STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145877	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Dolton	14325 South Blackstone Dolton, IL 60419

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to adequately supervise a resident who is at risk for aspiration and requires staff assistance during meals (R3) and failed to provide adequate staff supervision for a resident during smoking (R4). These failures affected two (R3, R4) of four resident reviewed for accidents and supervision and resulted in R3 sustaining an injury during mealtime, while in her room unsupervised and required treatment of two sutures; R4 was found on the floor while out on the patio, unsupervised, during a smoke break and required transfer to local hospital for evaluation of swelling to forehead. Findings include: R3 is a [AGE] year-old female who has resided at the facility since 2020, past medical history includes, but not limited to other lack of coordination, cerebral infarction, unsteadiness on feet, dysphagia oral and oropharyngeal phase, type two diabetes, abnormal posture, hyperlipidemia, difficulty walking, other symptoms and signs concerning food and fluid intake, etc. On 9/24/2024 at 1:40PM, R3 was observed in her room, awake, alert, and oriented with some confusion sitting in her wheelchair. R3 answers yes or no to questions but was speaking in what appears to be a different language. R3's Minimum Data Set (MDS) assessment dated [DATE] section C (cognitive patterns) scored resident with a BIMS score of 00, section GG (Functional status) of the same assessment documented that R3 requires partial/moderate assistance to substantial / maximal assistance to being dependent on staff for all ADL care needs including eating. R3's Care plan initiated 5/27/2020, revised 9/20/2024 documented that R3 requires assistance with meal consumption related to diagnosis of dementia, decrease in strength and endurance, and lack of coordination. Interventions includes provide cueing as needed, offer substitutes, and provide socialization during meals. R3's Care plan initiated 4/21/2020 and 1/02/2024 states that R3 is at risk for nutritional problem related to current diet and diagnosis. Interventions include Monitor/document/report as needed any signs and symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility reported incident dated 6/27/2024 documented in part: the evening of 6/27/2027, resident was observed in her room asleep in front of her bedside table bleeding from her mouth. Resident was sitting up with her bedside table in front of her having dinner, resident had nodded off and bumped her chin on the bedside table, sustaining the lip wound and bruised area to her chin. Progress note documented by V4 registered nurse (RN) dated 6/27/2024 17:41:15 states as follows: Writer's attention called into resident's room notifying of a bleeding gum, upon assessment bleeding noted to resident's upper mouth/gums as well the bridge of the mouth. Resident's mouth was cleaned out and attempt made to stop the bleeding. Writer unable to stop bleeding currently. Nurse Practitioner (NP) made aware, and orders received to send resident to a local hospital emergency room . 9/24/2024 at 2:44PM, V5 certified nursing assistant (C.N.A) stated that she was at work the day R3 injured herself, R3 was in her bed around 5 to 5:30PM and was eating dinner. V5 stated she was not in the room with resident, her roommate was there eating too, when V5 came back, she saw blood on resident's cover, V5 could not see where the blood is coming from and R3 could not open her mouth. V5 called the nurse who came and assessed resident and noted that she was bleeding from her mouth. V5 added that R3's roommate was in the room at the time but did not see anything, both were eating dinner when V5 saw them last. R3 eats by herself and does not require staff assistance, she only require supervision if she does not eat. V5 added that she was not in the room and cannot explain how R3 got her injury. 9/24/2024 at 3:54PM, V4 (RN) stated that she was assigned to R3 the day she had an incident, she was called by the C.N.A, when she got to the resident's room, she noted that she was bleeding in her mouth. V4 stated she could not stop the bleeding she called the NP and received an order to send the resident to the hospital. V4 added that R3 was sitting up in bed, there was nothing in front of her or on the floor, the blood was on the resident, no blood was noted on the bed or floor. V4 stated that she doesn't usually work that set, R3 eats by herself and does not require staff supervision except when she refuses to eat, then staff will assist her. V4 then stated that she thinks R3 feeds herself with supervision, V4 was not sure the last time she saw R3 before the incident. V4 stated that she was passing medication at the time. Feeding assistance policy provided by V1 (Administrator) (undated) states its purpose as to assist the resident to obtain nutrients and hydration. Under procedures, #20 states: report all pertinent observations and resident preferences for food to the charge nurse. Swallowing, chewing, choking episodes, bite and gag reflex, lip closing, poor tongue control, etc. to be recorded in the nursing notes by a licensed nurse. R4 is an [AGE] year-old male admitted to the facility on [DATE], past medical history includes orthostatic hypertension, unspecified psychosis due to a substance or known physiological condition, pain in unspecified joint, history of falling, laceration without foreign body of scalp, other fracture of left femur initial encounter for closed fracture, hyperlipidemia, type 2 diabetes, etc. On 9/24/2024 at 2:06PM, R4 was observed in his room sitting in a wheelchair, awake and alert with some confusion. R4 was asked if he recalls going to the hospital and what happened. He stated that he remembers going to the hospital but not sure why, surveyor asked R4 if he recalled falling in his room and he (R4) said that he remembers falling outside not in his room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R4's Facility MDS dated [DATE] section C, scored R4 with a BIMs of 08, section GG of the same assessment coded R4 as requiring staff assistance for all ADL care. R4's Smoking care plan initiated 8/20/2024 states, I am a smoker, I will not smoke without supervision through the review date. Interventions include - Instruct about smoking risks and hazards and about smoking cessation aids that are available, observe clothing and skin for signs of cigarette burns, etc. An incident report dated 9/22/2024 18:43:17, by V7 (RN) states: Resident had an un-witnessed fall 09/22/2024 6:00 PM Location of Fall: outside patio writer was called outside (patio) and observed resident sitting in the floor next to his wheelchair on 09/22/2024 6:00 PM. 9/25/2024 at 3:30PM, V7 (RN) stated that she was called by a staff because someone fell outside, she went there and saw R4 on the floor with the rest of the residents, they were supposed to be monitored by the activity aide, but she was not there at the time. They assisted resident back to his wheelchair, V7 assessed resident with no injuries. 9/25/2024 at 3:58PM, V8 (Activity Aide) stated she was supposed to be monitoring the residents that were outside smoking the day R4 fell . V8 stated she had just stepped out to go to the cart and get more cigarettes. V8 stated she came back and R4 was on the floor. V8 stated the incident occurred around 5:30PM there were about seven residents outside at that time. V8 stated that she was the only one monitoring the smoke break, it was the last smoke break, and she (V8) usually monitors it before she leaves. V8 stated that she did not inform anyone that she was going inside so no one was monitoring the residents while she was gone. Facility smoking policy revised 10/24/2022 states its purpose as to provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. It is also the objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy. Under safety measures, the policy states that a Smoking Safety Assessment will be completed to determine the level of assistance and supervision needed during smoking, the ability to carry and store smoking materials, and if a smoking apron is indicated. The plan of care shall reflect the results of this assessment. This assessment will be completed upon admission, quarterly and with significant change.