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	07/25/2025

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record reviews, the facility failed to ensure residents were treated in a dignified manner by providing timely toileting assistance. This failure affected three residents (R48, R61, and R113) reviewed for resident rights on the sample of 45. Findings include:On 7/22/25 at 3:20 PM, R48 was observed sitting in the dining room. R48 stated that R48 was wet and staff won't change R48's brief. R48 stated that staff had not changed her brief since she got in reclining chair for breakfast.On 7/22/25 at 3:40 PM, V18 CNA (certified nurse aide) was observed providing incontinence care for R48. R48 was observed to have a saturated panty liner (13 inches x 28 inches) in a saturated brief.On 7/22/25 at 3:40 PM, V18 CNA stated that V18 provides incontinence care to assigned residents twice, once at the beginning of shift and once at end of shift.On 7/23/25 at 12:50 PM, R113's call light was observed to be activated. At 1:00 PM, when questioned if R113 needed staff assistance, R113 removed blanket and pointed to incontinence brief. When questioned if R113 needed to have brief changed, R113 nodded head 'yes'. At 1:14 PM, V21 CNA was observed entering R113's room, turned off R113's call light and exited room. At 1:16 PM, V21 informed V11 CNA that R113 needed to have brief changed. At 1:25 PM, V11 entered R113's room to provide incontinence care.On 7/24/25 at 1:15 PM, when R61 was questioned if R61 needed brief changed, R61 stated that R61 needed to use the bathroom as R61 had been holding her urine waiting for staff to assist R61. V20 CNA was informed that R61 needed to use the bathroom. V20 transported R61 via wheelchair to R61's room. V20 checked the front of R61's brief and stated that the brief was dry. V20 was asked to check the backside of the brief; it was saturated with urine.On 7/24/25 at 1:20 PM, V20 CNA stated that V20 provides incontinence care for assigned residents at the beginning of the shift and right before shift ends.On 7/25/25 at 9:50 AM, V6 ADON (assistant director of nursing) stated that incontinent residents should be checked and changed every 2-3 hours, more often if heavy wetter.The facility's incontinence care policy, revised 1/16/18, notes incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or every two hours.

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

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review the facility failed to ensure that the state inspections are available for the residents to read without having to ask the staff for them. This affects 4 of 4 residents (R91, R40, R111, R23) in the sample of 45 resident reviewed for residents' rights for state inspection. Findings include: On 7/23/25 at 11:10am R98 (president of resident council) said the survey binder/ state inspections was at the front desk. R23 and R111said they don't know what the survey binder are with the state survey results.On 7/25/25 at 8:48am during tour, there was no survey binder observed out in view at the front desk. Request was made to review the survey binder with previous state inspections, V5 (receptionist) looked at the binders that was located in the back of the receptionist desk and stated that the binder is not there. V34 (Regional Nurse Consultant) said the survey binder should be at the front desk. V34 and V12 looked for the survey binder in the administrator's office, and around the front desk area, foyer near the smoke patio.7/25/25 8:57am V12 (DON) presented the survey binder and stated that V5 did not know what the survey binder was. V12 was asked should V5 know what the survey binder is, just in case the resident request to see the binder. V12 declined to answer. V12 was asked should the binder be available for the resident to review without asking, V12 declined to answer.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to accurately incorporate a resident's directive for life sustaining treatment into the medical record. This failure affected one resident (R9) reviewed for advance directives in the sample of 45.Findings include:On [DATE] at 1:30 PM, V8 SSD (social services director) stated that R9 is a full code. This surveyor and V8 reviewed the completed POLST (practitioner order for life-sustaining treatment) form, dated [DATE], in R9's medical record, acknowledged that R9 has signed DNR (do not resuscitate) form. V8 stated that the R9's family revoked the DNR status. When questioned for documentation of revocation, stated it is in her progress notes. This surveyor reviewed V8's progress notes with her, V8 stated that there is no documentation that DNR was revoked. V8 stated that neither R9's care plan nor the face sheet were not updated to note change in R9's code status.R9's face sheet, care plan, and POS (physician order sheet) note R9 is a full code.The facility's advance directives policy, revised [DATE], notes if a resident or health care representative indicates an advanced directive regarding CPR (cardiopulmonary resuscitation) or scope of treatment (POLST form), the appropriate forms will be completed. Advanced directives shall be included in the resident's plan of care and will be reviewed during the care plan meeting with the resident and/or the resident's legal representative when present. A resident, their legal representative or authorized health care representative may rescind their advance directive(s) at any time. An oral revocation will be documented in the resident's health records indicating the time, date, and place of verbal expression.