STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005177	A. BUILDING: _____ B. WING _____	C 03/14/2025

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APERION CARE LAKESHORE	7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigations 2581741/IL187374 and 2581312/IL186511	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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care needs of the resident.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure ongoing precautions were put into place and consistently maintained, and failed to ensure residents were in a safe position, for 1 residents (R2) of 3 residents reviewed for safety. These failures resulted in R2 falling out the bed, sustaining a right femur fracture.

Findings include,

R2's clinical record indicates: R2 is a sixty-seven-year-old admitted with the following medical diagnosis of severe morbid obesity, bilateral primary osteoarthritis of knee, fracture of right femur, major depressive disorder, post-traumatic disorder, anxiety disorder, overactive bladder, and unsteadiness on feet, embolism of lower extremity.

R2's Minimum Data Set (MDS) Brief Interview Mental Status score= 15, indicating R2 is

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cognitively intact. R2's MDS section GG indicates R2 is total dependent for ADL incontinence care and personal hygiene assistance. R2 requires maximum assistance with bed mobility.

R2's Care plan indicates in part:
4/1/22, R2 at risk for falls related to osteoarthritis of knee. Interventions:
Be sure R2 is centered in bed when sleeping.
Check and change R2 three times per shift for incontinence, toileting before and after meals, upon rising in the morning and before bed at night. (8/24/22). 10/5/21, R2's bed height to be placed where R2's feet are flat on the floor.
2/22/22, be sure R2's call light is in reach. R2 needs prompt response to all requests for assistance.
8/3/2021, R2 has limited mobility in bilateral lower extremities related limited mobility, osteoarthritis in both knees.
7/21/24, R2 has an ADL and functional ability for self-care and mobility deficit related to osteoarthritis of knee. Interventions: R2 requires extensive assistance by staff to turn and reposition in bed.
1/25/24, R2 is totally dependent on staff for toilet use.
2/20/25, R2 has a right hip fracture.

R2's fall history:
9/3/21 R2 observed sitting on the floor; R2 was trying to transfer self.
10/4/21 R2 observed on bathroom floor; slipped while trying to sit on toilet seat.
11/2/21 while staff answering call light, observed R2 sitting on the floor trying to transfer from wheelchair to the bed.
10/4/23 observed R2 on floor next to bed; R2 said she was dreaming and fell to the floor.

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Intervention: ensure resident centered in bed while sleeping.
1/31/25 1040 am resident was observed sliding out of bed but before staff could get to R2 she fell out of bed.

R2's Hospital Discharge Instructions, dated 2/15/25, indicated:
Diagnosis: Femur Fracture.

Diagnostic Radiology report, dated 2/14/25: Acute mildly displaced fracture of the medial femoral metaphysis.

On 3/13/25 at 10:00 AM, R2 stated, "On 1/31/25, day shift (V5, Certified Nurse Assistant) came to assist me, because I was soiled with bowel movement and urine. The last time I was changed was 4AM. (V5) assisted me to turn on to my right side, and I grabbed my side grab bar to hold on. I told (V5) I could not turn any further because I was the edge of the bed. (V5) was trying to remove the linen from under me, and she pushed me forward while doing so. Then my left leg flopped over the bed mattress, and I kept going. I ended up somehow in a sitting position between my bed and the wall, underneath the window. (V5) ran out to get assistance. (V4, Assistant Director of Nursing), (V6, Restorative Nurse/Licensure), and a few Certified Nurse Assistants. (V4) asked me what happened, and I explained to her how I feel out the bed, due to the fact I told (V5) to stop, and she kept pushing me over. I did not slide out the bed trying to reposition myself; that is not true. After I fell I was not in pain, just sore. (V13, Licensed Practical Nurse) was my nurse and called an ambulance for me. When the ambulance arrived, I refused to go to the hospital because I was not in pain at this time. The pain slowly increased over time to horrible

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pain, then I was sent to the emergency room. I learned my femur bone was broken. This would have never happened, if (V5) stopped pushing me over when I told her to stop."

On 3/12/25, at 11:00 AM, V5, Certified Nurse Assistant, stated, "Start of my shift, I made rounds and (R2) was sleeping in twisted position near the edge of the right side of her bed. I did not check to see if she needed incontinence care because she was sleeping, and I did not move her to the center of the bed because I did not want to wake her up. I took (R2) her breakfast tray, but she was still sleeping. Later around 10:20AM, I was making rounds picking up the breakfast trays, and observed (R2's) leg hanging out of the bed, between the bed and the wall. By the time I reached (R2), she had fallen off the bed onto the floor in a sitting up position between the bed and wall. I called out for assistance. (V13, R2's nurse/Licensed Practical Nurse/LPN), (V4) and other nurses and Certified Nurse Assistants came to assist. (R2's) nurse, (V13), and (V4, Assistant Director of Nursing) assessed (R2). (V6, Restorative Nurse), another Certified Nurse Assistant, and I assisted (R2) off the floor using a mechanical lift into bed. Once (R2) was in bed, (V6) and I provided incontinence care to (R2); she had a bowel movement. During ADL care, (R2) did not complain of pain or have any signs of distress. Once the ambulance came, (R2) refused to go get checked out. Around a week or so later, (V4, Assistant Director of Nursing) told me not to work with (R2) anymore, because (R2) told (V11, Insurance Case Manager) that I pushed her off the bed. (V4) suspended me pending investigation. I did not push (R2) off the bed onto the floor. I saw her hanging off the bed but could not reach her in time. I returned to work a few days later. Upon the start of my shift, I

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should have repositioned (R2) in the center of the bed and checked to see if she needed to be cleaned up, maybe she wouldn't have fallen. I did not want to wake her up."

