STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145969	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Forest Park	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50469 Based on observation, interview, and record review the facility failed to ensure resident call light is within reach. This deficiency affects 5 (R11, R102, R148, R191, R261) of 5 residents in the sample for 36 reviewed for accommodation of needs. Findings include: 1. On 1/14/25 at 7:35 AM, R148 observed in bed alert and verbal with feet touching foot board. R148 said that she could not reach her call light. Call light observed behind bedside dresser on floor. On 1/14/25 at 8:06 AM, V5 (Registered Nurse) said that call light should be kept within reach in case the resident needs assistance. V5 said the call light should not be behind dresser on the floor. R148 is admitted on [DATE] with diagnosis in part but not limited to type 2 diabetes mellitus without complications, generalized anxiety disorder, history of falling, other lack of coordination. A focused care plan for alteration in comfort indicated intervention including call light within reach dated 10/03/24. 2. On 1/15/25 at 10:42 AM, R11 observed in wheelchair alert and verbal, clean and dry no odors in the room. Call light observed behind dresser on the floor. R11 said she could not reach call light, she said usually staff hangs it on side rail. On 1/15/25 at 10:55 AM, V6 (Licensed Practical Nurse) said that staff must have forgot to put call light within reach when they got her up into the wheelchair. V6 said that call light should not be behind dresser, it should be within resident reach in case they need assistance. R11 is admitted on [DATE] with diagnosis in part but not limited to type 2 diabetes mellitus with stable proliferative diabetic retinopathy, difficulty in walking, history of falling, primary osteoarthritis. A focused care plan for at risk for falls and injury related to osteoarthritis, requires assistance with activities of daily living indicated interventions including ensure the resident call light is within reach and encourage the resident to use it for assistance as needed dated 6/1/19. 3. On 1/15/25 at 10:50AM, R102 observed in bed alert and verbal, observed call light on floor under wheelchair. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25/ at 10:55 AM, V6 (Licensed Practical Nurse) said that call light should not be on floor under wheelchair, it should be within resident reach in case they need assistance. R102 is admitted on [DATE] with diagnosis in part but not limited to anemia, type 2 diabetes mellitus with other circulatory complications, generalized osteoarthritis, overactive bladder. A focused care plan for potential complications related to cerebral vascular accident with left hemiparesis indicated interventions including call light within reach dated 8/25/22. On 1/16/25 at 12:35 PM, V2 (Director of Nursing) said that all call lights should be placed within residents reach and answered promptly by any staff available. The call light should be within reach in case the resident needs an assistance. Facility's policy on Call light revisions 2/2/18. Purpose: To respond to residents requests and needs in a timely and courteous manner. Guidelines: 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location. 39781 4. On 1/14/25 at 7:02AM, Observed R191 lying in bed with right arm flexion contracture. His call light is placed on his bedside dresser, not within reach. Called V9 Nursing supervisor and showed observation made. V9 said that resident's call light should be within reach. She took the call light and placed within R191's reach. R191 is admitted on [DATE] with diagnosis listed in part but not limited to non-traumatic intracerebral hemorrhage in hemisphere subcortical, Hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting right dominant side, Seizures, Cerebral edema, Aphasia, Dysphagia, Gastrostomy. 5. On 1/14/25 at 7:12AM, Rounds made to R261 with V9 Nursing Supervisor. Observed 261 lying in bed with language barrier. He speaks Spanish and making hand gesture to elevate his head. Observed call light is on the floor. V9 said that resident's call light should be within reach. She picked up the call light and placed within R261's reach. R261 is admitted on [DATE] with diagnosis listed in part but not limited to hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting left non-dominant side, Respiratory failure, Type 2 Diabetes Mellitus.