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and interviews, the facility failed to provide privacy while providing a bed bath. This affected one resident (R48) reviewed for privacy while receiving direct care on the sample of 45. Findings include:On 7/23/25 at 9:35 AM, V11 CNA (certified nurse aide) and V6 ADON (assistant director of nursing) were observed entering R48's room. V11 closed the door behind them. R48's roommate was observed sitting in wheelchair facing R48's bed. V11 gathered supplies to provide R48 a bath. R48's privacy curtain was not closed around R48's bed. R48's right arm was removed from gown exposing right breast. At 9:41 AM, R48's left arm was removed from gown exposing both breasts and abdomen. At 9:44 AM, another staff member entered R48's room to speak with V6. Afterwards, V11 pulled the privacy curtain to finish bathing R48.On 7/25/25 at 9:50 AM, V6 ADON stated that the resident's door should be closed and privacy curtain pulled around resident's bed to provide privacy prior to providing resident care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview the facility failed to ensure the resident room was clean and sanitary for one of 8 residents (R59) in total sample of 45 reviewed for clean homelike environment. Findings include:On 7/22/25 at 1:10pm R59 said the floor in his room is dirty and sticky. Surveyor shoes was sticking to the floor when taking steps.Facility policy titled housekeeping, no date noted denotes in-part to provide guidelines to maintain a safe and sanitary environment for residents, facility staff and visitors.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have an appropriate diagnosis for the use of antipsychotic medications, failed to identify a specific behavior for the use of an antipsychotic medication. This failure affected two residents (R8 and R9) reviewed for unnecessary medications on the sample of 45.Findings include: 1.R9's medical record notes R9 with diagnoses including but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. On 7/23/25 at 3:45 PM, V12 DON (director of nursing) provided this surveyor with signed psychotropic consents for gabapentin (for treatment of nerve pain) and mirtazapine (appetite stimulant). When questioned if this was all of R9's signed consents for psychotropic medications, V12 responded yes. On 7/24/25 at 11:50 AM, V6 ADON (assistant director of nursing) reviewed R9's current medication orders. V6 stated that R9 is receiving olanzapine for a psychotic disorder. V6 reviewed R9's medical diagnoses and stated that R9 has dementia. V6 reviewed R9's psychotropic consent forms and was unable to find a consent form for olanzapine in R9's electronic medical record. When questioned if olanzapine was appropriate for a resident with a diagnosis of dementia, V6 did not respond. On 7/24/25 at 1:30 PM, V6 presented a signed consent for R9's olanzapine. V6 stated that she found the consent form in the medical record office. When questioned if this consent should be in R9's electronic medical record, V6 responded yes. When questioned why the consent dated 4/10/24 was not uploaded prior to this surveyor asking about it today, V6 responded I don't know. V6 unable to articulate how V6 was able to find a one page document not in a binder and placed in the medical records office more than a year ago so quickly. R9's care plan, initiated 10/10/24, notes R9 uses psychotropic medications olanzapine related to disease process mood disorder. R9's POS (physician order sheet), dated 8/12/24, notes an order for olanzapine 2.5mg (milligrams) oral at bedtime for antipsychotic. R9's psychotropic medication intervention review, dated 5/5/25, notes targeted behaviors include anxiety and agitation. Prior to 4/9/24, V33's NP (psychiatry nurse practitioner) documentation notes R9 with dementia without behaviors. On 4/9/24, R9 expressed desire to discharge home with family. V33 noted R9's judgement to be fair, short term memory fair, long term memory adequate. R9 obeys commands. V33 started R9 on olanzapine 2.5mg oral at bedtime. Prior to R9 starting any antipsychotic medication, V33 documented with each visit GDR (gradual dose reduction contraindicated due to potential worsening. After olanzapine started, V33 continued to document GDR contraindicated. Per the FDA (food and Drug Administration), olanzapine is approved for the treatment of schizophrenia. Elderly residents with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Olanzapine (zyprexa) is not approved for the treatment of residents with (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia-related psychosis. 2.R8's diagnosis include but are not limited to Unspecified Dementia, unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbances, Mood disturbance, and Anxiety, Unspecified Dementia, Severe, with Mood Disturbances, Depression, and Anxiety Disorder. Cognitive score of 15, intact. 