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
	IL6002059	A. BUILDING: _____ B. WING _____	C 04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE OAK LAWN	9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453

(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 #219329/IL132487	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.610a 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. 300.1210b) 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. 300.1210d)6)	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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 Regulations are not met as evidenced by: Based on interview and record review this facility failed to develop fall/safety prevention interventions to ensure the bed remained in the low position while occupied for 2 of 3 residents (R1 and R2) reviewed for fall prevention interventions. This failure resulted in R1 falling from the bed while in the highest position and being transported to the local hospital and treated for an opened, bleeding dehiscence wound to left above the knee amputation. Findings Include: R1 was admitted with the diagnosis of Dementia and Complete Left Traumatic Amputation at the Knee. R1's fall assessment dated 3/8/21 documents: fall risk due to intermittent confusion, chair bound medication use and diagnosis. On 4/20/2021 at 10:05am, V4 (nurse) said, R1 was a high fall risk due to R1's amputation. I'm not sure what fall intervention that was in place. R1 was sitting on the side of the bed. R1 did not want to lie down in bed. R1 was anxious about going home. R1 slid off the bed. R1 hit the floor with her stump. R1's stump opened up. I couldn't stop R1's stump from bleeding. I discharged R1 to the hospital.	S9999		

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S9999	Continued From page 2 On 4/20/2021 at 10:56am, V5 (Nurse) said, R1 was alert with periods of confusion. R1 was a high fall risk. R1 was non-compliant with everything. R1 tried to make unassisted transfers. I heard R1 fall. R1 was observed with an open stump with some bleeding after the fall. On 4/20/2021 at 12:47pm, V8 (cna) said, R1 liked to raise her bed up to the highest position. R1 kept raising the bed to the highest position the night she fell. When I entered, R1's room after the fall, R1's bed was in the highest position. On 4/20/21 at 1:20pm, V1 (DON) said, R1 would attempt to put her legs out the bed. R1 could raise the height of the bed. R1 had periods of confusion. R1 likd to sit side of the bed. R1's care plan dated 3/9/21: R1 is at risk for falls due to impaired thought process and below knee amputation. Intervention: Call light in reach and bed height where feet touch the floor. R1 fall incident dated 3/21/21 documents: R1 had an unwitnessed fall from the bed. R1 was observed on the floor sitting upright. R1 had new injuries to left stump, staple loosen but in place, moderate amount of bleeding from stump, wrapped with towel to stop the bleeding. 911 called. R1 was transferred out to hospital. Predisposing Physiological/situation Factors: R1 had gait imbalance, left below the knee amputation and R1 was sitting. Emergency department diagnosis dated 3/21/2021 documents: R1 had a fall from bed with some bleeding: Diagnosis: Wound Dehiscence (wound separation were the edges no longer meet).	S9999		

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S9999	Continued From page 3	S9999		

R2's brief interview for mental status dated 3/18/21 documents a score of six with indicated servere cognitive impairment. R2's fall assessment date 2/8/21 documents: fall risk due to intermittent confusion, chair bound, medication use and diagnosis.

On 4/16/2021 at 12:36pm, Surveyor observed, R2 in bed. R2's bed was in the highest position. R2 did not have a fall mat on the floor while in bed.

On 4/16/2021 at 12:52pm, Surveyor observed, V2 (Director of Nursing/DON), lowering R2's bed. V2 said, we told R2 we have to keep the bed in the lowest position.

On 4/16/2021 at 1:08pm, V2 (Director of Nursing) said, R2 is at high risk for fall with a history of falls. Interventions are put in place to prevent future falls. R2's bed was not in the lowest position nor was the fall mat in place. R2 is on the falling leaf program. The falling leaf program is for residents with a history of falls, had one fall in the facility and education was not appropriate. R2 should have had fall mats in place and the bed should have been in the lowest position. R2 has a care card that will inform the staff of what intervention we put in place after a fall. R1 was a fall risk. R1's intervention was to keep the bed in the lowest position and call light within reach. R1's staple came loose on the amputation site/stump. R1 was discharge to the hospital due to the amputation site bleeding.

On 4/16/2021 at 3:14pm, V9 (Administrator) said, R2's bed was up. V2 (Director of Nursing) corrected the problem. It is not a chronic issue. Staff use residents care cards for fall interventions.

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S9999	Continued From page 4 R2's fall incident dated 2/8/21 documents: R2 had an unwitnessed fall on 2/8/21. R2 was noted in side lying position beside bed. Predisposing Physiological Factors: Impaired memory, decline in cognitive skills and incontinent. Interventions: bed in the lowest position and fall mat while in bed. R2's care plan dated 2/8/21 documents: R2 is a risk for falls. R2's bed to be in the lowest position and floor mats in place when resident is in bed. R2's care card documents: R2 bed in the lowest position, floor mat when in bed. Fall Prevention Program dated 11/28/21: The program will include measures which determine the individual needs of each resident by assessing the risk of fall and implementation of appropriate interventions. Safety will be implemented for each resident identified at risk. B	S9999		