STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008015	A. BUILDING: _____ B. WING _____	C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MARSEILLES	578 WEST COMMERCIAL STREET MARSEILLES, IL 61341

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S 000	Initial Comments Facility Reported Incident of 5/24/21/ IL134562	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to complete a fall investigation and fall risk assessment and review and revise fall interventions following an unwitnessed fall for one (R1) of three residents reviewed for falls. These failures resulted in R1 experiencing a subsequent fall resulting in a right hip fracture.	S9999		

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S9999	Continued From page 2 Findings include: The facility Fall Prevention Program, revised 12/20/20, documents the following: "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." This same policy documents, "The Fall Prevention Program includes the following components: Methods to identify risk factors. Methods to identify residents at risk. Assessment time frames. Use and implementation of professional standards of practice. Notification of physician, family/legal representative. Communication with direct care staff members. Documentation requirements. Care plan incorporates: Addresses each fall. Interventions are changed with each fall, as appropriate. Preventative measures." This policy also documents, "A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions." R1's quarterly MDS (Minimum Data Set) Assessment, dated 4/7/21, documents R1 is severely cognitively impaired and requires extensive assistance of staff for dressing, toileting, personal hygiene, bathing, and walking. This assessment documents that R1 requires limited assistance of staff for bed mobility, locomotion on and off unit, and with eating. This assessment also documents R1 is frequently	S9999		

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S9999	Continued From page 3 incontinent of bladder and occasionally incontinent of bowels and has a history of falls. R1's Current Care Plan, documents R1 has had "falls with minor injury related to rolling out of bed while attempting to change her clothing on 5/17/20, 5/26/20, and 5/26/20. This same Care Plan documents R1 had a fall on 4/11/21, 4/14/21, 5/11/21, 5/12/21, and 5/15/21. The Fall Risk Assessments for R1, dated 4/9/21, 4/11/21, 4/14/21, 5/11/21, 5/12/21, and 5/15/21 documented scores between 15 through 24, all indicating and documenting R1 is "At risk for falls." On 6/10/21 at 2:40 pm, V2 DON (Director of Nursing) stated she does all the fall investigations at the facility. V2 stated if a resident falls, the Nurse is to assess the resident, start the initial fall report, document it in the resident's Progress Notes, make the notifications and send the initial report to State Agency if there is an injury. V2 stated the Nurses are to call her if a resident has a fall and if there is an injury, she will notify V1, Administrator. V2 also stated all resident falls are discussed in the morning meeting and interventions are put into place and placed on the resident's care plan by herself or the Care Plan Coordinator. 1. The Progress Notes for R1, dated 5/24/21 at 4:00 am, documents "Resident (R1) observed laying on the floor with a pillow on her head. This nurse asked resident if she put herself on the floor. She responded by saying, 'I don't know.' Resident was put back to bed with 2 persons assist. Will continue to monitor resident on this shift." R1's Progress Notes do not contain any further documentation, body assessment, fall	S9999		

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S9999	Continued From page 4 assessment, or follow up documentation for R1's fall. R1's EHR (Electronic Health Record) does not include a follow up assessment, new Fall Risk Assessment, Care Plan review or revision, Neurological assessments post fall, required notifications, or Un-Witnessed Fall Report. On 6/10/21 at 1:25 pm, R6 stated (R1) was her roommate and fell quite a few times. R6 stated, "The last time she (R1) fell in our room, I was sleeping, it was dark out. I heard her hit the floor and woke up. I saw her near the end of the bed and she was trying to crawl back towards her bed. I hollered for the staff. They came real quick and put her back to bed. (R1) fell again later that morning and broke her hip but I didn't see that one." On 6/11/21 at 1:55 pm, V2, DON, stated she did not know that R1 had fallen on 5/24/21 at 4:00 am until now. V2 confirmed the night Nurse who discovered R1 had fallen at 4:00 am should have followed the fall protocol, initiated the fall investigation report and made the necessary notifications. V2 also stated she did not do an investigation for this fall because it wasn't reported to her and she was unaware. 2. The facility's Un-Witnessed fall Report #943 for R1's 5/24/21 fall at 7:20 am was initiated by V3, RN. V3 documented, "I was called to residents' room due to resident was sitting on her left buttock with her back against the side of the bed. No complaints to me regarding any pain at the time. Upon doing range of motion, she complained about right sided pain. This is being considered an un-witnessed fall but due to her position. She did not hit her head. Resident	S9999		