07/22/2025 10:30 AM R8 in her room in bed. R8 alert and oriented. No restlessness or inappropriate responses during conversations. After reviewing R8's records and comparing to her statements R8 presents with mild confusion to some circumstances, including indication for her most recent hospitalization. Hospital Record admission 7/14/25, readmission 7/17/25, states chief complain abdominal pain and later determined related to hernia. On 7/24/25 at 12:28PM V6, Infection Preventionist, said she is also the psychotropic nurse. V6 reviewed R8's medications with the surveyor. V6 said R8 receives Olanzapine for psychotic disorder. V6 read off R8's diagnosis from R8's diagnosis list including Unspecified Dementia with Mood and Severe Disorder, Adjustment Disorder with Anxiety, Anxiety Disorder and Depression. V6 was asked what specific R8's displays that she requires Olanzapine. V6 said R8 has anxiety, she gets overwhelmed. V6 said the nurses check off on the Medication Administration Record (MAR) if the resident is having any behaviors. V6 was asked to review the MAR with the surveyor to show the target behaviors. V6 said it has not been entered into the system since her recent readmission. The surveyor reviewed the entire month of July 2025 MAR with V6. V6 said it's not there. V6 presented psyche therapy notes from 7/18/25 for R8's behaviors. V6 said this is what they talk about and she is treated. Only diagnosis are listed and conversations but no displayed behaviors were addressed related to use of Olanzapine. V6 was asked to present documentation she can find of R8 displaying behaviors that may require treatment with Olanzapine. On 7/25/25 no documentation was provided. Review of R8's Order Summary Report includes Olanzapine Tablet 7.5mg two times a day for psychotic behavior. Review of R8's care plan includes I use psychotropic medication Olanzapine. No specific behavior related to medication use is documented. Review of R8's Active Diagnosis MDS dated [DATE] includes Non-Alzheimer's Dementia, Anxiety, and Depression. No other Psychiatric/Mood disorder. Additional diagnosis includes Unspecified Dementia with severe mood disturbances. Review of R8's MDS dated [DATE] for Behavioral Symptoms indicates none displayed. The facility policy for Psychotropic Medication – Gradual Dose Reduction dated 2/1/18 states the purpose is to ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, this facility failed to follow its policies and procedure to ensure resident received incontinence care at least every two hours or as needed, and failed to ensure a resident was positioned per physician order for feeding. This affected four residents (R103, R48, R61, and R113) reviewed for activities of daily living assisted by staff on the sample of 45.Findings include:On 7/22/25 at 12:25 PM, R48 was observed in reclining chair in dining room; head was raised 30 degrees. R48 was brought lunch tray. R48 was not repositioned, the chair back was not raised to the upright position. R48 was observed coughing after each bite taken.On 7/23/25 at 8:50 AM, R48 was observed in bed with head of bed raised 30 degrees. R48's breakfast tray was positioned in front of R48. V10 CNA (certified nurse aide) was observed in R48's room. R48 asked V10 to have the head of bed raised so R48 could eat breakfast. V10 stated that R48 can raise the head of bed herself and exited room.On 7/23/25 at 9:00 AM, V12 DON (director of nursing) stated that R48 is alert and oriented x 3. V12 stated that R48 keeps scooting self-down in bed. V12 stated that R48 is finished with breakfast. This surveyor and V12 entered R48's room. R48 had only consumed two bites of breakfast. When questioned if R48 is positioned correctly in bed to eat meal, V12 responded R48 can raise the head of bed herself. V12 asked staff to reposition R48.On 7/23/25 at 9:30 AM, R48 was observed to be in the same upright position. Throughout this survey, R48 was not observed scooting self-down in bed or chair.On 7/25/25 at 10:10 AM, V28 NP (nurse practitioner) stated that a resident on aspiration precautions should be sitting in an upright position for all meals. V28 stated that V28 expects staff to carry out physician orders. On 7/25/25 at 10:50 AM, V12 DON and V6 ADON (assistant director of nursing) presented R48's care plan for problematic behavior in which R48 acts characterized by inappropriate behavior related to dementia, anxiety disorder, major depressive disorder, and stroke. R48 slides self in bed. It was initiated on 7/17/25. When questioned what interventions have been put in place to prevent R48 from sliding self-down in bed or chair during and after meals, V12 and V6 did not respond. When questioned if R48's physician has been notified of this behavior, V12 and V6 did not respond. V12 and V6 were informed that during this survey, this surveyor did not observe R48 exhibiting this behavior.R48's modified barium swallow study, dated 5/14/25, notes study was completed to rule out aspiration, assess extent of oropharyngeal dysphagia, change in oral function. Speech pathologist impressions: suspect at least moderate oropharyngeal dysphagia secondary