STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 Complaints Investigation 2391956/IL157299 2391817/IL157096 No deficiency Facility Reported Incidents: FRI of 02.08.23/IL156911 FRI of 02.20.23/IL157317	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 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. Section 300.1210 General Requirements for Nursing and Personal Care 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. These regulations were not met as evidenced by: Based on observations, interviews, and records reviewed the facility failed to follow the care plan interventions, failed to implement effective interventions, and conduct root cause analysis to prevent or reduce the risk of falling. This affected 3 of 4 residents (R1, R4, and R6) all reviewed for falls and fall prevention. This failure resulted in R1 falling while trying to retrieve a television remote sustaining a laceration to the right ear. This failure also resulted in R6 rolling out of bed and sustained Impression: 6.2mm oblique transverse fracture of posterior superior corner of this C4 vertebral body which appears acute, and acute appearing impacted fracture to the nasal bone. The findings include:	S9999		

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S9999	Continued From page 2 On 3/23/23 at 11:50AM the surveyor toured the units with V19, MDS/Care Plan/ Restorative Nurse. V19 presented a binder with list of residents at risk for falls. V19 presented the list on each unit, an undated copy was presented to the surveyor. R1 is listed with interventions low bed is not indicated for R1. R4 has bilateral side rails listed as an intervention. A.R1 is 43 years old with diagnosis including but not limited to Muscle Wasting and Atrophy, Obstructive and Reflux Uropathy, Spina Bifidia, Protein Calorie Malnutrition, Dysphagia, retention of Urine, Functional Quadriplegia, Hyperlipidemia, Hypertension, Convulsions, History of Traumatic Brain Injury, and History of Falling (onset date 10/29/22). On 3/23/ at 9:58AM V12, Licensed Practical Nurse (LPN), said on 2/20/23 R1 had just returned from the hospital that shift and he fell. V12 said the CNA said R1 was pointing at the television and she had tried to turn it on for him, but it did not turn on. V12 said R1 was trying to get the remote, I told R1 I was going to get him the remote and left the room. V12 said before I got the remote he rolled out of the bed. V12 said I can't remember if a floor mat was in use. V12 said R1 had a cut on his head and the Director of Nursing told her to send R1 back to the hospital. R1 had a fall on 2/20/23 at 5:55PM. Incident report documents R1 observed face down on the floor next to the bed. R1's progress notes dated 2/21/23 document the cause of R1's fall is he rolled out of bed or attempted a self transfer. R1 has traumatic brain injury and has moments of impulsive behaviors. Intervention update stated R1 moved closer to the nurses' station, ensure personal items are within reach on bedside table.	S9999		

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S9999	Continued From page 3 The care plan dated 2/20/23 keep all needed items in reach. Care plan intervention dated 10/31/22 states anticipate and meet resident needs. Intervention dated 2/13/23 states bedside matt. Hospital records obtained dated 2/20/23 documents R1 underwent a laceration repair to his right ear. Laceration documented to measure length 1.5 x depth 2. R1 received 4 sutures. On 3/22/23 at 3:10PM V5, LPN, said on 3/14/23 the CNA called for him and said the CNA had been changing R1 in bed. V5 said the CNA said she "was dropping him (R1) to the floor mat." V5 said R1 was in the bed receiving care when he fell. V5 said there was only 1 CNA in the room when R5 fell. V5 said R1 is always restless. V5 said R1 was a fall risk. V5 said R1 is able to move side to side, but it is not purposeful movements, he needs staff assistance to roll for care. On 3/28/23 at 10:38AM V24, CNA, said on 3/14/23 she was replacing R1's linens with him in the bed. V24 said R1 rolled over to the side and he kept going and rolled off the bed. V24 said I have not seen a fall list or symbols to indicate who is a fall risk. R1 incident report dated 3/14/23 at 8:50PM documents the CNA said R1 rolled onto his floor mat while the CNA was changing him. R1's progress notes dated 3/16/23 document the cause of R1's fall is muscle weakness and lack of coordination. Intervention R1 will be a 2 person assist. R1's care plan for bed mobility initiated on 1/16/23 reads R1 requires assistance with bed	S9999		

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S9999	Continued From page 4 mobility. Intervention dated 1/16/23 documents Provide assistance of 2 persons disciplines listed RN, LPN, CNA, and RN. ADL self care performance deficit care plan intervention dated 3/15/23 notes extensive assist by 2 persons. Fall intervention dated 3/14/23 documents change to 2 person assist with bed mobility tasks. (This intervention has been in place since 1/16/23.) On 3/24/23 at 11:01AM V17, LPN, said when R1 fell on 3/18/23 I was entering the room and saw R1 on the floor, on the right side of the bed. V17 said R1 had been in the bed when she saw him about 10 minutes earlier and he was moving some in the bed. V17 said his sheet was off his feet, I repositioned his sheet and spoke with him. V17 said R1 looked like he had rolled out of his bed, all of his body was on the floor mat. V17 said R1 was incontinent when he fell. V17 said R1 is not able to turn himself purposefully, he has control of his upper body more than his lower. V17 said R1 can't just turn himself. Incident report dated 3/18/23 at 3:15PM for R1 documents he was on floor mat on the right side of the bed. On 3/24/23 at 10:10AM V7, RN, said on 3/20/23 the CNA called my attention and I saw R1 on the side of the bed sitting, we asked him what happened. V7 said R1 said he said he wanted to get up. V7 said R1 said he fell from the bed. V7 said R1 does not roll he scoots. V7 said I had seen R1 around 2:00PM he got his medication. When I saw R1 he was ok, he was calm, he was not restless and he was not hot. V7 said R1 was a fall risk. V7 said we don't have a fall list or a fall binder. R1's progress notes dated 3/20/23 at 2:02AM document R1 observed on the floor beside his	S9999		

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S9999	Continued From page 5 bed. On 3/20/23 at 2:38PM R1 was observed sitting on the floor by his bed. The root cause of one fall documented at 2:28PM is documented R1 restless in bed and was hot causing him to move about in bed and due to muscle weakness and lack of coordination R1 rolled self to floor. The root cause documented at 2:31PM states poor coordination with increase restlessness. On 3/24/23 at 11:20AM V18, CNA, said R1 is known for falling. V18 said I was on my 15 min break and I was told R1 had fallen. V18 said for R1 to turn in the bed he is an extensive assist. V18 said she has seen R1 put his foot on the ground or put his feet on the side of the bed. On 3/24/23 at 11:33AM V19, MDS/Care Plan Restorative Nurse, said on 3/14/23 I assessed R1 and he can move his arms and legs purposefully. V19 said R1 can turn side to side. V19 said last week R1 was having seizures and was more restless. V19 said when a fall occurs the nurse will inform the family, doctor, and add an immediate intervention. V19 said the Inter-disciplinary Team (IDT) will discuss the fall and develop appropriate interventions from the root cause. V19 said the root cause is the reason for the fall. V19 said identifying the contributing factors that caused a fall will lead to new interventions. V19 said R1 is weak with muscle atrophy and spinal bifida. V19 said diagnosis alone are not the root cause of a fall. V19 said more than a diagnosis is needed for a root cause. V19 said once the intervention is added the staff needs to follow the intervention listed on the care plan. V19 said every wing has fall list with interventions. On 3/24/23 at 12:33PM V21, Director of Rehab, said when she was working with R1 he was not	S9999		

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S9999	Continued From page 6 able to roll in the bed independently. V21 said I have not seen R1 being restless or moving around in the bed. R1's Physical Therapy Discharge Summaries are dated 2/7/23 and 3/22/23. On 3/29/23 at 10:06 AM V19, MDS/Care Plan Restorative, said if a resident is having behavior, like restlessness, rolling, kicking, then I may not leave the resident in their bed. V19 said I may get them in a chair and take them to activities or nurses station to get them to supervision. V19 said if a resident is having behaviors during the shift the nurse should assess the resident to find out why they are having the behavior. V19 said after a fall the new intervention should be listed on the care plan. V19 said the intervention is added to the care plan during the interdisciplinary team meeting. V19 said the root cause of R1's fall on 2/20/21 was that R1 was trying to get up by himself. V19 said there was not charting about a remote related to R1's fall. V19 said bed mobility includes rolling from side to side. V19 said if the staff is changing R1's bed linens and he is in the bed, there should be 2 persons with him, one on each side of the bed. The surveyor asked V19 if R1's care plan before 3/14/23 stated 1 or 2 person assistance for bed mobility. While reviewing the care plan V19 said "I am confused" the care plan included both 1 and 2 person assist. V19 discussed the restorative care plan for bed mobility that states 2 person assist. V19 said all disciplines should use 2 person assistance for R1's bed mobility. While reviewing R1's care plan V19 said according to the care plan R1 should have 2 person assistance when rolling. V19 said on 3/18/23 R1 rolled out of bed because he was hot. V19 said the root cause of R1's fall on 3/19/23 was because he was restless. V19 discussed the root cause of R1's 2 falls on	S9999		

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S9999	Continued From page 7 3/20/23. V19 said a bedside floor mat was provided to R1 on 2/13/23. V19 said I can't prove the interventions are preventing the falls. On 3/29/23 at 12:45PM V33, Physician, said I have told the staff they need to bring R1 out to the nurses station, it could help prevent a fall. V33 said people need to pay attention to R1 so he does not fall. R1's Fall Risk Assessment dated 2/12/23 notes he is at risk for falls with a score of 14. B.R6 is 83 years old with diagnosis including, but not limited to Ataxia, Lack of Coordination, Dementia, Adult Failure to thrive, Seizures, Syncope and Collapse, Protein Calorie Malnutrition, Hyperlipidemia, Bipolar Disorder, Intellectual Disabilities, Hypertension, Atherosclerotic heart Disease, and Dysphagia. On 3/28/23 during two interviews at 10:38AM and 11:05AM V24, CNA, said R6 had been in the bed when she did rounds. V24 said R6 was able to move himself in the bed. V24 said R6 was a 1 person assist with cares if he was not being combative. V24 said R1 was not having any behaviors before the fall, "he was fine." V24 said if R6 had been combative or aggressive that shift she would have reported to her nurse. V24 said the nurse, V31, called her to the room and V24 saw R6 on the floor and he was bleeding from the nose. V24 said R6 became combative while she was assisting to get him off the floor. V24, CNA, said R6 was fine before the fall. V24 said if R6 was trying to be up and down or getting up on his own from the bed, I would have assisted him into a chair and probably brought him up to the nurses station for supervision. On 3/28/23 at 1:07PM V31, Registered Nurse,	S9999		

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said I had been in R6's room giving his room mate medications. I then went out to the hallway to prepare R6's medications. V31 said "I heard a bump, so I ran in," and called for help. V31 said R6's room mate said R6 was restless and fell. V31 said when I saw R6 he was on the floor in a sitting position trying to get up. V31 said R6 was sent to the hospital. V31 said when R6 came back to the facility he had a cervical collar a healing wound on his nose. V31 said R6 will get restless when he is incontinent and move from side to side. V31 said when R6 fell she had no eye vision of the room. V31 said before the fall R31 was in bed with is eyes closed, head of the bed was slightly elevated, about 30 degrees, and only the head pillow was in use. V31 said R31 had no rails in use, no floor mat, no alarm, and the call light was not on. V31 said V24 and V25, both CNAs, got R6 off the floor. V31 said before the fall, I was not told R5 was kicking. V31 said the CNAs will let me know when the patient is restless and I will check them. V31 said the CNAs will report when they are being hit or abused by residents. V31 said R6 was a fall risk before he fell.

Transfer Form notes on 2/8/23 R6 was transferred to the hospital for a nose laceration.

Progress Notes dated 2/2/23 note R6 has weakness and extensive assistance with bed mobility. Progress Notes dated 2/8/23 note R6 observed on floor by his bed after a fall. Laceration on nose with swelling. Progress Notes dated 2/9/23 documents R6 admitted to hospital with diagnosis of Neck Injury. Progress Notes dated 2/9/23 notes the root cause of the fall was R6 "flailing and combative."

R6's Functional Status assessment dated 2/7/23

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S9999	Continued From page 9 notes he required extensive assist for bed mobility and transfer. Cognition on 2/7/23 is documented to be severely impaired. R6's fall risk assessment documents him at risk for fall with a score of 13. R6's hospital records dated collection on 2/8/23 CT Spine Cervical. Impression: 6.2mm oblique transverse fracture of posterior superior corner of this C4 vertebral body which appears acute. Spine surgical consultation is advised as the injury appears to involve least 2 columns and may be unstable. CT examination of the facial bones collected 2/8/23 impression: nasal septum is sharply angulated as the anterior aspects for acute fracture with deviation of the anterior portions of the left increased from previous exam suggestive of acute fracture with comminuted acute appearing impacted fracture of the distal aspect of the nasal bone. C.R4 is 62 years old with diagnosis including but not limited to Hemiplegia/Hemiparesis, History of Traumatic Brain Injury, Schizoaffect Disorder, Lack of Coordination, Fusion of Spine - Cervical Region, Seizures, Cerebrovascular Disease, Dysphagia, Abnormal Posture, Disorder of Brain. On 3/22/23 at 10:22AM R4 interviewed. R4 said when I fell the CNA was standing where you are, surveyor on side of bed at about R4's knee level. R4 said the CNA said she was going to change me. R4 said the CNA pulled on the sheet under me and then I just rolled and fell off the bed. R4 was alert to name, month, and situation when surveyor spoke with him. The surveyor observed R4 had one halo rail to the top side of his left bed and no standard style side rails.	S9999		

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S9999	Continued From page 10 On 3/22/23 at 10:32AM R4 observed in his bed with a halo on the top left side of his bed, no siderails. On 3/22/23 at 1:45PM V3, LPN, said R4 is alert and oriented times 2 to 3 and is sometimes forgetful. V3 said R4 knows what is going on.V3 said R4 does not complain about anything. V3 said R4 fell off the bed one time. V3 said following the fall R4 requested side rails, he did not have them before the fall. V3 said when R4 fell, I was called to the room by the CNA, V2. V3 said V2 said R4 was on the floor, when I walked in R4 was on his back on the floor. V3 said R4 said I fell and he did not say any description of the fall. V3 said V2 was in R4's room, but she did not witness the fall. V3 said V2 said she was in the restroom in the room. V3 said V2 said R2 was trying to do patient care, but V2 said she did not witness him fall. On 3/22/23 at 2:03PM V2, CNA, said on 3/5/23 I was preparing to change R4. V2 said R4 was flat in the bed. V2 said I had not touched R4 and was in the bathroom getting the towels and bucket ready for bathing. V2 said I heard it (sound) and ran out and saw R4 on the floor. V2 said R4 had not asked for anything before the fall. V2 said R4's bed had not been raised for patient care. V2 said she did not see R4 roll out of bed. During a second interview on 3/24/23 at 1:19PM V2 said R4 had fallen sometime after breakfast and before lunch. V2 said she had done rounds at the start of her shift and he did not need any care at that time. V2 said she served R4 his breakfast in bed and had set him up to eat. V2 said R4 is alert and knows what is going on. V2 said R4 sometimes leans to the side. V2 said when she provided R4 his breakfast she had to reposition	S9999		

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him in the bed. V2 said someone else helped me reposition R4 before breakfast, V2 said she did not know the name of the person who helped her reposition R4. V2 said she is not sure who collected R4's breakfast tray on 3/5/23. V2 said she later entered R4's room and stood at his bedside when letting him know she would give him a bath. V2 said she then went into the bathroom. V2 said when she initially into the room R4 was flat on the bed. V2 said "I am not sure how the bed was when I saw him on the floor." V2 said R4 always has a lift sheet under him.

On 3/24/23 at 11:50AM the surveyor observed, with V19, R4 with bilateral half side rails on his bed. R4 said they put the side rails on the bed the day before yesterday.

On 3/24/23 at 12:23PM V20, MDS Coordinator, said with assistance R4 can roll and he can move a little with staff assistance. V20 said R4 can move slightly on his own in the bed, but not without staff assistance. V20 said R4 cannot roll without staff touching him if he is flat in the bed. V20 said R4 is alert and oriented and does not lie. V20 said when R4 tells you things it is probably accurately. V20 said they said he rolled out the bed on 3/6/23. V20 said R4 is not impulsive. At 12:55PM V20 said R4's side rails should have been put in place following his fall.

On 3/24/23 at 12:33PM V21, Director of Rehab, said R4 was on therapy caseload. V21 said R4 was not able to turn unassisted in the bed. V21 said R4 has no function in his legs, he is not able to move his knees or hips. V21 said hip and knee movement is used for turning. V21 said in my opinion R4 can not roll out of bed unassisted. V21 said R4 is not impulsive and is alert and oriented, not confused or forgetful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 On 3/24/23 at 1:48PM V4, Social Services, said R4's cognition is a 10 out of 15, he is moderately impaired. On 3/29/23 at 10:06AM V19, said the root cause of R4's fall on 3/5/23 is that he rolled out of bed. V19 said the root cause does not say why R4 rolled out of bed, it needs to say more. R4'sDocumentation Survey Report for March 2023 notes on 3/3/23; 3/4/23; and 3/5/23 R4 required extensive to total assistance from staff for bed mobility. R4's cognitive assessment dated 2/28/23 notes a score of 10, moderately impaired. Incident report dated 3/5/23 notes R4 noted on the floor next to his bed. R4 noted to be oriented to place, time, person, and situation. Progress Notes dated 3/6/23 notes R4's root cause of the fall "rolled out of bed." R4's Occupational Evaluation and Plan of Treatment dated 2/28/23-3/14/23 notes R4's bed mobility assessment roll left and right = substantial/maximal assistance. R4's care plan for Activity of Daily Living assistance initiated on 8/28/19 identifies intervention bed mobility, extensive, 2 person. R4's fall care plan identifies on 3/8/23 half side rails added to the bed. On 3/24/23 at 10:10AM V7, RN, said if a fall risk resident with weakness is restless will tell staff to get them up, bring them out for us to keep an eye on them to prevent a fall.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 13 R6's fall risk assessment dated 2/26/23 notes he is at risk for falls with a score of 12. The facility policy Incident and Accidents review date 4/7/19 states all incident/accident reports are reviewed, signed, and investigated. The facility fall prevention program review date 11/21/17 states 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. Care plan incorporated interventions are changed with each fall, as appropriate. Preventative measures. Safety interventions will be implemented for each resident identified at risk. Fall safety interventions mentioned include, keeping resident belongings in reach, nursing personal will be informed of residents who are at risk of falling. (A)	S9999		