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
	IL6004147	A. BUILDING: ______ B. WING ______	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PEORIA HEIGHTS	1629 GARDNER LANE PEORIA HEIGHTS, IL 61616

(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: 2129078/IL141064	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b)4) 300.1210 b)5) 300.1210 c) 300.1210 d)6) 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 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	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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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 resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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.

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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 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure two staff assisted with a mechanical lift transfer (R5). The facility failed provide supervision to prevent falls (R6), investigate each fall to determine the root cause analysis, and implement appropriate interventions after a fall (R6), for two of three residents (R5, R6) reviewed for falls in the sample of seven. These failures resulted in R5 being dropped out of a mechanical lift sling onto the floor, fracturing R5's left humerus (bone between elbow and shoulder) that caused R5 pain and R6 falling while unsupervised in R6's room that resulted in R6 fracturing R6's right talus (bone in foot that forms part of the ankle joint).

Findings include:

The Facility's Fall Prevention Program dated 11/21/17, states "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine

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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. 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. The Director of Nursing is responsible for monitoring the Fall Prevention Program. Residents who require assistance will not be left alone after being assisted to bathe, shower, or toilet. This policy is a guideline only. Each resident has his or her own set of circumstances which may require that this policy not be followed. The needs of each resident supersede this policy."

The Facility's Transfers-Manual Gait Belt and Mechanical Lifts policy dated 1/19/18, states "In order 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. The transferring needs of residents will be assessed on an ongoing basis and designated into one of the following categories: Independent, 1-person transfer, 2-person transfer (ONLY when use of mechanical lift is not possible, sit to stand lift with 2 caregivers, and Mechanical lift with 2 care givers. Failure to comply with lifting guidelines may result in disciplinary action as deemed appropriate.

1. On 12/8/21 at 11:30 a.m., R5 was lying in bed with a sling on the left arm. R5 stated "I have a broken arm because I was dropped." R5 stated (V10 Certified Nurse Aide/CNA) was transferring R5 from the wheelchair to bed and the "next thing I knew I was on the floor. I was sent to the

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S9999	Continued From page 4 hospital, but I don't think I was admitted. My family and I declined surgery because of my age. I have been in terrible pain in my left arm and shoulder area. The nurses give me pain medications, but it just doesn't last long enough." R5's Minimum Data Set assessment dated 11/10/21 document R5 has severely impaired cognition. R5's Care Plan dated 11/16/21, documents R5 is total assist of two staff for transfers. R5's Fall Report dated 12/2/21 at 9:00 p.m., documents the following: R5 was being transferred to bed by V10 (Certified Nurse Aide) via full mechanical lift when a strap came loose by R5's left shoulder and R5 fell to the ground landing on R5's left side. V14 (Licensed Practical Nurse) assessed R5 and found R5 had pain and swelling at the left shoulder area. R5's Physician ordered an urgent X-ray which showed a humeral surgical neck fracture. R5's Shoulder X-Ray dated 12/2/21 at 4:18 a.m., states "Acute mildly displaced fracture of the left proximal humeral surgical neck." R5's Emergency Department Physician Note dated 12/3/21 at 3:51 a.m., states "(R5) complaining of left shoulder, elbow and wrist pain." R5's Final Report to the State Agency dated 12/9/21, documents (in addition to above fall report) "(R5's) family refused any surgical intervention and (R5) was returned to the facility. (R5) is to wear a sling to left arm at all times and pain management is in place. Staff re-educated on full mechanical lift procedure and ensuring all	S9999		

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straps of (mechanical lift) sling are secure prior to starting transfer. Facility (mechanical) lifts and slings were checked for any mechanical issues and safety (with no concerns identified)."

On 12/8/21 at 12:55 p.m., V14 (Licensed Practical Nurse) stated "I was (R5's) nurse working 6 p.m. to 6 a.m. on 12/2/21 when V10 (Certified Nurse Aide) dropped (R5) out of the (mechanical lift). I was passing medications down the opposite end of the hall from (R5's) room when (V10) came to me and reported that (R5) had shoulder pain. I told her I would be headed to (R5) soon and to tell (R5) I would bring (R5) pain medicine. I asked (R5) what was going on. (R5) told me that (R5's) shoulder hurt and that (R5) had fallen. Then (V10) started telling me that (R5) fell on the floor because the (mechanical lift) sling fell off the loop/clip. I educated (V10) that all (mechanical lift) transfers are to be done with a minimum of two staff assist."

