STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Elgin	134 North McLean Boulevard Elgin, IL 60121

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to hold care plan conferences with residents and their representatives and failed to invite residents and their representatives to participate in the care planning process. This applies to 6 of 6 residents (R1, R2, R3, R4, R5, and R6) reviewed for administration in the sample of 6. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including convulsions, abnormal gait and mobility, cognitive communication deficit, diarrhea, chronic pain syndrome, nontraumatic intracerebral hemorrhage, cerebral infarction, generalized anxiety disorder, bipolar disorder, major depressive disorder, mild vascular dementia with agitation, violent behavior, and low back pain. R1's MDS (Minimum Data Set) dated December 23, 2024 shows R1 has severe cognitive impairment, requires setup assistance with eating, partial/moderate assistance with showering, and supervision with all other ADLs (Activities of Daily Living). R1 is occasionally incontinent of bowel and bladder. On March 3, 2025 at 11:55 AM, R1 was sitting on the edge of his bed eating his lunch. R1 was not able to answer questions regarding care plan meetings due to his cognitive status. Facility documentation shows R1's MDS assessments were completed on June 22, 2024, September 22, 2024, and December 23, 2024. Facility documentation shows a multidisciplinary care plan meeting was held with R1 and V5 (POA-Power of Attorney for R1) on July 9, 2024 and September 23, 2024. The facility does not have documentation to show a care plan meeting has been held with R1, R1's family member, and the IDT (Interdisciplinary Team) since September 23, 2024. (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: 145740	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Aperion Care Elgin		STREET ADDRESS, CITY, STATE, ZIP CODE 134 North McLean Boulevard Elgin, IL 60121	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The EMR shows R2 was admitted to the facility on [DATE]. The EMR continues to show R2 was transferred to the local hospital on January 2, 2025 for a surgical procedure and returned to the facility on [DATE]. R2 was transitioned to hospice care on January 28, 2025. R2 has multiple diagnoses including malignant neoplasm of the border of the tongue, abnormal gait, lack of coordination, cognitive communication deficit, dysphagia, alcohol abuse, convulsions, alcoholic hepatitis without ascites, celiac disease, depressive episodes, and malignancy of the colon. R2's MDS dated [DATE] shows R2 is cognitively intact. The facility did not attempt to provide eating assistance to R2 due to her medical condition, and she requires supervision for all other ADLs. R2 is always continent of bowel and bladder. Facility documentation shows R2's MDS assessments were completed on September 3, 2024, October 25, 2024, January 24, 2025, and February 7, 2025. Facility documentation shows a care plan conference was held on September 10, 2024. The facility does not have documentation to show another care plan meeting has been held for R2 since September 10, 2024. 3. The EMR shows R3 was admitted to the facility on [DATE]. R3 was transferred to the local hospital on June 2, 2024, and returned to the facility on [DATE]. R3 has multiple diagnoses including, polyosteoarthritis, diabetes, abnormal gait, lack of coordination, dysphagia, skin cancer, heart failure, psychosis, delusional disorders, major depressive disorder, OCD (Obsessive Compulsive Disorder), hoarding disorder, and generalized anxiety. R3's MDS dated [DATE] shows R3 is cognitively intact, requires supervision with eating and oral hygiene, partial/moderate assistance with personal hygiene, substantial/maximal assistance with toilet hygiene, showering, bed mobility, and transfers between surfaces, and is dependent on facility staff for dressing. Facility documentation shows R3's MDS assessments were completed on June 13, 2024, July 23, 2024, August 27, 2024, September 16, 2024, October 25, 2024, January 22, 2025, and February 27, 2025. Facility documentation shows a care plan conference was held on December 11, 2018, and on November 18, 2024. The facility does not have documentation to show any other care plan meetings have been held for R3. 