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	05/05/2025

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 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** 49666 Based on observation, interview and record review, the facility failed to implement fall prevention interventions for a resident at high risk for falls for one (R1) out of three residents reviewed for falls in a total sample of three. These failures resulted in R1 had an unwitnessed fall on 04/01/2025. R1 sustained a left femur fracture. Findings include: Facility's final reported incident (FRI) report dated 4/2/25, documents in part, resident (R1) is alert and oriented to name. R1 needs consistent verbal cueing and reminder. R1's gait is unsteady, requires staff's assistance for transfers and ambulation. On 04/01/2025 at approximately 5:00 AM, resident (R1) observed in the room near bathroom on buttocks next to wheelchair. At 8:33 AM, nurse assessed R1 during am (morning) care and noted resident refusing to get out of bed. Resident stated, tengo dolor (Spanish translated to English means I have pain), while pointing to his lower back. Follow up with hospital revealed resident sustained a left femur fracture. R1's nurse's note dated 4/1/2025, 9:40 PM, documents in part called the hospital, resident (R1) being admitted with diagnosis of left femur fracture. On 05/03/2025, at 2:11 PM, V9 (Certified Nursing Assistant) states that V9 is not familiar with R1's care. V9 states I barely work on that floor; I (V9) do remember that night. I remember R1 kept pulling the call light, but R1 didn't want anything, every time I (V9) would go in there, R1 was just sitting on the edge of the bed. I did provide him with fresh water. V9 reports that when R1 had the fall, R1 was by the washroom, as if he was trying to go to the bathroom. V9 states I don't remember exactly if I changed R1 or if I took R1 to the washroom. I am not sure if I got a chance to document on him (R1) that night. V9 states that V9 did not know that R1 was a fall risk. V9 continues to state I know about the fall binder, but I did not look at that binder that night. V9 reports that it is important to know if residents are at high risk for falls to make sure the staff take the proper precautions, so the residents don't fall. On 05/03/2025, at 1:05 PM, via telephone V8 (Restorative Director/Licensed Practical Nurse) states that when V8 went to investigate R1's fall, R1 said he was trying to go to the washroom. V8 states from my knowledge he does not ambulate. He requires assistance with ADLs (activities of daily living) and mobility. (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 5/5/2025, at 3:28 PM, via telephone V12 (R1's Attending Physician) states R1 has history of falls, and a history of dementia. V12 states that residents can suffer a fracture from a fall. On 5/5/25, at 4:42 PM, via telephone V10 (Registered Nurse) states that she was the nurse on duty for R1 when R1 had an unwitnessed fall during 11:00 PM- 7:00 AM shift on March 31st, 2025, to April 1st, 2025. V10 states that it is important for residents who are incontinent to be checked if they need to be changed because it can be very uncomfortable. V10 states because some residents will try to get up to be clean and not wet. V10 continues to state that the CNAs are supposed to chart the care that they provide every night. V10 states that some major injuries that can happen from a fall are fractures and bleeding. R1's face sheet documents R1 is an [AGE] year-old individual admitted to the facility on [DATE], and has diagnoses not limited to: difficulty in walking, not elsewhere classified, repeated falls, restlessness and agitation, limitation of activities due to disability, cognitive communication deficit. R1's MDS/Minimum Data Set, dated dated dated [DATE], documents that R1 has a BIMS/Brief Interview for Mental Status score of 05/15, indicating that R1 has severely impaired cognition. R1's fall risk assessment dated [DATE] documents in part R1 is at risk for falls. R1's MDS section GG Functional Abilities dated 03/14/2025, documents in part that R1 requires substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. R1's MDS section GG Functional Abilities dated 03/14/2025, documents in part for mobility R1 requires substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) and for toilet transfer: The ability to get on and off a toilet or commode. R1's MDS section H Bladder and Bowel dated 03/14/2025, documents in part for urinary continence R1 is always incontinent (no episodes of continent voiding). Bowel continence R1 is always incontinent (no episodes of continent bowel movements). R1's care plan documents in part R1 is incontinence of bowel/bladder. Interventions to assist resident to bathroom, or use of bedpan. R1's March 2025, look back for CNA (certified nursing assistant) documentation for task: bladder and bowel elimination shows no documentation for the date 03/31/2025 11:00 PM- 7:00 AM shift. R1's March 2025 look back for CNA (certified nursing assistant) documentation for task: toilet transfer: The ability to get on and off a toilet shows no documentation for the date 03/31/2025, 11:00 PM- 7:00 AM shift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility document dated 11/17/17, titled comprehensive care plan documents in part the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Facility document dated 11/21/17, titled fall prevention program documents in part 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. Fall/safety interventions may include but are not limited to residents will be observed approximately every two hours and provide care as assigned in accordance with the plan of care. Facility document dated 05/18/23, titled Falling Leaf Program documents in part The Falling Leaf Program may be voluntarily implemented at the discretion of the facility as an additional intervention for the reduction of falls. With this program, the facility interdisciplinary team targets a select of residents who are at risk for falls. The staff will visually check all residents on the program as determined by the team to ensure safety, assist with care needs, and prevent unsafe self-transfers. Facility document dated 04/20/21, titled incontinence care documents in part to prevent excoriation and skin breakdown, discomfort and maintain dignity. Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode.