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S 000	Initial Comments FRI of 08.27.24/IL179704	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 comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999		

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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.

These requirements were not met as evidenced

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by:

Based on interview and record review the facility failed to develop an effective plan to prevent and/or reduce the risk of falling for a resident identified to at high risk for falls, and failed to follow their fall prevention protocol to complete fall risk assessments quarterly and accurately assess and document fall risk factors. This affected 6 of 6 residents (R1, R2, R4, R5, R6 and R7) reviewed for falls and fall risk assessments. This failure resulted in R1 having multiple falls R1 had a fall in his room on 8/27/24 at 7:45AM, and then another fall same day at 1:47PM in the dining room that resulted laceration in left side eye brow forehead requiring sutures on 8/27/24 and third fall on 9/12/24 in the dining room that resulted in left eyebrow laceration re-opening.

Findings Include:

R1 is 68 year old resident and still currently in the facility.
BIMs score of 2 (severe cognitive impairment).
Fall risk assessment dated 8/27/24 scored 13, and on 9/13/24 scored 14.

On 10/24/24 at 9:30AM, V12 (Restorative Nurse/Fall Coordinator) stated that a resident is consider high risk for fall if they scored 10 or higher on the fall risk assessment. V12 stated that residents with a history of falls and impulsive behaviors would have someone close to resident to monitor for any behavior.

R1 has a careplan for actual fall with major injury related to: nasal bone fractures, Parkinson's disease, left hip replacement, bipolar disease, developmental delay, ESBL (extended spectrum beta-lactamase -- bacteria) in the urine and acute

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kidney failure, poor balance, poor communication/comprehension, unsteady gait, impulsive behavior dated 9/19/24.

Behavior Note documented on 8/27/24 at 7:45AM, reads in part: R1 was observed sitting on the safety mat next to the bed, with the bed in lowest position.

On 10/23/24 at 2PM, V3 (LPN) stated that the incident was unwitnessed, V3 saw R1 lying on the floor mat next to his bed, bed was in low position. "I do not know how R1 got himself to the floor mat. R1 was not able to explain how it happened. I asked V2 DON (director of nursing) if I should document it as a fall, but V2 said to document it as a behavior because no one saw him fall off the bed".

On 10/24/24 at 9:30AM, V12 (Restorative Nurse/Fall Coordinator) stated that a fall incident is a change of plane. If fall unwitnessed and if the resident is not able to explain what happened, it is considered a fall incident. V12 stated that the fall incident should be documented and a fall risk assessment should be completed.

On 10/24/24 at 11AM, V2 (DON) stated that the incident happened early morning and that it was not a fall, because it was not a change of plane. V2 stated that R1's floor mat is the same height as his bed. R1 rolls off the bed, and the floor mat is the same height as his bed. Bed in low position. Floor mat is in place when R1 is in bed and when R1 is out of bed, we take the mat up and put it against the wall of R1's room, it does not leave R1's room.

On 10/24/24 at 11:15AM, the distance from the floor to the top of R1's mattress/bed was

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observed to be about 15 inches. The height of the floor mat was observed to about one inch. R1 was not observed to be present in R1's room. R1's floor mat was positioned on floor next to R1's bed.

On 10/24/24 at 11:16AM, V4 CNA (certified nurse aide) stated that R1's bed and floor mat is what R1 has always had since admission to this facility. V4 acknowledged that R1's top of floor mat is not at the same height as the top of his bed.

On 10/24/24 at 2:10PM, V4 CNA stated that R1 is usually awake when she arrives at 6:00AM. V4 stated that R1 should be on the get up early list. stated that R1 will activate his call light when he wakes up in the morning for toileting assistance. R1 needs prompt staff response to his call light. V4 stated that she did not see R1 sit himself on the floor on 8/27/24, when she arrived he was on the floor.

