STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Niles	6601 West Touhy Avenue Niles, IL 60714

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46344 Based on observation, interview, and record review, the facility failed to ensure that proper hot water temperatures were maintained in one shower room (Second Floor East Wing). This failure has the potential to affect 22 residents that currently reside on the Second Floor East Wing. Findings include: Per facility census report received during this survey, there are currently 22 residents residing on the second-floor east wing and have access to the shower room. On 3/2/2025 at 11:15AM, R46 said the water in the shower room does not get hot enough even when it is turned as far as it goes. Sometimes I do not want to take a shower because it is too cold. On 3/2/25 at 11:30AM, V6 (Certified Nursing Assistant) said the one shower room does not get very hot. I know maintenance has tried to fix the temperature in the past, but it remains the same temperature. Second Floor East Shower room was observed with V6. V6 ran the water for around five minutes. This surveyor and V6 felt the water to not get very warm. V6 said it will not get any warmer than this. On 3/3/2025 at 11:45AM, V12 (Maintenance Director) said the water temperatures should be between 100-110 degrees Fahrenheit. V12 checked the water temperature in the second-floor shower room with a thermometer which ranged between 90-95 degrees Fahrenheit. Facility policy titled Bathing - Shower and Tub Bath with revision date of 1/31/2018 states in part but not limited to the following: The purpose is to ensure resident's cleanliness to maintain proper hygiene and dignity. Turn on water and ensure that water is at a comfortable and safe temperature. Temperature should be 100-110 degrees Fahrenheit.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516 Based on observation, interview, and record review, the facility failed to use a low air loss mattress in accordance with manufacturer guidelines, for a resident with a facility acquired, Stage 4 pressure ulcer. This failure applied to one (R3) of three residents reviewed for pressure ulcers in a sample of 33 residents. Findings include: R3 is an alert and oriented [AGE] year-old with diagnoses including but not limited to chronic obstructive pulmonary disease, asthma, heart failure, anxiety disorder and presence of a cardiac pacemaker. On 3/2/25 at approximately 9:50 AM, R3 was observed asleep in bed atop an air mattress and in a supine position (laying on his back) with his upper torso raised. On 3/4/25 at approximately 9:50 AM, R3 was observed on his backside but was awake. Surveyor asked how he was doing and R3 responded that he was fine but that his back hurt and mentioned that the bed was very uncomfortable. Surveyor asked if he made the nurse aware and if he obtained medications for his pain and R3 responded that he did. Observations of the bed showed a bed pump with 8 green lights but with no markings to designate their significance, however the bed mattress appeared to be raised up in a concave (hump) manner. On 3/4/25 at approximately 10:05 AM, R3 was observed during wound care by V10 (Wound Nurse) and V18 (Certified Nursing Assistant/CNA) who assisted. V18 turned the resident to his right side to reveal the wound to show to the surveyor. V10 removed the wound dressing which revealed a very large and deep hole on R3's left buttock. V10 described the pressure ulcer and stated, (R3) first developed this last year around November 2024 as a DTI (deep tissue injury) because the resident was noncompliant with incontinence care. I don't have the exact measurements, but I'd say it's about 4.9 centimeters (length) by 2.8 (width) by 3.2 centimeters deep. Undermining is about 3.1 centimeters and there is no tunneling. Surveyor asked R3 during the treatment if what V10 said was true and that he was not compliant with incontinence care, R3 stated, No that is not true. They always come in when it's convenient for them like when I'm trying to rest or sleep or when I'm not even wet and I would know if I was wet. Surveyor asked when he asks for staff to come back at a later time, if they do, R3 stated, Sometimes but mostly they don't. They've talked to me about this, and I've explained to them that what I want is some flexibility, but they seem to keep doing what is convenient for them and not honor my requests. Surveyor asked if he was ever explained or shown his care plan to heal his wound, R3 stated, No. Surveyor asked if he was made aware of his care plan showing his resistance to care, R3 stated, I have never seen that or been told that. I don't resist care. I just want to be changed when I asked to be changed or when I'm actually wet and not when it's convenient for the nurses. When I call for someone to change me, it takes so long for someone to come, but when they do come, it's whenever its convenient for them like I said. There were times, when I asked to be changed and I'm told the CNA is on their break. Why can't some other CNA come, you tell me? (R3 getting upset). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor later asked V10 if R3's requests for CNAs to return when the resident was actually in need of changing were reasonable requests. V10 affirmed it was and indicated that R3's behavior improved and was better complying. MDS (Minimum Data Set) assessments dated 5/12/23, 8/12/23, 11/12/23, 2/12/24, and 5/12/24 all show no behaviors of resistance to care. Only until after the formation of R3's deep tissue injury on 7/8/24 does the MDS assessment dated [DATE] and consecutive MDS assessments thereafter show R3 with behavior of rejection of care occurring 1-3 days. V3 (Assistant Director of Nursing/ADON) and V10 (Wound Nurse) was asked to comment on these assessments, and both indicated they did not do the MDS assessments. After the wound treatment observation, V10 was shown the air mattress pump and was asked how the pump functioned, V10 indicated she was not aware of how the mattress pump functioned and that V12 (Maintenance Director) was solely responsible for applying the mattress when ordered and adjusting the mattress pump settings. Surveyor clarified if she was the wound nurse in charge of all wounds. V10 stated, Yes I am in charge of wounds, but I always just call V12 for the mattress and he puts the mattress on the bed. Surveyor asked what the green lights meant, and which green light was turned on. V10 said, It looks like the 5th light is on, but it's supposed to designate the weight of the resident and that's how it should be set with the resident's weight but there's no numbers on these lights to show what it's for, but I will ask V12. On 3/4/25 at 10:20 am surveyor questioned the maintenance director about his role with the air mattress application. V12 stated, We get them from storage we bought from company. I install the mattress on the bed, and I connect the pump. Surveyor asked how much pressure he sets the mattress to. V12 said, around 200 pounds to 250 pounds, maybe 300 for a heavy patient. Sometimes the nurse put on setting, sometimes the CNA. Surveyor asked if he was trained on how to apply the appropriate settings for the specialty air mattress. V12 said, No, but sometimes it's just a little button to adjust it and I adjust it to see how it looks. Surveyor clarified if he adjusted the mattress by sight only. V12 said, Yes, I look at it and I touch it too. It's like kicking a tire and if it's hard enough it's ok. Surveyor clarified again so the other surveyors heard what he stated. V12 stated, It's like kicking a tire but I don't know if it's exactly right, so I just do it too by touching the mattress to see if it's hard enough. Surveyor requested to obtain copy of the air mattress pump/mattress manual. Manual titled Alternating pressure and low air loss mattress replacement system with defined Perimeter reads in part, Weight setting buttons (=) and (-). The weight setting buttons can be used to adjust the pressure of the inflated cells based on the patient's weight. As the weight setting increases, the pressure level indicator lights up (green) with each added level of pressure. Eight pressure lights are available and indicated by increasing green light indicator. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 12:21 PM, surveyor returned to observe R3 with V3 (ADON). R3 was laying on his backside and with no appearance of any positional changes except for earlier wound observation. Surveyor asked V3 about the air mattress pump to ensure its accurate functioning. V3 stated, Yes it's fine, it looks like it's on. Surveyor asked what the lights on the pump meant and how she knew the pump was fine. V3 stated, I don't know, there's nothing on the pump but lights. I don't do anything with these beds or pumps. It's just V10 and V12's responsibility not mine. Surveyor asked if she was the assistant director of nursing and if V10 was under her supervision, V3 responded, No. I am not responsible for her. On 3/4/25 at 12:45 PM, V2 (Director of Nursing/DON) said (in the presence of survey team), I recommend residents who need to be on the air mattresses along with V3 (ADON) and V10 wound nurse. We own our own mattresses and don't rent them so (V12) puts them in position on the bed. He sets the pump and makes sure the motor works and inflates. He services them if there is an issue. Surveyor asked if V12 knows how to apply the appropriate inflation settings. V2 stated, I believe he should know how to inflate them to coincide with the resident's weight or he'll ask the nurse. Surveyor asked if there was any in-service training on how to operate the air mattresses and pumps. V2 stated, There was no in-service done. On 3/4/25 at 1:15 PM, V10 (Wound Nurse) clarified with surveyor that the light turned on R3's pump was designated to be for a 280-pound resident. Surveyor asked R3's weight. V10 stated, He's around 165 to 170 but he's never been that heavy. Surveyor asked if R3 was always on the same weight setting since he obtained the mattress over a year ago. V10 said, I think so. Surveyor asked what impact a wrong setting of too much inflated mattress could do. V10 stated, It can cause pressure on the wound. The wound can get worse with an inaccurate setting because the weight matters and the mattress is not going to sink. The mattress will be a little more pressure will increase pressure on the wound. Records showed R3 to be at 167 lbs. on 10/1/24; 169 lbs. on 11/1/24; 170.6 lbs. on 12/2/24; 173 lbs. on 1/3/25; 169 lbs. on 2/1/25 and 165 lbs. on 3/4/25. On 3/4/25 at 1:34 PM V19 (Wound Doctor) said, I've been seeing him (R3) awhile for probably several months and when I was