

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145913	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Aperion Care Burbank		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 West 79th Street Burbank, IL 60459	
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** Based on observation, interview and record review, the facility failed to provide adequate supervision and interventions for a resident assessed as being at risk for falls. This failure affected one (R9) of three residents reviewed for falls. This failure resulted in harm with injury when R9 was found on the floor in his room and sustained an impacted distal radius fracture to right wrist and reverse obliquity IT fracture of right hip. R9 underwent a surgical procedure of insertion of intermedullary rod to proximal femur. Findings include: R9 is 97 years and has resided at the facility since 2023. Past medical history includes but is not limited to unspecified dementia, other lack of coordination, displaced oblique fracture of lower end of right radius, subsequent encounter for closed fracture with routine healing, other reduced mobility, history of falling, essential primary hypertension etc. On 7/7/2026 at 8:45AM R9 was observed in bed, awake with confusion, hard of hearing but using a hearing device. R9 was asked what happened the day he fell and injured himself and he said, I don't know what happened, I can't remember. Minimum Data Set (MDS) assessment dated [DATE] section c (cognition) documented a brief interview for memory (BIMS) score of 7, indicating that R9 is cognitively impaired. Section GG (functional) of the same assessment documented that R9 requires supervision or touching assistance for eating and partial/moderate assistance for oral hygiene, personal hygiene, and rolling left to right, substantial/maximal assistance for upper and lower body dressing, sit to lying and lying to sitting on side of bed, chair/bed -to-chair transfer, and dependent on staff for toilet transfer, tub/shower transfer, toilet hygiene and putting or taking off foot wear. R9 is dependent on manual wheelchair, requires supervision/touching assistance to wheel 50 feet with two turns, and dependent on staff to wheel 150 feet in the corridor or similar space. Nurse's note dated 5/5/2026 at 00:56:43 (12:56 AM) by V24 LPN (Licensed Practical Nurse) stated the following: Certified Nurse Assistant (CNA) was out in the hallway and heard door slam in R9's room. Writer went to investigate and found resident lying behind the door up against the wall. Slowly and carefully pulled Resident to lie straight on the floor. Body assessment revealed pain in the right wrist with abrasion and right hip pain. 98-90-18-136/64 95% RA (Vital Signs). (Tele-Health Company) called and due to unwitnessed fall with R9 taking Eliquis, to send to ER (Emergency Room) 911. Director of nursing (DON) notified, as well as R9's son. Hospital record dated 5/5/2026 documents in part: History of present illness (HPI), R9 is a [AGE] year-old male, PMHx (Past Medical History) of Dementia (A&O [Alert and Oriented] x1-2, wheelchair bound), Osteoporosis, Prior stable T12 vertebral burst fracture (no operative intervention), Prior PE (Pulmonary Embolism) on Eliquis (described as provoked in 2023, however on chronic DOAC [anticoagulants]), Prostate cancer (diagnosed 20 years ago) managed with hormonal therapy (completed), BPH (Benign Prostatic Hyperplasia), HTN (Hypertension), Chronic sensorineural hearing loss who presented to the ED on 5/4/26 following unwitnessed fall, on anticoagulation, at his nursing (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility. admitted for fragility fractures of the R (right) distal radius, R Proximal femur. History obtained from patient and patient's son (POA-Power of Attorney) present in the room. Patient was in his usual state of health until the evening of 5/4/26, when he reportedly got up from his bed / wheelchair at his SNF (skilled nursing facility) to close his door, when he fell onto his R side. No staff were present in the room at the time to witness the event. However, it is likely R9 hit his head. R9 is a poor historian, baseline dementia. Patient does not remember falling. He reports he does not remember much but denies chest pain, dizziness before the fall. He denies any current abdominal pain, chest pain, SOB (shortness of breath), n/v/d (nausea/vomiting/diarrhea). Patients son reports the only medication he is currently on is the Eliquis. R9 at baseline uses a wheelchair due to a previous fall about two years ago. METs (Metabolic Equivalents of task)< 4 at baseline. He is nearly