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 11/14/2019

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

(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	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

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These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure resident safety during a transfer using a mechanical lift, by failing to have two staff assist during the transfer. The facility failure to follow the policy and safety guidelines for mechanical lift transfers, resulted in a significant injury for 1 of 3 residents (R1), who sustained a fracture as a result of a fall related incident during a one-person staff transfer using a mechanical lift.

Findings include:

R1 was admitted to the facility on 2/13/16. R1 has diagnoses that include dementia, abnormal posture, weakness and unsteadiness on feet. R1 is alert and orient with periods of confusion. The Minimum data set (MDS) dated 9/5/19, documented that R1 required total dependence and 2 person assist, with transfers. The facility also identified that R1 required a 2 person assist with all transfers.

On review of the care plan for R1 initiated on 7/31/17, facility staff identified that R1 required assistance with transfers using mechanical lift with the following interventions: ensure bed wheels are locked: properly lock brakes on wheelchair; provide cues for safety; and two person assist required for transfer

On review of the facility reportable fall document dated 10/29/19, staff documented under the description of occurrence, "Resident sustained a witnessed fall on 10/27/19 during transfer from bed to wheelchair with staff present. While staff was lowering resident to her wheelchair during

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transfer resident began to slide down from sling and was lowered to the ground by staff."

The facility fall investigation interviews were reviewed for the fall incident of 10/29/19. According to the documented interview for V7 (Certified Nursing Assistant), facility staff documented the staff stated "after R1 was transferred from bed to her chair via mechanical lift, she began to gradually slide out of chair, I attempted to stop her but was unsuccessful in doing so. The resident landed on her knees and I protected her head as she went further to the floor." The interview conducted by V12 (Unit manager) documented, "R1 had witnessed fall, CNA stated resident slid out of chair onto her knees after transferring." The interview done by V11 (nurse), documented, "was notified by CNA that resident slid out of chair onto the floor. Nurse observed resident lying on the floor in front of her wheelchair." Facility staff documented that during the interview, V4 (CNA) stated, "I was requested to come in room by nurse to assist with transferring R1 back to wheelchair after fall." R1 interview documented "staff present during incident but could not prevent her from sliding down from wheelchair." No other interviews provided for fall investigation.

On 11/14/19 at 10: 18 AM, V2 (DON) stated falls are investigated by interviewing all staff on unit during the fall and directly caring for resident. R1's fall was reported to the nurse by V7 (CNA). V7 stated she had assistance with transfer but we have not been able to identify staff who assisted V7 with transfer. The assigned staff on unit stated they did not assist V7 with transfer; and V7 has not been able to be contacted since incident. Facility staff stated that all mechanical lift transfers, require two person assist for safety

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S9999	Continued From page 4 reasons and to prevent injuries. On 11/14/19 at 10: 53 AM, V24 (NP) stated, "residents requiring a mechanical lift should have 2 staff members present in order to transfer safely. The facility reported R1 had a witnessed fall. The X-rays revealed fractures of tibia and fibula and R1 was sent to hospital. For R1 to sustain a fracture in both tibia and fibula would have resulted from a hard fall. I do not think if R1 was assisted to the floor she would have sustained 2 fractures to lower leg." The facility policy titled Transfers- Manual Gait Belt and Mechanical Lifts dated 1/19/18, documented in the section referred to as Purpose: "to protect the safety and well -being of the staff and residents and to promote quality care, this facility will use mechanical lifting devices for the lifting and movement of residents. Mechanical lifting devices shall be used for any resident needing a two person assist or who cannot be transferred comfortably and/or safely by normal transfer technique." (B)	S9999		