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	05/19/2025

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 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 interview and record review, the facility failed to ensure a resident's safety while providing incontinence care. This failure affects one of three residents (R2) reviewed for falls in a total sample of six residents. This failure resulted in R2 sustaining left leg fracture to the tibia and right leg fracture to the femur, requiring hospitalization. The past non-compliance occurred from 05/5/2025 to 05/13/2025. Findings include: R2 is a [AGE] year-old female. R2's diagnoses are but not limited to end stage renal disease, chronic pulmonary edema, chronic respiratory failure, dependence on renal dialysis, major depressive disorder, stroke, heart failure, adult failure to thrive, traumatic subdural hemorrhage, and dependence on supplemental oxygen. R2's BIMS (Brief Interview for Mental Status) dated 5/01/2025, notes R2 is alert. R2's MDS (Minimal Data Set) Section GG dated 4/03/2025, notes R2 is dependent with toileting. R2 requires substantial to maximal assistant to roll left and right in the bed. R2's care plan notes R2 is at risk for falls. Interventions include observe and report unsafe conditions and situations. Staff is to ensure proper positioning. Lying to sitting on the side of bed is dependent. Progress note dated 5/5/2025, notes R2 had a witnessed fall on 05/05/2025, at 5:00 PM. The aide informed the nurse that the resident slid down from her bed during a brief change. R2 landed on the floor on her knees. R2 was assessed for pain, injury, wound, and possible fracture -- none noted. R2 had bilateral leg pain. R2 said she fell as she rolled over during a briefs change. Progress note dated 05/07/2025, notes R2 was admitted to the local hospital for left fibula fracture. On 5/17/2025, at 11:54 AM, R6 stated, R2 was in the mechanical lift. The side rail had to be up for her to roll out of bed because she cannot move. The aide that handled her is rough. It was one aide. I was told it was supposed to be two aides. She did not go get any help right away when R2 fell. That aide was standing there in a state of shock. R2 kept saying she was on her knees. R2 landed on her knees. The aide left the resident by herself to go get help instead of calling for help. It was a man aide that came and picked R2 up and put R2 in the bed. R2 was crying out telling the aide please be patient with me. They did not take x-rays until the next day. They did not send R2 out right away either. This place needs to be shut down. R2 laid in bed with those fractures all night. R2 was begging for help. I never heard the aide say anything to the resident. I was told by a person who works here that R2 is in the hospital with broken bones. That aide is too rough, and I told the nurse about it. I want to remain confidential. I feel sad I could not help her that night. (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	On 5/17/2025, at 3:10 PM, V2 (MDS Nurse) stated, R2 is dependent for transfers. This means the staff needs to assist her totally or they might use a mechanical lift. On 5/17/2025, at 4:02 PM, V5 (Fall Coordinator) stated, R2 is more dependent with transfers. She is not able to ambulate. She is a mechanical lift for transfers. I reviewed this incident. From my understanding, it happened during toileting hygiene when the aide was trying to clean her. R2 fell out of the bed; she rolled out of bed. With transfers, R2 requires two people. With mobility, R2 requires maximum assistance with one aide. She can slightly roll over while the aide is changing her. I spoke with the nurse not the aide. The nurse stated she was informed that during toileting hygiene, R2 rolled out of bed and landed on her knees. The root cause of R2's fall was weakness, limited mobility related to functional ability deficits, and degeneration of the joints. R2 stated she rolled out of the bed and could not catch herself. The resident did not say anything else to me. On 5/18/2025, at 9:30 AM, V6 (Assistant Director of Nursing) stated, the nurse told me that she was notified by the aide that during ADL (Activities of Daily Living) care, R2 rolled towards the aide. The aide was not transferring R2 but was just doing regular ADL care. R2 was not able to keep her balance. She rolled and landed on her knees. X-rays were done and she was sent to the hospital. At the hospital, she had fractures to both legs. On 5/18/2025, at 10:00 AM, V8 (Certified Nursing Assistant) stated, R2 is a two person assist with the mechanical lift, or if she needs to be pulled up in bed. When staff is changing her in bed, staff is supposed to put up the bed rail and clean her. R2 can assist you with rolling and holding onto the bar while cleaning her. If staff forget to put the railing up while cleaning her, she is going to fall. The rail must be up because she has poor truck control. I do not see R2 letting staff clean her up without the rail being up or a second assistant being there in front of her. She will say, I'm scared or ask you to go to get some assistance? R2 is very verbal. She will tell staff what she needs, what to do or need to do. I heard about the incident, but I was not there. The aide that was helping told me that she was cleaning R2. When the aide turned R2 over to clean her, R2's head was hanging off the bed. The aide told R2 I got you. R2 said something about her legs. The aide stated she lowered R2 gently to the floor. It took four people to get R2 off the floor. The aide should have the rail