

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/16/2024
NAME OF PROVIDER OR SUPPLIER  Aperion Care Forest Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 West Roosevelt Road Forest Park, IL 60130	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32115</b></p> <p>Based on observation, interview, and record review the facility failed to ensure two residents who roomed together were compatible. This applies to 2 of 3 (R1, R5) residents reviewed for resident rights in the sample of 8.</p> <p>Findings include:</p> <p>On 9/15/24 at 10:15AM, R1 and R5 were in their room. R1 was asked about her room being cleaned. R1 became upset and started pointing at her roommate's side of the room. R1 pointed at a hamper that had R5's clothes in it. R1 was upset and said, look at the (expletive) clothes. The plastic hamper had a plastic disposable bag inside, open at the top. The hamper was filled with what appeared to be soiled clothes. R5 was sitting on her side of the room. Both R1 and R5 started arguing. R5 said those were her clothes and her stuff. R5 asked to speak to the surveyor and R1 said she wants to talk about me. She has dementia. Look at all the (expletive) clothes. R1 continued to say, don't pay her no mind'. R5 asked again to speak to the surveyor outside of the room away from R1. R5 appeared upset with R1. On 9/15/24 at 10:30AM, R5 said one side of the room is her side. R5 said R1 is so nosy and she [R1] thinks my side is her side. R5 said multiple times she is so nosy, and she has to keep her out of everything. R5 said R1 will find things out about her and then tell her family and friends.</p> <p>On 9/15/24 at 11:15AM, R1 was in her room in her bed. R1 said [R5] drives me crazy. She gets my blood pressure so high. R1 said she suffocates at nights. There are (expletive) things all over the place from her. R1 said I'm not going anywhere; they can move her.</p> <p>On 9/15/24 at 4:19PM, R1 said for 2.5 years they have paid her no mind. They should have moved her [R5] then. R1 said she did not sleep at all last night. She said [R5] has dementia, has her TV loud, she is cussing, and she isn't aware of what she does.</p> <p>On 9/15/24 at 11:30AM, V19 (Certified Nurse Assistant- CNA) said R1 and R5 just don't get along. They are constantly bickering and fighting. V19 said the staff has said stuff numerous times about them not getting along and nothing happens. V19 said they need separated. They are like night and day, one wants the air on, one wants it off. They are constantly bickering and should have been separated a long time ago.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/15/24 at 4:10PM, V2 (Director of Nursing) said she was aware of R1 and R5 having minor disagreements in the past. V2 said she has spoken to both residents and they both have voiced small complaints. V2 said if residents do not get along, they will do a room change and move one of the residents.</p> <p>On 9/15/24 at 3:15PM, V1 (Administrator) said R1 and R5 have been roommates for a while. V1 said on occasion, they have had arguments. They disagree once and awhile. V1 said this is the first he has heard that R1 did not want to be roommates with R5.</p> <p>On 9/15/24 at 1:35PM, V24 (Social Service) said she spoke with R1 yesterday, around 11:40AM. R1 told her she got in a disagreement with her roommate over the television being too loud. R1 told her she always gets into it with her roommate and they always have disagreements. V24 said when residents do not get along, they do an assessment to see if one should be moved. Based off what R1 had to say, V24 said she felt they should have a room change. V24 said she spoke with R5 who did not recall the incident. V24 said R5 said she did not think she needed to change rooms but was ok with the room change. V24 said R5 was moved to a new room.</p> <p>R1's facility assessment dated [DATE] shows R1 does not have any cognitive impairment and does not have behaviors. R5's facility assessment dated [DATE] shows she is cognitively impaired and has no behaviors.</p> <p>The facility Resident Rights policy approved on 1/4/19 shows Exercising rights means that resident have autonomy and choice, to the maximum extent possible, about how they wish to live their every day lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>32115</p> <p>Based on observation, interview, and record review the facility failed to ensure resident rooms, and the dining room were in a clean, sanitary condition for 2 of 3 residents (R1, R3) reviewed for clean, comfortable, homelike environment in the sample of 8.</p> <p>Findings include:</p> <p>1. On 9/16/24 at 10:15AM, R1 and R5 were in there room. R1 said they don't clean the room, and said look at the garbage. There was scattered debris on the floor that looked like food particles. The floor appeared dirty on both sides of the room with scattered paper debris on the floor. There was yellow liquid that appeared to be urine sitting in the toilet in the bathroom.</p> <p>On 9/16/24 at 10:30 AM, the fourth floor dining room had food and debris scattered throughout the floor. There were piles of old dried food stuff that appeared to be pushed and left along perimeter of the walls. There were dried liquid spills that were sticky when walking. All tables had pieces of food under them. Residents were in the dining room listening to music.</p> <p>On 9/15/24 at 11:00AM, V21 (Housekeeping) said she was assigned to the fourth floor. V21 said she was assigned to clean the 4th floor by herself. V21 said she cleans every room on the floor everyday if she is not by herself. She also has to clean the dialysis area, dining room, nurse station, common areas, and shower rooms. She will pull the garbage in every room, they can be smelly from the night. She said there used to be three housekeepers per floor, then two, and now one. There is one housekeeper assigned per floor for second, third, and fourth floors.