On 3/13/25 at 2:00 PM, V13, Licensed Practical Nurse, stated, "I was (R2's) nurse the day she slid out the bed. (V5, Certified Nurse Assistant) called out for help I entered (R2's) room and noted (R2) on the floor between the bed and wall. (R2) told me that she was trying to reposition herself and slid off the bed. During (R2's) body assessment, (R2) denied pain. The physician gave an order for (R2) to be evaluated at the hospital, but (R2) refused to go."

On 3/12/25 at 2:18 PM, V6, Restorative Nurse\Licensed Practical Nurse, stated, "(R2) is alert and oriented x3. (R2's) bed mobility I maximal assist; (R2) requires one staff to assist. For ADL care, (R2) needs total assistance from staff, and mechanical lift for transfers. (R2) has two side handles to assist with repositioning. On 1/31/25, I heard (V5) yell out for assistance. I walked in (R2's) room and observed (R2) in a sitting up position on the floor between the bed and wall. (R2) said that she slipped of the bed, I do not know the details. After (R2) was assessed, (V5) and I used the mechanical lift to transfer (R2) off the back into bed. (R2) had a large amount of bowel movement on her. I assisted (V5) in providing incontinence care. During ADL care, (R2) did not complain of pain. (R2) has fallen five times since her admission. (R2's) fall interventions are to ensure (R2) is centered in the bed while sleeping, check resident three times per shift for incontinence. If (V5) noted (R2) sleeping on the edge of the bed and did not assist and reposition her to the center of bed, (R2's) fall was avoidable. On 2/15/25, (R2) reported an

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increase in pain in her right leg area and (R2) agreed to go receive an evaluation and (R2) was diagnosed with right femur fracture."

On 3/13/25 at 3:04 PM, V4, Assistant Director of Nursing, stated, "On 1/31/25, I went into (R2's) room to provide assistance with the fall. (R2) said she slid out of bed, while trying to move over off the edge of the bed. (R2) was assessed on the floor, no compliant of pain or distress noted. (R2's) physician gave order to send (R2) to hospital for further investigation. (R2) had an incontinent episode and was cleaned up. Once the ambulance arrived, (R2) refused to go, she said there was not pain and did not want to go. (R2) requested that (V5) no longer takes care of her. I did not ask (R2) why she felt that way about (V5). I made sure (V5) did not provide any care for (R2). On 2/15/25, (R2) reported an increase in pain in her right leg area and (R2) agreed to receive an evaluation, and (R2) was diagnosed with right femur fracture. On 2/19/25, the Administrator received a phone call from (V11, Insurance Case Manager) and she said that (R2) reported she was pushed off the bed by (V5, Certified Nurse Assistant). (V1) and I both went to interview (R2) about her fall incident on 1/31/25. (R2) explained to (V1) and I, that she slid off the bed. I did not ask (R2) if (V5) had pushed her off the bed; I do not know why I did not ask her. (V5) was suspended. (V1) completed the IDPH (Illinois Department of Public Health) reportable and investigation. I was not made aware of the abuse allegation until 2/19/25. If (V5) observed (R2) early in her shift laying twisted on the edge of the bed, then (V5) should have followed (R2's) care plan and assisted (R2) in the center of the bed. (R2's) care plan also states for staff to provide ADL incontinent care three times per shift. If (V5) would have repositioned (R2) in the center in bed

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and provided ADL care, potentially (R2) would not have fallen off the bed."

On 3/12/25 at 4:25 PM, V1, Administrator, stated, "I was made aware of (R2's) fall with fracture and reported the incident to IDPH. I also made an addendum on 2/19/25, when I received a phone call from (V11, R2's Insurance Case Manager). I spoke with (R2), and she explained she slipped out of bed trying to reposition herself off the edge of the bed. During our interview, (R2) did not mention (V5) pushed her off the bed. (V5) was suspended and investigation was completed. The abuse allegation of the fall was not substantiated after interviewing other residents and nursing staff. I was not made aware of the abuse allegation until 2/19/25."

Policy documents in part:
Fall Prevention Program dated 11/28/12.
To assure the safety of all residents in the facility.
The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions.
Use and implement of professional standards of practice.
Care plan incorporates identification of all risk, address each fall.
Preventative measures, interventions are changed with each fall.
Assigned certified nurse assistant are responsible for initiating safety precautions. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained.
The resident will be checked approximately every two hours or as according to the care plan, to assure they are in a safe position.

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