to reduced bolus control and formation, decreased labial strength, decreased lingual coordination/strength, delayed initiation of pharyngeal swallow response, and reduced base of tongue strength. Observed at least mild post swallow residuals within superior hypopharynx. Suspect reduced swallow safety with possible aspiration as evidenced by immediate and delayed cough response with cyanosis after mechanical soft and larger cup sip with thin trials. Recommend puree diet with teaspoon sips of thin liquids via slow 1:1 supportive feeding assistance, in upright/midline position. Strict adherence to swallow precautions by staff for safe oral intake. Detailed diet recommendations include but not limited to: small bites, monitor rate, aspiration precaution, protective cough/throat clear, small sips by teaspoon, upright 90 degrees, no straws, monitor pulmonary status, and resident to be fed.R48's POS (physician order sheet), dated 5/16/25, notes an order for puree solids and nectar thick liquids, upright for all oral intake, slow rate, small bites/sips, alternate solids/liquids, no straws, aspiration precautions.R48's speech therapy's Discharge summary, dated [DATE], notes puree diet with nectar thick liquids. Recommendations include but not limited to upright posture during meals and upright posture for more than 30 minutes after meals. Prognosis to maintain function good with staff follow-through. R48 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharged from therapy due to exhaustion of benefits.The facility's physician orders policy, revised 1/31/18, notes when receiving physician orders by telephone, enter the order in the resident's chart. Be sure to include a diagnosis or indication for use. Verbal and telephone orders will be documented as such in the electronic medical record.On 7/23/25 at 11:25am, R103 was observed with a large bulging adult brief. V29 (nurse) checked R103 incontinence brief. R103 was observed with an adult brief and a urine soiled and saturated incontinence insert. V29 said, R103's insert was soaked with urine. V29 said, he doesn't no know why R103 had an insert inside of the incontinence brief. V29 said, he is not sure when the last time R103 was provided incontinence care. V29 said, it took over two hours for R103 to be soaked and saturated with urine.On 7/23/25 at 11:40am, V12 (don) said, residents should be provided incontinence care every two hours and as needed. On 7/22/25 at 3:20 PM, R48 was observed sitting in the dining room. R48 stated that R48 was wet and staff won't change R48's brief.On 7/22/25 at 3:40 PM, V18 CNA (certified nurse aide) was observed providing incontinence care for R48. R48 was observed to have a saturated panty liner (13 inches x 28 inches) in a saturated brief.On 7/22/25 at 3:40 PM, V18 CNA stated that V18 provides incontinence care to assigned residents twice, once at the beginning of shift and once at end of shift.On 7/23/25 at 12:50 PM, R113's call light was observed to be activated. At 1:00 PM, when questioned if R113 needed staff assistance, R113 removed blanket and pointed to incontinence brief. When questioned if R113 needed to have brief changed, R113 nodded head 'yes'. At 1:14 PM, V21 CNA was observed entering R113's room, turned off R113's call light and exited room. At 1:16 PM, V21 informed V11 CNA that R113 needed to have brief changed. At 1:25 PM, V11 entered R113's room to provide incontinence care.On 7/24/25 at 1:15 PM, when R61 was questioned if R61 needed brief changed, R61 stated that R61 needed to use the bathroom as R61 had been holding her urine waiting for staff to assist R61. V20 CNA was informed that R61 needed to use the bathroom. V20 transported R61 via wheelchair to R61's room. V20 checked the front of R61's brief and stated that the brief was dry. V20 was asked to check the backside of the brief; it was saturated with urine.On 7/24/25 at 1:20 PM, V20 CNA stated that V20 provides incontinence care for assigned residents at the beginning of the shift and right before shift ends.On 7/25/25 at 9:50 AM, V6 ADON (assistant director of nursing) stated that incontinent residents should be checked and changed every 2-3 hours, more often if heavy wetter.R48's MDS (minimum data set), dated 6/8/25, notes R48 is dependent on staff for toileting assistance. R48 is always incontinent of bowel and bladder.R61's MDS, dated [DATE], notes R61 requires substantial assistance from staff for toileting. R61 is always incontinent of bowel and bladder.R113's MDS, dated [DATE], notes R113 is dependent on staff for toileting assistance. R48 is always incontinent of bowel and bladder.R103's minimal data set (MDS) dated [DATE] brief interview for mental status documents a score of twelve which indicated moderate cognitive impairment. Section H (bladder and bowel) documents: urinary continence-frequently incontinence (seven or more episode of urinary incontinence). R103's care plan initiated on 9/18/24 documents: R103 have bowel incontinence related cognitive impairment. Interventions: Provide peri-care after each incontinent episode.The facility's incontinence care policy, revised 1/16/18, notes incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or every two hours.