up or had a second assistant. Some people just do not listen. If she did not know she could have asked another aide or looked in the POC. There is a care plan book to look in for information as well. On 5/18/2025, at 10:11 AM, V9 (Certified Nursing Assistant) stated, R2 has good bed mobility. She can grab the rail, and she can hold on. She is pretty good about that. She must have the railing to hold on to prevent her from failing. She will tell you make sure the rail is down. Her legs are not good. If there is no railing her legs may slide out. The railing must be up to prevent her from failing out of bed. I do not know what the situation was with that aide. I have worked with that aide, and she was new. I remember talking about the mechanical lift and having two people. If the railing was not up, she should have made sure both were up. Having the railings up is for safety. I was one of the people that helped to get R2 off the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/18/2025, at 11:10 AM, V12 (Certified Nursing Assistant) stated, yes, I remember what happened that day. Me and the nurse just got R2 from dialysis and put her to bed. The nurse stepped out and I begin to change R2 on her left side towards the door. I rolled her and her feet began to slide off the bed. As her feet where sliding, I began to push her back into the bed. She kept saying my legs are sore. I stated I needed to go get help because she was sliding out of the bed. She was holding the pole. I yelled for assistance. I had to put her down because she was sliding out of the bed, and she would not allow me to push her out of the bed. I was pushing her legs. The bed was on the floor. She did not fall. It took four of us to put her back in the bed. She did not fall, but I had to lower her down to her knees. She is not good at moving, staff must do all the work. I have only been in the facility for three weeks. Both bed railings were not up. Only the one railing towards us was up. I was never told information if she was a two person or one person. It looks like she required two people assistance. On 5/18/2025, at 11:50 AM, V13 (Registered Nurse) stated, I was the nurse that was on duty. After R2 came from dialysis, we transferred her to the bed with the mechanical lift. We positioned her for comfort. I went to pass medication. The aide called me and told me R2 had a fall. I checked her vitals, and they were normal. R2 had chronic knee pain. She stated the pain was the same. I notified the nurse practitioner (NP). The NP asked me to order bilateral hip and knee x-rays. I ordered them. I informed the relative. I notified the DON. The resident stated when the aide was changing her, she rolled over out of the bed when she turned on her side. The aides must put the railing up for her to hold on. When she turns, she can hold on to turn her upper body. The railing helps with safety and mobility. On 5/18/2025, at 1:06 PM, V23 (Director of Nursing) stated, I was informed about R2's fall. I do not recall when I was informed, but I was informed. She had slipped from the bed during ADL care. The aide assisted her to the floor. The aide stated she was performing peri-care and she felt the resident coming close to her. She tried to reposition the resident, and it was not happening. She assisted the resident to the floor. The resident is alert. I did not get a chance to interview her before she went to the hospital. The IDT (Interdisplinary) team reviews all the falls, the fall risk assessments, description of the falls, factors, root causes analysis and IDT interventions. I expect staff for dependent residents to look at bed mobility, transfers, and ADL care. If they do not know what type of assistance a resident requires, I expect them to ask other nurses or aides. On 5/19/2025, at 10:26 AM, V25 (Nurse Practitioner) stated, I am aware of the patient. They did inform me about the assisted fall. I had treated her for medical problems. Yes, it is possible for the resident to fall out of bed and sustain fractures. Being an elderly frail resident she is an increased risk for fractures. Facility policy titled Fall Prevention Program, dated 11/21/2017, notes 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. Safety interventions will be implemented for each resident identified at risk. Direct care staff will be oriented and trained in the Fall Prevention Program. Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and as addressed on the plan of care. Prior to the survey date of 05/19/2025, facility had taken the following action to correct the noncompliance: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. R1 new fall assessment completed with new interventions and are plan updated. 2. Nursing staff in-serviced on fall policy and interventions from 05/06/2025 to 5/09/2025. Nurses and aides in-serviced on high-risk residents, frequent monitoring and supervision. 3. Aides and nurses in-serviced on proper bed mobility and positioning. 4. Facility wide assessment has been done to identify all residents that are at risk for fall new interventions put in place. The binder was updated, and care plans were updated. Audits will be conducted daily to ensure fall risks are completed and interventions are in place. After any fall occurs for six months and discussed in daily meetings. 5. Nurses in-serviced on completing new fall risk assessments after fall interventions are updated and care plan is updated. The director of nursing and the nurse consultant will audit each new fall with record review and observation to ensure compliance weekly for six months.