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	IL6015333	A. BUILDING: _____ B. WING _____	C 05/26/2024

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APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

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S 000	Initial Comments Complaint Investigations 2491860/IL170600 2491640/IL170331	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 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	S9999		

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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 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. (Section 3-202.2a of the Act)

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.

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.

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe environment by not adequately assessing, monitoring or supervising residents at risk for falls for 4 of 5 (R1, R3, R4, R5) reviewed for falls; and failed to follow their fall prevention program by not ensuring fall interventions were securely in place for a resident (R1) with a history of and risk for falls. These failures resulted in R1 falling and being hospitalized for laceration to the left ear; R3 falling and being hospitalized for laceration to the left eyebrow; R4 falling and being hospitalized for right femur fracture with surgical repair; and R5 falling and being hospitalized for left femur fracture. Findings include: (R1) 1. On 05/24/2024 at 11:40 AM, R1 said he had a fall incident a few months ago in March. R1 added that after taking his nighttime medication, he sat on the side of his bed and had "went out". R1 then said he awoke approximately ten minutes later and was on the floor next to his bed and he was bleeding from his left ear. He said the nurse who came to check him out, sent him to the hospital where he received stitches to his left ear and stayed at the hospital for a few days. On 05/24/2024 at 12:00 PM, reviewed fall leaf program binder located at nursing station on the third floor. R1 was not listed on undated fall leaf program residents. R1 was listed on undated fall intervention log that indicated R1 should have non-skid strips to the floor at bedside to improve	S9999		

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traction/prevent slipping and call for assistance. (Non-skid strips were not observed in place during interview with R1 on 05/24/2024 at 11:40 AM or during room observation at 4:01 PM.)

On 05/24/2024 at 1:14 PM, V8 (Licensed Practical Nurse) said on day of R1's fall incident, R6 (R1's roommate) went to the doorway around 10:00 PM and said that R1 was on the floor. Upon entering R1's room, V8 saw R1 on the floor with blood coming from his left ear. V8 (LPN) added that R1 is on seizure precautions, is a frequent faller, and seemed confused after the fall. V8 then said that she had previously discussed R1's frequent falls with previous Director of Nursing.

On 05/24/2024 at 2:17 PM, V6 (LPN/Restorative Nurse) said R1 takes seizure medications that make him sleepy, so his meds were adjusted a few months ago because R1 was "sedated at times". V6 added that R1 had previous falls on 02/24/24 and 03/09/2023. At 02:26 PM, V6 reviewed fall leaf program residents then indicated that R1 was mistakenly not included but will be added due to his history of falls, medical diagnosis, seizure precautions and seizure medications. V6 then said R1 has current fall interventions in place to: call don't fall and non-skid strips to floor near bedside and non-skid footwear.

R1's face sheet indicated resident recently admitted to facility on 01/09/2024 and has a past medical history not limited to: hemiplegia and hemiparalysis following cerebral infarction affecting left non-dominate side, seizures, abnormalities of gait and mobility, lack of coordination, weakness, age-related physical debility, unspecified escherichia coli, bipolar

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disorder, insomnia, and tremors.

R1's Fall Risk Assessment dated 02/24/2024 indicated R1 is at risk for falls.

R1's care plan with last completion date of 04/09/2024 reads in part: risk for falls and injury related to falls. Risk factors: requires assistance with ADL's, possible medication side effects, seizure disorder, tremors, cerebrovascular accident with left hemiplegia (date initiated 12/30/2023).

R1's hospital paperwork dated 03/02/2024 indicated resident was treated by V10 (Emergency Room MD) for laceration to the left earlobe status post unwitnessed fall encounter at facility.

R1's facility reported final incident report dated 03/08/2024 indicated R1 had a fall incident on 03/02/2024 in his room and sustained a laceration to his left ear. R1 was emergently transferred to local hospital where he received five stitches to the open area on his left ear. Report also indicated R1 requires supervision to limited assistance with activities of daily living (ADL's), transfers and toileting.

