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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146001	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care International	4815 South Western Ave Chicago, IL 60609

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on observation, interview and record review, the facility failed to ensure ADL (Activities of Daily Living) care was provided for a dependent resident who required assistance with bladder and bowel incontinence for one of three residents (R3) reviewed for ADL care. Findings include: On 4/12/2024 at 1:15 PM R3 was observed sitting up in bed with head of bed elevated approximately 45 degrees, oxygen per nasal cannula gastric tube feeding was infusing at 70cc/hour (cubic centimeter/hour) on infusion pump at bedside, splint was noted to left hand. Bilateral side rails were elevated, low air loss mattress was on and functioning, bed, in low position, call light was not within reach (tied to right side rail, dangling on floor between side rail and bed frame). R3 was unable to answer questions. Roommate's call light activated at 1:29 PM. On 4/12/2024 at 1:30 PM, with V5 (CNA). Blue line noted to front of R'3 brief. V5 said that means she's wet. V5 opened R3's brief, brief was saturated with dark colored urine. V5 repositioned R3 onto R3's right side, exposing the back of R3's brief. Dark brown stool was noted to R3's gluteal cleft and brief, brief was saturated with dark colored urine extending to the top of R3's brief. V5 said V6 (CNA) is assigned to R3 today, she is on break. On 4/12/2024 at 2:22 PM, V6 (CNA) said I didn't realize R3 was assigned to me. I saw her in the morning but didn't change her. The first time I changed her was this afternoon with V5, we changed her together around 2 PM. On 4/12//2024 at 3:53 PM, V2 (ADON-assistant director of nursing) said staff should check on residents at least every two hours in order to turn and reposition and complete incontinence care if needed. V2 said a blue strip on the front of a resident's incontinence brief means the resident is wet. Surveyor informed V2 of observation made with V5 (CNA-Certified Nursing Assistant. V2 responded, that means V7 (Agency LPN-Licensed Practical Nurse) did not make rounds. V2 said if a resident is not changed in a timely manner, resident could develop skin breakdown. On 4/16/2024 at 3:20 PM, V15 (LPN-Licensed Practical Nurse) said, soiled resident should be changed immediately, if not, skin breakdown could occur. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/2024 at 3:30 PM, V16 (CNA-Certified Nursing Assistant) said, You can tell that someone has been left soiled for awhile if the incontinent pad and top sheet are soaked or soiled, urine is going up the back of the brief, brief is full, urine is dark. On 4/16/2024 at 4:33 PM, V3 (Wound Care Coordinator) said, if a resident is left soiled for a prolonged period of time you may see a full brief, wet incontinent pad, possible odor, dark colored urine in brief; if not changed timely they could develop MASD (Moisture-associated Skin Damage) that can easliy progress to a Stage 2 pressure ulcer. R3's medical record (Face Sheet) documents R3 is an [AGE] year-old admitted to the facility on [DATE] with diagnoses including but not limited to: Parkinson's Disease Without Dyskinesia, Type 2 Diabetes Mellitus, Unspecified Asthma, Pleural Effusion, Chronic Obstructive Pulmonary Disease, and Gastrostomy Status. R3's MDS (Minimum Data Set, 4.4.2024) documents: -Section C Cognitive-Patterns Cognitive Skills for Daily Decision Making: severely impaired. -Section GG-Functional Abilities and Goals Toileting hygiene: Dependent-Helper does ALL of the effort. Resident does not of the effort to complete the activity. -Section H-Bowel and Bladder 3/3-always incontinent Care plan (initiated 1.18.2024) documents in part, R3 has potential for complications related to incontinence of Bowel/Bladder. Incontinent care will be provided. Check and change Q2-3H (every 2-3 hours) and PRN (as needed). Incontinence Care Policy (Effective 11.28.2012, Revisions 1.16.2018) documents in part: Guidelines: Incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or every two hours and provided perineal and genital care after each episode.