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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. Based on interviews and records reviewed the facility failed to follow orders and obtain a urine analysis ordered on 4/6/25 for a resident with a history of urinary tract infections This affected one resident (R22) reviewed for physician orders on the sample of 45.The findings include:R22 has impaired cognition and diagnosis include, but are not limited to Alzheimer's Disease, Major Depressive Disorder, and Dementia. R22's Functional Abilities dated 6/3/25 identifies dependent on staff for toileting hygiene and always incontinent of urine.On 07/22/2025 at 10:36 AM R22 sitting in a wheel chair in the dining room. R22 alert, confused not talking or verbally responding, just looks at the surveyor.On 07/22/2025 at 3:45PM V24, R22's daughter, said on 4/6/25 I came to visit my mother and she was rambling. V24 said when she does that, I know that is a sign she is developing a UTI. I notified the nurse. We asked what happened, was anything going on with her and telling them she is not herself. V24 said then on 4/24/25 my sister came to see mom and had her sent to the ER. V24 said at the emergency department R22 was found to have a UTI. V24 said I talked to V12, DON, about this, the nurse not acting on R22's reported symptoms until my sister came in to report her concerns. V24 said talking to V12 got me no where.On 7/25/25 at 9:24AM V23, CNA, said I have been taking care of R22 for the last 3 months. R22 does not speak or communicate her needs. She comes in and out of it, sometimes more alert. V23 said R22 is always incontinent, she does not use the toilet and is not able to say when she needs to be changed. V23 said I don't know if she has a history of Urinary Tract Infections. On 7/23/25 at 2:10PM V6, Infection Preventionist, said R22 does not meet the criteria for antibiotic use, but she had the prescription for the antibiotic from the hospital. On 7/24/25 at 6:25pm V25, LPN, said I work both day and evening shifts and I float around the building. V25 said I know who R22 is. I don't know her to have a history of UTIs. I have seen R22's family visiting her while I am working. V25 said I can't remember if R22's family reported anything to me about her needing to get a Urine Analysis (UA), there's so much going on in that building. V25 said I must have gotten the order if I put it in the chart. V25 said if a change in resident condition is report, I asses the patient, report to the doctor, and document. V25 said in a situation when urine is needed to be collected and we don't get it on our shift we pass it on to the next shift. V25 said lab results are found in the resident computer chart. R22's Order Detail report dated 4/6/25 includes an order UA, reflex to culture. The order was written by V25.On 7/25/25 at 9:48AM V6, Infection Preventionist, said risk factors for UTI include sitting in urine, poor hydration, poor peri care or incontinent care. V6 said residents that are incontinent are at risk for UTI. At 11:07AM V6 said R22 has a history of UTI, in the past.On 7/24/25 at 2:03PM V6 said R22's family did not speak to me specifically about UTI or UA. V6 said I found out that R22 had a UTI after she returned from the hospital on 4/24/25. At 2:17PM V6 said if a UA is ordered we expect the staff to get it done right away.On 7/24/25 at 1:08PM V12, DON, was asked if she was aware of R22's family reporting signs that they know are symptoms of R22 developing a UTI? V12 said I was on vacation. V12 was asked for the dates she was on vacation and did not give them or say how many days she was on vacation. V12 was asked about R22's symptoms being reported on 4/6/25. V12 said I don't know what happened, I wasn't here. V12 handed the surveyor labs for R22 dated March 2025 and said the doctor saw R22 on 4/17/25.On 7/24/25 at 1:46PM V26, Acting Administrator, said if a family reports a concern I would expect it be documented on a concern form and the appropriate department follow up. At 2:14PM V26 said V6 was off from 4/11/25- 4/14/25. (5 days after R22's family reported symptoms.) V26 said we do not have results for R22's UA ordered on 4/6/25.7/25/25 9:07AM V12, DON, said the NP saw R22 on 4/7/25 for the symptoms of UTI and said she was fine. V12 presented a progress note for R22.On 7/25/25 at 9:48AM V6, Infection Preventionist, said risk (continued on next page)

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	145660	A. Building B. Wing	07/25/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	factors for UTI include sitting in urine, poor hydration, poor peri care or incontinent care. V6 said residents that are incontinent are at risk for UTI. At 11:07AM V6 said R22 has a history of UTI, in the past. On 7/25/25 at 9:54AM V28, Nurse Practitioner, said I saw R22 on 4/7/25, just routinely. V28 said I see all the patients weekly. V28 said R22 is alert and oriented times 1 or 2. V28 said you can speak to R22, but it doesn't make sense to her. R22 can physically respond, but she does not respond verbally. V28 said I assessed R22 for abdominal tenderness on 4/7/25 and she displayed no signs. V28 said abdominal tenderness is not always present for a UTI. V28 said I don't recall speaking to R22's family about a UTI. V28 said if the staff or family reported a concern I would have documented what they reported to me. V28 said I am in the facility Monday thru Friday. V28 said I am not on call on the weekends. V28 said if I had written an order, I would have written a progress note. V28 said I expect the staff to carry out physician orders given. V28 said I didn't know R22 had an order for a urine analysis written on 4/6/25. V28 said it is important to treat a UTI, she could have gone septic if not treated. A