Facility reported incident with date of occurrence of 8/27/24, reads in part: Thorough investigation completed. Medical record review and interviews of witnesses reveals on 8/27/24, R1 sustained a witnessed fall. Prior to the fall, R1 was notes sitting in the dining room. R1 did not request for assistance, but quickly got up to grab a cup of water, then stumbled on the table resulting in a fall. R1 sustained an opened area on the left eyebrow. Medical records review indicates that prior to admission, R1 has a history of acute comminuted mildly depressed bilateral nasal bones fractures with slight rightward deviation of the nose, acute nasal bone fracture which is superimposed upon an old chronic nasal bone fracture. R1 was transferred to the hospital for further evaluation and was diagnosed with closed fracture of nasal bone age indeterminate and

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laceration of the left eyebrow with 7 stiches.

On 10/23/24 at 11:15AM, V3 (LPN) stated that on 8/27/24, around after lunch, staff alerted V3. "V3 come here we need you". Few steps away from walking in the hallway." I just passed by the dining room" V3 stated that V3 saw R1 on the floor. R1 lying on the side, with active bleeding under eye and wheelchair right next to R1. Wound care came after me and attended to the wound. R1 is extensive assist and able to self-propel, propels with his feet Does not use footrest. R1 needs assistance with standing due to cognition and poor safety awareness with impulsive behavior. R1 is high risk for fall. Staff are already on alert for fall, staff keep extra eye on R1 to prevent from falling.

On 10/23/24 at 11:40AM, V4 (CNA), stated that on 8/27/24, V4 just changed R1's clothes after lunch meal, pushed R1 into the dining room. V4 stated that V4 heard an emergency bathroom call light alarming and she did not put any resident in the bathroom so V4 left the dining room to attend to call light. V4 stated "I am not sure if any other staff member was in there. Waiting for activity staff to come around. When I returned they are picking R1 up already from the floor". R1's gait is very unsteady. R1 has a behavior of trying to get up and reaching for whatever is in front of him. R1 is a reacher. R1 is going to get whatever is in front of him, especially food and drink. R1 is a busy resident, would try to get everything and would reach anything in front of him.

On 10/23/24 at 1:35PM, V10 (Restorative Aide) stated that R1 was sitting in the chair and R1 reached for some water. R1 was in the long table in the dining room. R1 stood up and fell forward. R1 hit the ground. V10 stated V10 was sitting in

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the alternate side of the table. There were 5 or 6 residents in the dining room. V10 stated that this was the first time watching R1 in the dining room, V10 was not aware of any impulsive behavior of R1. V10 stated V10 got up but was not able to stop the fall. We try to prevent falls. I do not know if he is high risk for fall.

R1's hospital record dated 8/27/24, reads in part: 2.5 cm laceration located to the left forehead eyebrow. 2 deep sutures to close soft tissue and 6 superficial sutures to close the skin. CT (computerized tomography) scan of R1's head/brain with an impression of mild left forehead soft tissue swelling and age indeterminate mildly depressed nasal bone fracture.

IDT FALL COMMITTEE NOTE dated 8/30/24, reads in part: Contributing factors: impaired memory, confused, anti-hypertensive user, antipsychotic use, gait imbalance, incontinent, weakness and narcotic use. Prior interventions and support provided: bed in lowest position, behavior monitoring, non-skid socks/footwear in place, call light in reach, and R1 was brought close to the dining room/nurses station. Root cause of the fall determined by IDT: R1 was impulsive behavior attempted to grab a cup of water from the table in the dining room and stumble on the table. R1 requires 1 person assist with ADL and transfer. New intervention put at the time of the fall, bed moved against the wall to prevent from sliding out. Anti-slip mat and anti-rollback were added to R1's wheelchair. Floor mat added to the side of R1's bed.

Fall initial occurrence note dated 9/12/24, reads in part: R1 had an un-witnessed fall 09/12/2024 4:45 PM Location of Fall: Unit 1 Dining room,

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Nurse was told by RCS (Resident Aide) that R1 fell, when the writer went to Unit 1 dining room, RCS already put R1 back on his wheelchair. Noted small blood on the floor and left upper eyebrow. Sent to local hospital for evaluation.