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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** 15301 Based on interview and record review, the facility failed to properly assess and obtain a physician's order for newly identified skin alteration for one of three residents (R2) reviewed for wounds. Findings include: R2's medical record (Face Sheet) documents R2 is an [AGE] year-old admitted to the facility on 2.24.2022 with diagnoses including but not limited to: Cerebral Infarction, End Stage Renal Disease, Type 2 Diabetes, Peripheral Vascular Disease, Idiopathic Aseptic Necrosis of Right Foot, and Idiopathic Aseptic Necrosis of Left Foot. On 4/12/2024 at 3:53 PM V2 (ADON - Assistant Director of Nursing) said V11 (LPN-Licensed Practical Nurse/Treatment Nurse) notified me that resident R2 had to go out (to the hospital), it was serious. V2 said, when V8 (Agency LPN-Licensed Practical Nurse) assessed the wound (documented as skin tear by V8), V8 should have completed a head-to-toe assessment; head to toe assessments should be completed with each new wound. On 4/16/2024 at approximately 12:30 PM, V11 (LPN-Licensed Practical Nurse/Treatment Nurse) said, regarding R2, I went to change her dressings (to both feet). I glanced at risk management (3/18/2024) and noted a new skin issue for R2, it was not a skin tear. I wasn't expecting to see what I saw based on the previous nurse's (V8's- LPN-Licensed Practical Nurse) note. V8 should have done a head-to-toe assessment on R2 as well as described in detail what she saw (regarding new skin alteration to R2's right hip). On 4/17/2024 at 11:12 AM via telephone, V8 (Agency LPN-Licensed Practical Nurse) said, the CNA (Certified Nursing Assistant), I don't remember her name, told me R3 had something on her right hip. I looked at it, it was a skin tear, like skin shear, like it was already healing. She (V9) told me she saw it the day before but didn't report it. I called her (R2) doctor. I got an order to refer her to wound care. I patched her up, I don't know what I used, I can't just tell you stuff off the top of my head. I documented it in her chart. I paged wound care multiple times (they were still in the facility), they didn't respond. I endorsed her (R2) to the next shift (nurse) and I punched out. I'm agency, I don't wait around. On 4/17/2024 at 1:26 PM via telephone, V9 (CNA-Certified Nursing Assistant) said, on 3/17/2024, I reported to V8 (LPN) R2 had a skin tear to her right hip; the area was red and looked like the skin had been rubbed away. I found it while I was in the process of cleaning (R2) up. I don't remember what time it was when I was cleaning her up, I called V9 to come in and look at it, I didn't wait. I did not notice any discoloration to R3's feet, they were covered with dressings. I did not tell V9 that I saw it (skin alteration) the day before but didn't report it. The 17th (March) was my first day back from vacation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/2024 at 3:26 PM, Nurses Note Narrative, signed by V8 documents, I was informed by CNA of new skin concern. I went to assess the patient, and observed skin tear on right side hip. I then notified (Physician) who gave orders to have wound care follow up. I also notified patients family whom was in facility at the time. No wound assessment or physician's order for dressing to right hip noted. On 3/18/2024 at 12:01 PM Nurses Note Narrative, signed by V11 documents, wound care: This writer was informed through the risk management system that the resident had an opening to the right hip, she was assessed and was noted with an unstageable pressure wound to the right hip measuring 4.0 cm (centimeter) x 6.0 cm depth unknown, that was 60% necrotic soft adherent, 25% deep maroon and 15% pale pink with no drainage noted. The primary MD (physician) was notified and new orders were received to cleanse with (normal saline) pat dry, paint with betadine and cover with a dry dressing daily. Physician's orders for February 2024- March 2024 were reviewed. No treatment order was found for 3/17/2024 for dressing to R2's right hip.

