

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2025
NAME OF PROVIDER OR SUPPLIER APERION CARE INTERNATIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 4815 SOUTH WESTERN AVE CHICAGO, IL 60609		
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S 000	Initial Comments Facility Reported Incident of 4/1/25-IL190120	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/15/25

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S9999	<p>Continued From page 1</p> <p>and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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 care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>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.</p> <p>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".</p> <p>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.</p> <p>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.</p> <p>R1's face sheet documents R1 is an 88-year-old</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>individual admitted to the facility on 03/11/2025, 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.</p> <p>R1's MDS/Minimum Data Set dated 03/14/2025, documents that R1 has a BIMS/Brief Interview for Mental Status score of 05/15, indicating that R1 has severely impaired cognition.</p> <p>R1's fall risk assessment dated 03/11/2025 documents in part R1 is at risk for falls.</p> <p>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.</p> <p>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.</p> <p>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).</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>R1's care plan documents in part R1 is incontinence of bowel/bladder. Interventions to assist resident to bathroom, or use of bedpan.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(A)</p>	S9999		