</p> <p>On 9/15/24 at 12:12PM, V15 (Housekeeping Supervisor) was helping clean rooms. V15 said there is a housekeeper on each floor. They should be cleaning the dining room after breakfast and lunch. V15 said each room should be cleaned daily, including under the bed. They should be dusting everything, pulling the garbage, cleaning the bathroom, mopping, and sweeping under the beds, and all around the room.</p> <p>The facility Concern/Compliment form dated 7/23/24 shows R1's sister came to visit and found room dirty. Family requested housekeeping.</p> <p>There were three other Concern Compliment forms completed for rooms on the same floor (4th). These included concerns on 5/21/24 while visiting resident the room was a mess. The mattress smelled like urine and floor was sticky. The dining room was a mess. Requesting that the room be deep clean ASAP. On 5/29/24 the concern form shows called saying room was dirty. I called back and told her the room will be deep cleaned today. Another form shows Residents sister voiced concerns regarding residents floor being dirty on 8/12/24.</p> <p>The facility provided a Housekeeping Cleaning Checklist dated 8/15/24 that shows R1's room was last deep cleaned on 8/15/24.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 9/15/24 at 11:30AM, R3's room had scattered pieces of garbage and debris on the floor. R3's side of the room had what appeared to be broken pieces of dried noodles under the bed, and pieces of chips, and food debris scattered around the bed. There was scatted pieces of paper, and paper towel on the floor by the garbage can inside the door. There was what appeared to be dried food stuck on the floor at the bottom of R3's bed, and the floor was sticky.</p> <p>On 9/15/24 at 11:36AM, V20 was cleaning on R3's floor. V20 said he was the only housekeeper for that floor, and they were short today. V20 said there should be two housekeepers for the floor. V20 said he was staying for a second shift, and yesterday there was no one there at all cleaning that (second) floor. V20 said he would scrape and sweep the floor in every room. He would also empty the garbage in every room. If the floor was bad enough, he would mop it. He also cleans the dining room and nurse station on the floor.</p> <p>On 9/15/24 at 12:02PM, R3's room had been cleaned by housekeeping. There was still dried food stuck to the floor by the foot of the bed, and dried noodles where still under R3's bed.</p> <p>On 9/15/24 at 1:29PM, R3 was in his room, lying in bed. R3 said he had concerns with how they cleaned his room. R3 pointed to where his bed meets the wall, and there was thick dust along the wall. R3 asked the surveyor to look where the bed rests along the closet, and there was thick dust and paper debris. R3 said they do not clean under his bed. He has lived at the facility 6 months and has never seen them move his bed to clean.</p> <p>On 9/15/24 at 4:02PM, V1 (Administrator) said there should be two staff/housekeepers on each of the residential floors (2,3 and 4). There should also be one housekeeper for the first floor, and one floor tech. V1 said daily cleaning would include clearing any garbage, replacing paper products, wiping down bed, counters, and cleaning the bathrooms. They should dust, clean any spills, wipe the bedside tables, and mop in each room. V1 said they should be cleaning under the beds.</p> <p>The facility provided a Housekeeping Cleaning Checklist that shows R3's room was last deep cleaned on 7/31/24.</p> <p>The undated facility Housekeeping Services Policy shows To ensure that the facility, equipment, furnishings, and resident rooms are maintained in a sanitary manner, to provide a comfortable environment, and to prevent the development and transmission of infection.</p> <p>Policy: it is the policy of the facility to maintain a clean, odor free, comfortable, and orderly environment in all health care and public areas, which meet the sanitation needs of the facility and residents right for a safe, clean, comfortable homelike environment.</p> <p>Guidelines:</p> <p>1. the Housekeeping Department employs and trains sufficient numbers of personnel to meet the residents and to carry out the responsibilities.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38488</p> <p>Based on interview and record review the facility failed to ensure physician orders for a urinalysis was completed for 1 of 3 residents (R2) reviewed for laboratory services in the sample of 8.</p> <p>Findings include:</p> <p>R2's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include dementia without behavioral disturbance, protein-calorie malnutrition, primary generalized osteoarthritis, mood disorder due to known physiological condition, primary osteoarthritis of left hip, hypertensive heart disease without heart failure, vitamin B deficiency, and hypertension.</p> <p>R2's electronic medical record showed a urinalysis was ordered 8/3/24 after a fall occurrence.</p> <p>R2's 8/6/24 Physician Progress Note showed, . Pt (patient) presents today alert, sitting in dining room &amp; in no acute distress. Pt s/p (status post) fall without injury 8/3/24, UA ordered and not carried out at this time. Staff educated on frequent monitoring, fall and safety precautions .</p> <p>R2's lab results showed no urinalysis was collected until 8/21/24 and the results showed R2 had a urinary tract infection.</p> <p>R2's August 2024 Physician Order Sheet showed a new order for Bactrim (antibiotic) for treatment of a urinary tract infection on 8/23/24.</p> <p>On 9/15/24 at 4:40 PM, V7 Regional Nurse said she reviewed R2's record and said the physician order for a urinalysis should have been completed when ordered 8/3/24. V7 confirmed no urinalysis was completed for R2 until 8/21/24.</p> <p>The facility's policy revised 1/29/18 showed, Laboratory Testing Incident Reporting . Purpose: To outline the responsibilities for reporting and review of incidents associated with laboratory testing as ordered by a resident's physician to safeguard the resident . Laboratory test errors may include: . a. Physician's order is improperly transcribed b. The laboratory service is not notified of the test request . d. The nurse failed to collect the correct specimen .</p>		