STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD , FOREST PARK, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation Survey 2597210 / 2580069	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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 were not met as evidenced by: Findings include: R1 is a 79-year-old resident of the facility with a Brief Interview for Mental Status (BIMS) score of 12, and with pertinent medical diagnosis including but not limited to Displaced Comminuted Fracture of Shaft of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing; Age-Related Osteoporosis; Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease; End Stage Renal Disease; and Dependence on Renal Dialysis. On 08/11/2025 at 1:04 PM, upon request, R1 agreed to speak with this Surveyor in her room. R1's room was dark; the television was on, so R1 turned it off; a wheelchair was located on the right side of R1's bed; one attachable wheelchair footrest was noted on the seat of the wheelchair; and the room appeared clutter-free. R1 said that most of the time, the pain level from her right leg, post-surgery, was a ten out of ten, but, on occasion, it went down to five. R1 said she didn't remember the date, but about two weeks ago, at about 1:00 or 2:00 PM, V4 (CNA) wheeled her outside of her room, while on her wheelchair, in order to take her to get her hair done at the facility's hair salon. R1 said that as V4 was pushing her in the hallway, her right foot rolled under her wheelchair, she "hollered," then V4 ran back to her room to get a footrest, fastened it to the wheelchair, and placed her right foot on it. R1 said her knee was "hurting so bad." R1 said V4 then wheeled her to her hair appointment; and when she was done, she was wheeled back to her room. On 08/12/2025 at 11:50 AM, R1 reiterated to this Surveyor that on 07/29/2025, V4 was wheeling her on her wheelchair towards the hair salon, and that she had no footrests on either side of the wheelchair at the time she was being pushed down the hallway. R1 said that	S9999		

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S9999	Continued from page 2 after her right foot rolled under her wheelchair, V4 went inside her room, got a footrest for her, fastened it to her wheelchair, placed her right foot on it, and wheeled her to her hair appointment. On 08/11/2025 at 11:17 AM, V12 (Family Member) told this Surveyor that about two weeks ago, on a Tuesday, at about 5:50 PM, R1 called her from the long-term care facility, and said V4 rolled her right leg under her wheelchair while she was taking her to the beauty shop, and her wheelchair did not have a leg brace to support her leg. V12 said that R1 told her that, after V4 realized R1's right leg had been rolled under the wheelchair, she put a leg brace on the wheelchair and put R1's right foot on it. V12 said that the hospital doctor told her R1's right leg had been fractured in two places. On 08/14/2025 at 9:29 AM, V4 told this Surveyor that on 07/29/2025, R1's right foot came off her wheelchair's leg rest while she was wheeling her about halfway down the hallway to the hair salon for an appointment. V4 said she did not know how it happened, only that it (R1's right foot) slipped off. V4 said she never looked at R1's feet or legs while she was pushing her wheelchair from behind. V4 said that when she went to the front of the wheelchair after R1 "hollered, ow, my leg," R1's leg was under the wheelchair, but she did not know how far it had gone under. In a progress note from 07/29/2025 at 6:28 PM, V13 (RN) stated in part that R1 verbalized pain on her right knee and said that it was "during transfer when she went down to the salon this morning." In a progress note from 07/30/2025 at 9:00 AM, V14 (APN) stated in part that R1 presented with "very bad" knee pain and "ten out of ten" severity for one to two days. In a progress note from 08/01/2025 at 11:34 AM, V15 (NP) stated in part that R1 complained of pain to her right leg, which was not improving with medication, and the pain had been there since her foot dragged under the wheelchair while she was going for an appointment. On 08/12/2025 at 12:32 PM, V6 (APN, Orthopedic Surgery) told one of the Surveyors that she remembered R1 and her injury while at the hospital; and she believed it would have been unlikely that R1's right foot would have gotten caught underneath the wheelchair if the footrests and her feet were put on properly (if they were put on at all).	S9999		

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S9999	Continued from page 3 On 08/12/2025 at 12:40 PM, V5 (Restorative Nurse) told this Surveyor that she assessed residents to determine if they were able to move on wheelchairs unassisted, and in R1's case, she was unable to wheel herself, independently, and needed "substantial dependent assistance with locomotion." V5 said she had approved two footrests for R1's wheelchair and had instructed nurses and CNA's to ensure they were attached to R1's wheelchair whenever she was going to any destination. V5 said R1 had minimal strength in her legs, her core strength was weak, she was unable to hold her legs up for a long period of time, and believed that it would always be a safe measure to put both footrests on her wheelchair for long distances, like going to the hair salon. V5 said that due to R1's poor functional abilities in her lower extremities, if she was not positioned well while the CNA was transporting her, there could be a problem; so, the staff should make sure that there was proper resident positioning prior to pushing R1. V5 reiterated that, due to R1's weak lower extremities, it was most important that her feet and body be positioned properly. R1's MDS, section GG, dated 07/18/2025, stated in part that R1 was wheelchair "dependent," and, thus, unable to wheel herself fifty feet unassisted. On 08/12/2025 at 2:38 PM, V1 (Administrator) told this Surveyor that the administration did not have a facility policy that addressed the proper supervision and use of wheelchairs on 07/29/2025, when R1's right leg injury happened. V1 said they looked for one but could not find it. V1 also said that no video footage of R1's wheelchair incident on 07/29/2025 existed because it had been erased after seven days, and no one reviewed the footage while it was available because there was a lot of footage to go over in order to locate it. R1's x-ray report, dated 08/01/2025, stated in part that R1 suffered an "acute comminuted distal femur fracture" and an "11mm lateral displacement with distal fragments." A hospital progress note dated 08/06/2025 at 2:25 PM from V6 stated in part that R1 presented to the hospital with a "closed right distal supracondylar femur fracture after getting right leg caught under wheelchair while someone was pushing her." R1's hospital summary report dated 08/06/2025 described R1's operative procedure as "closed reduction and intramedullar nailing right distal femur on 8/5."	S9999		

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S9999	Continued from page 4 The facility provided documentation to the Survey team on 08/12/2025 that outlined steps the facility began taking on 08/02/2025 to address the acceptable supervision for and proper use of assistive devices, such as a wheelchair, after R1's incident. Prior to the survey date of 08/11/2025 the facility had taken the following actions to correct the noncompliance: conducted an in-service training on the following topics:Proper Placement of Feet on FootrestsEmphasis on correct use of footrestsImportance of proper foot positioning during wheelchair useFall Prevention StrategiesIndividualized interventions and supervision tailored to resident needsReinforcement of fall prevention protocolsSafe Handling and Use of WheelchairsCompetencies and training completed for all nursing staffFocused on proper wheelchair use and resident safety during transfers and transportOn-going monitoring by facility administration "A"	S9999		