

Illinois State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0050187</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/19/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>APERION CARE INTERNATIONAL</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4815 SOUTH WESTERN AVE , CHICAGO, Illinois, 60609</b>                        |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S0000                                                             | Initial Comments<br><br>Complaint Investigation 2681843/2741216<br><br>Facility Reported Incident of 12/26/2025- 2711878                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                         | S0000               |                                                                                                                          |  | 02/27/2026                                      |  |
| S9999                                                             | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1210b)<br><br>300.1210d)6)<br><br>Section 300.1210 General Requirements for Nursing and<br>Personal Care<br><br>b) The facility shall provide the necessary care and<br>services to attain or maintain the highest practicable<br>physical, mental, and psychological well-being of the<br>resident, in accordance with each resident's<br>comprehensive resident care plan. Adequate and properly<br>supervised nursing care and personal care shall be<br>provided to each resident to meet the total nursing and<br>personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care<br>shall include, at a minimum, the following and shall be<br>practiced on a 24-hour, seven-day-a-week basis:<br><br>6) All necessary precautions shall be taken to assure<br>that the residents' environment remains as free of<br>accident hazards as possible. All nursing personnel<br>shall evaluate residents to see that each resident<br>receives adequate supervision and assistance to prevent<br>accidents.<br><br>These requirements were not met as evidenced by:<br><br>Based on interviews and record reviews, the facility<br>failed to ensure resident safety and supervision while<br>transporting one resident (R1) in a wheelchair without<br>leg rests resulting in the resident sustaining a<br>fracture This failure affected one residents (R1) out<br>of six residents reviewed for safety and supervision. |                                                                         | S9999               |                                                                                                                          |  | 02/27/2026                                      |  |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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Illinois State Department of Health

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| S9999                                                             | <p>Continued from page 1<br/>Findings include:</p> <p>R1's Face sheet dated 2/17/2026 documents a diagnosis of but not limited to other specified disorders of muscle, right side sciatica, unilateral primary osteoarthritis-right knee, age-related osteoporosis without current pathological fracture, and limitations of activities due to disability.</p> <p>R1's Minimum Data Set Section C 12/19/2026 dated documents a BIMS (Brief Interview Mental Status) Score of 15 which is an indication of an intact cognition.</p> <p>R1's Care Plan initiated 8/11/2025 and revised on 12/30/2025 documents, in part a focus for extremities related to other abnormalities of gait and mobility, sciatica right side, unilateral primary osteoarthritis right knee and cerebral infarction, risk for falls related to other abnormalities of gait and mobility- sciatic right side, unilateral primary osteoarthritis right knee.....she is able to self-propel in hall without leg rests short distances.</p> <p>R1's Physician Order Sheet has an active order dated 12/2/2025 Therapy: OT Evaluation and Treatment 2-4 x/week x 41 days, to address activities of daily living retraining, therapeutic activities, therapeutic exercises, neuromuscular reeducation, wheelchair management and training (w/c mgt/trng)., and discharge (d/c) planning.</p> <p>R1's Physician Order Sheet has an active order dated 12/2/2025 Therapy: PT Evaluation and Treatment 3 to 5 x/week x 41 days. Physical Therapy (PT) skilled services may include Therapeutic Exercises, Therapeutic Activities, Neuromuscular Re-education, Wheelchair Management.</p> <p>R1's Physician Order Sheet has an active order dated 12/26/2025 at 12:08 PM, documents transfer to hospital emergency room for x-ray of left ankle, fibula, and tibia per resident and family's request.</p> <p>R1's Hospital After Visit Summary documents, in part, a diagnosis of closed nondisplaced fracture of medial malleolus of left tibia, initial encounter.</p> <p>R1's Physician Progress Note dated 12/26/2025 at 10:20 AM documents Was asked to reassess patient after she twisted her knee this am. Patient with pain on palpation of superior tibia, patellar tendon, lateral joint lines. Pain with varus and valgus testing. Continue tramadol, Check L knee Xray, and Limit weightbearing of LLE until knee Xray results available.</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

