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 _____	C 01/13/2025

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 Investigation of Facility Reported Incident of November 13, 2024/IL182517	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 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	S9999		

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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 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 R1's plan of care to provide supervision with meals (eating), ensure R1's assistive mobility device was within reach and ensure R1 was wearing appropriate footwear. R1

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who is high risk for falls, was left in the room unsupervised. R1 had a fall incident on 11/13/24 that resulted in subdural hematoma. This past noncompliance occurred from 11/13/24 to 11/18/24.

The findings include:

R1's Admission record documented initial admission date on 7/12/22 with diagnoses not limited to Other osteomyelitis upper arm, Type 2 diabetes mellitus, Atherosclerosis of coronary artery bypass graft(s), Cognitive communication deficit, Difficulty in walking, Unspecified protein-calorie malnutrition, Metabolic encephalopathy, History of falling, Nontraumatic acute subdural hemorrhage, Essential (primary) hypertension, Solitary pulmonary nodule, Contusion of right front wall of thorax, Other dysphagia, Latent tuberculosis, Hyperlipidemia, Unspecified glaucoma.

MDS (minimum data set) dated 11/13/2024 showed R1's cognition was moderately impaired. R1 needs supervision or touching assistance with eating; Substantial/maximal assistance with chair/bed and toilet transfer.

On 1/12/25 At 11:40am V9 (Regional Nurse Consultant) informed surveyor that facility created a past noncompliance for R1's fall incident on 11/13/24 and binder was presented to the surveyor. V9 said R1 was identified as high risk for fall, the RCA (root cause analysis) has been identified, and the action plan and plan of correction were in place.

On 1/12/25 At 11:45am V2 (Director of Nursing /DON) stated she investigated the fall incident of R1 on 11/13/24 and reported to state agency due

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to diagnosis of subdural hematoma. V2 said R1 came back from an appointment with her son and was served her meal in her room. V2 said the fall might have been prevented if R1 was placed by the nurse's station or dining room for close supervision. V2 stated R1 was identified as high risk for falls. No surgery was done in the hospital and R1 was readmitted to the facility on 11/17/24.

On 1/12/25 at 12:48pm V13 (Licensed Practical Nurse/LPN) said he has been working R1 and was the nurse during the fall incident on 11/13/24. He said R1 went out for appointment with her son and came back to the facility. V13 said she was served dinner in her room because it was late already. V13 said he was informed by V15 (Certified Nursing Assistant/CNA) that R1 was on the floor. V13 stated he was on the 2nd floor at the time of R1's fall incident. When he was informed, he immediately went to the 3rd floor and saw resident laying on the floor. V13 said there was food sitting on the table. He said the walker was farther away from the bed and close to the closet. He said R1 got up from the wheelchair, lost her balance and fell. V13 said there was indication that R1 hit her head against the floor because of the bruise and skin tear on forehead. He Informed the doctor and R1 was transferred to the hospital. V13 stated R1 was admitted in the hospital with diagnoses of subdural hematoma. He stated he can't remember if R1 was toileted and did not check if R1 was wearing a proper footwear. V13 said R1 was high for fall, if R1 was placed near the nurse's station and if walker was accessible or within reach to R1 then the fall might have been prevented.

On 1/12/25 at 1:11pm V14 (CNA) stated V14 has been working with R1 who can speak minimal

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English. He said he was working with R1 on 11/13/24. R1 came back from out on pass and was served dinner in her room. V14 said R1 was sitting up in wheelchair, call light was within reach and instructed to call for help. V14 stated he went for his break and was informed that R1 fell and was about to be transferred to the hospital. V14 stated R1 would usually eat in the dining room, and she is high risk for fall. V14 said if resident was placed in the dining room, by the nurse's station, or if R1 had called for help, the fall might have been prevented.

