STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014617	A. BUILDING: _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE INTERNATIONAL	4815 SOUTH WESTERN AVE CHICAGO, IL 60609

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S 000	Initial Comments Facility Reported Incident of 3.12.2024/IL171557	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 300.1210d)6) 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 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	S9999		

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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.

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 requirements were not met as evidenced by:

Based on interview and record review the facility failed to develop and implement individualized fall prevention interventions for one of three residents (R1) reviewed for falls. R1 fell four times in 26 days, including two falls on the same day (4/1/2024). This failure resulted in R1 falling and sustaining fractures of the sacral spine and coccyx on 3/12/2024.

Findings include:

On 4/12/2024 at 1:39 PM R1 was observed sitting in wheelchair behind nurses station. R1 said I fell five times, they told me not to get up. I had to go to the bathroom, they didn't help me, I wouldn't have got up (to the bathroom) if they had, I wouldn't have got up by myself.

On 4/12/2024 at 11:38 AM, V4 (Restorative Director/Fall Nurse) said the IDT (Interdisciplinary

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Team) is responsible for determining the Root Cause Analysis for falls and developing interventions to prevent further falls.
R1's medical record (Face Sheet) documents R1 is a 73-year-old admitted to the facility on 12/29/2023 with diagnoses including but not limited to: Gastroparesis (condition that prevents proper stomach emptying), Chronic Obstructive Pulmonary Disease, Lack of Coordination, and Repeated Falls.

R1's MDS (Minimum Data Set, 2.22.24) documents: BIMS (Brief Interview for Mental Status): 14 (cognitively intact)

R1's medical record documents on 3/12/2024 at 8:02 AM Nurses Note Narrative: Writer was informed by staff that resident had a fall in room. Upon entering room, resident was noted on floor at foot of bed in supine position, complaining of pain. Head to toe assessment was done, resident complaint of pain when trying to assess during ROM (range of motion), and resident couldn't move. Resident vital's were taken, complaints of pain was 8/10, and 911 was called. Resident informed staff that she was trying to get to closet, but when asked why, she didn't know. She also stated that she hit her head. Neuro Checks initiated, and ambulance came and transferred resident to (local emergency room) for further evaluation. PCP (primary care physician) was notified, (Power of Attorney-POA) was informed.

R1's medical record documents on 3/5/2024 at 1:15 AM Fall Occurrence Note documents in part:" The Nurse observed the resident on the in the hallway of the facility. Resident was observed on the floor in the hallway in a upright seated position scooting down the hallway. When this Nurse asked the resident what was she doing the

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resident replied she had gotten out of bed to go to the bathroom in the process she forgot where she was going."
IDT (Interdisciplinary Team) Committee Meeting Note documents in part: "Resident had an unwitnessed fall in bedroom and proceeded to the hallway where she was observed scooting down the hall on her buttocks."
Root Cause of the fall determined by IDT: "Root cause of fall is resident has increased confusion."
What new interventions and/or changes are suggested by the IDT at this time?: "Resident sent to ER for evaluation to rule out abnormalities."
Intervention is medical response to a fall event.

R1's medical record documents on 3/12/2024 at at 725AM Fall Occurrence Note documents in part: "Writer was informed by staff that resident had a fall in room. Upon entering room, resident was noted on floor at foot of bed in supine position, complaining of pain. IDT (Interdisciplinary Team) Committee Meeting Note documents in part: "Resident had unwitnessed fall attempting to retrieve something from closet."
Root Cause of the fall determined by IDT: "Root cause of fall is resident has poor insight on functional ability, a strong history of confusion r/t (related to) other recent falls."
What new interventions and/or changes are suggested by the IDT at this time?: "Neuro consult."
Intervention is medical response to a fall event.

R1's medical record documents 4/1/2024 at at 3:09AM, Fall Occurrence Note documents in part: "Writer was informed by staff that resident had a fall in room. Upon entering room, resident was noted on floor at foot of bed in supine position. When asked was she in any pain, resident replied

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"No". Resident stated" I was trying to get up to go to work with that man over there". Writer asked resident "Where was she trying to go?" Resident replied "I'm going home. I'm not staying here. I gotta go to work. Y'all going to get me in trouble".
IDT (Interdisciplinary Team) Committee Meeting Note documents in part: "Resident had unwitnessed fall at bedside."
Root Cause of the fall determined by IDT: "Root cause of fall is resident has altered mental status r/t (related to) abnormal labs".
What new interventions and/or changes are suggested by the IDT at this time?: "Administer meds (medications) per MD (physician) order."

R1's medical record documents 4/1/2024 at 3:45 PM Fall Occurrence Note documents in part: "Resident is observed on the floor in an upright seated position next to the resident's bed. This writer asked the resident why she was on the floor she said she had to go (to) the restroom. At this time the resident is very confused"
IDT (Interdisciplinary Team) Committee Meeting Note in part: "Resident had unwitnessed fall at bedside."
Root Cause of the fall determined by IDT: "Root cause of fall is resident continues to have altered mental status."
What new interventions and/or changes are suggested by the IDT at this time?: "Remain in high visible areas at all times."

R1's Emergency Room medical record reports document, CT Abdomen Pelvis with contrast dated 3/12/24 notes acute, mildly displaced fractures of the S3 vertebral body and coccyx.

R1's fall with no injury care plan (initiated 1.5.2024) and at risk for falls care plan (initiated 1.5.2024) does not document any fall

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S9999	Continued From page 5 interventions for falls of 3.5.2024 or 3.12.2024. (B)	S9999		