review of R22's Progress Notes dated 4/6/25-4/25/24 was completed. Physician saw R22 on 4/17/25 and he reviewed labs from 3/24/25, no mention of the UA ordered 4/6/25.Review of R22's Progress Notes dated 4/8/25 written by V28 states is seen today for Chronic Care Management.Progress Notes dated 4/24/25 at 9:57AM states R22's family reporting to V12 that R22 is not at baseline. Physician offered labs and UA with C&S and fluids. Family requested R22 be sent for evaluation. At 10:24AM R22 transported to hospital for evaluation via 911.Order Summary Report dated 4/25/25 includes Cefuroxime 500mg tablet for 7 days.Facility provided hospital record dated 4/24/25 identifies R22 urinary tract infection she was given a dose of Rocephin and is given a prescription at discharge. Diagnosis is Acute cystitis. Urine analysis collection date 4/24/25 includes criteria of urinary infection.Review of the facility McGreer Criteria for Infection Surveillance Checklist for R22 includes her name, room number, and date of infection 4/25/25. Nothing is filled out past that information on the form.Review of R22's history includes history of UTI.No Concern/Grievance form was found In April from R22's family.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, and record reviews, the facility failed to ensure enteral feeding and tubing is properly labeled and dated before administration, failed to ensure tubing was in correct position in the feeding pump for one resident (R113) reviewed for enteral feedings on the sample of 45. Findings include:On 7/22/25 at 3:30 PM, R113 motioned for this surveyor to enter his room. When questioned what the matter was, R113 pointed to his gastrostomy feeding that was hanging on the intravenous pole next to his bed. R113's gastrostomy feeding tubing was observed not connected to the feeding pump and the clamps on the tubing were open. The feeding container was not labeled with R113's name or date and time hung.On 7/22/25 at 3:35 PM, V12 DON (director of nursing) came to R113's room. V12 stated that the feeding should not be running like that. V12 stated that the tubing should be connected to the pump. V12 stated that the day shift nurse didn't know how to connect the tubing to the feeding pump. When questioned what is the expectation for the nurses if they do not know how to use the equipment, V12 responded the nurses should ask V12 for assistance.On 7/22/25 at 3:40 PM, V9 RN (registered nurse) came into R113's room. V9 stated that the feeding container should be labeled with the R113's name and the date and time feeding started. V9 stated that the tubing should be connected to the feeding pump to ensure the correct amount of feeding per hour is administered.The facility's gastrostomy tube feeding and care policy, revised 8/3/20, notes cyclic feedings are prescribed amount of formula volume is given over a specific period of time and given by an enteral feeding pump. The feeding container should be labeled with resident's name, flow rate, date and time hung.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, and record reviews, the facility failed to ensure oxygen tubing changed and dated weekly. This failure affected two residents (21 and R48) reviewed for respiratory care on the sample of 45. Findings include:On 7/22/25 at 10:05 AM, R21 was observed in room with oxygen tubing placed behind R21. R21's oxygen tubing was undated.On 7/22/25 at 10:30 AM, R48 was observed in dining room. R48's oxygen tubing was dated 7/14/25. On 7/23/25 at 9:35 AM, R48's oxygen tubing was dated 7/23/25.On 7/25/25 at 9:50 AM, V6 ADON (assistant director of nursing) stated that oxygen tubing is changed weekly and as needed. V6 stated that the oxygen tubing should be dated when changed. V6 stated that the date noted on the oxygen tubing should match the date documented in the resident's MAR (medication administration record). R21's POS (physician order sheet), dated 9/18/22, notes an order to change out, date, and label oxygen tubing every night shift every Sunday.R48's POS, dated 3/27/24, notes an order to change out, date, and label oxygen humidifier 500ml (milliliters) and oxygen tubing every night shift every Sunday.R48's MAR, dated July 2025, the nurse noted R48's oxygen tubing was changed 7/13 and 7/20.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview the facility failed to post Nurse Staffing Data in a prominent area available for residents and visitors. This failure has the potential to affect all residents residing in the facility. The findings include:07/22/2025 11:49 AM Staffing not posted at desk, V5, Receptionist, handed surveyor the schedule for review. Surveyor requested the information be provided. Surveyor checked in the area and no posting seen.07/22/2025 1:56 PM V3, Interim DON, said Human Resources, V2, created the Daily Nursing staff census today. V3 said I am unable to provide the Daily Nursing Staff Census for the past 30 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the medication storage policy by having opened undated medication and expired medication of the medication cart. This affected four of four residents (R3, R74, R113 and R95) reviewed for labelling and storage in the sample of 45. Findings Include:R3 was diagnosis with Dementia Mellitus. R3's physician order dated [DATE] documents: Insulin lispro solution - Inject as per sliding scale (start date [DATE]). R74's physician order dated [DATE] documents: Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) Instill 1 drop in right eye eve (start date [DATE])On [DATE] at 12:18pm, during medication cart inspection with V31 (nurse), R3 was observed with lispro insulin dispensed date [DATE] open and not dated. V31 said, R3's insulin was used, open and not dated. V31 said, R3's insulin should have been