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 06/15/2023

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 Complaint Investigation # 2394404/IL160326 F689 cited	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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 interview and record review, the facility failed to ensure that proper precautions were in place during therapy session for a resident who was assessed as being at risk for falls. This failure affected one resident (R3) who had a witnessed fall during therapy, was transported to the hospital where she was diagnosed with a hip fracture, requiring a surgical intervention. Findings include: R3 is a 55-year-old female who was admitted to the facility on 8/5/2021, with past medical history including, but not limited to encounter for other orthopedic aftercare, acquired absence of left leg below knee, type 2 diabetes mellitus with diabetic neuropathy, presence of left artificial hip, fracture of unspecified part of neck of femur, major depressive disorder, anxiety disorder, delusional disorder, etc. On 6/12/2023 at12:35PM, R3 was observed in	S9999		

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S9999	Continued From page 2 her room, awake, alert and oriented and stated that she was having an occupational therapy session with a staff, she was required to pick up some socks that the staff dropped on the floor using a Reacher, R3 walked to the first clothing with a walker, wanted to pick up the socks and fell, R3 said she heard a pop and knew that she had broken something. This was her first time doing this exercise, she had a gait belt on her, but the staff did not hold on to the belt, she was just standing there. R3 said that she is used to a staff holding on to her gait belt and another staff following behind with her wheelchair when she is walking with her walker, she added that she is very upset because she was getting ready to go home before this happened, and this could have been avoided if the staff was holding on to her gait belt. Hospital record documented resident's diagnosis as hip fracture requiring operative repair. Facility reported incident dated 5/24/2023 documented in part, while resident was participating in her walking therapy, resident verbalized losing her balance and falling to the floor. She remained alert and oriented, was transferred to the hospital, admitted with the diagnosis of closed displaced fracture of the left femoral neck. Fall risk assessment dated 2/26/2023 coded R3 with a score of 11 (at risk for falls). Minimum data set assessment (MDS) section G (functional) coded R3 as requiring supervision with one-person physical assist for transfer, bed mobility for bed mobility and transfers, and limited assistance with one-person physical assist for walk in room and walk in corridor. Care plan initiated 10/9/2022 stated that R3 have functional task performance deficit related to impaired mobility generalized weakness, left BKA, etc.	S9999		

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S9999	Continued From page 3 Interventions include lying to sitting- supervision or touching assistance, sit to lying, supervision or touching assistance, sit to stand partial/moderate assistance, etc. Another care plan initiated 9/14/2021 states that R3is at risk for falls related to cognitive impairment, new BKA, generalized weakness, pain, impaired mobility, etc. Interventions include to encourage resident to participate in activities that promote exercise physical activity for strengthening and improved mobility, PT to evaluate and treat, therapy to screen. 6/13/2023 at 12:10PM, V5 (OT Assistant and Director of Rehab) said that she has been discussing discharge plan with R3, they went to the room to do some exercise of her (V6) tossing some socks on the floor and the resident are supposed to pick them up with a Reacher while standing/walking. R3 had a gait belt on and came to the location in her wheelchair. When R3 stood up with a walker, V5 said that she would have taken the wheelchair for safety reasons, this was her first time doing this exercise with the resident, she has walked in the past but always with a walker. V5 said that when they were doing the exercise, R3 stood up from her wheelchair, her left hand was on her walker, and she was holding the Reacher in her right hand. Resident reached and picked up a sock, tried to put it in a container and lost her balance and fell to her left side. when the resident bent down, she can't recall holding on to the gait belt. R3 cannot ambulate independently only with a walker, V5 also said that for residents that are unsteady, staff is supposed to follow them with a wheelchair, she has seen restorative staff do that with R3. V5 was asked what she could have done differently to prevent the incident and she said, "possibly holding on to the gait belt or with staff following her with a wheelchair, at that time, I did not think	S9999		

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S9999	Continued From page 4 it was necessary". Occupational therapy treatment encounter notes dated 5/24/2023. Presented by V5 documented the precautions for R3 as fall risk. On 6/13/2023 at 12:39PM, V4 (LPN) said that the day R3 had a fall, she was on the phone when a therapy staff was yelling that R3 was on the floor, she ran to the area and saw the resident on the floor, the therapy staff was standing by the resident who was lying on her right side. V4 said she don't know if the staff used it or not, she has seen the restorative staff walking with R3, there are usually 2 staff, one staff will hold on to the gait belt and the other staff will be following them with a wheelchair. 6/15/2023 at 1:16PM, V27 (Restorative aide) said that she is familiar with R3, have worked with her since August of last year, when they do a restorative activity with R3, if she is already sitting in her wheelchair, staff will put a gait belt around her waist and position the walker in front of the resident. They will assist resident to a standing position to hold on to the walker, when the resident starts to walk, one staff will hold on to the gait belt, and the other will be following behind with resident's wheelchair. V27 said that the purpose of the gait belt is for safety, to enable the staff ease resident to her wheelchair if she gets weak and need to sit down. She added that she is aware that resident wears a prosthetics on her left leg, will consider her a fall risk. 6/15/2023 at 1:30PM, V28 (Restorative aide) said that she was at work the day R3 had a fall with injury but R3 was in therapy at that time. She has worked with R3 as a restorative aide with R27, it is usually 2 staff with the resident when she is walking with her walker, one holding on to her gait	S9999		

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S9999	Continued From page 5 belt and the other following with her wheelchair. V28 said that the restorative people would not do an activity that requires resident to pick something from the floor while standing, she considers R3 to be slightly unsteady and would expect staff to hold on to her gait belt. V28 said that R3 has never been assessed as not needing chair follow and they always take that precaution with her. Facility falls prevention program revised 11/21/2017 presented by V2 (DON) states in part in its 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 for falls to provide necessary supervision and assistive devices are utilized as necessary. (A)	S9999		