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 |
|---|---|---|---|
| | IL6015333 | A. BUILDING: ______<br>B. WING ______ | C<br>04/27/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| APERION CARE FOREST PARK | 8200 WEST ROOSEVELT ROAD<br>FOREST PARK, IL 60130 |

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| S 000 | Initial Comments<br><br>Facility Reported Incident of April 1, 2021/IL132563 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210b)<br>300.1210d)6)<br>300.1220b)3)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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:<br>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:<br>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.<br><br>Section 300.1220 Supervision of Nursing Services | S9999 | Attachment A<br>Statement of Licensure Violations | |

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b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Based on observation, interview and record review the facility failed to develop interventions to promote a safe environment for a resident (R1) with cognitive deficits, wandering behaviors and the behavior of sitting on top of furniture. This is based on 1 (R1) of 3 residents reviewed for safety and fall prevention. This failure resulted R1 sitting on a dresser and then falling forward onto her head. R1 was observed with swelling to the head. R1 subsequently was sent to local hospital and diagnosed with a fall at nursing home, closed head injury, large frontal scalp hematoma, and non-displaced neck fracture.

Findings include:

R1 is a 72 year old female, R1 plan of care shows R1 has diagnosis of hypertension, insomnia, unspecified other frontal-temporal dementia, unspecified signs and symptoms involving cognitive functions and awareness, dementia with

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other disease classified elsewhere with behavioral disturbance, other Alzheimer's disease, history of falling, unspecified psychosis not due to substance or known physiological condition, contusion of right eyelid and periocular area, cellulitis of unspecified orbit, unspecified displaced fracture of seventh cervical vertebra, subsequent encounter for fracture with routine healing and Alzheimer's disease unspecified.

R1 facility incident report dated 4/1/2021 at 2:16pm shows unwitnessed incident in resident room completed by V8 (Nurse). Incident note states "Resident (R1) falls from the nightstand in the room next door. Resident was told not to sit there, but resident still sitting there. Resident was noted to be on the floor by CNA assigned, resident was asked if she was okay, and the resident stated yes, but my head hurt. Resident was asked what happened, resident said that she fell out from the nightstand, upon head-to-toe assessment, resident is noted with a big inflammation on her front head, resident was asked if she has pain on the scale 0 to 10, resident said yes, but she did not grade it she just said pain on her head, resident was assisted to her room and bed for facility transfer order."

Incident note dated 4/1/2021 at 2:16pm notes "injuries observed at time of incident was hematoma to forehead. Mental status is orientated to person, place, and situation. No injuries reported post incident." Predisposing environmental factors, "none" box is checked. Predisposing physiological factors, "none" box is checked. Predisposing situation factors, "none" box is checked.

Witness statements dated 4/1/2021 from V4

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(LPN Licensed Practice Nurse), V5 (CNA Certified Nursing Assistant) and V8 (Nurse) show the same statement as follows "Resident (R1) falls from nightstand in the next-door room. Resident was told not to sit there, but resident still sitting there. Resident was noted on the floor by CNA assigned, resident was asked if she was okay, and the resident stated yes but my head hurt. Resident was asked what happened, resident said that she fell out from the nightstand, upon head-to-toe assessment, resident is noted with a big inflammation on her front head. Resident was asked if she has pain on the scale 0 to 10, resident said yes, but she did not grade it she just said pain on her head, resident was assisted to her room and bed for facility transfer orders."

Witness statement from V6 (Housekeeping staff) dated 4/1/21 shows that V6 observed resident (R1) suddenly fall forward as she was trying to reach for something. She stated that she observed resident sitting on nightstand.
On 04/01/2021 2:16 PM resident statement: Resident stated that she fell out from a nightstand where she was seated.

Incident report dated 4/1/21 at 2:16pm states that the DON, POA, and Physician were all notified of the incident at on 4/1/21.

Assessment noted on 4/1/2021 at 2:16 pm included the following:
Vital Signs: BP 169/89 - Lying, left arm at 15:14
Temp 98.1 at 15:15
Temporal Artery pulse 77, regular at 15:15
Respiration 18 at 15:15
Pain level 0 at 12:53
O2 98% on room air at 15:15
Assessment: "Unwitnessed fall, neurological

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| S9999 | Continued From page 4<br>checks initiated. Alert and oriented to time, person, place, and situation. No changes in range of motion from normal baseline. New injury observed. Resident is noted with a big inflammation on her front head."<br>Actions/ Interventions: "Resident (R1) was assisted back to her room and bed, vital was taken, ice package was given, neuro checks continue, head to toe assessment is done, 911 is called, MD, ADON, DON, and family member are made aware, resident is kept sitting up until ambulance comes."<br>Intervention: "Resident is told not to sit on nightstands, resident is monitored every 5 minutes."<br><br>R1 progress note titled "fall IDT" states root cause of fall: "Resident has cognitive deficits due to cognitive deficits secondary to dementia and Alzheimer's. Resident was sitting on the dresser as she was attempting to reach for an item."<br><br>R1 progress notes dated 4/1/21 at 10:15p.m shows, "writer called hospital for update on resident status post fall. Nurse on duty, stated resident has been admitted for C7 fracture with possibility of surgery. A surgical consult will be held in the AM at for definite plan. If no surgery is done, resident may possibly return to facility tomorrow 4/2/21, as stated by NOD (Nurse on Duty). Power of Attorney aware."<br><br>R1 emergency department records dated 4/1/21 shows admitting diagnosis fall at nursing home, closed head injury, large frontal scalp hematoma, dementia with behavioral disturbance and non-displaced C7 lamina fracture.<br><br>On 4/15/21 at 10:04a.m R1 was observed walking down the hallway, then entering her | S9999 | | |

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| S9999 | Continued From page 5<br><br>room. V3 (Nurse) followed. R1 was observed with purple discoloration to the right side of her face, neck, and mouth area. R1 had large swelling to right side of her head extending down to her face. During an attempt to interview R1, she observed to be alert to name. When asked how she got the discoloration to her face, R1 replied "Oh no not again!". R1 then proceeded to move things around on her bed. R1 continued saying random words.<br><br>On 4/15/21 at 10:08a.m, V3 (Nurse) said she was the nurse assigned to R1 today (4/15/21). V3 said R1 sustain the bruising and swelling to the head from a fall. V3 said R1 fell from a chest dresser in another resident's room. V3 said R1 would always go to that room and sit on the dresser. V3 said the staff would have to constantly redirect R1 because R1 has dementia and R1 does not remember what you tell her. V3 said R1 had been going in that room and sitting on the dresser for "awhile".<br><br>On 4/15/21 at 10:56a.m V5 (CNA) said R1 has been going into another resident's room and sits on the dresser. V5 said she needs to constantly tell R1 to get down when she sees R1 on the dresser. V5 said she did not witness the fall on 4/1/21. V5 said R1 had been going into that room and sitting on the dresser for about 2 weeks prior to R1 falling from that dresser. V5 said she did not inform anyone that R1 had been sitting on the dresser. V5 told R1 she should not be sitting on the dresser because she could fall and hurt herself. V5 stated R1 is elderly and most elderly people are weak. V5 said R1 does not remember what you tell her because R1 has dementia and therefore R1 always must be redirected. | S9999 | | |

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| S9999 | Continued From page 6<br><br>On 4/15/21 at 11:20a.m V4 (Nurse) said on 4/1/21 he saw R1 in another resident's room sitting on the dresser. V4 said he redirected R1 down and took R1 back to her room and put R1 in the bed so that R1 could go to sleep. V4 said about 10 minutes later, he was sitting at the nurse's station when he heard a loud boom sound. He immediately got up and went toward the sound. V4 said he observed R1 on the floor and getting up. V4 said as he approached R1 he observed some swelling to R1's head. V4 said he did an assessment and took R1 to her room. There he noticed that the swelling to R1 head was very soft. V4 said an ice pack was given to R1 and her vital signs were assessed. V4 said it had only been 10 minutes between the time he took R1 to her room and R1 returning to another room then falling from the dresser. V4 said he did not inform anyone that he saw R1 sitting on that dresser prior to the fall. V4 said R1 should not be on the dresser because she could fall from the dresser just as she did. V4 said he does not know how long R1 had been going in that room and sitting on that dresser but that R1 goes into that room often to visit with her friend. V4 did say he has heard the aides tell R1 to get off the dresser in the past but he does not know when that was.<br><br>On 4/15/21 at 11:32a.m V6 (Housekeeper) said on 4/1/21 she was standing near the elevator, when she saw R1 sitting on the dresser in the room across from the elevator. V6 said she saw R1 fall forward, face first onto the floor. V6 said a loud sound was made when R1 hit the floor. V6 said she saw the nurse go to the room where R1 had just fallen. V6 said she did not see R1 reach for anything prior to falling. V6 said she has seen R1 sitting on that dresser in the previously, however she could not remember the date. V6 said she did not notify anyone that R1 was sitting | S9999 | | |