gone there was a wound NP (Nurse Practitioner) that took over, but I just saw the resident last week. R3's wound to his buttock and I diagnosed it about 250 days ago. At the time he was having debridement (surgical removal of necrotic dead skin). I gave all the orders on how to resolve the wound and yes I ordered the offloading air mattress. Surveyor asked the importance of a properly inflated mattress. V19 said, Well it is one component in the treatment of this wound, which is multi-modal including turning and repositioning, nutrition, but it can impact other factors include albumin of 2.9 and anemia. R3's albumin ranged from about 3.8 range, and he had some behavior and anxiety issues which also affected it and reluctance of care, fear of falling out of bed. As for the albumin levels during this time, it ranged from around 3.9 at the highest down to 3.7. He had some weight loss from around 206 to 169 pounds and fecal incontinence. Surveyor asked if the pressure setting on the mattress should be adjusted to the weight loss. V19 said that it should but repeated that it is only part of a multi modal treatment and other factors he mentioned that impacted healing. On 3/4/25 at 3:00 PM, V2 (DON) later returned to the conference room to inform the survey team that R3's mattress was removed and replaced with a properly functioning mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's pressure ulcer care plan revised 10/3/24 reads in part (but not limited to), I have a potential for impairment to skin integrity related to immobility, incontinence, and refusal of care. I have pressure ulcer on left buttock. Goal: I will not develop alteration in skin integrity. Interventions: Assess/record changes in skin status. Avoid positioning in affected wound area. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Keep skin clean and dry. Use lotion on dry skin. Low air loss mattress. Minimize pressure over bony prominences. Protective skin barrier cream as ordered. Turn and repositioning q 2 hrs. and as needed. Facility wound prevention policy revised 1/15/2018 titled Pressure Ulcer Prevention reads in part, To prevent and treat pressure ulcers/pressure injury. Maintain clean/dry skin during hygiene measures. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. Change bed linen per schedule and whenever soiled with urine, feces, or other material. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. Pressure reducing mattresses are used for all residents. Specialty mattresses such as low air loss, alternating pressure, etc. may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple stage 2 wounds or more Stage 3 or Stage 4 wounds.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews, the facility failed to follow their policy and procedures for psychotropic medication administration by not ensuring a gradual dose reduction evaluation was performed quarterly for a resident receiving psychotropic medications. This failure applied to one (R82) of five residents reviewed for unnecessary medications. Findings include: R82 is a [AGE] year-old male with a diagnosis history of Cognitive Communication Deficit, Generalized Anxiety Disorder, Insomnia, and Partial Paralysis due to Stroke who was admitted to the facility 05/17/2024. R82's current physician orders include active orders effective 05/17/2024 for half of 150mg tablet of Trazodone (antidepressant/sedative and SSRI inhibitor) to be given by mouth at bedtime for sleep and three 125mg for Depakote/Divalproex (Anticonvulsant) capsules by mouth three times a day for anxiety. R82's current care plan initiated 05/18/2024 includes interventions for cognitive loss/dementia. R82's care plan initiated 05/20/2024 documents he is receiving sedative/hypnotic therapy including trazadone (sedative) for insomnia. R82's care plan initiated 05/18/2024 documents he has a mood problem related to anxiety, & dementia with interventions including administer medications as ordered, monitor/document for side effects and effectiveness, and Behavioral Health consults as needed (psycho-geriatric team, psychiatrist etc.). R82's February and March 2025 Medication Administration Records documents he received Depakote and Trazadone as ordered daily. R82's Physician Progress Note dated 03/04/2025 documents he was evaluated by the psychiatrist on 05-25-2024 and does not include a GDR (Gradual Dose Reduction) assessment or determination. R82's medical records and psychiatric progress notes from admission to current do not include an assessment for a gradual dose reduction. On 03/05/25 at 02:02 PM V2 (Director of Nursing) stated Gradual Dose Reductions are supposed to be performed with resident's quarterly reviews and they are either deemed not in the best interest of the resident or they are attempted. V2 stated or we try to perform a gradual dose reduction if by a resident's behavior it's determined psychotropic medications are no longer needed and we attempt to reduce the dosage. V2 stated there is only one psychiatric progress note available for R82. The facility's Psychotropic Medication/Gradual Dose Reduction Policy received 03/05/2025 states: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of the policy is To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standards of practice and are prescribed at the lowest therapeutic dose to treat such conditions. Residents who use psychotropic drugs shall receive gradual dose reductions and behavior interventions unless clinically contraindicated, in an effort to discontinue or reduce the medication. A gradual dose reduction shall be encouraged at least twice yearly unless previous attempts at reduction have been unsuccessful, or reduction is clinically contraindicated.