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S9999	Continued From page 5 unable to give description. ROM (range of motion) appeared adequate except some pain when raising right leg. Placed in bed. No injuries observed at time of incident." A Late Entry Progress Note for R1 (dated 5/24/21) documented by V3 RN, documents, "Resident (R1) had an un-witnessed fall 5/24/21 7:20 am. (R1) unable to say what happened. Assessment: Un-witnessed fall, neurological checks initiated. Alert and disoriented per usual baseline. No changes in range of motion from normal baseline. No injuries observed. Actions Taken: assisted into chair, after consultation with Hospice and family it was decided to send her to ER (Emergency Room) for evaluation." The Progress Note for R1, dated 5/24/21 at 1:39 pm (in reference to R1's 7:20am fall) by V3 RN, documents, "Was called to resident room by CNA to observe resident sitting on her left buttock on the floor in front of bed with her back resting against the side of bed. There was nothing she could have hit her head on. It appears she slid out of bed onto her buttock. Neuro (neurological) checks was within normal limits. No complaints of pain at this time. ROM was within normal limits for this resident. Placed resident in bed." The Progress Note for R1, dated 5/24/21 at 1:54 pm by V3 RN, documents, "Hospice nurse arrived at 11:00 am. Spoke to Hospice, MD (Medical Doctor) and family about sending resident to (local hospital) for X-ray of right hip and pelvis. EMS (Emergency Medical Service) notified and took resident to Hospital. Resident left building at 12:05 pm." The Progress Note for R1, dated 5/24/21 at 2:07 pm by V2 DON, documents, "Received call from	S9999		

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S9999	Continued From page 6 Hospice nurse stating that resident will be revoking Hospice at this time and will be admitted to the hospital due to right hip fracture." On 6/10/21 at 3:00pm, V3 RN (Registered Nurse) stated V6, CNA (Certified Nursing Assistant), called her to R1's room early in the morning on 5/24/21 because R1 was on the floor. V3 stated R1 was sitting on the floor with her back to the bed and was leaning to her left side. V3 stated she did a body assessment and there was no left leg swelling, no left leg bruising or left leg rotation and R1 did not complain of any pain at the time and her vital signs were good. V3 stated she, V5, CNA and V6, CNA got R1 up off the floor and put her into bed Later in morning, V5 and V6 got her up into a reclining wheelchair and took her to the dining room. V3 stated when the Hospice Nurse came to the facility around 11:00 am, she (V3) went with her to the dining room to check on R1. V3 stated at that time noticed R1's right leg rotating outward and R1 was complaining of right hip pain. V3 stated Hospice called R1's family and the decision was made to send R1 to the local hospital for an X-ray. V3 stated she received a call from Hospice later in the day that R1's right hip was fractured. V3 also stated there were no other incidents for R1 that day that were reported to her. On 6/11/21 at 11:11 am, V6, CNA stated she was working on the dialysis hall that day and was not involved with R1's fall, did not see R1 on the floor, and does not know anything about R1's fall. On 6/11/21 at 1:09 pm, V4 CNA stated she saw R1 in bed during her 6:00 am rounds when she first got to work but didn't see her again until after she fell. V4 stated she was in another resident room providing am cares at the time of R1's fall.	S9999		

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S9999	Continued From page 7 She stated V6, CNA found R1 on the floor and notified V3, V5 , CNA helped get R1 off the floor into bed. The facility's Final Investigation report for R1, dated 5/28/21, documents on 5/24/21 at 7:20 am "(R1) was observed on the floor beside her bed. No initial complaint of pain. Assessed by nurse and assisted into chair. About 30 minutes later she began to complain of right hip pain. Examination in ER (emergency room) revealed a nondisplaced fracture of right hip. Surgery was performed. Care plan was reviewed, and interventions added to increase monitoring while in bed at night." On 6/11/21 at 1:55 pm, When V2, DON, was asked about how she investigated this fall she stated, "I talked with all the staff that work the unit, the roommate, and other residents or staff. I don't write up the interviews of the people I talk to." V2 stated she puts the summary into the Fall Report and on the Final Reports that are sent to the State Agency. V2 stated R1 was found on the floor at 7:20 am and there were no other staff or resident interactions. V2 confirmed V3 RN, V4, V5, and V6, CNAs, worked the unit on 5/24/21. V2 stated she doesn't know why she did not list V4 and V5 CNAs on the Fall report and does not know why V6 is saying she doesn't know anything about R1's fall. V2 also stated she had added to increase monitoring while in bed at night because the nurses work 12 hour shifts, 7:00 am to 7:00 pm. V2 stated she was not aware of R1's previous fall at 4:00 am, does not know what happened, and does not know if something else may have occurred between R1's 7:20 am fall and 12:05 pm when Hospice arrived at the facility and right hip rotation was seen and R1 complained of right hip pain.	S9999		

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