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	12/29/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident's indwelling urinary catheter drainage bag was covered with a privacy bag to maintain resident's right to privacy and dignity. This failure affected one resident(R3) of two residents, reviewed for privacy and dignity.Findings include:R3 was admitted to the facility on [DATE] with diagnoses which include but are not limited to Tracheostomy Status, Quadriplegia, Neuromuscular Dysfunction of Bladder, and Urinary Tract Infection (on 10/7/25).On 12/22/25 at 11:30am, R3 was observed in bed with indwelling urinary catheter drainage bag resting on the floor, and without privacy bag. The Urinary drainage bag was visible to persons passing by in the hallway. Again at 11:45am, the urinary drainage bag was still in the same position, visible to anyone walking down the hall. At this time, V3 (RN/Registered Nurse), who was observed earlier caring for R3, was asked why the drainage bag should not be resting on the floor and exposed to anyone standing or walking down the hallway. V3 stated that R3's bed is in a low position, and she (V3) did not know how to prevent the drainage bag from touching the floor. V3 added that R3 is able to understand questions and able to answer yes or no in response.On 12/22/25 at 11:55am, V2(Director of Nursing) was notified and V2 stated that the urinary drainage bag should not touch the floor and that there should be a privacy bag covering the drainage bag for the resident's privacy. V2 later informed the surveyor that V3 and other staff members were given in-service training regarding the care of indwelling urinary catheter.R3's care plan dated 11/10/25 states that R3 has an indwelling urinary catheter related to pressure injury. Goal states that R3 will be free from catheter related trauma through the review date.Facility's policy on Dignity dated 11/28/12 and latest revision on 4/23/18 states: This facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Staff Should I carry out activities in a manner which assists the residents to maintain and enhance his/her self-esteem and self-worth. Maintaining a residents' dignity should include but is not limited to the following: Refraining from practices demeaning to residents such as living urinary catheter bags uncovered, etc.

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
	145877	A. Building B. Wing	12/29/2025

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

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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 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** Based on observation, interview, and record review, the facility failed to ensure that a resident's indwelling urinary catheter drainage bag did not rest on the floor directly, to prevent potential contamination of the drainage bag from the floor surface. This failure affected one resident (R3) of two residents reviewed for indwelling urinary catheter care.Findings include:R3 was admitted to the facility on [DATE] with diagnoses which include but are not limited to Tracheostomy Status, Quadriplegia, Neuromuscular Dysfunction of Bladder, and Urinary Tract Infection (on 10/7/25).On 12/22/25 at 11:30am, R3 was observed in bed with indwelling urinary catheter drainage bag resting on the floor, and without privacy bag. The Urinary drainage bag was visible to persons passing by in the hallway. Again at 11:45am, the urinary drainage bag was still in the same position, visible to anyone walking down the hall. At this time, V3 (RN/Registered Nurse), who was observed earlier caring for R3, was asked why the drainage bag should not be resting on the floor and exposed to anyone standing or walking down the hallway. V3 stated that R3's bed is in a low position, and she(V3) did not know how to prevent the drainage bag from touching the floor. V3 added that R3 is able to understand questions and able to answer yes or no in response.On 12/22/25 at 11:55am, V2(Director of Nursing) was notified and V2 stated that the urinary drainage bag should not touch the floor to prevent contamination, and that there should be a privacy bag covering the drainage bag for the resident's privacy. V2 later informed the surveyor that V3 and other staff members were given in-service training regarding the care of indwelling urinary catheter.R3's face sheet and progress notes dated 10/7/25 shows that R3 was admitted to this facility on 8/20/25 and that R3 was sent to the hospital with a diagnosis of Urinary Tract Infection (UTI) on 10/7/25(about 7 weeks after admission to the facility).R3's care plan dated 11/10/25 states that R3 has an indwelling urinary catheter related to pressure injury. Goal states that R3 will be free from catheter related trauma through the review date. Intervention states to monitor for signs and symptoms of urinary tract infection.Facility's policy on Urinary Catheter Care dated 11/28/12 with latest revision date 2/14/19 states: Purpose - Established guidelines to reduce the risk of or prevent infections in residents with an indwelling catheter. #7 states: Urinary drainage bag and tubing shall be positioned to prevent either from touching the floor directly. May place the drainage bag and excess tubing in a secondary vinyl bag or other similar device to prevent primary contact with the floor or other surfaces.