Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008783	A. BUILDING: ______ B. WING ______	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE SPRING VALLEY	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

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S 000	Initial Comments Complaint: 2024821/IL124060 F 580 D, F 684 D F689 G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1	S9999		

but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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. Restorative measures shall include, at a minimum, the following procedures:

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.

Section 300.3240 Abuse and Neglect

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S9999	Continued From page 2	S9999		

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed 1) to provide supervision during toileting for one resident (R2), reviewed for falls. 2) facility failed to notify the physician timely of an unwitnessed fall. This failure resulted in R2 sustaining a fatal closed head injury, after a fall in the bathroom.

FINDINGS INCLUDE:

The facility policy, Fall Prevention Program, dated (revised) 11-21-17 directs staff, " 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. Residents who require staff assistance will not be left alone after being assisted to bathe, shower or toilet."

The facility policy, Physician-Family Notification-Change in Condition, dated (Revised) 11-13-18 directs staff, "To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient and effective manner. The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practioner; and notify the resident's legal representative or an

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S9999	Continued From page 3	S9999		

interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention."

R2's Physician Order Sheet, dated June 2020 includes the following medications: Clopidogrel (anticoagulant) 75 MG (milligrams) by mouth one time daily and Aspirin EC (Enteric Coated) (anticoagulant) 81 MG by mouth two times daily.

R2's Progress Notes, dated 6/5/2020 at 7:17 P.M. document, "(R2) had an unwitnessed fall at 7:00 P.M., in resident's bathroom. Notified by (V22/Certified Nursing Assistant) (CNA) that (R2) had fallen in bathroom and hit head on floor. (R2) bleeding from small laceration to right eyebrow. (R2) said, I went to reach for the door handle of the bathroom door, lost my balance and fell. I hit my head on the floor. Steristrips applied. Bleeding continued so (R2) sent to ER (Emergency Room)."

R2's ED (Emergency Department) Note, dated 6/5/2020 documents, "ED arrival time 1940 (7:40 P.M.) (R2) brought in from nursing home."

R2's Admission Record documents that R2 was admitted to the facility on 4/26/2020. This same document includes R2's diagnoses: Orthopedic Aftercare, Displaced Fracture of Greater Trochanter of Right Femur, Unsteadiness on Feet, Lack of Coordination and Abnormalities of Gait and Mobility.

R2's Fall Risk Assessment, dated 4/26/2020 documents that R2 has a history of falls, has balance problems while standing and walking, has decreased muscular coordination and has predisposing disease that place her at high risk

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S9999	Continued From page 4	S9999		

for falls.

R2's Care Plan, dated 4/26/2020 includes the following Focus/Interventions, "I am at risk for fall/injury from weakness and tiredness related to recent hip replacement. Follow facility fall protocol."

R2's Minimum Data Set Assessment, dated 5/8/2020 documents under Section G0110 (Activities of Daily Living Assistance), "Requires extensive assist of two plus staff for transfers, walking in room and toileting." This same document includes under Section G0300 (Balance During Transitions and Walking), "Not steady, only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfers."

R2's Progress Notes, dated 6/5/2020 at 7:17 P.M. document, "(R2) had an unwitnessed fall at 7:00 P.M., in resident's bathroom. Notified by (V22/Certified Nursing Assistant) (CNA) that (R2) had fallen in bathroom and hit head on floor. (R2) bleeding from small laceration to right eyebrow. (R2) said, I went to reach for the door handle of the bathroom door, lost my balance and fell. I hit my head on the floor. Steristrips applied. Bleeding continued so (R2) sent to ER (Emergency Room)."

The facility form, Incident Witness, dated 6/5/2020, from V22/CNA documents, "I assisted (R2) to the bathroom with (R2's) walker, positioned (R2) in front of the toilet with the walker in front of (R2). I left the bathroom to give (R2) some privacy and as I was removing (R2's) roommate's dinner tray, I turned around and (R2) was on the floor. It happened in a few seconds.

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S9999	Continued From page 5	S9999		

(R2) sat up and I noticed a laceration to (R2's) eyebrow and it was bleeding so I called (V21/Registered Nurse) (RN)."

R2's ED (Emergency Department) Note, dated 6/5/2020 documents, "ED arrival time 1940 (7:40 P.M.) (R2) brought in from nursing home. States (R2) was using walker and went to bathroom and turned to the right side trying to grab doorknob. The doorknob was too far away and (R2) fell onto the floor hitting the right side of (R2's) face on the ground." This same document includes, "Physician Exam: Right supraorbital, right temporal localized swelling, about 2 CM (centimeters) in diameter each with small laceration above the right eyebrow. Skin: 2 CM lac (laceration) above right eyebrow. Right periorbial ecchymosis with bruising at the right temporal region." This document concludes with, "(R2) presents with mechanical fall at the nursing home. Normal neurological exam. Has bruising to the right temporal region and right suproribital region. There is a small laceration at the right eyebrow. (R2) is experiencing some facial pain but not in acute distress at this time. Takes Aspirin. CT (Computerized Tomography) of head reveals large right subdural hematoma. Contacting (Regional Trauma Center) for stat (immediate) transfer."