Nurses Note dated 9/12/2024 at 21:42, reads in part: Back from local hospital and after being evaluated with diagnosis .of fall initial encounter, Injury of Head, initial encounter, Acute Cystitis without hematuria. Sutures from left eyebrow off, steri- strips intact and covered with band aid. No discoloration noted at this time.

On 10/23/24 at 3pm, V11 (RN) stated that a resident aide informed V11 about R1 fall. Dining room R1 blood on the floor, and noted R1 already on the wheelchair. Blood on the left eye brow. Sutures still present on the laceration, and noted blood coming out from that area, small amount. Dry dressing and bleeding stop. Sent out for further evaluation. R1 returned and hospital removed sutures and placed steri strips. R1 usually bend forward and reach for something, and that probably what happened. Last seen resident in the dining room and the aide was there, female RCS.

On 10/24/24 at 11AM, V2 (DON) stated that the fall incident on 8/27/24, witnesses interviewed, they bring R1 in the dining room. Restorative was there, she was sitting around the corner not close to R1, She was not able to catch the fall. R1 was trying to grab a cup of water. Reached and fell forward from sitting in the wheelchair. R1 has history of multiple falls when he was at the group home. R1 has multiple falls prior to coming in the facility. High risk for fall that's the reason we bring him in the dining room, R1 is very impulsive, no sense of safety awareness. Supervision in the

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dining room. Stated that the fall incident on 9/12/24, R1 was in dining room and they are people supervising. CNA was in the dining room. CNA observed R1 dropped the spoon on the floor and R1 bent down and fell of the wheelchair. R1 is quick, and people were watching R1. Facility does not do one on one supervising. There are other people also in the dining room that they have to watch. Staff are monitoring other high risk for fall residents and the facility do not do one on one.

IDT FALL COMMITTEE MEETING NOTE dated 9/13/24, reads in part: Contributing factors: Impaired memory. Situational factor: behavior symptoms. Root Cause: impulsive behavior attempted to pick spoon from the floor in the dining room when he slid and fell.

On 10/23/24 at 1:35PM, V10 (Restorative Aide) stated that if any residents with such behavior and history of fall. Staff keep eyes on them and monitoring. Staff should be sitting close enough to be able to redirect the resident. Close enough to stop the reaching behavior of R1 for safety and prevent fall incident.

Fall Prevention Program with a revision date of 11/21/2017, reads in part:
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. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. The fall Prevention Program includes the following components: Methods to identify risk factor,

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methods to identify residents at risk, use and implementation of professional standards of practice, immediate change in interventions that were successful, communication with direct care staff members. Care plan incorporated: identification of all risk/issue, address each fall, interventions are changed with each fall as appropriate, preventative measure. Safety interventions will be implemented for each resident identified at risk. Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan.

R2's medical record notes R2 was admitted with diagnoses including, but not limited to, high blood pressure, hypertensive urgency (occurs when blood pressure readings are 180/110 or higher but there is no organ damage or symptoms), history of falls, and primary osteoarthritis of ankle and foot.

R2's POS (physician order sheet) notes an order, dated 5/14/24, for amlodipine besylate (medication to treat high blood pressure) 10mg (milligrams) oral daily. On 5/15/24, there is an order for hydralazine (medication to treat high blood pressure) 50mg oral every 8 hours. On 6/25/24, there is an order for olanzapine 2.5mg oral for mood/agitation. On 8/13, there are orders for furosemide (medication to treat fluid retention) 20mg oral daily. On 8/22/24, there is an order for lisinopril (medication to treat high blood pressure) 10mg oral daily.

R2's admission fall risk assessment, dated 5/14/24, notes R2 does not take any high risk medications. R2 was receiving amlodipine besylate. It also notes R2 does not have any predisposing diseases, such as arthritis. R2 was

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admitted with a diagnosis of primary osteoarthritis of ankle and foot. It notes R2 is not at risk for falls.

R2's fall risk assessment, dated 7/10/24 at 5:45PM, notes no falls in the past three months. This assessment was completed after R2 fell at 5:00PM. It notes R2 is not at risk for falls.