(R3)
2. On 05/24/2024 at 12:11 PM, observed V5 (Certified Nursing Assistant) pushing R3 in his wheelchair out of his room. Observed dressing to R3's left outer eye, resident alert to self. V5 said R3 had an injury to his left eye from his fall a few weeks ago.

On 05/24/2024 at 2:42 PM, V6 (LPN/Restorative Nurse) said regarding R3's last fall on 05/06/2024, he was observed sitting on the toilet

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seat with a facial wound and was sent out to a local hospital for a laceration to his left brow. V6 added that R3 has dementia and should be closely monitored by staff.

R3's FRI (facility reported incident) final report dated 05/14/2024 indicated resident was observed sitting on the toilet by staff with a bleeding open wound to his left eyebrow on 05/06/2024. R3 self-reported falling to the floor while ambulating to the bathroom, stood himself up from the floor then continued to ambulate himself to the bathroom. R3 was emergently transferred to a local hospital where he received six sutures to the laceration above his left eyebrow.

R3's hospital paperwork dated 05/06/2024 indicated that R3 was treated emergently by V11 (Doctor of Osteopathic Medicine) post fall for facial lacerations and received stitches.

R3's Fall Risk Assessment dated 5/6/2024 indicated R3 is at risk for falls.

R3's face sheet indicated resident admitted to facility on 04/01/2024 and has a past medical history not limited to: epilepsy, dementia, generalized osteoarthritis, abnormal posture, lack of coordination, history of falling, syncope and collapse, and insomnia.

R3's active physician orders showed order to clean left eyebrow with normal saline, pat dry, apply triple antibiotic ointment then cover with dry dressing daily and as needed (active date 05/09/2024); send resident to [hospital] for further evaluation related to fall and left eyebrow laceration per family request (active date of 05/06/2024).

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R3's care plan with last completion date of 4/17/2024 reads in part: at risk for falls and injury related to falls. Risk factors: requires assistance with ADL's, possible medication side effects, incontinence, Seizure disorder, syncope, dementia, history of falls, spinal stenosis, osteoarthritis (date initiated 02/17/2023).

(R4)
3. R4's face sheet indicated resident admitted to facility on 12/30/2021 and has a past medical history not limited to: abnormalities of gait and mobility, hemiplegia and hemiparalysis following cerebral infarction affecting right dominate side, fatigue, abnormal posture, lack of coordination, right femur fracture, history of falling, vascular dementia, seizures, insomnia, hypertension, and repeated falls.

R4's facility reported final incident report dated 02/28/2024 indicated resident had a fall incident while staff was present on 02/27/2024. R4 stood to adjust himself, slipped and fell the complained of right hip pain. Report also indicated that R4 requires assistance with ADL's, transfers and toileting. Fall incident report indicated R4 was transferred into a wheelchair post fall, taken to his room and transferred back to bed. Upon further assessment of range of motion, R4 complained of right hip pain and was then sent out emergently for x-ray of right hip.

R4's hospital records dated 2/28/2024 through 03/04/2024 and discharge summary signed by V12 (Medical Doctor) on 03/04/2024 both indicated resident was treated for a right femur fracture post fall in the shower at facility that required surgical repair on 02/28/2024.

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R4's fall risk assessment dated 03/04/2024 indicated resident is at risk for falls.

R4's care plan with last completion date of 03/14/2024 reads in part: at risk for falls and injury related to falls. Risk factors: requires assistance with ADL's, possible medication side effects, cerebrovascular accident with right side weakness, frequent falls, seizure disorder, low back pain, incontinence, abnormal gait/mobility, lack of coordination, abnormal posture, fatigue. Readmitted to the facility status post-acute hospital stay 03/04/24 (date initiated 12/31/2021, revision on 03/14/2024).

On 05/26/2024 at 4:33 PM, V13 (Certified Nursing Assistant) indicated that after she showered R4, she left the resident unattended to retrieve an incontinence brief from the next shower stall when R4 had a fall incident and complained of right hip pain. V13 (CNA) then indicated that she "put him in his chair and took him to the room then went to inform the nurse".

