STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008650	A. BUILDING: _____ B. WING _____	C 10/20/2021

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APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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
S 000	Initial Comments Complaint Investigation 2147503/IL139097	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010b) 300.1030a)3) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3220f) 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 300.1010 Medical Care Policies b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee. Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 3) Traumatic injuries (for example, fractures, burns, and lacerations). 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 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	S9999		

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S9999	Continued From page 2 resident's guardian or representative, as applicable. 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. 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. 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 basi 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 300.3220 Medical Care	S9999		

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S9999	Continued From page 3 f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to implement progressive interventions and supervision for two of three residents (R2 and R3) reviewed for falls in a sample of seven. This failure resulted in R3's fall sustaining a Inferonasal Laceration, a Nasal Contusion with possible Occult Nasal Fracture, Epistaxis (nosebleed), and another fall sustaining a Fractured Hip requiring hospitalization and surgical repair. This failure also resulted in R2 sustaining a Subarachnoid Hemorrhage and Subdural Hematoma (brain bleeds). Findings include: R3's Care Plan, dated 06/16/2021, documents "I am at risk for falls R/T (Related To) Hypertension, weakness and medication use." It also documents "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." R3's Electronic Health Record (EHR) documents R3 has had 11 falls from 06/01/2021 to 10/08/2021. R3's Fall Risk Assessment, dated 06/17/2021 documents "Intermittent Confusion" it also documents R3 is at risk for falls.	S9999		

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S9999	Continued From page 4 R3's Fall-Initial Occurrence Note, dated 06/18/2021 3:42 PM, documents R3 had an unwitnessed fall in his bedroom. Alert and disoriented per baseline. No investigation provided by facility upon request. New intervention-call for assistance by using the call bell. R3's Fall-Initial Occurrence Note, dated 07/09/2021 1:40 PM, documents fall in resident room attempting to pick up water pitcher. Alert and disoriented per baseline. Intervention instructed to use call light. R3's Fall- Initial Occurrence Note, dated 07/13/2021 1:15 PM documents fall in resident's bathroom room. Resident observed attempting to walk from bathroom. Resident unsteady and staff lowered to floor. The facility did not provide investigation upon request during this investigation. No immediate intervention documented. R3'S EHR documents R3 was found on floor on 07/16/2021 at 3:45 AM. No investigation provided upon request during this investigation. No intervention put in place. R3's EHR, dated 07/19/2021 4:35 PM, documents "Fall IDT Note: Attendee's present: IDT (Intermediate Disciplinary Team) members. Summary of the fall: resident lowered to the floor by aide. Root cause of fall: resident became unsteady. Intervention and care plan updated: resident assisted back to chair, increased monitoring. R3's EHR, dated 07/29/2021 8:38 PM documents "Other/General Note, Note Text: CC (Chief	S9999		

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Complaint)/HPI (history of present illness) This Visit Chief Complaint/Reason for this Visit: Fall. HPI Relating to this Visit (R3) is being seen today S/P (Status Post) fall. On 07/27/2021, he was attempting to go to the restroom. He lost his balance and fell to his buttocks in the restroom. He was incontinent of urine and stool when the nurses found him. He was cleaned up and helped back to bed. He denies pain during exam. He uses a wheelchair to move about the facility but states that the chair is too big to fit in the bathroom. He states that he feels fine and does not have any issues today."

R3's Fall Risk Assessment, dated 07/30/2021 05:30 AM, documents that R3 has intermittent confusion is chair bound with balance problems while standing, walking and decreased muscular coordination.

R3's EHR, dated 07/30/2021 at 6:12 AM, documents R3 was found on floor. No intervention put in place.

R3's Fall Risk Assessment, dated 08/03/2021 8:31 AM, documents that R3 has intermittent confusion is chair bound with balance problems while standing and requires use of assistive devices.

R3's EHR, dated 08/04/2021 4:30 PM documents Fall IDT Note: Attendee's present: IDT members. Summary of the fall: resident found on floor on bottom. Root cause of fall: resident gets up on his own as he does not remember he is weak. Intervention and care plan updated: resident spoke with his son regarding resident getting up.

R3's Fall Risk Assessment, dated 08/09/2021 11:55 AM, documents that R3 has intermittent

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confusion is chair bound with balance problems while standing and requires use of assistive devices.

R3's Nurses Notes, dated 08/09/2021 12:02 PM documents Fall: Time of fall; location of fall; vital signs: resident stumbled on way to bathroom, fell to knees and then got right back up, able to move all extremities WNL (Within Normal Limits), resident is his own Power of Attorney, so no notification of family was required, NP (Nurse Practitioner) notified, resident educated on asking for help with transfer of ambulation.

