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
	IL6001085	A. BUILDING: ____ B. WING ____	C 07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE BRADLEY	650 NORTH KINZIE BRADLEY, IL 60915

(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
S 000	Initial Comments Complaint: 2275305/IL148765	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 2 These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were positioned safely in bed to prevent falls and minimize fall risk. This failure resulted in one resident (R1) falling from bed and sustaining a 7 cm (centimeter) laceration to her leg. This applies to 3 residents (R1, R3 and R4) reviewed for falls. The findings include: 1.) R1 was admitted to the facility on May 27, 2022, per the admission face sheet and was discharged to the hospital on July 7, 2022. The physician orders dated July 1, 2022, showed that R1 had diagnoses of anemia, diabetes, anxiety, depression, chronic kidney disease stage 3, and dysphagia. R1's progress notes dated July 7, 2022 showed that at 1:04am, R1 was found on the floor between the wall and the bed. The note showed that R1 had a laceration to the right leg and was sent to the community hospital for evaluation and treatment. R1's July 7, 2022, Emergency Department Procedure Note showed R1 received sutures to a 7 cm laceration to her right lower leg. The note also showed R1 "believed she rolled out of bed and fell to the floor." On July 8, 2022 at 6:30pm V6 RN stated, "I found R1 on the floor (on July 7). She had a cut on her right leg. We stopped the bleeding with a gauze wrap, assessed her vital signs, and sent her to the hospital. The bed was about waist high and	S9999		

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S9999	Continued From page 3	S9999		

the wheels on the bed were not locked". On July 11, 2022, at 7:50am V7 CNA (Certified Nursing Assistant) stated she "could hear R1 calling out for help. I went with another staff member and R1 was on the floor between the wall and the bed. The bed was in a high position and the wheels were not locked. R1 had a cut on her right leg. I know she went to the hospital. [R1] did not return". V7 said that the wheels should be locked and the bed should be in the low position.

R1's Fall care plan showed a June 16, 2022, intervention that R1 used a bariatric-sized bed, and her July 5, 2022, MDS (Minimum Data Set) showed that R1 requires extensive assistance from two or more staff members for bed mobility. The clinical record showed that a fall risk assessment was not done until after the fall on July 7, 2022, and showed that R1 was at risk for falls.

The facility policy for falls dated November 11, 2017, showed that fall risks should be done on admission. The policy showed that safety interventions would be implemented for each resident identified at risk for falls and that all assigned nursing personnel were responsible for ensuring ongoing precautions were maintained consistently.

On July 8, 2022 at 12:15pm V1 Interim DON (Director of Nursing) stated, "The fall assessments should be completed on admission. The staff are to make sure the wheels are locked". V1 verified that R1's clinical record does not reflect a fall risk assessment on admission.

On July 8, 2022, at 11:45am V3 Restorative Aide stated, "R1 is at risk for falls even though she is bed bound. R1 requires total assistance with

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toileting and transfers. R1 can reach for things and will put her legs over the edge of the bed. R2 and R3 are also at risk for falls. R3 requires the bed to be in a low position and mats to the floor. I do not do the fall risk assessments and have no input in making the care plans. I assist on implementing what is put on the care plan".

2). R4 was admitted to the facility April 26, 2021 per the admission face sheet.

The physician orders dated July 1, 2022, showed that R4 was admitted to the facility with diagnoses of cerebral infarction, repeated falls, left sided weakness, respiratory disease, Atherosclerotic heart disease and pain.

On July 12, 2022, at 8:45am, R4 was lying in bed trying to eat oatmeal and the oatmeal was dropping onto her gown. Approximately four inches of R4's right shoulder was hanging off of the edge of the bed. R4's body was angled to the right side with a rolled blanket under the left shoulder blade (R4's weaker side). The call light was placed to the left side of her body. R4 had a fall precautions bracelet to the left wrist, and R4's bed was in the high position. The head of R4's bed was at a 45 degree angle.

R4 stated, "I do feel uncomfortable lying like this, but I can't straighten myself out. I can't pull the light cord. My left side is weak." The surveyor activated R4's call light. Staff came in the room to see why the light was on. After prompting, the staff repositioned R4 to the center of the bed but R4 remained on her right side, and staff left her bed in the high position.

R4's current care plan for falls showed that R4's bed should be kept at the lowest level, and a

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S9999	Continued From page 5	S9999		

pillow be at her side to remind her where the edge of the bed is.

On July 12, 2022 at 11:10 am V9 Administrator stated, "The staff should not be laying R4 on her right side to eat," and that there should not be a rolled up blanket under R4's left shoulder.

R4's fall risk assessment dated June 1, 2022, showed that R4 is at risk for falls. R4's June 15, 2022, MDS showed that R4 had moderate cognitive impairment, and requires extensive assistance of at least two staff members for bed mobility.

3.) R3 was admitted to the facility June 13, 2022, per the admission face sheet. The physician order sheet dated July 1, 2022, showed that R3 had diagnoses of lack of coordination, cognitive communication deficit, dysphagia, kidney failure, dementia, schizoaffective disorder, anxiety disorder and spondylosis in the cervical region. R3's July 1, 2022, fall risk assessment dated showed that R3 is at risk for falls, and R3's current care plan does not include a care plan for falls.

On July 8, 2022, at 10:30am R3 was lying in bed. R3 was non-verbal. R3's June 20, 2022, MDS showed that R3 was severely cognitively impaired and R3 required extensive assistance of at least two persons for bed mobility.

On July 12, 2022, at 9:00am, V8 CNA prepared to change R3's incontinence brief. V8 stated, "R3 is new to me. I have never taken care of him before. I have not changed him yet. I can change him myself. Sometimes residents fall. Haven't you noticed that they are short-staffed everywhere?" As V8 rolled R3 away from her in

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S9999	Continued From page 6 the bed, R3 was stiff and resisted being turned, and R3 grabbed at and reached out into the air for something to hang on to. V8 continued trying to turn R3 to his left side and R3's body was approximately five inches away from the edge of the bed. V8 pulled out one side of the sheet from under R3. R3 could not hold a side lying position without assistance and fell backwards onto his back while V8 went around the other side of the bed. V1 DON entered the room to check on R3 and V8. V1 said that R3 requires two staff for bed mobility. On July 12, 2022, at 11:10 am V9 Administrator stated, "R3 requires 2 staff for positioning in the bed... There is always enough staff to assist". (B)	S9999		