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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** 15301 Based on interview and record review the facility failed to develop and implement individualized fall prevention interventions for one of three residents (R1) reviewed for falls. R1 fell four times in 26 days, including two falls on the same day (4/1/2024). This failure resulted in R1 falling and sustaining fractures of the sacral spine and coccyx on 3/12/2024. Findings include: On 4/12/2024 at 1:39 PM R1 was observed sitting in wheelchair behind nurses station. R1 said I fell five times, they told me not to get up. I had to go to the bathroom, they didn't help me, I wouldn't have got up (to the bathroom) if they had, I wouldn't have got up by myself. On 4/12/2024 at 11:38 AM, V4 (Restorative Director/Fall Nurse) said the IDT (Interdisciplinary Team) is responsible for determining the Root Cause Analysis for falls and developing interventions to prevent further falls. R1's medical record (Face Sheet) documents R1 is a [AGE] year-old admitted to the facility on [DATE] with diagnoses including but not limited to: Gastroparesis (condition that prevents proper stomach emptying), Chronic Obstructive Pulmonary Disease, Lack of Coordination, and Repeated Falls. R1's MDS (Minimum Data Set, 2.22.24) documents: BIMS (Brief Interview for Mental Status): 14 (cognitively intact) R1's medical record documents on 3/12/2024 at 8:02 AM Nurses Note Narrative: Writer was informed by staff that resident had a fall in room. Upon entering room, resident was noted on floor at foot of bed in supine position, complaining of pain. Head to toe assessment was done, resident complaint of pain when trying to assess during ROM (range of motion), and resident couldn't move. Resident vital's were taken, complaints of pain was 8/10, and 911 was called. Resident informed staff that she was trying to get to closet, but when asked why, she didn't know. She also stated that she hit her head. Neuro Checks initiated, and ambulance came and transferred resident to (local emergency room) for further evaluation. PCP (primary care physician) was notified, (Power of Attorney-POA) was informed. R1's medical record documents on 3/5/2024 at 1:15 AM Fall Occurrence Note documents in part: The Nurse observed the resident on the in the hallway of the facility. Resident was observed on the floor in the hallway in a upright seated position scooting down the hallway. When this Nurse asked the resident what was she doing the resident replied she had gotten out of bed to go to the bathroom in the process she forgot where she was going. IDT (Interdisciplinary Team) Committee Meeting Note documents in part: Resident had an unwitnessed fall in bedroom and proceeded to the hallway where she was observed scooting down the hall on her buttocks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Root Cause of the fall determined by IDT: Root cause of fall is resident has increased confusion. What new interventions and/or changes are suggested by the IDT at this time?: Resident sent to ER for evaluation to rule out abnormalities. Intervention is medical response to a fall event. R1's medical record documents on 3/12/2024 at at 725AM Fall Occurrence Note documents in part: Writer was informed by staff that resident had a fall in room. Upon entering room, resident was noted on floor at foot of bed in supine position, complaining of pain. IDT (Interdisciplinary Team) Committee Meeting Note documents in part: Resident had unwitnessed fall attempting to retrieve something from closet. Root Cause of the fall determined by IDT: Root cause of fall is resident has poor insight on functional ability, a strong history of confusion r/t (related to) other recent falls. What new interventions and/or changes are suggested by the IDT at this time?: Neuro consult. Intervention is medical response to a fall event. R1's medical record documents 4/1/2024 at at 3:09AM, Fall Occurrence Note documents in part: Writer was informed by staff that resident had a fall in room. Upon entering room, resident was noted on floor at foot of bed in supine position. When asked was she in any pain, resident replied No. Resident stated I was trying to get up to go to work with that man over there. Writer asked resident Where was she trying to go? Resident replied I'm going home. I'm not staying here. I gotta go to work. Y'all going to get me in trouble. IDT (Interdisciplinary Team) Committee Meeting Note documents in part: Resident had unwitnessed fall at bedside. Root Cause of the fall determined by IDT: Root cause of fall is resident has altered mental status r/t (related to) abnormal labs. What new interventions and/or changes are suggested by the IDT at this time?: Administer meds (medications) per MD (physician) order. R1's medical record documents 4/1/2024 at 3:45 PM Fall Occurrence Note documents in part: Resident is observed on the floor in an upright seated position next to the resident's bed. This writer asked the resident why she was on the floor she said she had to go (to) the restroom. At this time the resident is very confused IDT (Interdisciplinary Team) Committee Meeting Note in part: Resident had unwitnessed fall at bedside. Root Cause of the fall determined by IDT: Root cause of fall is resident continues to have altered mental status. What new interventions and/or changes are suggested by the IDT at this time?: Remain in high visible areas at all times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's emergency room medical record reports document, CT Abdomen Pelvis with contrast dated 3/12/24 notes acute, mildly displaced fractures of the S3 vertebral body and coccyx. R1's fall with no injury care plan (initiated 1.5.2024) and at risk for falls care plan (initiated 1.5.2024) does not document any fall interventions for falls of 3.5.2024 or 3.12.2024.