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| S9999                                                             | <p>Continued from page 2</p> <p>R1's Physician Progress Note dated 12/26/2025 at 10:24 AM, documents later reported Left tibia and Left medial and lateral malleolar pain. Will also check Left tibia/fibula Xray, Left ankle Xray.</p> <p>R1's Physician Progress Note dated 12/26/2025 at 10:57 AM, R1 reported holding her legs up while being pushed by V9 (Occupational Therapist) in a wheelchair; her left leg fell, and she heard a "pop." R1 informed V9 and was assisted back to bed via mechanical lift. R1 complained of pain to nurse, jokingly stating, "the therapist messed up my good leg," laughing until V9 left. After V9 exited, staff overheard R1 crying on phone, saying, "the therapist messed up my leg and I heard a pop. They are ordering an x-ray." R1 was evaluated by the physician, who ordered x-rays. R1 and family declined x-rays at facility and requested transfer to the hospital emergency room for an evaluation of R1's left leg. Primary physician notified; orders given to transfer to Northwestern Hospital ER for evaluation and imaging of left leg pain.</p> <p>R1's Fall Risk Assessment dated 8/11/2026 documents, in part, ambulation/elimination status chair bound.</p> <p>On 2/17/2026 at 9:52 A.M., V4 (R1's family member) stated on 12/26/2026 at 10:51 A.M., R1 called crying to inform her (V4) of the incident that occurred an hour earlier. V4 stated R1 stated V9 (Occupational Therapist) arrived to her room to take her occupational therapy for a therapy session and to put R1's leg rest on her wheelchair; V9 stated he didn't see the leg rests and recommended R1 lift her legs in a crunching position; while wheeling R1 down the hallway, R1's foot rolled under the wheelchair; she (R1) began to yell telling the occupational therapist that her leg was under the wheelchair; V4 stopped the wheelchair and walked away to inform V11 (Medical Doctor) sitting at the nursing station; V11 palpated R1's left leg and ordered an Xray; V9 went to R1s room and found the leg rests while V11 assessed R1's leg; V9 returned the wheelchair and applied the leg rests; V9 continued to the physical therapy room despite R1 informing him (V9) and V11 she (R1) was in pain; V9 asked R1 to stand and R1 informed V9 she could not stand because she was in too much pain; R1 stated to V9, "You broke my leg."; V9 returned R1 back to her room; and the Certified Nurses Assistants put R1 back in bed via a mechanical lift. V4 stated she (V4) called V1 (Administrator) as she traveled to the facility and informed him (V1) of the incident. V4 stated V11 ordered an Xray but she (V4) refused an Xray and requested R1 be sent to the</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

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| S9999                                                             | <p>Continued from page 3</p> <p>Emergency Room (ER) for an evaluation. R1 was transferred to the ER and her (R1's) diagnosis was a fracture left leg.</p> <p>On 2/17/2026 at 10:31 am, R1 stated the Certified Nurse's Aides transferred R1 from her (R1's) bed via mechanical lift to the wheelchair. R1 stated the wheelchair's leg rest were on her (R1's) table. R1 stated V9 (Occupational Therapist) arrived at her room to wheel her to the physical therapy room; R1 asked V9 to apply her leg rests and V9 informed her (R1) to hold her legs up; R1 had on shoes and as V9 rolled R1 down the hallway, R1 heard a popping sound as her leg rolled under the wheelchair while V9 pushed her down the hallway; R1 yelled out to V9 to stop the wheelchair and her leg was broken; V9 stopped the wheelchair, went back to R1's room to retrieve the leg rests, returned to the wheelchair and applied the leg rests; V9 continued to roll R1 down the hallway and saw V11 (Medical Doctor) at the nursing station; V9 whispered in V11's ear and V11 walked over to R1's leg and palpated R1's leg; V11 informed V9 and R1 he (V11) would request a Xray; V9 applied an ice pack to R1's leg and stated he was sorry; V9 wheeled R1 to the therapy room despite R1 informing V9 she could not do occupational therapy because she was in too much pain, V9 asked R1 to stand and R1 informed V9 that the pain was too unbearable for her to stand; V9 wheeled R1 to her room; R1 stayed in her wheelchair until the Certified Nurse Assistant (CNA's) came with the mechanical lift to place her back in bed; R1 thought the therapist would call the ambulance but he didn't; the nurse did not come and assess her leg and she was experiencing pain of 9/10 on numeric scale; she called her granddaughter and her granddaughter had to come to the facility to request she (R1) be transported to the emergency room; her granddaughter arrived and V3 (Director of Nursing) and V9 were in V3's office; R1's granddaughter she overheard V9 informing V3 the leg rests were on at the time of the incident when the leg rests was not applied to the wheelchair at the time of the incident.</p> <p>On 2/17/2026 at 12:24 pm, V1 (Administrator) informed surveyor via electronic email that the facility no longer has video footage related to R1's incident because the facility's video camera system does not store footage for that long.</p> <p>On 2/17/2026 at 2:22 pm, V10 (Certified Nurse Assistant-(CNA) stated residents should have their leg rests applied to their wheelchairs during transferring around the facility. V10 stated the purpose of the leg rests is to prevent a resident from falling or getting</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