R2's fall risk assessment, dated 9/11/24, notes R2 takes 1-2 high risk medications currently or within last 7 days. R2 was receiving amlodipine besylate, hydralazine, and olanzapine. It also notes no falls within the past three months. R2 fell on 7/10/24. It also notes no predisposing diseases, such as arthritis. R2 was admitted with a diagnosis of primary osteoarthritis of ankle and foot. R2's gait/balance was not assessed. R2 was hospitalized 9/3-9/11 with medication changes. This was not identified on R2's assessment. It notes R2 is not at risk for falls.

R4's medical record notes R4 with diagnoses including, but not limited to, stroke with paralysis affecting left dominant side (primary diagnosis on 8/3/2023) and history of falling.

R4's fall risk assessment, dated 8/7/24, notes no falls within the past three months. This assessment was completed post fall. It also noted R4 does not have any predisposing diseases, such as stroke. It notes R4 is not at risk for falls.

R4's fall risk assessment, dated 8/21/24, notes R4's gait/balance was not assessed. It also notes R4 does not have any predisposing diseases, such as stroke. It notes R4 is not at risk for falls.

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R4's fall risk assessment completed prior to 8/7/24 was done on 10/18/23.

On 10/24/24 at 9:40AM, V12 (restorative nurse/falls coordinator) stated that V12 has been the falls coordinator at this facility for the past two years. V12 stated that a fall risk assessment is completed on all residents on admission, re-admission, status post fall, and quarterly. V12 stated that a resident is identified as a high risk for fall if the fall risk assessment score is 10 or higher. V12 stated that the resident's care plan would note resident is at risk for falls not at high risk for falls. V12 stated that nurses are expected to complete the fall risk assessments. V12 stated that the IDT (interdisciplinary team) will assess each resident and determine if the resident is at risk for falls. When questioned where is the IDT's assessment documented in the resident's electronic medical record, V12 did not respond. V12 stated that R2 had an unsteady gait and was on this facility's falling list. When questioned reason why R2 would be on the facility's falling list if all of R2 fall risk assessments, dated 5/14, 7/10, and 9/11, note R2 is not at risk for falls, V12 responded that the fall risk assessment is done at the discretion of the nurse. When questioned if V12 reviews the resident's fall risk assessment for accuracy, V12 responded 'no'. R4's fall risk assessments were reviewed with V12; R4 is identified as not at risk for falls. When questioned why R4 does not have any fall risk assessments done from 10/8/2023 until R4 fell on 8/7/2024, V12 responded she does not know. V12 stated that R4 is unable to stand. When questioned if the nurse is expected to check all that apply for the R4's gait/balance, V12 did not respond. When questioned if R4's fall risk assessments were accurate, V12 responded she

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does not know.

R5's medical record notes R5 with admitting diagnoses including, but not limited to, multiple fractures - skull, ribs, cervical spine, history of falling, and high blood pressure.

R5's only fall risk assessment was completed on admission on 3/6/2024.

R6's medical record notes R6 with diagnoses including, but not limited to, high blood pressure, difficulty in walking, abnormal posture, and lack of coordination.

R6's fall risk assessment, dated 10/8/24, notes no falls within the past three months. This assessment was completed post fall. It also notes R6 is not at risk for falls.

R7's medical record notes R7 with diagnoses including, but not limited to, stroke with paralysis affecting right dominant side (primary diagnosis on 12/16/2021), seizure disorder, high blood pressure, Parkinson's disease, and history of falling.

R7's only fall risk assessment since admission on 12/16/2021 was completed on 2/24/2022. This assessment notes R7 does not have any predisposing diseases, such as high blood pressure, stoke, seizures, or Parkinson's disease.

A review of the facilities fall prevention program, revised 11/21/2027, notes a fall risk assessment will be performed by a licensed nurse at the time of admission. A fall risk assessment will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012173	A. BUILDING: _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WESTCHESTER	2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154

(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
S9999	Continued From page 13 performed at least quarterly and after any fall. (B)	S9999		