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	06/07/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure staff do not leave the resident's EHR (electronic health record) open when unattended. This failure affected 1 (R3) resident reviewed for confidentiality of record in the total sample of 13 residents. Findings include:R3's admission Record documented that this resident's diagnoses include but are not limited to COPD (Chronic Obstructive Pulmonary Disease), chronic respiratory failure with hypoxia, and Type 2 Diabetes Mellitus.R3's (04/08/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 09. Indicating the resident's mental status as moderately impaired.On 06/06/2026 at 9:16am V5 (Licensed Practice Nurse) dispensed R3's medications.On 06/06/2026 at 9:38am, V5 left the EHR screen on, and visible, with R3's information accessible/viewable on the screen. V5 entered R3's room with R3's medications and took R3's vital signs. V5 left the medications at R3's bedside and went out of the room.On 06/06/2026 at 9:40am, V5 stated he left the EHR screen on, with R3's personal health information visible because he knew he was going to come back to the medication cart anyway.On 06/06/2026 at 1:15pm, V2 (Director Of Nursing) stated the EHR of the resident has resident's information and should not be left open unattended. V2 stated the expectation is after preparing the medications, close the screen and lock the med cart before going inside the resident's room to pass the medications. V2 stated leaving the EHR open is a HIPAA (Health Insurance Portability and Accountability Act) violation.The (undated) Medication Administration General Guidelines document, in part Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedures. Preparation. 14. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. In addition, privacy is maintained at all times for all resident information by closing the MAR book when not in use.The (undated) Electronic Health Record documented, in part Purpose. To stablish the means by which this facility (i) allows only authorized users make entries into electronic health records and identifies the date and author of every entry; (ii) safeguards the confidentiality of patients records. Confidentiality. Users are required to maintain the confidentiality of electronic patient health records.

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure medications were disposed of where resident could not accessed them. This failure affected 1 (R12) resident reviewed for hazard and supervision in the total sample of 13 residents. Findings include:On 06/06/2026 at 1:28pm, V2 (Director Of Nursing) stated the 4th floor is a long term memory care unit. It is the facility's locked unit. On 06/07/2026 at 11:37am, R12 was observed propelling herself towards the nurses' station. On 06/07/2026 at 11:38am, R12 was rummaging through the garbage can. V15 (Licensed Practice Nurse) redirected R12 to stop what she was doing. Inquiring about what just transpired, V15 stated she (R12) was touching the garbage, and she (V15) stopped her right away and she (R12) was saying clean, clean. V15 stated she has a behavior of organizing whatever is in front of her. On 06/06/2026 at 9:56am, R12 was propelling herself on the hallway where V5 (Licensed Practice Nurse) was passing medications. On 6/06/2026 at 10:29am, during the medication administration observation with V5 (Licensed Practice Nurse), there were 2 blue capsules and 2 white tablets in a med cup in the trash can attached to 4th floor medication cart 3. On 06/06/2026 at 10:36am, V5 started dispensing R5's medications. On 06/06/2026 at 10:57am, V5 brought R5's medications inside R5's room. On 06/06/2026 at 11:09am, while both V5 and this surveyor were inside R5's room, observed R12 outside of the room, propelling herself towards the trash can that was attached to medication Cart 3. This surveyor informed V5 that R12 was getting close to the trash can. V5 and this surveyor went out of R5's room. On 06/06/2026 at 11:10am, V5 checked the trash can per surveyor's request and stated there were 2 blue pills and 2 white pills in the trash can. V5 stated R13 refused his medications, and he (V5) disposed of the medications in the trash can. V5 stated the expectation is to throw them where residents could not access the medications. V5 disposed the medications in the sharp container attached in medication cart 3 just above the trash can. On 06/06/2026 at 1:19pm, V2 (Director of Nursing) stated the nurse is expected to dispose of the medications where the resident cannot access them for safety because they are not to take medications that are not prescribed to them. V2 stated if a resident refused the medications, these could be disposed of in the sharp container that is attached to the med cart for safety.On 06/06/2026 at 3:30pm, V2 (Director of Nursing) presented this surveyor with The Medication Administration General Guidelines and read the guideline An adequate supply of disposable containers and equipment is maintained on the medication card for the administration of medications. Disposable containers are never reused. V2 stated each med cart has container where the staff could dispose of medications that were refused by the residents for safety.R12's admission Record documented that this resident's diagnoses include but are not limited to dementia, Alzheimer's Disease, hypertension, and schizophrenia. R12's (04/27/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 03. Indicating the resident's mental status as severely impaired. The (undated) Medication Administration General Guidelines document, in part Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedures. Preparation 5. An adequate supply of disposable containers and equipment is maintained on the medication card for the administration of medications. Disposable containers are never reused. The (10/24/2022) Medication/Narcotic Destruction documented, in part 6. Non-controlled medications may be placed in the Drug Buster container or may be placed in a container with an undesirable material such as cat litter or used coffee grounds or in a sharps container.