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| S9999                                                             | <p>Continued from page 4<br/>injured. V10 stated she (V10) was not aware of R1's injury on 12/26/2026.</p> <p>On 2/17/2026 at 3:39 pm, V1 (Administrator) stated he (V1) does not have a policy for Accident/Hazards/Supervision or wheelchair policy. The surveyor requested a wheelchair manufacture policy.</p> <p>On 2/18/2026 at 10:24 am V14 (Licensed Practical Nurse) stated he is not aware of the incident that occurred with R1; residents that can self-propel and do not require leg rests and residents who cannot self-propel require leg rests; restorative gives us the information on which residents require leg rests or not via a mobility log; leg rests should be care planned; had an in-service on leg rests; and not for sure if an order is required for leg rests.</p> <p>On 2/18/2026 at 10:34 am, V15 (Licensed Practical Nurse) stated on 12/26/2025 at an unknown time; V9 (Occupational Therapist) informed me (V15) R1's leg had dropped on the floor and was twisted while being transported via wheelchair by him (V9); R1 had her leg rests on at the time she was notified of R1's injury and pain medication was requested; pain medication was administered; restorative staff informs the nurses which residents require leg rests via restorative book log; a physician's order is needed for self-propelling; not sure if R1 had an order for self-propelling; and the purpose of leg rests is to prevent injury and provide safety; received in-service on any resident that need leg rests to put them on; and pain medication was provided after R1's injury.</p> <p>On 2/18/2026 at 10:45 am, V9 (Occupational Therapist) stated he (V9) arrived at R1's room to transport her R1 to the therapy room for a session. V9 stated he did not apply R1's leg rest prior to leaving R1's room and began to push R1 with her legs raised from the floor via wheelchair out of R1's room into the hallway. V9 stated while pushing R1 via wheelchair, R1's leg dropped and flexed backward under the wheelchair after passing 2 rooms in the hallway; R1 yelled "You are on my leg"; V9 stopped the wheelchair and went to retrieve R1's leg rests from her (R1's) room; V9 attached R1's leg rests and walked to the nursing station to inform V11 (Physiatrist-pain doctor); V11 assessed R1's leg and ordered pain medication, X-ray, and no weightbearing on the left leg until X-ray is resulted; he (V9) wheeled R1 to her room and 3 Certified Nurse's Assistants aided in transferring R1 to her bed via mechanical lift; leg rests are used especially when transporting residents to the gym; in-serviced on leg rests for resident who require leg rests; and purpose</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0050187</b> |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                              |  | (X3) DATE SURVEY COMPLETED<br><b>02/19/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>APERION CARE INTERNATIONAL</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                         |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4815 SOUTH WESTERN AVE , CHICAGO, Illinois, 60609</b> |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                                                                   |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S9999                                                             | <p>Continued from page 5<br/>of leg rest is to prevent injury and keep residents safe.</p> <p>On 2/18/2026 at 11:42 am (via telephone interview), V16 stated she (V16) assisted another Certified Nurse's Assistant in transferring R1 to her (R1's) wheelchair for therapy. V16 stated the therapist entered the room before she (V16) applied the leg rests and informed her he would take over from that point; was informed of the incident later; R1 requires leg rests because she cannot move her legs; everyone knows leg rests are necessary to prevent injury when legs cannot move the wheelchair; remembers an in-service on applying leg rests no matter what as soon as residents are placed in the wheelchair.</p> <p>Reviewed Email from V1 (Administrator) which documents the facility does not have a wheelchair policy or a Accident/Hazard/Supervision policy.</p> <p>On 2/18/2026 at 12:03 P.M., V17 stated he (V17) believes R1 who requires total care ankle was twisted while being transferred by V9 (Occupational Therapist) during a gym session; V9 informed V17 of the incident; V17 performed an assessment of R1's leg ordering pain medicine, an X-ray, and no weight bearing on R1's left leg until the results of the X-ray were read; unsure if the X-ray was performed at the facility or the hospital; R1's hospital discharge diagnosis was a closed fracture with no surgical intervention and no weight-bearing to the left leg; R1 was upgraded to weight bearing between January 16 to January 23, 2026; and recommends consulting the Physical/Occupational Therapist to determine if leg rests were required to prevent the fracture to R1's left leg.</p> <p>On 2/18/2026 at 12:31 pm, V18 (Restorative Director) stated R1 is capable of self-propelling herself in the wheelchair; R1 did not require leg rests before the incident and did not require leg rests now; V18 and the physical therapist conduct an assessment to determine a residents mobility functional ability; nurses are provided a restorative log containing residents mobility needs; residents care plan contains a focus for mobility intervention; verified R1's care plan contains a focus dated 8/11/2025 revised on 12/30/25 for wheelchair mobility with self-propelling ability but the restorative log dated 2/16/2026 she (V18) developed and provides to the nurses documents R1 requires a wheelchair with leg rests; and an in-service was provided on leg rests recently.</p> <p>On 2/18/2026 at 1:42 am, V3 (Director of Nursing) stated the (Certified Nurse's Assistant-(CNA) is</p> | S9999                                                                   |                                                                                                                          |                                                                                                   |  |                                                 |  |