R3's EHR, dated 08/11/2021 10:43 AM documents Fall IDT Note: Attendee's present: IDT members. Summary of the fall: resident witnessed stumbling, fall to knees, then get back up to bed. Root cause of fall: resident walking around on his own. Intervention and care plan updated: therapy to evaluate/treat, fall leaf placed by name on door frame.

R3's Fall-Initial Occurrence Note, dated 08/30/2021 12:22 AM, documents vitals and responsible party name and number only. No investigation provided and no intervention put in place documented.

R3's EHR, dated 09/07/2021 10:39 AM documents Fall IDT Note: Attendee's present: IDT members. Summary of the fall: resident found on floor. Root cause of fall: resident attempted to get up on his own. Intervention and care plan updated: sitter initiated.

R3's Fall Risk Assessment, dated 09/21/2021 11:13 PM, documents that R3 is disoriented x3 (x-times) (to person, place, and time) at all times, 3 or more falls in past 3 months, and balance

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S9999	Continued From page 7 problems while standing. R3's Fall-Initial Occurrence Note, dated 09/21/2021 11:15 PM, documents witnessed fall in his room between bathroom and bedroom. Description of occurrence: Resident was walking back from the bathroom, without assist and stumbled and went to the floor onto his knees. Resident statement: Resident was walking back to bed from the bathroom when he stumbled and went to his knees hitting his nose on the bed. Alert and disoriented per baseline. Resident has a medium sized abrasion on his left knee. And bloody nose. No new interventions initiated to prevent further falls were documented. No investigation provided by facility. R3's Nurses Notes, dated 09/22/2021 3:00 PM, documents "Narrative: Resident returned from (Local Hospital) ED (Emergency Department) facility (08:00 AM) with discharge diagnosis of mechanical fall with Inferonasal Laceration repaired with Dermabond, Nasal Contusion with possible Occult Nasal Fracture and Epistaxis which was easily controlled in the ED." R3's EHR, dated 10/08/2021 11:57 AM, documents "FALL-INITIAL OCCURRENCE NOTE, Fall Description: Resident had a witnessed fall 10/08/2021 11:40 AM Location of Fall: Resident fell in his room. Resident got out of his bed and started walking towards his bathroom, before staff could reach resident, he fell on the floor landing on his left hip and shoulder. Resident has full ROM (range of motion) in left upper and lower extremities, but resident is complaining of pain rated 7.5/10 in left hip after standing up. Resident stated his left hip was not hurting very bad at all before he stood up. Resident denies any pain in left shoulder.	S9999		

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Resident did not hit his head. Fall was witnessed. on 10/08/2021 11:40AM. Resident statement (if applicable): Resident stated he was trying to walk to the bathroom and fell. Resident denies hitting his head and denies pain in left shoulder. Resident stated his hip was not hurting very bad at all before he stood up, but once resident was standing, he stated his left hip was hurting and rated the pain 7.5/10."

R3's EHR, dated 10/08/2021 12:43 PM, documents "Nurses Note Narrative: Resident left facility via ambulance en route to (Local) hospital d/t (due to) resident falling and c/o (complaints of) pain in left hip rated 7.5/10."

R3's EHR, dated 10/09/2021 at 12:43 AM, documents "Nurses Note Narrative: Resident admitted to Hospital."

R3's EHR, dated 10/10/2021 at 2:15 AM, documents "Nurses Note Narrative: Per (Hospital RN) from (Local Hospital) resident is having surgery in the AM and they are in need of his POA (Power of Attorney) paperwork. Will call back in AM."

R3's EHR, dated 10/11/2021 at 4:46 PM, documents "Admission Note Text: resident received to room 104-3 at approximately 4:18 PM, by wheelchair from (Local) area hospital related to recent fall resulting in a fracture of the left femur, resident noted to have 20 staples in left hip, no other skin issues noted at this time."

On 10/18/2021 at 11:15 AM, V3, Quality Assurance Nurse, stated that R3 had a fall that caused a fracture. Stated that R3 was sent to hospital and fracture was repaired (R3) returned back to the facility. V3 stated that R3 is

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noncompliant with safety interventions.

On 10/18/2021 at 12:15 PM, R7 stated that (R3) has problems with his vision and can only read at a third to fourth grade level. R7 stated that he had witnessed R3's fall and witnessed the last one that sent him to the hospital. R7 stated that he is not sure if R3 pulled the call light but knows that R3 was yelling for help before getting out of the bed.

