STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003511	A. BUILDING: _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE NILES	6601 WEST TOUHY AVENUE NILES, IL 60714

(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 Investigation of Facility Reported Incident of December 6, 2022/IL154825	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective 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.	S9999		

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S9999	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure resident's safety by failure to follow its fall prevention policy. The facility failed to implement R2's fall care plan interventions to prevent another fall which caused her to sustain a left hip fracture that requires hospitalization. The facility also failed to revise the care plan based on the IDT (Interdisciplinary team) recommendations after the incident investigation. The facility failed to complete the fall assessment accurately and failed to complete the fall assessment after each fall occurrence as indicated in the policy. This deficiency affects all five (R1, R2, R3, R4 and R5) residents reviewed for resident safety and fall prevention program. Findings include: 1.) R1 was admitted on 11/30/20 with diagnosis listed in part but not limited to fracture of upper end of left humerus, Dementia, Psychotic, Mood and Anxiety disturbance, Age related osteoporosis without pathological fracture, Contracture left knee, Dysphagia following cerebral infarction. R1's care plan indicates that she is at risk for falls. Intervention: follow fall protocol. R1 has ADL self-care deficit AEB: Dressing total dependence- 1 person assist, Toilet use total dependence- 1 person assist, Personal hygiene total assist - 1 person assist (dated initiated and revised 12/21/22). R1 has incident report dated 12/2/22 for injury of unknown origin resulting to age indeterminate left proximal humerus surgical neck fracture. Incident report submitted to IDPH has Quality	S9999		

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S9999	Continued From page 3 Improvement plan: In-serviced and re-educated staff on policies and procedures for transfers, repositioning, changing and ADLs. Care plan updated for 2 persons dependent care at all times. On 1/4/23 at 10:53am, R1 in left side lying position in bed with oxygen via nasal cannula connected to oxygen concentrator. She has gastrostomy tube feeding connecting to feeding pump. She is on low air loss mattress with bed not in the lowest position. R1 has floor mat on the left side of the bed. R1 is verbally unresponsive. The surveyor called V11 (Registered Nurse/RN) and showed R1's bed position. V11 used the bed control to adjust the bed in lowest position. V11 said that this is not a low bed, but it should be in the lowest position. V11 said that R1 was recently hospitalized due to left upper arm fracture from unknown origin, she came in with left arm sling but there is no order. R1 does not have left shoulder sling. R1's medical record indicates no order of left arm sling. On 1/5/23 at 10:29am, the surveyor observed R1 in right side lying position with bed in high position with V15 (Certified Nurse Assistant/CNA). V15 adjusted the bed to its lowest position using bed control. V15 said that bed should always be in the lowest position when they are in bed for safety. R1 has left arm sling on. On 1/5/23 at 1:00pm V2 (Director of Nurses/DON) informed of above observation. V2 said that bed should be in the lowest position. The CNA probably left the bed up after providing personal care. V2 said that that R1 does not have order for left arm sling. She does not know who put it on. V2 said that after each fall or any incident of injury of unknown occurrence the root	S9999		

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S9999	Continued From page 4 cause analysis is discussed by IDT (interdisciplinary team) and formulates new care plan interventions to prevent future falls or injury of unknown occurrence. V2 said that care plan intervention is updated by either V4 (Restorative Nurse/Fall Coordinator) or V6 (Minimum Data Set {MDS}/Coordinator). At 1:20pm V6 said that she did not update R1's care plan, V4 should update that care plan. V4 said that she updated R1's care plan but did not revise it based on IDT recommendations after the investigation of injury of unknown. 2.) R2 was admitted on 10/08/20 with diagnosis listed in part but not limited to displaced intertrochanteric fracture of left femur, History of falling, Age -related osteoporosis wit pathological fracture left hand, Nondisplaced fracture of proximal phalanx of left middle finger, Major Depressive disorder, Nontraumatic subarachnoid hemorrhage from middle cerebral artery, orthopedic aftercare, Cerebral infarction, Fracture of neck right femur, Heart failure. R2's care plan indicates: She has limitations with ADLs (activities of daily living) related to behavioral issues, muscle weakness, Hypertension, Diabetes Mellitus and Dementia. She is resistive to care. She is at risk for fall and needs supervision during mealtime. She is high risk for falls and injury because she is very private and used to be independent and do not like asking for help, sometimes get confused and unaware of safety measures. Education and use of call light don't apply to her related to impaired cognition. She is often disoriented. She has episode of agitation and delusions and has tendency to be non-compliant of safety measures despite of education. Call light was identified at risk for injury when bed. In the past she had hx (history) of falls and sustained injury. She has history of	S9999		

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S9999	Continued From page 5 ambulated without assistance, lost her balance. She has history of urge to walk without assistance when she feels that she is strong enough to walk. She has history of getting up from geriatric chair, lost her balance and fell. She has an actual fall on 7/21/21, 8/21/21, 8/15/22 and 12/6/22. Most recent fall she sustained left hip fracture. R2's incident reported to IDPH dated 12/6/22 indicated: Time of occurrence: 6:05am. Description of occurrence: R2 was self-transferring from geriatric-chair lost her balance and had a fall/Injuries: Swelling to the left side of her face and pain to left hip. Action taken: A head to toe assessment was completed by the nurse, pain medication offered, and resident was sent to hospital via 911. Physician and family notified. Final report 12/9/22. R2 has returned to facility, no surgical intervention was done. Hospital records indicate resident is at elevated risk due to R2's advance age and history of Congestive Heart Failure. Voltaren gel and acetaminophen have been ordered for pain management. Also, WBAT (weight bearing as tolerated) to Left Lower Extremity. Non-slip pad has been applied to the geriatric chair and frequent round is in place. On 1/4/23 at 10:47am, V11 (RN) said that R2 is alert and oriented x 1 with confusion. She speaks mainly Korean language. She needs total care with ADLs and transfers. She has behavioral issues. V11 said that R2 has fall incident on 12/6/22 in the night shift. V13 (Agency CNA) placed R2 in a geriatric chair due to restlessness and left in the hallway for supervision instead of leaving in her room. R2 fell from geriatric chair when she tried to get up. R2 has history of multiple falls with injury.	S9999		

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S9999	Continued From page 6 On 1/5/23 at 12:00pm, the surveyor observed R2 siting in the geriatric chair waiting for lunch to be served. She is confused. The surveyor observed R2 with V11 (RN) that non-slip pad is not applied on R2's geriatric chair. On 1/5/23 at 12:11pm, round made to R2's room with V15 (CNA) and V3 (ADON) no laser sensor alarm is in place in R2's room for safety. V3 said that it was broken and was not replaced. On 1/4/23 at 1:37pm, review R2's medical records with V2 (DON). V2 said that on 12/6/22 R2 unwitnessed fall. Found lying on the floor with head against the wall in front of her geriatric chair at 6:05am by the hallway. R2 is gets up by night shift. She has behavioral issues at times such as restlessness. R2 is confused. V12 (Agency RN) assessed R2 and observed swelling on left side of the face and pain to left hip. Staff transferred R2 back to geriatric chair. R2's PCP and family were notified. R2 sent to hospital via 911. R2 admitted with acute nondisplaced intertrochanteric fracture of left hip. R2 is re-admitted on 12/8/22. No surgical intervention was done. R2's care plan was updated: Voltaren gel and acetaminophen have been ordered for pain management. WBAT (weight bearing as tolerated) to Left Lower Extremity. Non-slip pad has been applied to the geriatric chair and frequent round is in place. Informed V2 that R2's care plan interventions were not updated based on root cause analysis IDT recommended written in R2's incident report submitted to IDPH. V2 said that V4 (RN/Fall Coordinator) should update the care plan. Informed V2 that previous fall interventions were not implemented: Monitor and sit in chair outside the room for close monitoring. Re-educate staff regarding maintaining 1:1	S9999		

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S9999	Continued From page 7 observation. Laser sensor alarm. Pain care plan was not revised after the fall injury for pain management. Pain assessment for cognitively impaired was not done. R2's fall assessment done on 8/15/22 after fall incident indicated not at risk for fall. V2 said that V4 (RN/Fall coordinator) is new to her position. V2 said that she will address concerns presented. On 1/6/23 at 8:35am V3 (ADON) said that if the resident is restless/agitated, resident should not be left unattended and should be in within vision. Numerous calls attempted to both V12 (Agency RN) and V13 (Agency CNA) who were assigned for R2 at the time of incident dated 12/6/22 but no response. Both V1 and V2 are aware and tried to contact too but failed. 3.) R3 was admitted on 6/1/20 with diagnosis of Parkinson's disease, Dementia, Age related osteoporosis, Major depression, Difficulty walking, Gait abnormality, Fracture of left acetabulum, Fracture of left pubis, Fracture of left clavicle, Osteoarthritis, Intervertebral disc degeneration lumbar region, Osteoporosis, History of falls. R3 has unwitnessed fall incident on 6/19/22. No fall assessment was done on 6/19/22 after fall incident. 4.) R4 was admitted on 9/8/20 with diagnosis listed in part but not limited to Difficulty walking, Dementia with behavioral disturbances, need for assistance with personal care, Dysphagia, Lack of coordination, generalized anxiety disorder, Major depressive disorder, Psychosis, Osteoarthritis, Age related osteoarthritis, Mild cognitive impairment. R4's care plan indicates: She requires psychotropic meds to help manage and alleviate conditions: Psychosis/	S9999		

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S9999	Continued From page 8	S9999		

paranoid/delusions, Agitation/periods of restlessness/, Depression, Mood swings/mood lability, Anxiety/neurosis, Disruptive behavior as evidenced by resistance to care. She requires assistance with walking r/t impaired balance, unsteady gait. She has potential to lose balance and stumble because she takes some medications that can make her dizzy, tired, confused, or weak. She prefers to sit next to bed sitting on her fall mat. She is crawler. She grew up in a culture that likes to sleep and sit on the floor. She is not compliant to safety measures and refusing to use rolling walker as her assistive device and gait belt on. Education does not apply to her r/t cognitive impairment. She has history of wandering at times in hallways and walk very fast. She refused to wear appropriate footwear when transferring and ambulating, she sometimes removes it. She requires redirection and assist to dining room or in room right away. She has ADLs self-care deficit r/t impaired balance, dementia, arthritis. She has been yelling and scratching staff without provocation. She has been talking to herself, screaming, and arguing/angry with someone that does not exist, hitting shoe on floor. She sometimes experiences delusions and hallucinations and become agitated and have the tendency to hit other resident or staff. She is at risk for fall r/t unsteady gait, confusion. She has an actual fall on the following dates: 7/22/22, 8/20/22, 9/27/22, 11/6/22, 12/20/22 at 7:20am and 12/20/22 at 2:30pm.

On 1/5/23 at 12:11pm the surveyor observed R3 sitting in a geriatric chair in the dining room waiting for lunch to be served. She is confused. No verbal response.

R4 most recent unwitnessed fall incident dated

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S9999	Continued From page 9 12/20/22 at 7:20am indicated that R4 was found sitting on the floor inside the washroom facing the toilet. Assessed R4 and noted cut on the left eyebrow with dried blood noted to surrounding area. Cleanse affected area and applied dressing. Also noted dried blood on her blanket and a small towel next to bed. Also noted bump on the back of her head with no bruise noted at this time. No other skin issues or any further injuries. R4 able to move all extremities. Denied any pain. R4 is alert and oriented x 1, as her baseline. R4 unable to give description of what had happened. R4's physician and family were notified. At around 4:30pm, the nurse saw R4 holding a pillow, stumble across the hallway into the room across. The nurse ran to R4 and called for help. V2 (DON) who was at the nursing station. Both entered the room and saw R4 lying I her left side with left arm extended and head on the floor. R4 was heard saying it hurts in Korean. Nurse lifted the head and put the pillow under and R4 was sent out to the hospital for evaluation. On 1/5/23 at 12:13pm observed R4 in the dining room sitting in geriatric chair with both legs upon the table. R4 is confused. No verbal response. On 1/5/23 at 1:13pm Review R4's medical record with V3 (ADON). R4's fall care plan was not updated after 2 fall incidents on 12/20/22. V4 said that V4 should updated the care plan after each fall occurrence to prevent future fall. V4 said that R4 should be on 1:1 supervision or the frequent monitoring done by staff should be documented in the chart. 5.) R5 was admitted on 11/23/18 with diagnosis to include but not limited to mild cognitive impairment, Age related osteoporosis without pathological fracture, Major depressive disorder,	S9999		

