

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 04/10/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide accepted standards of clinical practice by failing to provide necessary care and services in administering necessary medications, failed to identify signs and symptoms of hypotension, and failed to notify the RN and physician before having dialysis treatment. This failure affects 1 (R2) of 3 residents reviewed for professional standards in the sample of 3.</p> <p>Findings include:</p> <p>R2 was a [AGE] year old with diagnoses including but not limited to pulmonary disease, systemic sclerosis, hypertensive heart and kidney disease, end stage renal disease, dementia, and dependence on renal dialysis.</p> <p>Care plan dated [DATE] reads in part, I am at risk for decreased cardiac output related to hyperlipidemia, carotid stenosis. Primary medical history of Atherosclerosis of Aorta , Cardiomegaly, MI, readmitted to the facility status post acute hospital stay, continue with interventions ([DATE]). Goal: I will maintain hemodynamic stability: No palpitations, no complaints of chest pain nor discomfort, vital signs stable through next review. Interventions: Administer medications as ordered. Assess cardiac system PRN (As Needed). Assess for any chest pain, chest heaviness, chest discomfort, vital signs stable through next review. Assess respiratory system PRN. Assess for any chest pain, chest heaviness, chest discomfort. Inform MD. Encourage participation in activities of choice. Encourage resident to change positions slowly and sit on side of bed for few minutes prior to attempting to stand. Encourage resident to report symptoms If edema present, encourage resident to elevate feet as much as tolerated. Monitor lab values and report to physician. Monitor vital signs as ordered and PRN. Report any abnormalities to MD. Notify physician of any problems. Observe for edema/headache, angina, fatigue, dizziness, lightheadedness/blurred vision, syncope, dyspnea without exertion, pain, tingling or numbness in extremities, palpitations, urinary retention, SOB/general weakness, vomiting and report to MD.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:10 AM V4 (LPN Licensed Practical Nurse) said, I was the nurse on duty the day R2 died. I remember her because the husband is always here on (R2's) dialysis days and he was worried because her blood pressure was low that morning. Before the resident went to dialysis, I took the blood pressure myself and it was low when I took it in the morning around 10 AM and can't say exactly but it was under 100. I gave Midodrine because there's a doctor's order for it. I didn't call the doctor because the order was already there to give if it was low. Surveyor asked what the Midodrine medication was for, V4 said, It's to bring the blood pressure up so it's safe to get dialysis. I gave it and told the husband that I took the blood pressure again. It was still low but higher than it was, but I can't say exactly what it was. The husband was worried but I assured him it would be fine for her to get dialysis and he didn't want her to miss her day anyway. Next thing I know is that I got a call from V5 (dialysis nurse) and they told me that the resident coded and since she was DNR (Do Not Resuscitate) they didn't do CPR or anything. Surveyor asked whether the charge nurse or doctor was contacted regarding the abnormally low blood pressure, V4 said, I did not, I just followed the doctor's order to give the medication when the blood pressure is low. Surveyor asked what the determining factor or level of hypotension (low blood pressure) that would warrant her to give the medication or inform the doctor, V4 said, There's no particular number but if it's not at baseline blood pressure which was around the upper 110's. Surveyor asked if R2's blood pressure was at baseline, V4 said, No, it wasn't. Surveyor asked if the doctor should have been called in this instance, V4 said, Probably.</p> <p>Review of R2's February MAR (medication administration record) and interdisciplinary progress notes showed that the anti-hypotensive medication Midodrine was not administered/provided on [DATE] as indicated in interview by V4. Furthermore, the last time the medication Midodrine was provided to R2 as shown in the MAR was on [DATE] when the resident previously experienced abnormally low blood pressure. There were no documented entries in R2's record showing V4 informed the RN in charge or physician of the low blood pressure prior to receiving dialysis.</p> <p>On [DATE] at 1:38 PM, V2 (director of nursing) stated, The nurse should be looking at the MAR (medication Administration Record) to see whether blood pressure medications were given or held prior to going to dialysis. If the blood pressure is too low, we would normally give Midodrine or if it's too high than to give blood pressure medications. The nurse should be assessing for vital signs and fill out the communication form that goes with the patient to dialysis. The nurse should check for code status, the last and current vitals and any medication changes and whether the patient is on isolation. All this should be filled out and given to the dialysis nurse We assess the resident before they are taken up for dialysis treatment and are weighed before and after dialysis. Surveyor asked if the doctor should be informed of any changes in condition such as an abnormally low or high blood pressure, V2 said, It depends on nursing judgement whether to call the doctor or not.</p> <p>On [DATE], a facility-to-dialysis communication report dated [DATE] written by V4 (LPN), reads: 10:22 AM prior to receiving dialysis, R2 's blood pressure was 104/52. (There was no indication or communication noted pertaining to having received anti-hypotensive medications prior to dialysis treatment).</p> <p>Treatment Flowsheet dated [DATE] written by V5 reads in part, Patient Alert and Oriented x1, was confused, per V4 patient was hypotensive on the floor before dialysis. Patients pre-dialysis vitals were 106/65 Pulse 128 with a low resting blood pressure and tachycardia.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Illinois General assembly on Professions, Occupations, and Business Operations (225 ILCS 65/) Nurse Practice Act.(225 ILCS 65/55-30) (Section scheduled to be repealed on [DATE]) Sec. 55-30 reads in part, LPN scope of practice. Practice as a licensed practical nurse means a scope of nursing practice, with or without compensation, under the guidance of a registered professional nurse or an advanced practice registered nurse, or as directed by a physician assistant, physician, or other health care professionals as determined by the Department, and includes, but is not limited to, all of the following: Conducting a focused nursing assessment and contributing to the ongoing comprehensive nursing assessment of the patient performed by the registered professional nurse. Collaborating in the development and modification of the registered professional nurse's or advanced practice registered nurse's comprehensive nursing plan of care for all types of patients. Implementing aspects of the plan of care. Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of patients. Serving as an advocate for the patient by communicating and collaborating with other health service personnel. Participating in the evaluation of patient responses to interventions. Communicating and collaborating with other health care professionals. Providing input into the development of policies and procedures to support patient safety. (Source: P.A. 100-513, eff. 1-1-18.)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Deficiency Text Not Available		