On 10/19/2021 at 9:11 AM, V6, Certified Nurse's Assistant (CNA), stated that R3 is at risk for falls. V6 stated that R3 did have times when he was confused but could tell you when he needed to go to the bathroom. V6 stated that he needed assistance with going to the bathroom. V6 stated that he used his call light, or he would yell for help. V6 stated that you had to get to him quick or he would try to take himself. V6 stated that R3 needed to be monitored but with only 1 CNA on the hall that is not possible. V6 stated that if you are taking care of someone else you may not know that his light is on and it will take a while to get to him.

On 10/19/2021 at 10:44 AM, V2, Director of Nursing (DON), stated that R3 is a fall risk. V2 stated that R3 was brought to the facility because he was having falls at home, during his stay at the facility this has continued. V2 stated that they have placed him on increased monitoring and every hour toileting program.

On 10/19/2021 at 11:30 AM, V3 stated that increased monitoring means resident will be checked on every 30 minutes.

On 10/19/2021 at 11:40 AM, V12, Licensed Practical Nurse (LPN), stated that she does not

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S9999	Continued From page 10 know what the leaves on the resident's door mean. V12 stated that she was not aware that the leaves were to indicate who was at fall risk. On 10/19/2021 at 12:39 PM, V7, CNA, stated that R3 fell a lot. V7 stated that R3 had to be watched. V7 stated that R3 would use his call light or yell help. V7 stated that they are understaffed and can't monitor R3 every 30 minutes and are not able to take him to the bathroom every hour. V7 stated that they rely on him to let them know when he needs to go and try to get to him before he tries to transfer himself. V7 stated that when you are in the room and we are short staffed this is not possible. V7 stated that this has happened before and R3 fell. On 10/19/2021 at 1:44 PM, V8, LPN, stated that she was called to R3's room and he was on the floor. R3 stated that she wasn't sure if he was going to or coming from the bathroom. V8 stated that he was assessed on the floor and did not complain of pain but when he got up, he started complaining of pain. V8 stated that she sent him to the hospital. V8 stated that "R3 is someone that you have to answer his light or his yell for help quick or he will try to take himself." V8 stated that R3's confusion is his normal state. V8 stated that she had 2 CNAs on the hall 1 of her CNAs went to lunch, 1 CNA was doing something, and she was passing pills. V8 stated that she doesn't know if R3 is on 30-minute monitoring or to be toileted every hour. V8 stated that they just couldn't get to him quick enough. On 10/20/2021 at 10:39 AM, V10, Primary Physician, stated that if the staff were following the interventions that were put in place, the fall could have been prevented.	S9999		

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S9999	Continued From page 11 On 10/20/2021 at 12:13 PM, V13, CNA, stated that she was assigned to the hall when R3 fell. V13 stated that she returned from break and was told he fell. V13 stated that she asked him what happened and R3 said that he pulled his call light and yelled for help and no one came so he tried to take himself and fell. V13 stated that she repeatedly tells R3 this to keep him from falling. V13 stated that you have to respond to R3's call light quickly or he will fall. V13 stated that she was not aware that staff were to check on R3 every 30 minutes and place him on the toilet every hour. On 10/20/2021 at 2:36 PM V2, DON, stated that she would expect her staff to follow the interventions that were put in place. V2 stated that R3 had a sitter put in place due to his falls and the sitter had to be discontinued. V2 stated that if she had enough staff that she would have continued the sitter as R3 needs to be monitored. R2's Care Plan, dated 08/09/2021, documents "I am at risk for falls. Goal: I will not sustain serious injury through the review date. Interventions 08/09/2021 Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 08/09/2021 Follow facility fall protocol. PT (Physical Therapy) evaluate and treat as ordered or PRN (as needed). Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (Interdisciplinary Team) as to causes." No further updates/revisions were made to R2's fall care plan.	S9999		

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S9999	Continued From page 12 The Facility's Accident and Incident log, dated September 2021, documents R2 had a fall on 09/22/2021 with no injury. It also documents October 2021, R2 had a fall on 10/02/21 with injury. The facility did not provide Occurrence report or investigations for either fall upon request during this investigation. R2's Fall Risk Assessment, dated 08/06/2021, documents R2 is not at risk for falls. R2's Fall Risk Assessment, dated 09/22/2021, documents R2 is at risk for falls. R2's EHR does not document 09/22/2021 fall. R2's EHR, dated 09/24/2021 12:40 AM, documents "Nurses Note, Narrative: (R2) returned from (Local Emergency room) visit via ambulance transport. (R2) appeared in pleasant mood and was cooperative with author's interactions. paperwork received from (local hospital) was noted for no negative findings from lab and diagnostic tests. (R2) was negative for any hip, back or cranial fractures. author advised (R2) to remain seated and to please wait for assistance with any transfers. vitals noted at 116/82 blood pressure 98.4F temperature 92 pulse 93 SPO2 (Pulse Oximetry). No new treatment orders were advised." R2's EHR, dated 09/24/2021 09:34 AM, documents "Nurses Note, Narrative: Resident had c/o (complaints of) nausea without vomiting. NP made aware and received NO (new order) for Reglan 10 mg (milligrams) PO (by mouth) q6 (every 6) hours PRN (as needed)"	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008650	A. BUILDING: _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

