Illinois Donattment of Bublic Health

| U SIONIIII | epartment of Public | Health | | | | |
|--|--|--|---------------|---|--------|------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | COMPLETED | | |
| | | | | | | |
| IL6014617 | | B. WING | | | 5/2020 | |
| NAME OF S | PROVIDER OR SUPPLIER | STREET AD | DRESS CITY S | STATE, ZIP CODE | | |
| TOTALE OF I | NOTICE TO THE OFFICE TO THE OF | | TH WESTER | | | |
| APERIO | N CARE INTERNATIO | NAL | , IL 60609 | MANE | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ON | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | | COMPLETE DATE |
| TAG | NEODENOMI ONE | SO IDENTIFY THE THE OTHER TONY | TAG | DEFICIENCY) | FRAIE | DATE : |
| 7. | | | | | | |
| S 000 | Initial Comments | | S 000 | | | |
| | | | | | | |
| | Complaint Investiga | ation | | | | |
| | 2089158/IL128864 | | | | | |
| | 2000 100/12 12000+ | | | | | |
| 59999 | Final Observations | | S99 99 | | | : |
| | I IIIai Observations | | 00000 | | | |
| | Statement of Licer | nsure Violations | | | | |
| | | | | | | |
| | | | | | | |
| | 300.1210a) | | | | | |
| | 300.1210b) 300.1210c) | | | | | |
| | 300.1210d)6) | | | | | |
| | 300.1210d)3) | | | | | |
| | 300.3240a) | | | | | |
| | , | | | | | |
| | 0 11 - 000 4040 | On a seal Description and for | | | | |
| | Nursing and Person | General Requirements for | | | | |
| | Nursing and Ferson | rial Care | | | | |
| | | | | | | |
| | a) Compreher | nsive Resident Care Plan. A | | | | |
| | | ticipation of the resident and | | | | |
| | | dian or representative, as | | | | |
| | | evelop and implement a | | | | |
| | | re plan for each resident that | | | | |
| | | le objectives and timetables to 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 | | | | | |
| | | | | | | |
| 10 | | | | | | |
| | , · | ge planning to the least | | | | |
| | | ased on the resident's care | | | | |
| | | sment shall be developed with | | Attachment A | | |
| the active participation of the resident and the resident's guardian or representative, as | | | • | | | |
| | | n 3-202.2a of the Act) | | | | |
| | approadic. (Coolidit o 202.24 of the flot) | | | | | |

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | |) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|------|----------------------------|--|
| | | 11 004 404 7 | B. WING | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET AD | | | | | 11/2 | 25/2020 | |
| | | 4815 SOU | TH WESTE | STATE, ZIP CODE RN AVE | | : | |
| APERIO | N CARE INTERNATION | NAL. | , 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 | Continued From pa | ge 1 | S9999 | | | | |
| | care and services to practicable physical well-being of the reseach resident's complan. Adequate and care and personal or resident to meet the care needs of the resident direct to the care services. | care-giving staff shall review | | Б | | | |
| | and be knowledgeable about his or her residents' respective resident care plan. | | | | | | |
| | nursing care shall in | subsection (a), general nolude, at a minimum, the practiced on a 24-hour, pasis: | | | į | *** | |
| | to assure that the re as free of accident h nursing personnels | ry precautions shall be taken esidents' environment remains nazards as possible. All hall evaluate residents to see eceives adequate supervision revent accidents. | W. | | | | |
| | Section 300.1220 S Services | Supervision of Nursing | : | | | >> | |
| | | nall supervise and oversee the the facility, including: | | | | | |
| | | an up-to-date resident care nt based on the resident's | | | | | |

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|----------------------------|--|-------------------------------|--------------------------|
| | | *** | A. BUILDING: | | C | |
| IL6014617 | | IL6014617 | B. WING | | 11/25/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| APERIO | APERION CARE INTERNATIONAL 4815 SOU | | | RN AVE | | |
| (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 | comprehensive ass and goals to be accomprehensive ass and goals to be accomposed and personnel, represent nursing, activities, of modalities as are or be involved in the plan. The plan shall reviewed and modificated as indicated. The plan shall be remonths. Section 300.3240 Amounts and a modern plan shall be remonths. Section 300.3240 Amounts and care plan interviewed and care plan interviewed and care plan intervention three residents (R1) sample of six. This from a raised bed to laceration (cut) to the fracture. Findings include: | ressment, individual needs complished, physician's orders, and nursing needs. Inting other services such as lietary, and such other ordered by the physician, shall reparation of the resident care if the in writing and shall be ited in keeping with the care if the interest of the resident's condition. In writing and Neglect of the ited at least every three if the ited in keeping with the care if the ited in keeping with the care if the it | S9999 | | | |
| | | ncluding but not limited to: ve, Lack of Coordination, | | | | |

PRINTED: 01/11/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6014617 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 SOUTH WESTERN AVE APERION CARE INTERNATIONAL** CHICAGO, IL 60609 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) S9999 Continued From page 3 S9999 Atrial Fibrillation. R1 is severely cognitively impaired (BIMS-Brief Interview for Mental Status =7), requires extensive assistance of one for bed mobility and toileting. Side Rail Assessments 04.16.2020: Rehab notified resident to reposition self in bed with use of side half rails. Agreed with right and left half side rails for increased bed mobility. Side Rail Assessment 07.17.2020: Bar or railing is attached to resident's bed frame. Half right and left side rail for increased bed mobility, transfer ability and increased independence for self-care during rehabilitation. Side Rail Assessment 10.19.2020: Bar or railing is attached to resident's bed frame. Half right and left side rail for increased bed mobility, and increased independence for self-care during rehabilitation. Witnessed Fall Progress Note (11.21.2020) documents: "Writer was informed by staff that resident incurred a fall while staff was performing patient care. Upon assessment writer observed laceration to the right side of the forehead with swelling and moderate amount of bleeding, also the resident's nose was swollen." Emergency Department Record (11.21.2020)

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documents admitting diagnoses including laceration to forehead and nasal bone fracture.

V6 (CNA-Certified Nursing Assistant), 11.22.2020 at 4:55 PM, said, "I went to give (R1) her care around 6:00 AM-6:20 AM. She was a little

combative. Every now and then she gets like that. She was okay when I first came into the room. Then she said "turn me loose", she turned away. from me, threw her leg over to the other side falling out of bed onto her right side. Het go. The

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PRINTED: 01/11/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6014617 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 SOUTH WESTERN AVE** APERION CARE INTERNATIONAL CHICAGO, IL 60609 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 4 bed was about 3-3 1/2 feet off the floor when she fell." "Usually you can do her by yourself. She has gotten upset with other CNAs attempting to provide care. But if we come back with two CNAs. she's calmer. The nurses know about her behavior. The nurse will go in and talk to her and we come back in about 20 minutes to see if she'll let us provide care." This writer asked V6 why two CNAs don't routinely go in to provide care (for R1), V6 said, "We don't usually have enough help to do that. Most of the time I can handle her on my own." "She fell a week ago (11.14.2020). My suggestion was side rails There were no side rails on the bed when she fell (11.22.2020). V9 (CNA), 11.22.2020 at 4:04 PM, said, V6 told me R1 jerked away when V6 was trying to change R1 and fell on the floor. She's (R1) not a person that one person could take care of. There were no side rails on the bed. If there was, she could have turned and held on and she wouldn't have fallen. She was in a low bed, it was about three feet off the floor." V10 (Nurse), 11.22.2020 at 4:10 PM said, "V6 told me R1 became combative during care, R1 has a history of agitation. She becomes combative. She'll try to push you away She'll do everything she can to get away from you. There

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should have been someone else in there when she gets like that. I think there should be two."

V4 (CNA), 11.22.2020 at 4:30 PM, said, R1 gets agitated if she's not changed right away when she's wet. I usually have another person with me. You can't really do it (perform incontinence care) by yourself. Plus she needs help moving side to

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|--|--|--|---|--|-------------------------------|--------------------------|
| THE ACTION AND ADMINISTRATION AN | | IL6014617 | B. WING | | C 11/25/2020 | |
| NAME OF | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| APERIO | N CARE INTERNATIO | 4845 SOL | JTH WESTE | • | | |
| | | CHICAGO | D, IL 60609 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| S9999 | Continued From page 5 | | S9999 | | | |
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