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40001 Based on interview and record review the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents (R68) reviewed for abuse in a sample of 36. Findings include: On 1/15/2025 at 9:40am R68 said that R93 was her roommate in December and had accused her of taking a blanket and slapped her twice then scratched her on the nose. R93 was moved to another room on the same unit which she must come pass several times a day to smoke, and other activities, a couple of days ago R93 was blocking the hallway and she asked her can she come pass, and R93 started yelling at her and said go around and don't touch my chair. On another occasion R93 noticed R68 wheeling past by the nurse's station, and yelled out profanity saying get away from me now). R68 said I am not afraid of R93 but would like her to stop yelling at me when I'm wheeling past, I don't know why R93 is still on this floor she had an issue with another roommate. R68 said she spoke with the social worker and informed her about how R93 yells at her and the social worker said, that's just how she is. On 1/16/2024 at 10:30am V28(Social Worker) said she did follow up with R68 to ensure she was ok, and she said she was doing great and never mentioned that R93 was yelling at her. On 1/16/2025 at 12:00pm V35 (Certified Nurse's Assistant), said I am familiar with R68 and R93, R68 is a nice lady very approachable alert and oriented times three she smokes a lot but other than that she is a good resident. R93 is alert with periods of confusion and has been aggressive with several roommates she will accuse them of taking her items and will become aggressive if no-one stops her, she's had several roommates in the past. I was not on duty when R68 and R93 had an altercation on 9/10/2024 or 12/27/2024. On 1/16/2025 at 1:55pm V2(Director of Nurses-DON) said R68 is alert and oriented times three, she likes to smoke. R68 and R93 were roommates until an altercation occurred in December on the 27th and R93 scratched R68 on the nose she was confused and accused R68 of taking her blanket. R93 was sent out to the hospital and upon returning she was placed in a private room up front on the same hallway. R93 did have an altercation with a previous roommate on 9/10/2024, she was not sent out, the roommate said that R93 was confused about her belongings and felt safe. On 1/16/2025 V1(Administrator -Abuse Coordinator) said he was not familiar with R68 or R93 until the altercation on 12/27/2024 that resulted in R68 obtaining a scratch on her nose and R93 being transferred to the hospital and upon returning R93 was placed in a private room on the same hallway. I was not aware that R68 had complained about R93 and launched a full investigation, R93 is now moved to another floor. The altercation on 9/10/2024 was about R93 being confused of her belongings and the roommate said according to the incident that she felt safe, and no move was made. On 1/17/2025, at 9:30am, V45(Certified Nurse's Assistant-CNA), said that she was R93 CNA the day the altercation occurred on September 10, 2024, but was not in the room and that R93 is very confused at times and does accuse her roommates of taking her blanket and other items, she can become argumentative with her roommate and staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/2025, at 9:40am, V44(Certified Nurse's Assistant-CNA), said she is familiar with R68 and R93 and she was their CNA, the evening the altercation occurred on 12/27/2024 she was not in the room, R68 came to the nurse's station saying that R93 had scratched her nose and accused her of taking a blanket. R93 was sent to the hospital and upon returning placed in another room on the same unit. R93 can become confused, R68 is alert and oriented times three. A care plan dated 1/15/2025 indicates R68 has a diagnosis of schizoaffective disorder, anxiety disorder and absence of left and right foot, a focus of abuse and neglect and exploitation trauma, goal to be treated with respect, sensitivity, dignity and feel safe while I live here in the facility. An intervention to report any verbalization of abuse or neglect to administrator immediately revised on 12/30/2024. A care plan dated 12/30/2024 with a focus of R93 has the potential to be physically aggressive related to swing at others and make contact, goal demonstrate effective coping skills, communication to provide physical and verbal cues to alleviate anxiety. A focus I had potential to be verbally aggressive related to I cuss at others and falsely accuse them of taking my belongings, a goal demonstrates effective coping skills, an intervention monitor resident for behaviors and redirect as needed. On 1/16/2025 V3 (Assistant administrator) refused surveyor to have a copy of the incident on 9/10/2024 and 12/27/2024. Facility Policy: Resident's Rights for people in long term care facilities. Your rights to safety: You must not be abused, neglected, or exploited by anyone-financially, physically, verbally, mentally, or sexually. Abuse Prevention and reporting-Illinois Revisions on 10/24/22 This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation or property and mistreatment of residents. The of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services and mistreatment of residents. Protection of Residents: The facility shall take steps necessary to ensure the safety of residents including but not limited to the separation of the residents.