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S9999	Continued From page 13 R2's EHR, dated 09/28/2021 3:43 PM, documents "Fall IDT Note Attendees present: IDT members Summary of the fall: resident found on floor between bed and chair after fall. Root cause of fall: resident states she was getting back into bed and her legs got weak and she fell. Intervention and care plan updated: resident to see therapy. R2's Progress Notes, dated 10/02/2021 3:15 PM, documents "Health Status: Late Entry: Note Text: Writer was notified by floor nurse that this resident had been found on the floor in her room at end of her bed, by her wheelchair. Resident was able to tell staff she fell while trying to get up. Nurse states that she remained alert and was orientated to time and place. States that she did hit her head, but it was in the same place that she hit her head last week. One of the CNA's had brought in her clothing and the resident was able to go thru it and decide what she wanted to keep. Resident has been showing signs of confusion for the past week and was noted to be removing her oxygen a lot. Staff did start neuro checks." R2's EHR, dated, 10/04/2021 05:57 AM documents "Transfer to Hospital Summary, Note Text: O2 sat (Oxygen Saturation) 75% on room air. O2 sat fluctuates between 85% and 91%- and 5-liters oxygen via nasal cannula. Nasal cannula switch to face mask, patient continues to de-sat to 85%. Patient cognition severely decreased from the time this RN (Registered Nurse) came on shift at (11:00 PM) 10/03/2021 (confusion with slurred speech). Transport called to take patient to (Local) ER (Emergency Room). Patient transported to (Local) ER at approximately (05:30 AM) on 10/04/2021." R2's EHR, dated 10/04/2021 09:01 AM,	S9999		

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S9999	Continued From page 14	S9999		

documents "Nurses Note Narrative: Spoke with (Local Emergency Doctor) regarding resident. She asked if resident had fallen recently- I informed her that she had in fact fallen 10/02/2021 and it was unwitnessed. I gave a report to MD (Physician) regarding resident, that she is usually AOX3 (alert and oriented to person, place, and time), but at times can be confused. MD informed me that resident had in fact sustained a subdural and subarachnoid bleed and would be sent to Memorial Medical Center. Resident is also confused at ED currently."

R2's (Local Hospital) CT (Computed Tomography) of the Head without Contrast, dated 10/4/2021 9:39 AM, documents "Impression: 1. Subarachnoid hemorrhage overlying the left cerebral hemisphere. 2. Small subdural hematoma layering along the falx cerebrum anteriorly."

R2's (Regional Hospital) Discharge Paperwork, dated 10/11/2021, documents "Hospital Summary: I was in the hospital because of a brain bleed."

On 10/18/2021 at 3:15 PM, V4, CNA, stated that R2 is confused and requires more help than before.

On 10/19/2021 at 12:39 PM, V7, CNA, stated that she took care of R2 prior to falls. V7 stated that when R2 got sick she became weak and needed more help with transfers. V7 stated that R2 went from transferring by herself to needing 2 people to transfer. V7 stated that after R2's fall in September there wasn't nothing new put in place to keep her from falling. V7 stated that R2 was more confused. V7 stated that she had changed.

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S9999	Continued From page 15 On 10/19/2021 at 11:40 AM, V12, LPN, stated that R2 was a needy resident. V12 stated that she would pull her call light and kept her door open so she can see people walk pass. V12 stated that she would yell at staff to come in her room for different things as they walked by. V12 stated that she is not sure what interventions were put in place for R2 after her fall. V12 stated that the residents that are positive for COVID have their doors closed so she wouldn't be able to call for anyone. V12 stated that she is not aware of what the leaf on the resident name plate means. On 10/19/2021 at 1:44 PM, V8, LPN, stated that she was not here when R2 fell but she had taken care of her prior to the fall. V8 stated that R2 is more confused and requiring more assistance than before. On 10/20/2021 at 10:39 AM, V10, Physician, stated that R2 brain bleed was from the fall. V10 stated that he is not sure about the fall but that the facility monitored the resident and notified the physician when resident started to show changes. The Facility's Fall Prevention Program, Revision date 11/21/2017, documents "Purpose: 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. It also documents Fall/safety interventions may include "Call lights are answered promptly." It continues "In the event safety monitoring is initiated for 15-30-minute periods, a documentation will be used to validate observations."	S9999		

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S9999	Continued From page 16 (A)	S9999		