Loss of Consciousness, Subsequent Encounter, Dysphagia, Tracheostomy Status. R64 has a trach collar. R64's POS (Physician order sheets) documented: 05/13/2024 : Contact precautions for ESBL (Extended spectrum beta-lactamase) in the trach. 04/18/2024: Enhanced Barrier Precautions (EBP) due to presence of a Tracheostomy. On 08/26/24 at 10:00 AM, surveyor observed gauze around R64's trach collar heavily soiled with secretions and informed V7 (Licensed Practical Nurse). At 10:06 AM, V7 was going in to change gauze around R64's trach. R64 is on Enhanced Barrier Precautions. V7 was not observed donning gown prior to changing the gauze. No hand hygiene or hand washing was also observed before and after providing care on R64. On 08/27/2024 at 9:28AM, V2 (Director of Nursing) was asked about expectations on staff related to oxygen care and infection control. V2 stated Expectation on staff relating to enhanced based precautions residents - if they are providing care, if they are touching anything, they are expected to wear personal protective equipment like gowns, gloves and perform hand hygiene before entering the room and hand washing before exiting the room. Oxygen tubing and humidifiers are to be changed every Sunday and labeled with the date. Facility's policy titled, Oxygen and Respiratory Equipment - Changing/Cleaning dated 1-7-19 stated in part but not limited to the following: Guidelines - Purpose 3. To minimize the risk of infection transmission Procedure 2. Nasal Cannula a. Nasal cannulas are to be changed once a week and PRN. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Whenever possible, residents using a portable oxygen tank, will be switched to a room oxygen concentrator while in their room. c. A clean plastic bag with a zip loc or draw string, etc. will be provided to store the cannula when it is not in use. It will be dated with the date the tubing was changed 4. Oxygen Humidifiers. a. Oxygen humidifiers should be changed weekly or as needed and will be dated when changed. Facility's policy titled Enhanced Barrier Precautions, dated 5/7/24 stated in part but not limited to the following: Guidelines: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloved during high-contact care activities that provide opportunities for transfer of MDROs (Multidrug-resistant organisms) to staff hands and clothing. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities, especially when care is being bundled: Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Facility's policy titled Hand Hygiene/Handwashing dated 7-30-24 stated in part but not limited to the following: Examples of when to perform Hand Hygiene (Either Alcohol Based Hand Sanitizer or Handwashing): At room entry Before performing an aseptic task Before exiting room After contact with blood, body fluids or excretions, mucus membranes, non-intact skins, or wound dressings After glove removal The facility's policy titled Urinary Catheter Care received and reviewed on 08/28/2024 states: The purpose of the policy is to establish guidelines to reduce the risk of or prevent infections in resident with an indwelling catheter. Urinary drainage bags shall be positioned to prevent from touching the floor directly. May place drainage bag in a secondary vinyl bag or other similar device to prevent primary contact with floor or other surfaces.