Illinois Department of Public Health

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	.ETED
<u> </u>		IL6015333	B. WING		06/0	2/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APERION	I CARE FOREST PAR	k	T ROOSEVE			
(74) (5)	SUMMARY STA	TEMENT OF DEFICIENCIES	PARK, IL 60	PROVIDER'S PLAN OF CORRECTI	ON	/VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000	*.		
	Complaint Investiga	ation:				
	Facility Reported In 2023/IL159713- F6		. 1 26	£;		
	Facility Reported In 2023/IL160067 - F6				-	
S9999	Final Observations		S9999			
·.	Statement of Licen	sure Violations:	{			
	1 of 2 Violations:		-			
	300.610a) 300.1210b)5) 300.1210c) 300.1210d)6)	W				
	Section 300.610 Re	esident Care Policies	~	1.0		
	procedures govern facility. The written be formulated by a Committee consist administrator, the a medical advisory of nursing and other	advisory physician or the ommittee, and representatives or services in the facility. The				
	The written policies the facility and shall by this committee,	ly with the Act and this Part. s shall be followed in operating II be reviewed at least annually documented by written, signed				,
	and dated minutes 300.1210 Section (Nursing and Perso	General Requirements for				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING: B. WING IL6015333 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

8200 WEST ROOSEVELT ROAD

ADEDION CARE EOREST PARK		VEST ROOSEVELT ROAD ST PARK, IL 60130				
(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		
S9999	Continued From page 1	S9999				
	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 eacresident to meet the total nursing and personal care needs of the resident.					
	 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highe practicable level of functioning. 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 se that each resident receives adequate supervision and assistance to prevent accidents.					
	These Regulations are not met as evidenced by Based on interview and record review, the facilifailed to supervise and provide minimum assistance to prevent falls for 1 of 3 residents rement of Public Health					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	-6160
		IL6015333	B. WING		06/02	; 2/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
APERIOR	N CARE FOREST PAR	SK .	ST ROOSEVE PARK, IL 601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 8E	(X5) COMPLETE DATE
S9999	(R2) reviewed for far This failure resulted fractures of the position ribs, left pneumothe contusion. Finding include. On 5/30/23 at 2:00 was informed by R fell in the bathroom with requested to be chand change R2. V8 V36 go into R2's rothat R2 has been oneeds were address did not complain or shift. On 6/1/23 at 2:00p checked on R2 in I was dry. He did no bathroom." V36 statime during rounds movement so she the third time she generation anything a had witnessed R2 out of the bathroom have seen him sitting and standing. V36 R2's fall status. He assistance". V36 sfall band if at risk fall status for the bathroof fall band if at risk fall status for the bathroof fall band if at risk fall status for the bathroof fall band if at risk fall status for the bathroof fall band if at risk fall status for the bathroof fall band if at risk fall status for the bathroof fall band if at risk fall status for the bathroof fall band if at risk fall status for the bathroof fall band if at risk fall status fall statu	alls in a total sample of 11. d in R2 suffering from acute sterolateral and lateral 5th-9th orax and slight left lung pm, V8 (RN) stated that she 2 at the end of her shift that he 1. V8 stated that R2 can walk to one assist. V8 stated that R2 anged and she sent V36 to go 3 stated that she witnessed from and was informed by V36 changed. V8 stated that R2 ssed during her shift, and he rehave any concerns during her with tell me he had fallen in the ated she checked the second after 2pm and R2 had a bowel changed R2. V36 stated that, gave him water and R2 did not about a fall. V36 stated that she walk to the bathroom and walk in the past; V36 stated "I ing at his bed side by himself 5 stated that she is not sure of a would put his call light on for stated that residents will have a falls and all fall risk residents wheelchair if they need to go				
:		pm, V9 (2nd Floor Supervisor) s informed by the outgoing				

