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 _____	06/16/2023

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

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S 000	Initial Comments Annual Licensure/Certification Complaint Investigation: 2394740/IL160717	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 and psychosocial needs that are identified in the resident's comprehensive assessment, which 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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	S9999		

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S9999	Continued From page 2	S9999		

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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to follow their policy and ensure that effective interventions were identified and implemented to prevent one resident (R49) of three residents reviewed in a sample of 19 from falling. The facility also failed to ensure that all staff are aware of fall risk status and interventions. This failure resulted R49 falling and suffering an injury to her head that required three staples.

Findings include:

Review of R49's final incident report dated 6/7/2023 documents resident was found sitting on the floor by her bathroom door. Resident did not know the cause of the fall. Laceration found to the back of the head and resident was sent to the emergency room. R49 was diagnosed with a head laceration and received 3 staples.

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S9999	Continued From page 3 Review of R49's hospital discharge instructions dated 6/4/2023 document the following: diagnosis: Fall, Injury of head, and Laceration of scalp. Follow up in 10 days to have staples removed. On 6/14/23 at 9:40 AM with V19 (Director of Korean Service) interpreting, R49 states she doesn't remember the circumstances of the fall. Observed 3 staples in the back right side of R49's head. On 06/15/23 03:31 PM V27 (Registered Nurse/RN) states V27 doesn't think she (R49) can comprehend if you tell her something. V27 states that sometimes in the evening R49 gets up once or twice and comes to the nurse's station. V27 states that last week was the last time she saw R49 come from her room to the nurse's station without assistance. V27 states R49's gait is not stable. V27 states, R49 doesn't need to have assistance with ambulation. V27 states R49 does not speak English. V27 states she has not received communication from therapy about their recommendation for R49 assistance while ambulating. V27 states someone should communicate with evening shift the therapy recommendations. On 06/15/23 03:40 PM V21 (Certified Nurse Assistant/CNA) states on 6/4/2023 he was in another resident's room and heard a thump. V21 states, he came out and found R49 on the floor by her bathroom. V21 states R49 is very confused at times. V21 states the more confused R49 is the more she tries to move around. V21 states that R49 walks with supervision, no hand-on assistance. V21 states he is not sure if R49 understands them when they tell her things. V21 states he can redirect R49 and then later she	S9999		

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S9999	Continued From page 4	S9999		

will come out of her room again after redirection. V21 states he only redirects her when she comes out of the room.

On 06/15/23 03:52 PM V6 (CNA) states R49 hates to sit. V6 states R49 likes to be out and moving. V6 states R49 was an elopement risk before the 6/4/2023 fall. V6 states she was not aware R49 was a fall risk before the 6/4/2023 fall. V6 states no one ever told her that R49 was a fall risk just an elopement risk and she was not giving R49 any assistance for ambulating before the 6/4/23 fall. V6 states R49 tries to get up to go to restroom or get up when she is hot. V6 states I don't think she really understands us, so they use gestures. V6 states she would gesture for her to use light; however, she never has seen the resident use the call light. V6 states, she doesn't believe R49 understands how to use the call light and is forgetful. V6 states that no one has ever directed her to frequently remind R49 to use her call light or call for help.

On 06/15/23 10:56 AM V18 (Physical Therapy Director of Rehab) states they started seeing R49 on 5/15/23 after R49's elopement and they are working on balance, strengthening, and cognition for speech, ADL training and toilet transfer. V18 states, R49 was having balance issues. When she stood, she would fall back or sideways. V18 states, the week before the 6/4/23 fall R49 required one person touch assist with ambulation. V18 states they inform nurses what we recommend verbally. V18 states R49 is forgetful. V18 states, R49 would "Definitely, forget to do the things we asked her to do." V18 states R49 is not safe ambulating alone as of 5/15/2023 until now.

Review of facility's falls log documents five falls since October 2022 for R49. R49 fell on 10/3/22

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S9999	Continued From page 5 (documented left arm fracture per progress notes), 11/25/22, 1/2/23, 4/1/23, and 6/4/2023. Review of fall assessments dated 1/6/23 and 4/1/23 documents resident was at risk for falls. Fall occurrence form dated 1/2/23 documents CNA saw resident falling backwards. Fall occurrence form dated 4/1/23 documents resident trying to transfer herself from chair and slid to the floor. R49's fall risk care plan documents the 1/2/23 fall intervention as follows: Remind patient on asking for assistance, frequent monitoring, and redirection. R49's fall risk care plan documents the 4/1/23 fall intervention as follows: Continue frequent monitoring and frequently reminding resident to ask for help. On 6/15/23 01:19 PM V2 (Director of Nurses) states R49 tries to get up on her own. V2 states that the interdisciplinary team including herself determine interventions after each fall. The facility's Fall Prevention Program policy dated 11/21/17 documents the following: 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. Care plan incorporates: Identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, preventative measures.	S9999		

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S9999	Continued From page 6 "B"	S9999		