On 1/12/25 at 1:59pm V15 (CNA) stated she had worked with R1 but was not the assigned CNA during the fall incident on 11/13/24. V15 said she heard R1 was moaning or something, saw R1 laying on the floor on her stomach, face down with a bruise and some blood on the floor. She said nurse was informed immediately. V15 stated "I don't believe R1 had any shoes on because I saw her shoes on the floor. R1 was wearing socks and might have slid. V15 stated R1's walker was by the radiator/closet and not accessible to the R1. V15 said R1 is high risk for falls. V15 said "she is always eating in the dining room". If the resident was in the dining room, closer to the nurse's station, or maybe if R1 was using a proper footwear, the fall might have been prevented.

On 1/12/25 at 2:37pm V3 (Assistant Director of Nursing/ADON) stated has been working in the facility since 2015. V3 stated she was informed by the nurse that R1 fell and had a bruise and skin tear on forehead. V3 said R1 was transferred to the hospital with a diagnosis of a subdural hematoma. She said the initial report was sent to state agency. V3 stated R1 is high risk for falls. The fall could have prevented, if R1

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was place in common area like dining room or nurse' station for close supervision.

Care plan date initiated on 2/24/23 documented in part: R1 at High risk for falls related to weakness. History of falls on: 5/17/2023, 12/19/2023, 7/15/2024, 11/13/2024. Care plan interventions included but not limited to: R1 to use walker. Ensure R1 is wearing appropriate footwear when ambulating.

Care plan date initiated 1/18/24 documented in part: R1 have an ADL self-care/ mobility performance (functional abilities) deficit. Eating: R1's usual performance is supervision.

Fall-initial occurrence note dated 11/13/24 documented in part: R1 had an un-witnessed fall in resident room on 11/13/2024 8:00 PM. Forehead bruised.

Nurses Note dated 11/14/2024 showed in part: confirmed R1's hospital admission with Admitting Diagnosis: Subdural Hemorrhage.

R1's CT (computer tomography) head wo contrast result dated 11/13/24 documented in part: Impression: Stable narrow caliber interhemispheric acute subdural hematoma.

R1's hospital records by V5 (Hospital Physician) history and physical notes dated 11/14/24 documented in part: R1 with mechanical fall in the nursing home. Was found on the floor, fall was unwitnessed. Frontal head contusion and bruising along the left hand and wrist. CT head with slim interhemispheric acute subdural hematoma. R1 is somnolent and complaining of neck pain. Waking up on and off on sternal rub and going back to sleep. Could not answer any

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of the subjective answer.

V4 (Nurse Practitioner/NP) progress note dated 11/20/24 documented in part: R1 was readmitted to the hospital 11/13-11/17 due to a fall, unwitnessed. R1 was found to have interhemispheric SDH (Subdural hematoma).

Facility's incident report dated 11/19/24 documented in part: R1 was last observed sitting in wheelchair eating her dinner, stood up, lost her balance, and fell to the floor. R1 had bruise and skin tear on the front/middle of the forehead and was sent to hospital with diagnosis of Subdural Hematoma.

Facility's fall prevention policy dated 11/21/17 documented 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. Assistive devices such as walkers and canes will be placed within reach of those residents. The resident will be reminded as needed to call for assistance before attempting to ambulate. Residents who require staff assistance will not be left alone after being Footwear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid.

Prior to the survey date of 1/13/25 the facility took the following actions to correct the deficient practice. Surveyor did observation, interview and record review and found the following action plans in place:
1. R1 was supervised by staff every 15 minutes

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S9999	Continued From page 7 and placed by the common area for close monitoring. R1's log monitoring every 15 minutes from 11/17/24 to 1/11/25 was in place. 2. R1 was evaluated by therapy upon readmission on 11/17/24. 3. V2 (DON) and V3 (ADON) in-serviced all staff on the facility's fall policy and individualized interventions. 4. Care plans updated with new interventions. 5. Fall assessment was completed upon readmission on 11/17/24. 6. R1 had no further fall after incident on 11/13/24. 7. V2 (DON) and V3 (Assistant Director of Nursing) stated that they discuss fall and interventions at morning meeting with IDT (interdisciplinary team). 8. Facility did a wide audit to ensure high risk residents care plans and interventions are up to date. 9. The facility's Quality Assurance Committee has monitored compliance through the daily and weekly internal Quality Assurance process. QA tool from 11/18/24 to 1/10/25 reviewed. "A"	S9999		