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	04/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper Personal Protective Equipment (PPE) was worn during wound care for one (R6) of four residents reviewed for Infection Control. The findings include:R6's admission record / face sheet shows admit date on 11/7/2025 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Other asthma, Type 2 diabetes mellitus, Acute on chronic systolic (congestive) heart failure, Unspecified fracture of upper end of right humerus, Venous insufficiency (chronic) (peripheral), Essential (primary) hypertension, Atherosclerotic heart disease of native coronary artery, Other myocardial infarction type, Heart failure, Unspecified osteoarthritis, Nephrotic syndrome, Spinal stenosis lumbar region without neurogenic claudication. MDS (Minimum Data Set) dated 2/6/26 shows R6's cognition is intact.On 4/7/26 11:55AM V11 (Wound Care Coordinator, LPN / Licensed Practical Nurse) stated R6 has diabetic ulcer / vascular on left heel - facility acquired on 2/16/26. Measurement on 4.5 X 5.2 X 0.1cm on 4/2/26. On 4/7/26 At 1:46PM Wound care observation conducted with V43 (Wound Care Nurse, LPN / Licensed Practical Nurse). She stated R6 has diabetic ulcer to left heel. Observed R6's room door with EBP (Enhanced Barrier Precautions) signage and shows providers and staff must wear gloves and a gown for the following high-contact resident care activities - wound care: any skin opening requiring a dressing. Observed R6 lying in bed, alert and oriented x 3, verbally responsive. Observed EBP signage posted on the wall at head part of R6's bed. Observed V43 performed hand washing and worn gloves. V43 did not wear a gown. Observed R6 with dressing stained with brownish drainage on left heel. V43 removed wound dressing. Observed left heel with pinkish wound bed with some blackish / necrotic tissue. Observed V43 cleansed wound with Dakin's solution, applied Honey and Silver alginate to wound bed then covered with dry dressing. V43 did not wear gown the whole process of wound care treatment observation.On 4/8/26 At 11:30AM V3 (DON / Director of Nursing) stated residents are placed under EBP if they have wound, indwelling medical devices such as indwelling urinary catheter, g-tubes. She stated during high care activities to residents on EBP such as wound care, staff are expected to wear proper PPE (Personal Protective Equipment) such as a gown and gloves to prevent cross contamination. V3 stated if staff is not wearing proper PPE staff could potentially cause cross contamination or organism could possibly be transmitted to other residents during wound care.On 4/8/26 at 1:40PM V50 (IP / Infection Preventionist Nurse, LPN) stated Residents placed under EBP are those with opening to the skin except colostomy, central line, wounds, g-tube, tracheostomy tube. She said during resident's high care activities such as wound care, staff are expected to wear gloves and a gown. V50 stated the purpose of proper PPE is to protect residents from any infection that staff could possibly have or to prevent cross contamination. She said residents are more susceptible to infection. She said if staff are not wearing proper PPE could possibly cause cross contamination to other residents that staff is assigned to. R6's POS (Physician Order Sheet) dated 4/7/26 shows active order not limited to: Left Heel - clean with Dakin 0.25%, pat dry, apply Iodosorb to wound bed then calcium alginate and cover with dry dressing 3x per week and prn. Use Medi honey and alginate with silver if Iodosorb not available every day shift every other day to promote wound healing. Facility's wound report dated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/8/26 show in part: R2 with vascular / diabetic ulcer to left heel. Measurement: 3.0 x 4.0 x 0.1cm. Pink or red non granulating = 40%. Necrotic soft, adherent = 60%. Scant serosanguinous exudate. Facility's treatment nurse floor assignment for V43 shows room [ROOM NUMBER]-134 and 204-237. Facility's wound report dated 4/8/26 shows 16 residents with skin impairment assigned to V43. `Facility's Enhanced Barrier Precautions show in part: Providers and staff must wear gloves and a gown for the following high-contact resident care activities. Wound care: any skin opening requiring a dressing. Facility's Enhanced Barrier Precautions policy dated 5/7/24 shows in part: To reduce risk of transmitting multidrug-resistant organisms (MDRO) and targeted MDRO when contact precautions do not apply for residents identified as higher risk. EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employes targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: Chronic wounds and / or indwelling medical devices even if the resident if not known to be infected or colonized with MDRO. Examples of chronic wounds include, but not limited: Pressure ulcer, Diabetic foot ulcers, Venous stasis ulcers. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities. Wound care: any chronic skin opening requiring a dressing.