

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 08/14/2025
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)
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. (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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(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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure adequate supervision and proper use of assistive devices for one wheelchair dependent resident (R1) of three residents reviewed, resulting in an injury requiring urgent transport to the hospital for an acute comminuted femur fracture. This past non-compliance occurred from 07/29/2025 to 08/05/2025. Findings include: R1 is a [AGE] year-old resident of the facility with a Brief Interview for Mental Status (BIMS) score of 12, and with pertinent medical diagnosis including but not limited to Displaced Comminuted Fracture of Shaft of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing; Age-Related Osteoporosis; Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease; End Stage Renal Disease; and Dependence on Renal Dialysis. On 08/11/2025 at 1:04 PM, upon request, R1 agreed to speak with this Surveyor in her room. R1's room was dark; the television was on, so R1 turned it off; a wheelchair was located on the right side of R1's bed; one attachable wheelchair footrest was noted on the seat of the wheelchair; and the room appeared clutter-free. R1 said that most of the time, the pain level from her right leg, post-surgery, was a ten out of ten, but, on occasion, it went down to five. R1 said she didn't remember the date, but about two weeks ago, at about 1:00 or 2:00 PM, V4 (CNA) wheeled her outside of her room, while on her wheelchair, in order to take her to get her hair done at the facility's hair salon. R1 said that as V4 was pushing her in the hallway, her right foot rolled under her wheelchair, she hollered, then V4 ran back to her room to get a footrest, fastened it to the wheelchair, and placed her right foot on it. R1 said her knee was hurting so bad. R1 said V4 then wheeled her to her hair appointment; and when she was done, she was wheeled back to her room. On 08/12/2025 at 11:50 AM, R1 reiterated to this Surveyor that on 07/29/2025, V4 was wheeling her on her wheelchair towards the hair salon, and that she had no footrests on either side of the wheelchair at the time she was being pushed down the hallway. R1 said that after her right foot rolled under her wheelchair, V4 went inside her room, got a footrest for her, fastened it to her wheelchair, placed her right foot on it, and wheeled her to her hair appointment. On 08/11/2025 at 11:17 AM, V12 (Family Member) told this Surveyor that about two weeks ago, on a Tuesday, at about 5:50 PM, R1 called her from the long-term care facility, and said V4 rolled her right leg under her wheelchair while she was taking her to the beauty shop, and her wheelchair did not have a leg brace to support her leg. V12 said that R1 told her that, after V4 realized R1's right leg had been rolled under the wheelchair, she put a leg brace on the wheelchair and put R1's right foot on it. V12 said that the hospital doctor told her R1's right leg had been fractured in two places. On 08/14/2025 at 9:29 AM, V4 told this Surveyor that on 07/29/2025, R1's right foot came off her wheelchair's leg rest while she was wheeling her about halfway down the hallway to the hair salon for an appointment. V4 said she did not know how it happened, only that it (R1's right foot) slipped off. V4 said she never looked at R1's feet or legs while she was pushing her wheelchair from behind. V4 said that when she went to the front of the wheelchair after R1 hollered, ow, my leg, R1's leg was under the wheelchair, but she did not know how far it had gone under. In a progress note from 07/29/2025 at 6:28 PM, V13 (RN) stated in part that R1 verbalized pain on her right knee and said that it was during transfer when she went down to the salon this morning. In a progress note from 07/30/2025 at 9:00 AM, V14 (APN) stated in part that R1 presented with very bad knee pain and ten out of ten severity for one to two days. In a progress note from 08/01/2025 at 11:34 AM, V15 (NP) stated in part that R1 complained of pain to her right leg, which was not improving with medication, and the pain had been there since her foot dragged under the wheelchair while she was going for an appointment. On 08/12/2025 at 12:32 PM, V6 (APN, Orthopedic Surgery) told one of the Surveyors that she remembered R1 and her injury while at the hospital; and she believed it would have been unlikely that R1's right foot would have gotten caught underneath the wheelchair if the footrests and her feet were put on properly (if they were put on at all). On 08/12/2025 at 12:40 PM, V5 (Restorative Nurse) told this Surveyor that she assessed residents to determine if they were able to move on wheelchairs unassisted, and in R1's case, she was unable to wheel herself, independently, and needed substantial dependent assistance with locomotion. V5 said she had approved two footrests for R1's wheelchair and had instructed nurses and CNA's to ensure they were attached to R1's wheelchair whenever she was going to any destination. V5 said R1 had minimal strength in her legs, her core strength was weak, she was unable to hold her legs up for a long period of time, and believed that it would always be a safe measure to put both footrests on her wheelchair for long distances, like going to the hair salon. V5 said that due to R1's poor functional abilities in her lower extremities, if she</p>		