V10's statement regarding R5's fall from the mechanical lift on 12/2/21 documents the following: V10 transferred R5 from the wheelchair to bed with a mechanical lift and no other staff assistance. R5's sling loop slipped off the hook and R5 fell to the ground with V10 trying to catch R5, V10 fell on top of R5. V10's statement does not document any further details.

On 12/13/21 at 1:43 p.m., V10 stated (via telephone interview) that she could not give any details of R5's fall on 12/2/21 until her union told her it was okay to do so.

On 12/9/21 at 11:12 a.m., V2 (Director of Nursing) stated V10 (CNA) did transfer R5 with a mechanical lift by herself when R5 fell from the mechanical lift on 12/2/21, and the facility policy is

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that all mechanical lift transfers require a minimum of two staff assist.

On 12/14/21 at 10:37 a.m., V2 stated "My investigation of (R5's fall on 12/2/21) documents that (V10) transferred (R5) by herself. (V10) was terminated (12/13/21)."

2. On 12/8/21 at 12:40 p.m., R6 was propelling self in a wheelchair by using R6's feet, from R6's room to the dining room for lunch. R6's right leg/foot had a hard plastic boot in place.

R6's Minimum Data Set assessment dated 11/11/21, documents R6 was admitted on 11/4/21, has moderately impaired cognition; requires extensive assistance with transfers; is unable to ambulate; uses a wheelchair; and R6 has an unsteady balance moving from seated to standing position and surface to surface transfer.

R6's Care Plan dated 11/16/21, documents R6 is at high risk for falls related to deconditioning, gait/balance problems, incontinence, and being unaware of her safety needs.

R6's Fall Report dated 11/5/21 at 11:55 a.m. documents the following: R6 had an unwitnessed fall in R6's bathroom. R6 stated R6 thought R6 could go to the bathroom by self and ended up on the floor. R6 had no injury. Immediate intervention was to educate R6 to use the call light and wait for help.

R6's Fall IDT (Interdisciplinary Team) note dated 11/8/21 at 10:57 a.m., states "The root cause of R6's fall (on 11/5/21) was transferring without assistance. New Intervention and care plan updated. (R6) receiving (Physical and Occupational) therapy."

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R6's Fall Report dated 11/12/21 at 2:15 p.m., documents the following: R6 had an unwitnessed fall in R6's room and was found sitting next to R6's bed. R6 stated R6 dropped R6's phone and leaned over to pick it up and fell forward out of the wheelchair. R6 did not have any injuries. A Reacher was provided to R6 and R6 was educated on its use and to use the call light for assistance.

R6's Fall IDT note dated 11/15/21, states "The root cause of fall (11/12/21 at 2:15 p.m.): Leaning too far forward in (wheelchair). Intervention and care plan updated: (R6) was given a Reacher to utilize for picking things up off the ground."

R6's Fall Report dated 11/13/21 at 6:30 a.m., documents the following: R6 had an unwitnessed fall in R6's bathroom. R6 stated "I couldn't wait for help to come, I did it myself." R6 had no injuries. New interventions: Laboratory orders received and encouraged (R6) to stay in supervised area when up in wheelchair. V20's (Certified Nurse Aide) statement on the fall report states "I was getting (R6) up and I took (R6) to the bathroom (and) I went to get assistance with (R6's) transfer to the toilet. When I came back (R6) was on the floor in the bathroom face down. (R6) did not call for help."

R6's fall IDT note dated 11/15/21, states "Root cause of fall (11/13/21 at 6:30 a.m.): (R6) attempting to use bathroom and transfer without staff assistance. Intervention and care plan updated: Staff to offer toilet (every two) hours."

On 12/14/21 at 11:57 am., V2 stated "I must have missed (V20's) statement (on R6's Fall Report dated 11/13/21) because the intervention we put

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in place was not appropriate. V2 stated a more appropriate intervention would have been not to leave R6 alone in the bathroom. V2 stated R6 must be supervised because she is very confused and forgets that she is not independent.

R6's Physician Note dated 11/17/21 at 3:26 p.m., documents R6 was seen by the physician who noted R6 had several falls attempting to self-transfer since admission. R6's physician stated R6's lab work was negative with a plan to "Monitor (R6)."