Illinois State Department of Health

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| S9999                                                             | <p>Continued from page 6</p> <p>responsible for applying the leg rests before and after transfer to bed or chair; no residents don't necessarily require an order for self-propelling; yes, it is an expectation that R1 can self-propel without leg rests; therapy determines if the resident is able to physically propel themselves and the information is kept in the therapy notes; during our morning meeting therapy will let the nurses know the residents mobility strength and ability; on 12/26/2025 R1 was able to self-propel; if staff is pushing a resident down the hall without leg rests, the resident requested to be pushed or the resident doesn't have the functional ability to self-propel; the cameras were not reviewed; the purpose of leg rests are to assist residents when they can't hold their legs up and or don't have the strength in their lower limbs to self-propel; this information is done upon assessment; we do not have a safety/accident policy; if the resident requires leg rests out of necessity and they are not being used, an accident can happen; and it depends if the resident leg drops the leg can get caught in the wheel of the wheelchair; an ergonomic position that is safe when staff are pushing a resident in the wheelchair is the resident self-holding their legs up from the floor or stretched straight out in front of the resident while the wheelchair is in motion; and an in-service was provided to all staff on leg rests.</p> <p>On 2/18/2026 at 3:14 pm, V1 (Administrator) stated he (V1) was informed on 12/26/2025 of the incident with R1. V1 stated he does not currently have an Accident/Supervision/Hazard policy. V1 stated we handle incidents or accidents based on the incident. V1 stated we come up with interventions as a team but not following any specific policy. V1 stated my (V1's) expectation to do anything in the building is to follow proper protocol. V1 stated if R1 was supposed to have leg rest on and she had leg rest on then it sounds like proper protocol was followed. V1 stated there is a risk for the resident's legs to be injured if there are no leg rests depending on the resident's functioning.</p> <p>(B)</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |