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 02/23/2023

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

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S 000	Initial Comments Facility reported incident of 1/17/2023/#IL155782 Facility reported incident of 2/2/2023/#IL156383	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 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 interview and record review, the facility failed to ensure that staff were aware of care plan interventions for residents at risk for falls and failed to ensure that a resident who required staff assistance with ambulation was provided with assistance while ambulating in the hallway. This failure affected two (R3, R4) of four residents reviewed for falls and resulted in R3 having an unwitnessed fall in room and being admitted to local hospital with a diagnosis of subdural hematoma and resulted in R4 having a fall while ambulating without staff assistance, which resulted in an inter trochanteric fracture, requiring surgical intervention. Findings include: R3 is a 64-year-old male who was admitted to the facility on 1/30/2023, with medical history including but not limited to: Traumatic subdural hemorrhage without loss of consciousness, unsteadiness on feet, dysphagia oropharyngeal phase, weakness, other lack of coordination,	S9999		

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S9999	Continued From page 2 history of falling, muscle wasting and atrophy hemiplegia and hemiparesis following unspecified cerebrovascular disease, etc. R3 was not at the facility at the time of the investigation, per progress note dated 2/3/2023, resident had an unwitnessed fall and was taken to the hospital by 911. Facility reportable dated 2/8/2023 stated that resident was observed lying on the floor in his room beside his bed facing the wall, rolled out of bed, time of incident 23:18PM. Same document stated that follow-up report from the hospital documented that CT of the head was positive for subdural hematoma, no significant midline shift. Fall risk assessment dated 1/30/2023 scored R3 as (12) at risk for falls, interim care plan dated 1/31/2023 stated that resident is at risk for fall, goal; I will not sustain any serious injury through the review date, the only intervention was to follow facility fall protocol. Minimum Data Set (MDS) assessment dated 2/3/2023 section C (cognitive) scored R3 with a BIMs score of 2 (severe cognitive impairment), G (functional) coded R3 as requiring extensive assistance with 2-person physical assist for bed mobility, transfer, dressing, toilet use and personal hygiene, extensive assistance with one-person physical assist for eating, locomotion in room and off unit. Section H (bowel and bladder) of the same assessment documented that R3 is always incontinent of bowel and bladder. 2/21/2023 at 3:29PM, V6 (LPN) said that the day R3 fell was her first time working with the resident, he was okay during medication pass,	S9999		

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S9999	Continued From page 3 maybe around 5:00PM, then she heard a yelling from resident's room, ran to the room and saw resident on the floor by the bed facing the wall. She got resident up with the help of other staff, assessed resident and noticed an old wound to his hip, there was no bleeding, but resident was grimacing to touch as if he is in pain, cannot tell if resident hit his head. V6 said that she does not know if resident is a fall risk, or if he has any fall interventions, she did not get any report from the outgoing nurse, resident is a new admit, they may have given report, but she cannot remember. V6 said she is not sure how resident takes his medication or the type of assistance he needed from staff, resident was alert but confused by the time he was sent to the hospital, his vitals were okay, and his neuro check seems to be normal. V6 does not remember who the C.N.A was and not sure the last time herself or the C.N.A saw resident before the fall. R4 is a 78-year-old male who was admitted to the facility on 5/4.2021, with history of Chronic obstructive pulmonary disease, dysphagia oropharyngeal phase, cellulitis left lower limb, unsteadiness on feet, essential primary hypertension, other lack of coordination, etc. R4 was no longer at the facility; was sent to the hospital on 2/4/2023 for coffee ground emesis as documented in medical record. Review of facility reportable showed that R4 had a fall on 1/17/2023 at approximately 10:30am while ambulating in the hallway with a cane. R4 was sent to the hospital was admitted and treated for a right hip fracture. Hospital record dated 1/17/2023 states, patient is from nursing home after a fall, states he was walking and lost his balance, fell, complained of right hip pain, denies	S9999		

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S9999	Continued From page 4 dizziness. X-ray show displaced inter trochanteric fracture. Resident had a surgical procedure (right hip pinning-ORIF) on 1/18/2023. R4 also had a documented fall in his room on 10/2/2022 while walking in the room and complained of pain to his left elbow as stated in resident's progress note. Fall risk assessment dated 4/30/2021 score resident as 12, at risk for falls. MDS assessment dated 12/22/2022 section G (functional) coded R4 as requiring supervision (oversight, encouragement, or cueing) with one-person physical assist for walk in room and supervision with set up for walk in corridor. R4 was also coded as requiring supervision to limited assistance with one-person physical assist for all other ADL cares. Fall care plan initiated 10/9/2018 and revised 7/7/2022 states that R4 is at risk for falls related to impaired mobility. Interventions include call light within reach, ensure resident is wearing appropriate footwear when ambulating or mobilizing with wheelchair, bed in low position at night, even floors free from clutter and spills, etc. ADL care plan initiated 1/8/2019, revised 10/6/2022 states that resident requires assistance with ADLS due to weakness and debility, under locomotion on unit; it states supervision, one person. On 2/22/2023 at 10:28AM, V9 (LPN) said that the day R4 fell, she was at the nursing station, the C.N.A called her stating that resident fell, she saw the resident on the floor in the hallway, in front of the conference room. R4 was going to an appointment, he was ambulating with a cane, 3	S9999		

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S9999	Continued From page 5 staff members were already with the resident before V9 got there, V9 assessed resident and noted a blood spot on his head, she cleaned the area and placed resident on a wheelchair. V9 was asked what type of assistance resident needed from staff and she said that he will ask for water sometimes, he does not look like a fall risk and V9 is not sure if resident has any fall precautions. At 12:40PM, V11 (MDS/Care Plan) said that nurses do a fall risk assessment on residents upon admission and after every fall, based on the score, the MDS will develop a fall care plan which have to be updated after every fall. V11 said that R4 ambulates with a cane; all residents are to be supervised by staff. The day R4 fell, V11 was told that R4 was supposed to go to an appointment, something happened, and he was going back to his room when he fell. V11 added that she is not sure if someone was with the resident when he fell; she was not present at the time. At 2:06PM, V12 (ADON) said that she has worked at the facility for a few months. For resident care needs or those that are risk for falls, communication is done in stand up and during shift change, the precautions with interventions in place should be communicated to the C.N.A. As by the nurses. V12 also said that resident's needs are also documented in the task section of the medical record. Document presented by V1 (Administrator) titled, Fall Prevention Program (revision date 11/21/2017), states: Purpose...to assure 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	S9999		

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S9999	Continued From page 6 supervision and assistive devices are utilized as necessary...Standards...the admitting nurse and assigned C.N.A are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. (A)	S9999		