4. The EMR shows R4 was admitted to the facility on [DATE] with multiple diagnoses including, adjustment disorder, hypertensive heart and chronic kidney disease with heart failure, atrial fibrillation, emphysema, and dependence on supplemental oxygen. Facility documentation shows R4's MDS assessments were completed on September 13, and December 2, 2024. Facility documentation shows an initial care plan meeting was held on September 16, 2024. The facility does not have documentation to show a care plan meeting was held with R4, R4's family member, and the IDT (Interdisciplinary Team) since September 16, 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145740	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The EMR shows R5 was admitted to the facility on [DATE] with multiple diagnoses including, major depressive disorder, asthma, abnormal gait and mobility, lack of coordination, suicidal ideations, obstructive sleep apnea, lymphedema, and hypertension. Facility documentation shows R5's MDS assessments were completed on May 18, 2024, August 15, 2024, November 15, 2024, and December 18, 2024. Facility documentation shows an initial care plan meeting was held on May 28, 2024. The facility does not have documentation to show a care plan meeting was held with R5, R5's family member, and the IDT since May 28, 2024. 6. The EMR shows R6 was admitted to the facility on [DATE] with multiple diagnoses including, dementia, abnormal gait, cognitive communication deficit, depression, and history of cerebral infarction. Facility documentation shows R6's MDS assessments were completed on March 3, 2024, March 10, 2024, June 7, 2024, September 7, 2024, and December 8, 2024. Facility documentation shows an initial care plan meeting was held on March 12, 2024. The facility does not have documentation to show a care plan meeting was held with R6, R6's family member, and the IDT since March 12, 2024. On March 4, 2025 at 2:22 PM, V2 (DON-Director of Nursing) said the facility does not have a care plan coordinator and no staff member has been assigned to ensure care plans are taking place. V2 continued to say care plan meetings should be held with the IDT, the resident, and the family members after each MDS review which is quarterly, or if there is a significant change with the resident. V2 said the facility is not currently holding care plan meetings quarterly or following significant changes with residents. On March 4, 2025 at 10:15 AM, V1 (Administrator) said the facility does not have a policy regarding care plan meetings. V1 also said the facility does not have a care plan coordinator at this time. V1 provided a copy of the facility's undated admission contract, entitled IL Admission Packet. The facility's Admission Packet shows, Family and Resident Participation in Care Plan Conferences: This facility conducts care planning conferences at regular intervals in order to develop the interdisciplinary approach to the care that is delivered. Members of each professional discipline attend care planning meetings and every aspect of care is addressed at these meetings. Care plan meetings are utilized to discuss any changes in condition or developments related to the Resident's well-being. This facility encourages the participation of both Residents and families in the care planning process. In fact, participation by the Resident and family is considered to be vital to the staff understanding the needs of the Resident and family. At a designated time prior to the care planning conference, both the Resident and family/authorized representative will be informed of the time and place of this scheduled meeting.

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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** 33330 Based on interview and record review, the facility failed to schedule neuropsychological testing for a resident as ordered by the neurology physician. This applies to 1 of 3 residents (R1) reviewed for improper nursing care in the sample of 6. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including convulsions, abnormal gait and mobility, cognitive communication deficit, diarrhea, chronic pain syndrome, nontraumatic intracerebral hemorrhage, cerebral infarction, generalized anxiety disorder, bipolar disorder, major depressive disorder, mild vascular dementia with agitation, violent behavior, and low back pain. R1's MDS (Minimum Data Set) dated December 23, 2024 shows R1 has severe cognitive impairment, requires setup assistance with eating, partial/moderate assistance with showering, and supervision with all other ADLs (Activities of Daily Living). R1 is occasionally incontinent of bowel and bladder. On March 3, 2025 at 11:55 AM, R1 was sitting on the edge of his bed, eating his lunch. R1 was not able to answer questions due to his cognitive status. On July 15, 2024 at 10:00 AM, V10 (Neurologist) documented R1 was seen in his office to address R1's partial symptomatic epilepsy with complex partial seizures. V10's discharge instructions show multiple orders, including, Neuropsychological testing referral. As of March 4, 2025, the facility does not have documentation to show the neuropsychological testing appointment was made for R1 or that R1 was seen by a neuropsychologist. On November 25, 2024, V10 (Neurologist) documented R1 was seen in his office. V10's documentation