dated when it was initially opened. R74 was observed with Brimonidine eye drop dated [DATE]. V31 said, R74's eye drops are dated [DATE]. V31 said, R74's eye drops are expired and they were good for twenty-eight days. V31 said, expired medication should not be on the cart. R113's physician orders dated [DATE] documents: Fiasp FlexTouch 100 UNIT/ML Solution pen-injector- Inject as per sliding scale (start date [DATE]). R95's physician orders dated [DATE] documents: Lyumjev KwikPen 100 UNIT/ML Solution pen-injector- Inject as per sliding scale (start date [DATE])On [DATE] at 12:35pm, during medication cart inspection with V32 (nurse), R113 was observed with Fiasp FlexTouch Solution pen-injector (insulin) dated [DATE]. R95 was observed with Lyumjev KwikPen 100 UNIT/ML Solution pen-injector (insulin) dated [DATE]. V32 said, insulin is good for thirty days. V32 said, both R113 and R95's insulin is expired. V32 said, expired medication should not be on the cart. On [DATE] at 12:50pm, V12 (don) said, not expired medication should be on the medication cart. V12 said, insulin is good for twenty- eight to thirty days after opening. V12 said, eye drops are good for thirty days. V12 said, insulin and eye drops are opened, the date they are open should be written on the package. Storage of Medication Policy no date documents: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedure for medication disposal and reordered from the pharmacy, if a current order exists. Certain medications or packages types, such as ophthalmics, once open, requires an expiration dated shorter than the manufacturer's expiration date to insure medication purity and potency. When the original seal of a manufacture's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened. If a vial or container is found without a date opened, the date open will automatically default to the date dispensed and the expiration date will be calculated accordingly. All expired medication will be removed from the active supply and destroyed in the facility, regardless of amount remaining.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to wear gloves while touching food while taking food temperatures before lunch was served, failed to wear beard nets and properly wear hair nets while in the kitchen area. This failure has the potential to affect all residents receiving meals in this facility. Findings include:The census on 7/22/25 was 114 residents. V12 DON (director of nursing) stated that there are four residents that are strict nothing by mouth.On 7/22/25 at 9:55 AM, V14 (cook), V15 (dietary aide), and V16 (dietary aide) were observed to have facial hair. V14, V15, and V16 were not wearing beard nets. V15 and V16 were observed with a hair net on head with hair extending below the hair net.On 7/22/25 at 10:40 AM, this surveyor observed a bag of hair nets and a bag of beard nets attached to door to the kitchen. V13 (dietary supervisor) arrived at the kitchen and placed a hair net on head with hair extending below the hair net.On 7/22/25 at 11:00 AM, V14 was observed preparing the gravy for the lunch meal service. V13 was not wearing gloves.On 7/22/25 at 11:05 AM, when questioned if any staff should be wearing beard nets, V13 responded he didn't know. When questioned if all of a staff member's hair should be in a hair net, V13 responded yes and put his long hair in his hair net.On 7/23/25 at 10:30 AM V6 ADON/IP nurse (assistant director of nursing/infection prevention nurse) stated that gloves are worn to prevent cross contamination.On 7/22/25 at 11:45 AM, V14 was observed checking food temperatures prior to serving meal. V14 wore a glove on his left hand while using his ungloved right hand to check the temperatures. The back of V14's right hand was observed touching the food while checking temperatures.Per the FDA (Food and Drug Administration) food code, dated 2022, notes food service employees shall wear hair restraints and beard restraints that are designed and worn to effectively keep their hair from contacting exposed foods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and records reviewed the facility failed to ensure staff wear gloves when handling soiled laundry and failed to follow the facility failed to follow its glucose testing policy by not placing a barrier between a used glucometer and the medication cart, and failed to perform hand hygiene and clean the glucometer while taking blood glucose levels. This affected two of two residents (R7, R3) reviewed for infection control practices and residents residing on the 200 hall. Findings Include: The findings include: On 07/23/2025 at 11:00 AM V4, Laundry Aide, observed in the 200 hall removing laundry from 1st soiled bin. V4 wearing no gloves. V4 then pushed her laundry cart to a 2nd bin wearing no gloves and adjusted the bag inside, closed the bin and then went to 3rd laundry bin. V4 wore no gloves when removing or adjusting bags on the soiled laundry bins. At 11:04 AM V4 said they tell us not to wear gloves when collecting laundry in the hall way. On 07/23/2025 at 11:52 AM V6, Infection Preventionist, said gloves should be worn when handling gloves with soiled items, yes laundry. V6 said gloves should be worn when removing laundry from the bin. V6 said gloves should be worn because the item is soiled and incase the bag tears. V4's orientation checklist dated 9/26/24 states she trained on linen handling, Infection Control procedures, and use of personal protective equipment. The facility Infection Prevention and Control Program policy dated 11/28/17 states the purpose includes all facility personnel are required to routinely wash hands and use appropriate barrier precautions to prevent transmission of infections. CDC.gov guidance accessed on 7/25/25 states Best practices for linen (and laundry) handling. Always wear reusable rubber gloves before handling soiled linen. R7 was diagnosed with type two Diabetes Mellitus. On 7/23/25 at 10:49am, during medication pass, V29 (nurse) was observed donning gloves, taking R7 blood glucose level, V29 took R7's blood glucose level, walked back to the medication cart, placed the blood glucose monitoring machine directly on the medication cart without any type of barrier, cleaning the machine or washing hands/using hand sanitizer after removing his gloves. R3 was diagnosed with type two Diabetes Mellitus On 7/23/25 at 10:51am, during medication pass, V29 took the same glucose machine he used on R7, donned new gloves, took R3's blood glucose level which resulted 147mg/DL without cleaning the machine or washing hands/using hand sanitizer after removing his gloves R3's blood glucose level on 7/23/25 at 10:54 documents: 147mg/dL On 7/23/25 at 11:08am, V29 said, he was supposed to wash/sanitize his hands before and after putting on gloves/removing gloves and in between each resident. V29 said, he was also supposed to clean the blood glucose machine between each resident with bleach wipes. On 7/25/25 at 12:50pm, V12 (don) said, she expects nursing staff to follow the glucometer policy, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff should put down a barrier, clean hands before and after donning/doffing gloves and clean the glucometer machine. Glucose Testing-Glucometer dated 11/28/12 documents: Place clean paper towel or clean barrier on surface and places supplies in surface. Remove gloves and perform hand hygiene. Hand Hygiene/Handwashing policy dated 11/29/12 documents: Hand hygiene means clean you hand by using either handwashing (washing hands with soap and water) antiseptic hand wash or antiseptic hand rub (i.e alcohol-based hand sanitizer including foam or gel.) Examples of when to perform hand hygiene: at room entry, before performing an aseptic task, before exiting room, before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, after contact with blood, body fluids or excretions and after glove removal.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review the facility failed to ensure the call light was functioning for a dependent resident R2 reviewed for functioning call light system in total sample of 45 residents.Findings include: R2 face sheet shows diagnosis of unspecified osteoarthritis, lack of coordination, need for assistance for personal care.On 7/22/25 at 2:37pm R2 said the call light for her bathroom shower is not working. R2 said the light should be working so that she can pull the string if she needs help from the staff. R2 did not give a situation/ time/ episode of an event that she pulled the shower call light and staff did not respond and she had to wait. R2 said she told maintenance about the call light last week.Surveyor pulled the cord to the call light for the shower (in R2 bathroom) , and the light did not illuminate at the call light box, or above the entry door to the room, the string did not pull.7/22/25 V30 (RN) was made aware immediately upon exit of R2 room that R2 call light for the shower is not working in R2's room.On 7/24/25 with assist from V7 (Maintenance staff) to check R2 call light for the shower, R2 call light for the shower was not working, it did not illuminate at the call box, above the door, and it did not activate at the nurse's station. V7 said the call lights should be functioning by activating and lighting up above the door and registering at the Nurses station call light system. V7 said he was made aware of the call light in R2 bathroom not working for the shower. V7 said he don't recall who informed him of the call light not working. V7 said she don't recall when he was informed that R2 call light for the shower was not working. V7 said the plan is for the company to fix the call light.Facility policy titled Call light last revision date 2/2/2018 denotes in-part call bell system defects will be reported promptly to the maintenance department for servicing. Check room frequently until system is repaired.Facility failed to present policy for functioning call light system upon exit of this survey.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and record reviews, the facility failed to have an effective pest control program and ensure the kitchen area was free from flying insects. This failure affects all residents that receive meals in this facility. Findings include:On 7/22/25 at 10:40 AM, this surveyor toured the facility's kitchen with V13 (dietary supervisor). In the pantry where canned goods are stored, there were several, too active to count, fruit flies present.On 7/22/25 at 10:50 AM, V13 stated that there is no food stored in the pantry. V13 stated they are just fruit flies. V13 stated that the outside pest control company came to facility yesterday and provided treatment in the kitchen.On 7/23/25 at 12:15 PM, V7 (maintenance director) stated that the outside pest control company are here today placing extra traps for fruit flies throughout facility, mostly in the kitchen. V7 stated that some fruit flies were observed under the dishwasher. V7 stated that V13 informed him yesterday afternoon of fruit flies in the kitchen.The outside pest control company's service inspection report, dated 7/7/25, notes preventative treatment was performed, no activity seen.The outside pest control company's service inspection report, dated 7/23/25, notes treatment for fruit flies performed. Deep cleaning is necessary in all dish room areas, mainly under the dishwasher machine, the food extractor, and all corners. All broken tiles, missing grout, need to be fixed to eliminate accumulation and stagnant water and prevent breeding for fruit flies, and cut their cycles of live.