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure the nurse administering the medications observed the resident while taking the medications, failed to ensure medications were administered one hour after the scheduled time, and failed to document medication administration after administering medications to the residents. These failures affected 6 (R5, R6, R7, R8, R9, and R10) residents reviewed for medication administration in the total sample of 13 residents.Findings include:R5's admission Record documented that this resident's diagnoses include but are not limited to spinal stenosis, hemiplegia (paralysis) and hemiparesis (muscle weakness), and osteoarthritis.R5's (05/11/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 12. Indicating the resident's mental status as moderately impaired.R5's (Schedule Date: 06/06/2026-06/06/2026) Medication Administration Audit Report documented that R5's 8am, 9am, and 10am medication administration time were more than one hour after the scheduled time except for Magnesium Gluconate. Of note, V5 documented time for the medication administration were between 4:57pm - 5:48pm.On 06/06/2026 at 10:29am, V5 (Licensed Practice Nurse) informed this surveyor he would be dispensing R5's medications. V5 was looking at the EHR (electronic health record) screen. On 06/06/2026 at 10:36am, V5 began preparing R5's medications.On 06/06/2026 at 10:57am, V5 brought R5's medications and blood pressure machine inside R5's room, placed the cup containing R5's medications on R5's side table, obtained R5's blood pressure and heart rate, and informed R5 to take her medications. R5 took one tablet and swallowed the tablet. On 06/06/2026 at 11:05am, R5 requested V5 to take her blood sugar. V5 left the room and brought the glucometer with him and checked R5's blood sugar. V5 left the room again, R5 started taking the medications one at a time without V5 present.On 06/06/2026 at 11:09am, outside of R5's room, this surveyor inquired V5 if he was going to observe R5 take the medications, V5 stated she (R5) said she wanted to take a rest. This surveyor and V5 went in the room and observed R5 took the last medication. R5 stated she did not say she wanted to take a rest.On 06/06/2026 at 11:20am, there were 16 residents on EHR (electronic health record) screen that remained on red. V5 stated he already passed their (R6, R7, R8, R9, and R10) medications but he had not documented them yet. And he just completed passing (R5)'s and still needed to pass medications to other residents. V5 stated he was supposed to document right after he gave the medications.On 06/06/2026 at 1:09pm, V2 (Director of Nursing) stated the expectation is to administer the medications one hour before and one hour after the scheduled time; the nurse should stay and watch the resident take the medications, to make sure the resident swallowed and tolerated taking the medication and is not choking; and medication administration should be documented right after the nurse administered the medications because that is the standard of practice. R6's admission Record documented that this resident's diagnoses include but are not limited to Type 2 Diabetes Mellitus, osteoarthritis, and schizophrenia.R6's (04/09/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 03.: Indicating the resident's mental status as severely impaired. R6's (Schedule Date: 06/06/2026-06/06/2026) Medication Administration Audit Report documented that R6's 8am, 9am, and 10am medication administration time were more than one hour after the scheduled time. Of note, V5 documented time for the medication administration were between 4:25pm - 5:12pm. The 10:00am treatment administration was documented at 5:29pm.R7's admission Record documented that this resident's diagnoses include but are not limited Type 2 Diabetes Mellitus, hypertension, and adult failure to thrive. R7's (04/22/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 03. Indicating the resident's mental status as severely impaired. R7's (Schedule Date: 06/06/2026-06/06/2026) Medication Administration Audit Report documented that R7's 9am medication administration time (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was more than one hour after the scheduled time. Of note, V5 documented time for the medication administration was at 5:08pm. R8's admission Record documented that this resident's diagnoses include but are not limited to hemiplegia (paralysis) and hemiparesis (muscle weakness), Type 2 Diabetes Mellitus, and dysphagia. R8 (05/21/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 05. Indicating the resident's mental status as severely impaired. R8's (Schedule Date: 06/06/2026-06/06/2026) Medication Administration