Illinois Department of Public Health STATE FORM

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LE IED
		IL6015333	B. WING		06/0	; 2/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ADEDIO	N CARE FOREST PAR	8200 WES	T ROOSEVE	ELT ROAD		
APERIO		FOREST	PARK, IL 60°	130		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
\$9999	Continued From pa	age 3	S9999			
	nurse that R2 fell of stated that an x-ray was sent to the host back positive. V9 s anybody he needed can walk to the bat	n his side in his room. V9 of his ribs was done and R2 spital once x-ray results came tated that R2 did not inform d assistance with toileting. He hroom by himself.				
	Assistance) stated one assist with bed sitting at the bedsid and V24 both state physical therapy everason. R24 stated (Occupational The	am, V24 PT (Physical Therapy that R2 needs a minimum of I mobility, turning side to side, de. V23 (Physical Therapist) of that R2 did not receive a valuation and did not provide a I that R2 was referred to OT rapy) on 2/27/23 but was a 5/23/23. He is receiving bed ue to max assist.				
	assessment is don interventions are d	m, V2 (DON) stated that a fall e on all residents and the fall ocumented in the care plan. V2 placed on the resident's door residents.				
		ted 2/27/23 reads; Physical uation and Treatment as				
	Fall risk assessme Score:13 Category	nt dated 2/27/23 reads; r: At Risk for Falls.				
	Facility's standing treat as indicated.	order set reads, PT eval and				
	Facility's fall incide and 5/10/23.	nts show; R2 fell on 4/11/23				
		t reads; Report to IDPH (Illinois blic Health) Reginal Office. Final 5/10/23.				

Illinois Department of Public Health

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	` '	CONSTRUCTION	COMP	PLETED
		IL6015333	B. WING		06/0	C 02/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		8200 WE	ST ROOSEVE	LT ROAD		
APERIO	N CARE FOREST PAR	FOREST	PARK, IL 601	30		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOWN CROSS-REFERENCED TO THE APPRINCED TO T	JLD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	PT Evaluation and days, to address th re-education, gait to manual therapy. Minimum Data Set reads; I-Toilet use:	red 5/23/2023 reads; Therapy: Treatment 3-5 x/week x 41 er-ex, ther-ac, neuromuscular raining, w/c management, Section G. Functional Status Self Performance 3 (Extensive				
	assist).	pport 2 (Offe-person priysical				
	falls and injury relatevaluate and treated Assist with toileting after meals, during 5/15/23 reads; PT,	2/27/23, reads "I am at risk for ted to falls". PT and OT to as indicated. 2/28/23 reads; upon awakening, before and rounds, before bedtime PRN. OT (Occupational Therapy) Therapy) to evaluate upon spital.				
	Impression: (1) Act and lateral left 5-9 segmental fracture	Report dated 5/10/23 reads, ute facture of posterolateral ribs, including comminuted of the 6th, 7th, and 8th ribs. Incumothorax and slight left				
		ed 5/11/23 reads; Current Diagnosis; Traumatic ial encounter.				
	Purpose: To assure	d; Fall Prevention Program; e the safety of all residents in				
	include measures needs of each resinand implementation	ossible. The program will which determine the individual dent by assessing the risk falls n of appropriate intervention to supervision and assistive as necessary				

Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	SURVEY PLETED
		IL6015333	B. WING		I	02/2023
	PROVIDER OR SUPPLIER N CARE FOREST PAR	8200 WE	DRESS, CITY, ST ST ROOSEVEI PARK, IL 601:	LT ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETE DATE
\$9999	each resident ident. Residents who rebe left alone after to or toilet. 2 of 2 violations: 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) Section 300.610 Real procedures govern facility. The written be formulated by a Committee consist administrator, the amedical advisory of nursing and othe policies shall comp The written policies the facility and shaby this committee, and dated minutes 300.1210 Section (Nursing and Persona) Comprehensive with the participation	esident Care Policies have written policies and ing all services provided by the policies and procedures shall Resident Care Policy ing of at least the advisory physician or the committee, and representatives er services in the facility. The oly with the Act and this Part. Is shall be followed in operating libe reviewed at least annually documented by written, signed of the meeting. General Requirements for				

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C B. WING IL6015333 06/02/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8200 WEST ROOSEVELT ROAD APERION CARE FOREST PARK FOREST PARK, IL 60130 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG **DEFICIENCY**) S9999 S9999 Continued From page 6 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental 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) 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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,

Illinois Department of Public Health

seven-day-a-week basis:

Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE:	
			A. BUILDING:			
		IL6015333	B. WING		06/0	, 2/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
APERIO	N CARE FOREST PAR	/K	ST ROOSEVE PARK, IL 60°			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	nge 7	S9999			
21	assure that the resi as free of accident nursing personnels	ecautions shall be taken to idents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents				
	These Regulations	are not met as evidenced by:				
	failed to supervise assistance to prevere reviewed for falls in	and record review, the facility and provide minimum ent falls for 1of 3 residents (R1) a a total sample of 11. This R1 suffering from a right semorrhage.				
-	remembers she wa	2:30PM, R1 stated that she as being assisted by CNA to walking with her walker when I backwards.				Ÿ.
	Nursing Assistant) R1 with walking to R1 asked her to ad	OPM, V35 (Agency Certified said while she was assisting the bathroom with her walker, ljust the toilet raiser before om, and while she was doing ell backwards.				
	Assistant - PTA) ar said that at the time minimal assistance staff has to physical	45AM, V24 (Physical Therapy nd V25 (Physical Therapy - PT) e of the fall, R1 needed with rollator, which means ally hold her while walking. V25				
	with her and R1 ha no one is holding h backwards, and he	R1 because he has worked is the tendency of falling when her because she leans or hips are very unstable. V24 their software does not allow				

putting in minimal assist so they put Illinois Department of Public Health

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING IL6015333 06/02/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **8200 WEST ROOSEVELT ROAD** APERION CARE FOREST PARK FOREST PARK, IL 60130 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 8 partial/moderate assist which could mean minimal to moderate assist. On 06/01/2023 at 1:18PM, V39 (PTA) said that around the time of R1's fall, he was just coming back from leave. He said that during that time, R1 needed minimal help with everything like transfers, and ambulation with rollator. He also mentioned that he told R1 that he felt R1 was not ready for the rollator use yet because she becomes really tired. He described that R1 manifests shakiness when she gets tired. He also said that during the treatment, he was just grabbing the gait belt that was on her because she was becoming really shaky. He also mentioned that minimum assist means constantly touching the resident to give them the 25% of help they need. On 06/02/2023 at 10:30AM, V39 stated that R1's therapy performance fluctuates but the safest assistance she needed is minimum assist by 1 person. R1's face sheet order summary report dated 6/2/2023 indicated admission of 05/23/2023 and diagnoses including repeated falls, presence of right artificial knee joint, presence of right artificial hip joint, dependence on renal dialysis, malignant neoplasm of left kidney, except renal pelvis, malignant neoplasm of colon, hypotension, fracture of coccyx, end stage renal disease, other low back pain, unsteadiness on feet, abnormal posture, other abnormalities of gait and mobility, and other lack of coordination. R1's fall risk assessment dated 3/6/2023 indicated at risk for falls, and gait/balance problem while standing and walking. Skilled evaluation dated 4/27/2023 indicated unsteady gait, poor balance, use of manual wheelchair, and safety concerns. Documentation survey report for April 2023

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indicated walking in the room did not occur for

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		IL6015333	B. WING			0 2/2023
, , , , , , , , , , , , , , , , , , , ,	PROVIDER OR SUPPLIER	8200 WES	ST ROOSEVE			
741 214101		" FOREST	PARK, IL 60°	130		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
S9999	4/24/2023 - 4/26/20 extensive assistance assist on 4/27/2023 Note dated 4/28/20 instructed with gait A x 1 (minimal assisurface for x (for) 4 pattern. PT Discharaservice 3/7/2023 to skill on ambulation assistance. Care prindicated R1 is at rifalls, and risk factorabnormal posture a Hospital admission indicated Neuro IC Care Unit History a concern of R SDH and CT Head without final result dated 4/stable known right hemorrhage, and in right tentorial subdetential subdetential subdetential subdetential amount of he patient requires no expends 75% or minimal (Contact)	pieze and 4/28/2023, and be with one-person physical B. PT Treatment Encounter 23 indicated R1 was training using rollator with min st by 1 person) on level 0 feet each and unsteady gait rege Summary for dates of 4/28/2023 indicated functional as partial/moderate an revised 5/24/2023 isk for falls and injury related to resinclude lack of coordination, and abnormal gait/mobility. record dated 4/29/2023 U H&P (Neurology Intensive and Physical) Note chief (right subdural hemorrhage), but IV (intravenous) contrast 1/29/2023 indicated findings of tentorial leaflet subdural mpression of stable known				
		on, balance, and/or stability				
	help than touching; (up to 75%) of the	nce" - Patient requires more expends half (50%) or more effort. Patient is able to body weight in initiating and				

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED			
		IL6015333	B. WING			C 02/2023			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE					
APERIO	APERION CARE FOREST PARK 8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE			
S9999	Continued From pa	ge 10	S9999	 -					
	when possible. Fall/safety intervent limited to: "Residents who requested be left alone after be shower, or toilet."	all residents in the facility, tions may include but are not juire staff assistance will not eing assisted to bathe, ce, and fatigue with							
	toward of Dublin Hardth		<u> </u>			100			