fully dependent on assistance/ devices to ambulate.Imaging: - XR R wrist/ R forearm (5/5) Comminuted minimally displaced fractures of the distal radius with impaction - XR R Hip-. (5/5) Linear oblique fracture across the right proximal femur with extension across the lower medial neck region, intertrochanteric region and proximal femoral shaftOn 7/7/2026 at 12:32PM, V2 (DON-Director of Nursing) said that resident's (R9) fall occurred on 3:00 to 11:00PM shift, resident's bed was close to the window, and he attempted to get up and walk to the door to close the door, resident can get up and make some steps, he should not be ambulating by himself without staff assistance. V2 said that R9 can transfer himself from bed to chair and chair to bed though he is not supposed to do so and V2 has seen him do that in the past. R9 was last seen in a wheelchair by the CNA, R9 then transferred himself to bed, got up from bed and walked to the door and fell. V2 affirmed that he had seen R9 self-transferring from bed to wheelchair but there was no intervention apart from R9 being redirected. Surveyor asked V2 if the redirection worked and he said no.Fall risk assessments dated 1/15/2026, 4/15/2026 and 5/8/2026 all indicated that R9 is at risk for falls. Fall care plan initiated 7/31/2023, revised 4/24/2026 documented that R9 is at risk for falls and injury related to falls. Goal: I will have interventions in place and reviewed as needed to address risk for falls and injury related to falls through next review. Interventions: provide visual cues to use call light for assistance, anticipate and meet the resident's needs, be sure resident's call light is within reach and encourage resident to use it for assistance as needed, bed height to be placed where my feet are flat on the floor, ensure the resident is wearing appropriate footwear. There are no interventions to address R9's confusion or attempt to ambulate independently.IDT fall committee note dated 5/5/2026 documented in part: Per nurse's note, C.N.A heard door slam in room. Resident observed to be lying behind the door and up against the wall. Resident was lying behind door blocking the door. Contributing factors: 6. impaired memory,7. confused, 4. gait imbalance,9. incontinent. Environmental factors: 17. There was already a safety intervention in place. Situational factors: 14. Ambulating without assist.2c. Contributing factors: Resident with dementia, alert with confusion, hard of hearing and requires assistance with ADLs, uses wheelchair for mobility and ambulation. Prior interventions and support provided: call light within reach, bed in low position. 7. Root cause of the fall determined by IDT: resident stated he went to close room door, resident noted with comorbidities that place resident at risk or fall. Due to resident impaired insight to current functional mobility secondary to -----, resident made attempt to ambulate from one side of room to door which resulted in a fall with injury. Resident considered wheelchair bound and has been since admission.On 7/8/2026 around 3:30PM, V2 (DON) said for residents at high risk for falls, staff are supposed to do more rounds, if a resident refuses assistance it should be reported to the nurse. A confused resident who is at risk of falling with a tendency to get up, staff should not leave them by themselves. R9 probably should have had more supervision, and it should be in the care plan.7/7/2026 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at 1:35PM, V35 (R1's POA) said that R9 cannot get up from bed without assistance and have not done so in years. Staff told him that there was too much noise in the hallway, resident got up and walked to the door to close the door, V35 said that is impossible because R9 is hard of hearing and could not hear the noise in the hallway without his hearing device. V35 said that facility then told him that someone put resident in bed and forgot to close the door. On 7/7/2026 at 1:55PM, V22 (Therapy manager) said that R9 has been currently in therapy since May 8th five times a week, they are training him to walk with assistance. Before the fall, resident received therapy and was able to stand and pivot, he is not supposed to walk by himself, can only transfer from chair to bed and bed to chair with assistance. On 7/8/2026 at 4:08PM, V22 said that R9 was trained on a walker the last time he was in therapy prior to the fall, but he was not discharged on a walker, resident was discharged on a wheelchair. V22 added that R9 is not supposed to walk by himself but for confused patients they can try to get up thinking that they can still walk. V22 