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	IL6007207	A. BUILDING: _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE BURBANK	5701 WEST 79TH STREET BURBANK, IL 60459

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S 000	Initial Comments Complaint Investigation 2499164/IL180643	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)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		

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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 are not met as evidenced by:

Based on interview and record review, the facility failed to provide the 2 persons assistance while turning one dependent resident in bed, and failed to have accurate record of the fall (R1). These failures affected one resident of three reviewed for accidents. This failure resulted in R1 falling to the floor and sustaining a frontal hematoma and laceration requiring glue to close.

The findings include:

R1 has diagnoses of Paraplegia, Complete, Dementia, Major Depressive Disorder, Mononeuropathy of Bilateral Lower Limbs, Cataract, Hemiplegia and Hemiparesis Following Cerebral Infarction, Contracture, and Immobility Syndrome (Paraplegic).

Progress Note, dated 2/15/24, documents R1 is a 2 person assist with bed mobility.

R1's MDS (Minimum Data Set), dated 8/7/24, notes a BIMS (Brief Interview for Mental Status) score of 3, impaired.
R1 is noted to have no physical or verbal behavioral symptoms. R1 is noted to have

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Functional Limitation in Range of Motion to her lower extremity on both sides. Section GG notes R1 is dependent on staff for toileting hygiene, sit to lying or lying to sitting on side of the bed and transfers. R1 requires substantial/maximal assistance with the helper does more than half the effort for rolling left to right. R1 had 0 falls since the prior assessment.

R1's fall risk assessment score is 14, dated 8/5/24.

R1's Restorative Observations, dated 8/5/24, notes right and left lower extremity paralysis/paresis. Existing contracture or limited range of motion.

R1's care plan designates requires assistance with bed mobility related to weakness. Intervention include provide assist of 1-2 staff as needed.

R1's Fall Initial, dated 10/24/24, noted R1 noted on floor by CNA (Certified Nursing Assistant) upon during rounds. Unwitnessed fall, precipitating and contributing factors: R1 confused, forgets to use call light and incontinent. New injuries observed raised area/ swelling/discoloration noted to right forehead. 911 called.

R1's IDT Fall Committee Meeting Note: resident was observed on the floor and stated she wanted to reposition herself and rolled over to the floor.

Review of V4 incident statement documents R1 observed on the floor. 911 called and transported resident to hospital for evaluation. V8's statement, "as I was doing rounds at about 4:00 AM I walked into (R1's) room to do a safety check

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and (R1) was on the floor. (R1) stated she rolled out of bed and hit her head." Both statements are dated 10/24/24. No statement from V13 was provided.

Fire Department record, dated 10/24/24, documents, "dispatched for the fall victim. Upon arrival crew located the patient laying supine on the floor. Alert and oriented times three. Patient's nurse stated the patient was being changed and cleaned in bed when she was rolled out. Patient hit her head on the floor when she fell. Staff had already performed general wound care to the patient's forehead. Patient's history and meds was obtained from staff on scene. Call received at 3:43AM and ambulance on scene at 3:50AM."

Hospital records, dated 10/24/24, "presents with mechanical fall out of bed, (R1) states nurses were changing her diaper and rolled her over and she kept rolling and fell to the ground. (R1) head strike with frontal hematoma. Additionally pain in knee with a hematoma just below the right knee. Contracture and external rotation of right hip. Pain in right knee with hematoma over right tibial tuberosity. Mental status: Alert and oriented to person, place, and time. Neurological: positive for headaches. Imaging results for bilateral hips, pelvis, knees, right tibia and femur listed as "results pending". Emergency Department Course: 10/24/24 agreeable to return to nursing home after irrigation and skin glue repair of laceration."

R1's IDT Fall Committee Meeting Note: resident was observed on the floor and stated she wanted to reposition herself and rolled over to the floor.

There is no record of R1 stating she was rolled out of bed during care to the facility during the fall

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investigation.

On 11/19/24 at 10:01AM, R1 was observed in bed with a bump on the right side of her forehead, scabbed over in the center, pink skin, and dry without drainage. R1 was asleep.

On 11/19/24 at 11:45AM, V4 said, "The CNA (Certified Nursing Assistant) called me to the room. I went to the resident room; after assessing (R1), I called 911 because the physician told me to send her to the hospital. At baseline, (R1) is alert and oriented x 2, and she is very responsive and has periods of confusion. (R1) is a 2 person assist for transfers and she typically sleeps throughout the night. (R1) had been checked not long before the fall. Whatever I wrote is what happened." V4 said she didn't remember more than what was written.

On 11/19/24 at 1:57PM, V8, CNA, said, "I don't know who (R1) is. I don't remember someone falling and getting a goose egg or large bump on their head. I have had people fall but I don't know their names. Some people are 2 person assists because they are combative."