(R5)

4. R5's face sheet indicated resident initially admitted to facility on 03/28/2024 with last admission date of 05/07/2024 and has a past medical history not limited to: hemiplegia and hemiparalysis following cerebral infarction affecting left non-dominate side, left femur fracture, end stage heart failure and renal disease, presence of left artificial hip joint, seizures and history of falling.

R5's care plan with last completion date of 04/09/2024 reads in part: at risk for falls and injury related to falls. Risk factors: requires assistance with ADL's, incontinence, possible

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medication side effects, left hemiparalysis, history of falls, seizure disorder, abnormal gait/mobility, unsteadiness, on feet, lack of coordination (date initiated 04/02/2024, revision on 04/08/2024).

R5's hospital record/note dated 05/06/2024 by V19 (Internal Medicine Resident) and V20 (Medical Doctor) indicated R5 presented with left femoral fracture post fall at the facility.

R5's facility reported final incident report dated 05/07/2024 indicated that resident had a fall incident while ambulating self to the bathroom on 05/02/2024 at 12:20 AM. R5 was emergently sent out to a local hospital for further evaluation and was diagnosed with a "mild left femur fracture".

R5's fall risk assessment dated 05/07/2024 indicated R5 is at risk for falls and had a recent admission in March for falls.

On 05/24/2024 at 11:00 AM, R5 was observed near second floor nurse's station. Resident alert to self and not interviewable at this time. Reviewed fall leaf binder located at nurse's station that indicated R5 is in the program.

On 05/25/2024 at 11:30 AM, V6 (Restorative Nurse/LPN) presented nursing in-service dated "05/24-05/25" with topics of fall prevention/falling leaf program.

On 05/26/2024 at 3:25 PM, V18 (Licensed Practical Nurse) said she was called to room by V15 (Certified Nursing Assistant) who said R5 was on the floor. Upon her assessment, she noted R5 laying on his side with a bed pad under his head. V18 added that R5 was "favoring his left shoulder, he said it was bothering him". She and two other staff members stood resident up and

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put him into the bed. She completed assessment and noted no range of motion limitations to lower legs. She notified all parties including physician, x-ray was ordered, which she added x-ray of left hip due to fall a few weeks prior in which left side was x-rayed as well. V18 (LPN) added that R5 couldn't tell her how he fell, but he had a history of falls and dementia. R5 transferred into a dialysis chair shortly after incident and was given acetaminophen prior to be transported to dialysis for "restlessness with dialysis". When R5 returned from dialysis, V18 (LPN) said she was no longer on duty but was told that R5 was x-rayed between noon and 1:00 PM that day and was found to have a femur fracture.

On 05/26/2024 at 3:34 PM, when asked for timeline of R5's post fall evaluation and treatment, V1 (Administrator) said the following: facility called for stat x-ray at 1:17 AM on 05/02/2024, x-ray technician arrived at 11:49 AM and x-rays were completed at 1:30 PM. Resident was not complaining of pain and vitals were stable so 911 wasn't necessary and we were told ambulance would be arriving shortly. It came at 4:15 PM then left 20 minutes later. I feel that my staff addressed the fall in a timely manner. Sending resident to dialysis at the time wasn't the wrong call because the resident was not stating pain or discomfort. Staff did make two follow up calls and were told tech was in route. Resident was stable and not in pain so waiting on x-ray tech made sense.

Fall Prevention Program policy last revised 11/21/2017 reads in part:

Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual

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S9999	Continued From page 10 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. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines: The fall prevention program includes the following components: Methods to identify risk factors, methods to identify residents at risk, care plan incorporates but not limited to the identification of all risk/issue and preventative measures. Safety interventions will be implemented for each resident identified at risk. Fall/Safety interventions may include but are not limited to: Direct care staff will be oriented and trained in the fall prevention program. Nursing personnel will be informed of residents who are at risk for falling. The fall risk interventions will be identified on the care plan. (A)	S9999		