R2's hospital Facial Bones CT, dated 6/5/2020 at 8:36 P.M. document, "Impression: Right-sided facial trauma involving zygomatic arch, maxillary sinus and orbital wall and rim. Maxillary sinus fracture involves gas outside the lumen of the sinus indicating an open fracture due to its involvement with sinuses. Intracranial hemorrhage."

R2's hospital Brain/Head CT, dated 6/5/2020 at

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S9999	Continued From page 6 8:36 P.M. document, "Ventricles: mass effect upon the right lateral ventricle related to the acute hemorrhage. Intracranial hemorrhage: There are several regions of acute hemorrhage. The acute hemorrhage has significant mass effect with dimensions of 7.5 CM AP (anterior to posterior) X 2.4 CM medial to lateral and extending nearly 8.7 CM craniocaudally. Midline shift: 5 MM (millimeters) right to left. Impression: Acute on chronic right subderal hemorrhage resulting in right-to-left midline shift. Additional acute blood within the sylvian fissure on the left with the inferior posterior left anterior fosa. Multiple facial fractures." R2's (Regional Trauma Center) Discharge Summary, dated 6/6/2020 documents, " (R2) was transferred after suffering a ground level fall at her nursing home. (R2) had been taking dual anti-platelet therapy. (R2's) imaging at the first hospital demonstrated a large subdural hematoma and subarachnoid hemorrhage as well as several orbital fractures. (R2's) mental status markedly declined prior to transport, so (R2) was intubated prior to arrival to (Regional Trauma Center). On arrival to (Regional Trauma Center), (R2's) sedation and paralytic was reversed. (R2's) exam did not improve with reversal or Mannitol. (R2's) POA (Power of Attorney) was consulted. (R2) apparently would never have wanted heroic measures to keep (R2's) self alive. Neurosurgery offered that surgery for (R2's) significant head bleed, (but surgery) would likely not provide a meaningful recovery. (R2's) POA elected for comfort measures to be initiated. (R2) was extubated. (R2) expired at 0400 (4:00 A.M.) on 6/6/2020. R2's Certificate of Death documents, "Cause of Death: Subdural Hematoma, Subarachnoid	S9999		

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S9999	Continued From page 7 Hemorrhage and Ground Level Fall (from injury on June 5, 2020 at 7:00 P.M.)." On 8/18/2020 at 9:50 A.M., V21/Registered Nurse (RN) stated, " I was working on June 5 (2020). It was around 7:00 (P.M.) and (V22/Certified Nursing Assistant) came and got me and said (R2) had fallen in the bathroom and hit (R2's) head. I went into the bathroom and (R2) was sitting up, on the floor. (R2) had a small laceration above (R2's) right eyebrow. (R2) said was alone in the bathroom and had reached to try and shut the door and fell and bumped head on the sink. I did ROM (range of Motion) on (R2). We helped (R2) up and set resident on the toilet. I put steri strips on the wound. I sent (R2) to the ER (Emergency Room) because the wound kept bleeding." On 8/18/2020 at 10:04 A.M., V22/Certified Nursing Assistant (CNA) stated, "I had came into work at 6:00 (P.M.) that night (6/5/2020). I got bumped to that hall. I usually work A Hall. I remember it was the first call light of the night. (R2) wanted to use the bathroom. I walked beside (R2) and (R2) used walker. (R2) said she felt unsteady. When we got to the bathroom, (R2) said was fine from here. When I left, (R2) was standing in front of the toilet. I stepped out of the bathroom, but was still in the room. I was cleaning up (R2's) roommate's dinner tray and I heard a loud thud. I found (R2) in the bathroom, on the floor. (R2) was bleeding from face. (R2) said had reached for the door and fell, tripping on walker. (R2) said thought hit head on the sink. I told (R2) not to move and I ran and got the nurse (V21). We helped (R2) back up. (R2) had a bump protruding above right eye and a cut above eyebrow. I didn't know (R2) couldn't be left alone in the bathroom. I feel so bad about all of this."	S9999		

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S9999	Continued From page 8 On 8/18/2020 at 11:07 A.M., V21/Registered Nurse (RN) stated, "I didn't talk to (V24/Physician) after (R2) fell. I messaged him after it was all done." On 8/18/2020 at 12;22 P.M., V24/Physician stated, " I was not called and informed that (R2) had fallen and hit (R2's) head. (R2) receives multiple anticoagulant medications and is at high risk for a brain bleed. If I had been called I would have told the facility to send (R2) by ambulance, immediately, to the ER (Emergency Room)." (A)	S9999		