added that residents who are confused and at risk of fall should not be left unsupervised in a wheelchair by themselves in the room. Physical therapy discharge, date of service 1/2/2026 -3/20/2026 documented that R9 was discharged with an assessment of supervision or touching assistance for chair/bed to chair transfer, sit to stand transfer, roll left to right and lying on side of bed. Ambulation: walk 10 feet- partial/moderate assistance. Walk 150 feet- not attempted due to medical condition or safety concern. On 7/8/2026 at 12:10PM V34 (R9's family member) said that her father (R9) has never walked in years or since he has been at this facility, there is no way he will get up by himself and walk all the way from the window to the door, she told the facility the same thing when they told her that was the cause of his fall. Timeline of incident provided by facility documented the following: 8:30PM, R9 observed sitting in wheelchair in the doorway to his room. 9:00PM -10:00PM - Staff in and out of room. (No description of R9's location or activity currently). 10:06PM, Staff members leave room during final rounds of the shift (No description of R9's location or activity currently). 10:08PM- Staff responded to sound of R9 falling and bumping into the door. Review of facility incident report did not indicate whether R9 was in bed or wheelchair prior to the fall according to staff statements and could not account for any staff who transferred resident from wheelchair to bed. Statement from V23 (Restorative C.N.A) documented that she saw R9 sitting in his wheelchair around 9:00PM, V23 was told that R9 refused to be transferred to bed. Statement from V24 (RN-Registered Nurse) stated that R9 was in bed around 8:30PM when she gave him medication, no sign of restlessness, V23 woke resident up to receive medication. Statement from V8 (C.N.A) indicated that R9 was in bed around 9:30PM and 9:45PM and refused to be changed. V8 saw resident in wheelchair in his room around 5:30PM, he was in bed after dinner, V8 did not assist him to bed. Another staff member who is on vacation and could not be interviewed documented that R9 was in his wheelchair around 8PM, then she heard the loud noise around 10:30PM while she was in another room. On 7/7/2026 at 3:03PM V23 (Restorative C.N.A) said that she recalls R9 and remembers the day he had a fall. V23 was busy with another resident when she was called to help get R9 up from the floor. V23 said that the last time she saw resident, he was sitting in a wheelchair in his room, another staff member told V23 that resident refused to be put to bed, resident is a two person assist but can be transferred by one person before the fall. V23 has never seen R9 trying to get up from his wheelchair. On 7/7/2026 at 2:11PM, V24 (RN) said that she recalls R9, she was in the room across from the resident when the certified nurse assistant (C.N.A) informed her that he heard the door slam and the resident was lying on the floor, half against the wall. Resident was pulled up, body assessment completed, R9 complained of pain to right hip and right wrist. V24 said that resident was in bed around 8:30PM when she last saw him, V24 said she cannot tell if resident can transfer by himself but she is of the opinion that resident needs help to transfer. V24 said that resident did not (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	have any indication of restlessness of wanting to get up from bed, V24 has never seen resident trying to get up, he is compliant with care and has never refused any type of care with her. On 7/8/2026 at 3:45PM, V8 (C.N.A) said that he remembers the day R9 fell, it happened on evening shift, V8 was in another patient's room around 8:30PM and finished around 9:15PM, V8 opened the door to R9's room, the nurse was in the room and told him that resident fell. R9 was in bed early, after dinner between 7:00PM and 7:30PM, V8 stated that he did not transfer R9 to bed, resident can be transferred with one person before the fall because he can stand and pivot, V8 has not seen resident walking, cannot remember if resident is a fall risk or had any fall precautions. Fall prevention policy revised 12/17/2025 stated in part: Purpose: to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality assurance programs will monitor the program to assure ongoing effectiveness. Standards: A fall risk assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines. Safety interventions will be implemented for each resident identified at risk. Fall safety interventions may include but are not limited to: The bed will be maintained in a position appropriate for resident transfers. Each resident will be screened by a specialist therapist at the time of admission, quarterly, after each fall, as appropriate, and with significant change in resident's mental and functional abilities. Residents who require staff assistance will not be left alone after being assisted to bathe, shower or toilet,		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food was served at temperatures that were palatable and attractive. This failure affected all 48 residents that consume food/beverages from the facility's kitchen. Findings include: Facility census (7/6/2026) documents 50 residents reside in the facility. 2 residents are NPO (nothing by mouth), therefore 48 residents consume food from the kitchen. Facility grievance log (1/1/2026-7/6/2026) documents nine concerns related to the facility's food and food preferences. R25's face sheet documents R78 is a [AGE] year-old resident with active diagnoses including acute cystitis, klebsiella pneumoniae, chronic obstructive pulmonary disease, congestive heart failure, anemia, muscle wasting and atrophy, neuromuscular dysfunction of bladder, and unspecified cerebral infarction. R25's minimum data set (6/16/2026) documents a brief interview of mental status (BIMS) summary score of 13, indicating R25 is cognitively intact. On 7/6/2026 at 10:30 AM, R25 explained the food here is s****. It's cold, it tastes bad. Yes, they (staff) know. It's s**** all the time. R24's face sheet documents R24 is a [AGE] year old resident with active diagnoses including acute and chronic respiratory failure with hypoxia, intervertebral disk degeneration, hemiplegia/hemiparesis following cerebrovascular disease affecting the left side, peripheral vascular disease, combined systolic and diastolic heart failure, and osteoarthritis. R24's minimum data set documents a brief interview of mental status (BIMS) summary score of 11, indicating R24 has cognitive impairment. On 7/6/2026 at 10:30 AM, R24 stated the food's not great, not up to my (R24's) standards. It's not what I am used to, doesn't have any seasoning. It often comes to my room cold. It's just not good. Facility weekly menu (approved 3/2/2026) documents the lunch served on 7/7/2026 was ranch baked chicken, potato wedges, buttered carrots, margarine, mixed fruit dump cake and a beverage. On 7/7/2026 at 12:22 PM, observed V31 (Cook) prepare a test tray for the survey team from the steam table in the kitchen. V31 plated a portion of carrots and potatoes. The potatoes appeared to be chunks of cut up potatoes with skin on and lacked seasoning. V31 weighed the chicken, placed it on the plate, and placed a dinner roll on the plate. The margarine, cake, and beverage were not provided with the test tray. V9 (Dietary Manager) affirmed the thermometer was properly calibrated and tested the temperatures of the food on the test tray. Initial temperatures of the food on the test tray were chicken: 123 F potatoes: 91 F and carrots 102 F. Observed steam table was turned on to the high setting, however minimal steam was observed billowing from the steam table. Surveyor placed hand approximately one inch over the water in the steam table, which felt mildly warm. V31 and V9 affirmed the steam table was operational. The plate was covered and added to the tray cart. On 7/6/2026 at 12:33 PM, the final lunch tray was passed to the residents. The temperature of the food on the test tray at point of service was chicken: 105 F, carrots: 91 F, and potatoes were 88 F. Temperatures were confirmed with V9 (Dietary Manager). Test tray was consumed; the carrots were lukewarm, the potatoes were cold and unseasoned, lacking any flavor. V9 affirmed food should be served at a palatable temperature when served to residents. On 7/7/2026 at 12:25 PM, V2 (Director of Nursing) explained food palatability is important so residents will want to eat the food and consume adequate nutrition. On 7/7/2026 at 12:30 PM, V5 (Nurse Practitioner) affirmed V5 has heard complaints from the residents about the facility's food. V5 recalled the complaints were related to food being unseasoned or not serving food from resident's ethnicities, such as Hispanic or African American. V5 explained in African American cultures, they typically have more seasoning in the food. Facility policy titled Menu Planning and Requirements (2020) documents menus are planned to provide nourishing, palatable, attractive meals that meet the (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nutritional needs of residents served. Planned menus take into consideration cultural backgrounds and food habits of residents.		