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on the dresser prior to the fall.

On 4/16/21 at 10:56a.m V8 (Nurse) said R1 fell from the dresser but she did not witness it. V8 said R1 always sits on that dresser and staff must redirect her but she continues to sit on the dresser. V8 said she does not remember if V4 informed her that R1 was sitting on the dresser prior to R1 falling on 4/1/21. V8 said R1 should not be sitting on the dresser because she could fall and hurt herself. V8 said R1 forgets what you tell her within 5 minutes and R1 must be reminded constantly. V8 said if she was informed, she would have kept and eye on R1. Meaning when she saw R1 sitting on the dresser, she redirected R1 back to her room.

On 4/23/21 at 12:03p.m V8 said she completed the incident report for R1. She said she filled it out very quickly and therefor missed some information on the report. V8 said the incident did not happen in R1's room but it happened in another room. R1 was not orientated to place and situation. R1 did not lose consciousness after the fall on 4/1/21. R1 was ambulatory. Furniture was a predisposing environmental factor in the incident. Impaired memory was a predisposing physiological factor in the incident.

On 4/16/21 at 11:16a.m V2 (ADON-Assistant Director of Nursing) said he conducts fall investigations for the facility. V2 said he was informed that R1 fell from the dresser on 4/1/21. V2 said when he arrived on the unit staff had taken R1 to her room and R1 was in the bed. V2 said he was not aware that R1 was going into another room and sitting on the dresser. V2 said when R1 fell it was the first time he had heard of R1 going in that room and sitting on the dresser. V2 said it is not safe for resident to be sitting on

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the dresser because they could fall. V2 said he should have been made aware so that he could have implemented interventions for R1. V2 said if he would have known he would have removed the dresser from the room. V2 said prior to the fall R1's fall score was 10 which represents a high risk for falls. V2 said R1's fall risk score is now 11. R1 remains a high risk for falls.

R1's fall risk assessment dated 3/16/21 shows a score of 10 (high risk).

R1's MDS dated 3/16/21 shows R1 has diagnosis of other frontotemporal dementia, unspecified symptoms and signs with cognitive functions and awareness, Alzheimer's, non-Alzheimer's dementia and Psychotic disorder (other than schizophrenia).

R1 care plan dated 4/10/2019 with revision date of 4/15/21 states (R1) has impaired cognitive functioning or impaired thought processes related to dementia.
Focus points on the care plan state "Due to my cognition I sit on furniture (i.e. nightstands)."
Some of the Interventions points on the care plan state "Administer medications as ordered. Monitor/document for side effects and effectiveness."; "Ask yes/no questions to determine the resident's needs."; "Upon observance of resident sitting on furniture i.e. nightstand. Staff will redirect the resident to a chair." Date Initiated: 04/05/2021 Revision on: 04/15/2021.
The intervention of redirecting R1 when observed sitting on a nightstand was not initiated until 4/5/21. V5 said she observed R1 sitting on the dresser 2 weeks prior to R1 falling on 4/1/21.

Additional care plan for R1 dated 3/26/2019 with

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| S9999 | Continued From page 9<br>revision date of 4/21/21 shows R1 is at risk for falls and injury related to falls. Risk factors include Major cognitive disorder, Dementia caused by behavioral abnormalities, possible medication side effects, incontinence, H/O (History of) falls, and Alzheimer's. It further states R1 will have interventions in place and reviewed as needed to address risk for fall and injury related to fall through next review.<br>(A) | S9999 | | |