shows R1 Not oriented to month or year. Unable to name things like phone, keyboard, mouse. Can name glasses and watch. Repeats phrase. V10 continued to document, [R1's] presentation and findings are consistent with a diagnosis of left parieto-occipital lobe epilepsy. Plan: Neuropsychological testing ordered previously. The following tests were ordered: None this visit, all ordered previously. On March 4, 2025 at 12:03 PM, V8 (Psychological NP-Nurse Practitioner) said she has been working with R1 for about six months. V8 said, A neuropsychological examination cannot be done by me. It is a completely different assessment. Not every psychologist can do that type of testing. It requires a neuropsychologist who is trained in that. With that type of testing, we can get a better picture of what is going on in the brain and it helps us to plan the resident's care. On March 4, 2025 at 10:02 AM, V2 (DON-Director of Nursing) said, [V10] (Neurologist) ordered neuropsychological testing. We did not make that appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy entitled Physician Orders - Entering and Processing revised 1-31-18 shows, Purpose: To provide general guidelines when receiving, entering, and confirming physician or prescriber's orders (a prescriber is noted as physician, nurse practitioner, and a physician's assistant). Guidelines: 5. Following a physician visit, a licensed nurse will check for any orders that require confirmation under Clinical orders pending orders. The orders will be confirmed by the nurse and the instructions for the order will be completed.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to schedule an ophthalmology appointment for a resident as ordered by the neurologist. This applies to 1 of 3 residents (R1) reviewed for improper nursing care in the sample of 6. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including convulsions, abnormal gait and mobility, cognitive communication deficit, diarrhea, chronic pain syndrome, nontraumatic intracerebral hemorrhage, cerebral infarction, generalized anxiety disorder, bipolar disorder, major depressive disorder, mild vascular dementia with agitation, violent behavior, and low back pain. R1's MDS (Minimum Data Set) dated December 23, 2024 shows R1 has severe cognitive impairment, requires setup assistance with eating, partial/moderate assistance with showering, and supervision with all other ADLs (Activities of Daily Living). R1 is occasionally incontinent of bowel and bladder. On March 3, 2025 at 11:55 AM, R1 was sitting on the edge of his bed, eating his lunch. R1 was not able to answer questions due to his cognitive status. On July 15, 2024 at 10:00 AM, V10 (Neurologist) documented R1 was seen in his office to address R1's partial symptomatic epilepsy with complex partial seizures. V10's discharge instructions show multiple orders, including, Ophthalmology referral. As of March 4, 2025, the facility does not have documentation to show the ophthalmology appointment was made for R1 or that R1 was seen by an ophthalmologist. On November 25, 2024, V10 (Neurologist) documented R1 was seen in his office. V10's documentation shows R1 Not oriented to month or year. Unable to name things like phone, keyboard, mouse. Can name glasses and watch. Repeats phrase. V10 continued to document, [R1's] presentation and findings are consistent with a diagnosis of left parieto-occipital lobe epilepsy. Plan: Visual impairment - referral to neuro-ophthalmology placed previously. The following tests were ordered: None this visit, all ordered previously. On March 4, 2025 at 10:02 AM, V2 (DON-Director of Nursing) said, [V10] (Neurologist) ordered an ophthalmology referral. We did not make that appointment. The facility's policy entitled Physician Orders - Entering and Processing revised 1-31-18 shows, Purpose: To provide general guidelines when receiving, entering, and confirming physician or prescriber's orders (a prescriber is noted as physician, nurse practitioner, and a physician's assistant). Guidelines: 5. Following a physician visit, a licensed nurse will check for any orders that require confirmation under Clinical orders pending orders. The orders will be confirmed by the nurse and the instructions for the order will be completed.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to ensure a resident received an MRI (Magnetic Resonance Imaging) as ordered by the neurologist. This applies to 1 of 3 residents (R1) reviewed for improper nursing care in the sample of 6. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including convulsions, abnormal gait and mobility, cognitive communication deficit, diarrhea, chronic pain syndrome, nontraumatic intracerebral hemorrhage, cerebral infarction, generalized anxiety disorder, bipolar disorder, major depressive disorder, mild vascular dementia with agitation, violent behavior, and low back pain. R1's MDS (Minimum Data Set) dated December 23, 2024 shows R1 has severe cognitive impairment, requires setup assistance with eating, partial/moderate assistance with showering, and supervision with all other ADLs (Activities of Daily Living). R1 is occasionally incontinent of bowel and bladder. On March 3, 2025 at 11:55 AM, R1 was sitting on the edge of his bed, eating his lunch. R1 was not able to answer questions regarding his MRI due to his cognitive status. On July 15, 2024 at 10:00 AM, V10 (Neurologist) documented R1 was seen in his office to address R1's partial symptomatic epilepsy with complex partial seizures. V10's discharge instructions show multiple orders, including, MRI Brain Epilepsy with and without contrast. Schedule this appointment to take place on or around July 15, 2024. The facility does not have documentation to show the MRI was scheduled for R1 as ordered by V10 (Neurologist). On November 25, 2024, V10 (Neurologist) documented R1 was seen in his office. V10's documentation shows R1 Not oriented to month or year. Unable to name things like phone, keyboard, mouse. Can name glasses and watch. Repeats phrase. V10 continued to document, [R1's] presentation and findings are consistent with a diagnosis of left parieto-occipital lobe epilepsy. Plan: MRI Brain epilepsy with/without contrast ordered previously.The following tests have been ordered MRI Epilepsy protocol (call [phone number] to set this up). On March 4, 2025 at 10:02 AM, V2 (DON-Director of Nursing) said, [V10] (Neurologist) ordered an MRI for [R1] on July 15, 2024. The MRI was supposed to be completed before his next visit on November 25, 2024. That was never done. When [R1] returned to the [V10] office on November 25, 2024 and the MRI was not completed, [V10] ordered it himself, and we finally got the MRI done on December 30, 2024. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy entitled Physician Orders - Entering and Processing revised 1-31-18 shows, Purpose: To provide general guidelines when receiving, entering, and confirming physician or prescriber's orders (a prescriber is noted as physician, nurse practitioner, and a physician's assistant). Guidelines: 5. Following a physician visit, a licensed nurse will check for any orders that require confirmation under Clinical orders pending orders. The orders will be confirmed by the nurse and the instructions for the order will be completed.

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to ensure transportation arrangements were made for a resident with a scheduled physician follow-up appointment. This applies to 1 of 3 residents (R1) reviewed for improper nursing care in the sample of 6. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE] with multiple diagnoses including convulsions, abnormal gait and mobility, cognitive communication deficit, diarrhea, chronic pain syndrome, nontraumatic intracerebral hemorrhage, cerebral infarction, generalized anxiety disorder, bipolar disorder, major depressive disorder, mild vascular dementia with agitation, violent behavior, and low back pain. R1's MDS (Minimum Data Set) dated December 23, 2024 shows R1 has severe cognitive impairment, requires setup assistance with eating, partial/moderate assistance with showering, and supervision with all other ADLs (Activities of Daily Living). R1 is occasionally incontinent of bowel and bladder. On March 3, 2025 at 11:55 AM, R1 was sitting on the edge of his bed, eating his lunch. R1 was not able to answer questions due to his cognitive status. On November 25, 2024, V10 (Neurologist) documented R1 was seen in his office. V10's documentation shows R1 Not oriented to month or year. Unable to name things like phone, keyboard, mouse. Can name glasses and watch. Repeats phrase. V10 continued to document, Future appointments: March 17, 2025 11:00 AM - V10 (Neurology). On March 4, 2025 at 10:34 AM, V1 (Administrator) presented the facility's Transportation Log. The Transportation Log showed residents with appointments for the period of March 3, 2024 to March 26, 2025. The Transportation Log did not show R1's scheduled appointment for March 17, 2025 at 11:00 AM to see V10 (Neurologist), or that transportation had been set up for R1 to attend the appointment. On March 4, 2025 at 2:47 PM, V6 (Transportation Coordinator) said, It is the nurse's job to set up the appointments. Then the nurse for each resident fills out a piece of paper to tell me the resident has an appointment and then I set up the transportation. [R1] was not on the transportation list because I did not set up transportation for an appointment on March 17, 2025. I was not aware he needed transportation. If the resident is not on the transportation list, the resident will miss the appointment because no transportation was set up for the resident.