On 11/20/24 at 12:54PM, V13, CNA, said, "On 10/24/24, there was only 2 CNAs that night. V13 I was coming to east hall (opposite R1 hall) and the nurse called me and said they had a fall. I went in the room and (R1) was on the floor next to the bed. V13 said she was trying to change her diaper and she fell." The surveyor who is "she"? V13 said V8 by name. V13 said, "(V8) told me she was trying to change (R1's) diaper in bed. I did not help in turning or changing R1 before the fall, I was on the East hall. They called 911 and I came back to my hall. I did not give a statement for the fall."

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On 11/20/24 at 11:50AM, R1 was in bed alert and oriented place and self, confused about time. The surveyor asked R1 what happened to her head? R1 she had a raised area, size and shape of an egg, with a scab in the center. R1 said her head and ankle hurt. R1 said, "You should have seen it before; it was bigger and ugly. The girl was turning me and was pushing me, and I kept saying stop, you're going to push me out. The girl kept pushing, and next thing I knew, I fell to the floor." V15, Director of Nursing, was brought to the room, and R1 repeated the incident that "the girl pushed her out of bed". R1 said, "It hurt my shoulder and my head." R1 was on air mattress. R1's right leg was contracted, with knee bent, and foot towards R1's torso. R1's left leg extended out in front of her.

On 11/19/24 at 12:11PM V5, CNA, said, "(R1) needs 2 persons to turn her. (R1) can't help with positioning and is heavy, and 2 people are needed to turn her. We don't have a rail for (R1). I have not seen R1 kick, fidget, or try to get of the bed. (R1's) cognition goes in and out; she does get confused."

On 11/19/24 at 12:49PM V7, CNA, said, "(R1) is 2 persons assist for cares. (R1) never tries to get up or out of bed. (R1) can't roll out of the bed, and she can't help to turn. (R1) is cooperative. (R1) had a fall; when I came back to work R1's face was swollen, all on the right side was swollen. (R1) said they were trying to roll her over and she fell. (R1) told me that. It can be possibly true. (R1) can't sit up in the bed and she can't stand or doesn't try to walk."

On 11/20/24 at 10:25AM, V11, MDS (Minimum Data Set) Nurse, said, "When the fall was

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discussed with the team, we were told the fire department picked (R1) off the floor after the fall. Per the documentation, (R1) rolled off the bed." At 10:43AM, V11 presented Functional Ability assessment, dated 8/7/24. V11 said, "(R1's) bed mobility is dependent. (R1) needs 2 person assistance. In the facility when someone is dependent, we use 2 people or more. (R1) has no behaviors that would mean she needs 2 persons for assistance. For turning and repositioning in bed, (R1) needs 2 people. (R1) has no strength in arms and legs. (R1) does not have the strength to turn herself in bed. I have no idea how she rolled out of bed. When they talked about the fall, I wondered too. Vased on our assessment, (R1) is dependent and can't roll herself. The binder at the nurses' station tells how many people can help. The staff gets trained to use 2 people. The staff is told if they use 2 people for the transfer, then they need to use 2 for bed mobility and changing briefs."

On 11/20/24 at 11:07AM, V10, Restorative Nurse, said, Anyone with a fall risk score below a 9 are at risk. (R1) was not part of the falling leaf program when she fell, and she is not now. Based on assessments, (R1) needs extensive assistance with care; she needs a lot of help. (R1) cannot get up, she can assist with slight movement, but staff would need to do the turning. (R1) can be between 1 to 2 person assist with bed mobility, it depends on staff. I can do (R1) by myself. It is in the kardex in computer chart; you can see how much staff (R1) needs for care." V10 read from Kardex and documented "BED MOBILITY with assistance." V10 said, "There is no direction if she needs 1 or 2 person, it depends on the person. Observation record will show if she has contractures. (R1) was not able to walk before the fall. I went over the fall. (R1) is

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on a bed mobility restorative program. The program says (R1) will practice repositioning in bed, and she does not use rails for program."

On 11/20/24 at 12:03PM, V12, Restorative Aid, said, "For (R1's) bed mobility, I go in and I turn her side to side, with another person at all times. I move her contracted leg as much as she can bear. (R1's) right leg is contracted and her left leg she does not bend. The CNA and I are doing all the work to turn her, she is dependent on staff. I have never seen her turn or try to roll. In all the time I have worked with (R1), she has never tried to roll or initiate the roll in bed."

On 11/20/24 at 12:28PM, V15, Director of Nursing, said, "I started last week. Paraplegia affects the ability to use legs."

On 11/20/24 at 1:10PM, V14, Regional Nurse Consultant, said, "We are going to investigate what (V13) and (R1) said."

Facility fall prevention program, dated 11/21/2017, states 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. The fall prevention program includes the following components: use and implementation of professional standards of practice. Care plan incorporates: Preventative measures. Safety interventions will be implemented for each resident identified at risk. Direct care staff will be oriented and trained in the Fall Prevention Program. Residents will be observed approximately every two hours to ensure the resident is safely positioned in the bed or chair

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S9999	Continued From page 8 and provide care as assigned in accordance with the plan of care. (B)	S9999		