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S9999	Continued From page 10 Anxiety disorder, Dementia, Difficulty walking, Fracture left wrist and hand, history of falling. R5's care plan indicates: She requires psychotropic meds to help manage and alleviate feeling of fear. Depression/behavior with depressive features, Mood swings/mood liability due to dementia and Anxiety/neurosis/anxiety disorder related problems. She requires the use of splint due to fractured left wrist from fall. ADLs self-care deficit. She is at risk for fall due dx of syncope and psychotropic meds. She has impaired cognitive function/dementia or impaired thought processed r/t dementia. Impaired decision making, psychotropic drug use, short term memory loss. She has senile dementia, education and reminders does not apply to her due forgetfulness. Requires re-direction and repetitive staff demonstration. She has history of falling in other resident's room. She missed the chair while attempting to sit loss balance and fell. She had fall incidents on 7/6/22, 10/3/22, 12/12/22 and 1/2/23. V4 (RN/Fall Coordinator) recent fall intervention for recent fall 1/2/23 indicates: Re-educate on patient on asking for assistance, frequent monitoring, and re-direction. R5's fall assessment done after fall incident on 11/25/22 and 1/2/23 indicated not at risk for fall. R5's most recent witnessed fall incident dated 1/2/23 indicates: CNA said that he saw R5 falling backward as he approached another resident who was trying to get out of her chair. He turned around and R5 was sitting on the floor. The nurse assessed R5 and felt bump on the back of her head. Nurse asked R5 if her head hurts and she stated in Korean that it hurts a little. Nurse took vital signs BP-150/74, PR- 72, RR-20. R5 denied feeling dizzy. Family and physician notified. On 1/5/23 at 12:15pm, observed R5 sitting in	S9999		

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S9999	Continued From page 11 chair in the dining room. She is confused. Ambulates without assistive device (walker). She does not have left hand splint. R5 was observed not wearing left hand splint since yesterday. On 1/5/23 at 2:10pm, review R5's medical records with 4 (RN/Fall Coordinator). Informed V4 that R5 does not wear left hand splint. R5 has an order and care planned for Left hand splint due to recent left wrist/hand fracture from fall. V4 does not know if R5 still need to wear her splint on left wrist. V4 said that there is no restorative assessment done for usage of left-hand splint after fall incident of 10/3/22. Informed V4 of 2 fall assessments done to R5 after each fall coded at not at risk for fall. V4 said that R5's fall assessment should be coded as at risk for fall. Informed V4vthat fall care plan interventions written after fall incident of 1/2/23 is inconsistent with the R5 care plan. Care plan indicated that she has senile dementia, education and reminders does not apply to her due forgetfulness. V4 said that on the incident of R5 on 1/2/23 in the dining room, there is only 1 CNA monitoring the residents in the dining room. The CNA was attending to another resident who was trying to get up that's why the CNA could not prevent the fall of R5. Facility's policy on Fall prevention program indicates: Purpose: To assure the safety of all residents in the facility, when possible. 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. The Quality assurance program will monitor the program to assure ongoing effectiveness.	S9999		

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APERION CARE NILES	6601 WEST TOUHY AVENUE NILES, IL 60714

(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
S9999	Continued From page 12 Guidelines: *Use and implementation of professional standards of practice. *Immediately change of interventions that were unsuccessful *Care plan incorporates interventions are changed with each fall, as appropriate. Preventive measures. *All assigned nursing personnel are responsible for ensuring ongoing precautions are in place and consistently maintained. *Accident/incident reports involving falls will be reviewed by the interdisciplinary team to ensure appropriate care and services were provided and determine possible safety interventions. Standard: *Fall risk assessment will be performed at least quarterly and with each significant change in mental functional condition and after any fall incident. In addition to the use of standard fall precautions, the following interventions may be implemented for residents identified at risk: *The frequency of safety monitoring will be determined by the resident's risk factors and the plan of care. *In the event safety monitoring is initiated for 15-20 minute periods, a documentation record will be used to validate observations. Assigned nursing personnel are responsible for completing the safety checks and documenting the same on the record. Safety monitoring will be discontinued when the risk factors requiring monitoring is no longer evident as determined by the supervising nurse or interdisciplinary care team. "A"	S9999		