R6's Fall Report dated 11/19/21 at 7:00 p.m., documents the following: R6 had an unwitnessed fall in R6's room. R6 was heard yelling from the room and R6 was found lying on floor, abdomen side down, near the dresser and wheelchair. R6 stated R6 was trying to reach for something, but R6's vision was poor, and misjudged the distance. R6 stated R6's ribs hurt and R6 did hit R6's head and it was also sore. R6 was sent to the hospital for evaluation.

R6's Hospital X-Ray report dated 11/19/21 at 10:03 p.m., states "Impression: Suspect acute Talar fracture."

R6's Hospital Physician Note dated 11/19/21 at 11:21 p.m., states "Clinical Impression: 1. Other fracture of right talus 2. Head contusion 3. Fall."

R6's Nurses Note dated 11/20/21 at 8:32 a.m., states "(R6) returned to the facility via (ambulance) stretcher. (R6) sent to the hospital on 11/19/29 related to a recent fall, rib pain, ankle pain. (R6's) diagnosis is fracture of right talus and head contusion. (R6) complaining of pain at this time, rating pain (at 7 out of 10 on the pain scale)."

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S9999	Continued From page 9 R6's Fall Report dated 11/21/21 at 3:22 a.m., documents the following: R6 had an unwitnessed fall and was found lying on the floor in R6's room next to the bed. R6 reported R6 was sleeping in R6's bed when R6 suddenly rolled out of bed and landed on the floor. R6 had no injuries. On 12/14/21 at 10:37 a.m., V2 stated there is not a Fall IDT note or documented investigation with root cause analysis and updated interventions for R6's falls on 11/19/21 and 11/21/21 falls. V2 stated "we missed them for some reason." R6's Fall Report dated 11/26/21 at 5:35 p.m., documents the following: R6 had an unwitnessed fall in R6's room. R6 was calling for help and was found lying on the left side, head near bed, legs toward door, oxygen off but right next to face. R6 had no injury. Immediate Intervention that "(R6) will be the last one up and first one to bed around mealtime." R6's Fall IDT note dated 11/29/21, states "The root cause of fall (11/26/21 at 5:35 p.m.): non-compliance with staying in dining room and went to room attempting to pick up something off the floor while in (wheelchair). Intervention and care plan updated: will be taken to dining room for meals close to mealtime as resident agrees to." R6's Fall Report dated 11/27/21 at 11:25 a.m., documents the following: R6 had a witnessed fall in her room. R6 was observed to be sitting on buttocks with back against the bed and legs extended forward. R6 stated "I didn't fall. I just slid off the bed." There was no witness statement with this report.	S9999		

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R6's Fall IDT note dated 11/29/21 at 10:12 a.m., states "Root cause of fall (11/27/21 at 11:25 a.m.): (R6) had sock with no shoes on. Intervention and care plan updated: (R6) to have proper footwear on at all times when not lying in the bed."

On 12/8/21 at 12:30 p.m., V18 (Licensed Practical Nurse) stated "(R6) is usually not a problem with falls when R6 is in bed, it's usually when R6's in the wheelchair and reaching for things on the floor. We have given R6 a grabber to use due to R6's poor balance. We try to keep R6 in sight at all times unless R6's in bed but R6's quick and sometimes gets past us. V18 stated R6 did recently have a fall that resulted in a fracture (right Talar) and now is wearing a boot on R6's right foot."

On 12/8/21 at 12:15 p.m., V17 (Certified Nurse Aide) states R6 is wearing a boot on the right foot due to a fracture received from falling. V17 stated R6 likes to pick things up off the floor. V17 states R6 is confused and doesn't remember that R6 has poor balance. V17 stated staff gave R6 a Reacher/grabber to use but R6 still will lean over and try to pick something up off the floor.

On 12/9/21 at 11:13 a.m., V2 (Director of Nursing) stated R6 "Likes to pick stuff up off the floor. We've given R6 a Reacher. R6 has poor balance. I've implemented a lot of interventions, but R6's still had quite a few falls. R6 is non-compliant and confused. R6 forgets that R6 needs help. R6 did have a fall that resulted in a Talar fracture. R6 had taken self back to R6's room and fell. I don't know what else I can do to keep R6 from falling."

"A"

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