Audit Report documented that R8's 8am and 9am medication administration time were more than one hour after the scheduled time. Of note, V5 documented time for the medication administration were between 5:14pm - 5:49pm.R9's admission Record documented that this resident's diagnoses include but are not limited to Parkinson's disease, dementia, and Type 2 Diabetes Mellitus. R9's (04/24/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 07. Indicating the resident's mental status as severely impaired. R9's (Schedule Date: 06/06/2026-06/06/2026) Medication Administration Audit Report documented that R9's 8am and 9am medication administration time were more than one hour after the scheduled time. Of note, V5 documented time for the medication administration were between 5:11pm - 6:00pm.R10'S admission Record documented that this resident's diagnoses include but are not limited hypertensive heart disease, COPD (Chronic Obstructive Pulmonary Disease), and schizophrenia. R10's (05/08/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 10. Indicating the resident's mental status as moderately impaired. R10's (Schedule Date: 06/06/2026-06/06/2026) Medication Administration Audit Report documented that R10's 8am, 9am, and 10am medication administration time were more than one hour after the scheduled time. Of note, V5 documented time for the medication administration were between 5:10pm - 6:10pm.The (undated) Medication Administration General Guidelines documented, in part Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedures. Preparation. 6. Five rights - right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. Administration. 10. Medications are administered within one hour before or after scheduled time. 16. The resident is always observed after administration to ensure that the dose was completely ingested. Refusal of medication. 1. Residents may actively refuse medications. Refusal may also be through cheeking or pocketing of pills in the mouth. To detect this, the nurse should observe the resident takes and swallows the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff don and doff gloves appropriately in an effort to prevent the cross contamination. This failure affects 1 (R5) resident reviewed for infection control during medication administration in the total sample of 13 residents. Findings include:R3's admission Record documents diagnoses including COPD (Chronic Obstructive Pulmonary Disease), chronic respiratory failure with hypoxia, and Type 2 Diabetes Mellitus.R3's (04/08/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 09. Indicating the resident's mental status as moderately impaired.R3's (Active Order as Of: 06/07/2026) Order Summary Report documented, in part Oxygen at 2-4 LPM (liters per minute) via nasal cannula continuous every shift. Active 04/14/2026.R5's admission Record documented that this resident's diagnoses including spinal stenosis, hemiplegia (paralysis) and hemiparesis (muscle weakness), and osteoarthritis.R5's (05/11/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 12. Indicating the resident's mental status as moderately impaired.On 06/06/2026 at 10:50am, during the medication administration observation with V5 (Licensed Practice Nurse) dispensed R5's medications in a med cup. R3 was seated on a wheelchair, propelling herself towards V5 and asked V5 if he could attach the nasal cannula to the oxygen tank located behind her wheelchair. V5 donned gloves, touched R3's nasal cannula tubing and touched the oxygen tank located behind R3's wheelchair, removed the oxygen tank and placed it close to the medication cart, touched R5's medication cup and placed the med cup inside the medication cart. This surveyor inquired if he was supposed to change his gloves before touching R5's med cup after he touched R3's nasal cannula tubing and oxygen tank. V5 responded that he did not touch (R5)'s medications, he only touched the medication cup. On 06/06/2026 at 1:31pm, V2 (Director Of Nursing) stated the expectation is to change gloves between residents to prevent cross contamination. V2 stated if he was wearing gloves and touched a surface, the nurse cannot touch another surface with the same gloves; he should have sanitized his hands after touching R3's oxygen tubing and oxygen tank and before touching her (R5) med cup to prevent cross contamination.The (undated) Medication Administration General Guidelines document, in part Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedures. Preparation. 2. Hand washing and hand sanitation: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly: C) after coming into direct contact with the resident. 4. Hand sanitation is done with an approved sanitizer: a) between hand washing, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface).The (undated) Glove Use - Nursing documented, in part Purpose: To Establish tasks, procedures, and required use of sterile and non-sterile gloves by nursing personnel. The facility will provide gloves of appropriate quality and size for nursing personnel and use appropriate type of gloves based on medical or surgical aseptic technique in accordance with universal/standard precautions and transmission based precautions. Nonsterile gloves shall be worn for procedures involving contact with mucous membranes or for other resident care. 5. Gloves used for contact shall be removed and discarded after contact with each person, fluid item, or surface.