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on observation, interview, and record review, the facility failed to follow their policy and procedures for safe and sanitary food by not ensuring resident's personal refrigerator temperatures were consistently monitored and accurately documented, failed to ensure that food stored in resident's personal refrigerators were stored and labeled properly, and failed to ensure that staff remove old and expired food items from resident's refrigerators. These failures affected four (R23, R40, R56 ad R80) of four residents reviewed for food safety. Findings include: [DATE] at 11:39 AM V2 (Director of Nursing) said that the Assistant Director of Nursing checks the temperature in the refrigerators in residents' rooms and they are documented in the temperature log attached to the refrigerator. Staff is supposed to document the temperature in the log when it is checked and that is the standard procedure. Regarding the items inside the refrigerator, there are assigned staff for different rooms who are supposed to check and make sure there are no expired items in the refrigerator. [DATE] 02:00 PM V3 (Licensed Practical Nurse) said that she is the one that documented the temperature in the refrigerator logs in resident's rooms. V3 said she made a mistake and documented a temperature before it was checked and that was not the right thing to do. [DATE] 10:13AM V13 (Dietary Manager) said that she oversees checking the refrigerator in six rooms on the second floor, she usually checks them whenever she is here on Mondays to Friday and on Sunday once every six weeks. The refrigerator is supposed to be checked every day to make sure that there is no expired food, that the temperature is okay, and that the food is appropriate for the resident's diet. V13 said that she checked one of the rooms on Friday and did not see any expired food. V13 stated that she is not sure what happens when she is not here or if anyone checks the refrigerators. V13 also said that all food items in resident's refrigerator should be labeled, as well as food brought from outside. Fresh fruits like banana or orange can be put in a container or plastic bag and labeled. Any food item not labeled can be thrown out after some days. Facility policy for food brought from outside revised [DATE] states in part: food brought to a resident by a family/visitor will be permitted with authorization. 4. Any food brought in is checked by nursing or food service. Food must be in a plastic container with a tight-fitting lid. 5. Food stored are labeled with resident's name and dated. 1.) On [DATE] 11:10AM, while conducting random observation on the second floor, noted the refrigerator in R56's room with the documentation of a temperature reading from [DATE] to [DATE] at 6:00AM. R56 stated that staff do not check the refrigerator every day, sometimes the temperature log will not be filled for days and one day someone will come and fill the whole spot with some numbers. Surveyor found the same documentation in four other rooms on the second floor, including in R23 and R80's rooms. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:34 AM surveyor observed R56's refrigerator contained multiple foods in containers with no labels or date and an orange outside of a container and without any labeling. On [DATE] at 10:40AM, R56 was observed being walked in the hallway by the restorative aide, he stated that he is doing okay today. Surveyor checked resident's refrigerator and noted several food items with no label or date on them. The temperature log was also noted with the temperature documented the previous day, 38.6, actual reading on [DATE] was 40 degrees. 2.) [DATE] at 9:45AM, the documented temperature on the log from the previous day remained the same in all the rooms. Surveyor checked the refrigerator in R23's room and noted the following items: 3 cartons of 2% milk with the following dates: [DATE]. [DATE] and [DATE]. 1 carton of 2% milk with no date on it,1 glass of juice with no date and 2 cups of pudding that were open with no cover. The puddings were all caked up with some brownish fluid at the bottom. Surveyor presented this observation to V7 (Certified Nursing Assistant/CNA) who was assigned to the room. V7 said that staff are supposed to check the refrigerators, it is not okay for residents to have expired food items in the room and the items are supposed to be labeled with resident's name and dated. 3.) [DATE] at 9:55AM, surveyor also found 1 carton of 2% milk in R80's refrigerator that was dated [DATE] and some slices of pizza wrapped in a [NAME] wrap with no name or date on the pizza. Resident's temperature log remained the same from the previous day, 38.1, actual temperature reading was 40. 4.) On [DATE] at 12:35 PM surveyor observed R40's refrigerator temperature log documented temperatures for [DATE] through [DATE]. On [DATE] at 9:34 AM surveyor observed R40's refrigerator temperature log unchanged from the previous day.