STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006829	A. BUILDING: _____ B. WING _____	C 02/08/2022

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APERION CARE HILLSIDE	323 OAKRIDGE AVENUE HILLSIDE, IL 60162

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S 000	Initial Comments Complaint Investigation 2290796/IL142982	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. 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. These requirements were not met as evidenced by: Based on observation and interview, the facility	S9999		

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S9999	Continued From page 2 failed to implement a plan of care with fall prevention interventions to include frequent monitoring and supervision for 2 of 3 residents (R1 and R2) with cognitive impairments both reviewed for fall prevention interventions. This failure resulted in R1 falling and sustaining a minimum displaced transverse mid radius shaft fracture. Findings include: A. R1 is 85 years old with diagnoses including but not limited to vascular dementia, history of falling, schizoaffective disorder, bipolar type, paranoid personality, restlessness and agitation, and anxiety disorder. R1's cognitive assessment score dated 1/12/22 is a 6, indicating severely cognitively impaired. R1's hospital history documents on 10/23/22 R1 was in the facility for one day and R1 fell out of her wheelchair. R1 was observed on 2/6/22 in her bed at 9:55AM. R1 stated, "My arm is broken. I can't use it." R1 stated she fell. R1 was unable to explain the circumstances of the fall or when it occurred. R1 pointed to her left arm and wrist when she said her arm was broken. Surveyor observed R1's left hand and upper arm. R1's sweater wrapped around her right lower arm. On 2/6/22 at 10:48AM V14 (Certified Nursing Assistant/CNA) stated R1 has mood swings and lacks patience. V14 said staff assist R1, and R1 can walk when she wants to. V14 stated, "R1 has a brace on her left wrist right now, so we have to help her." On 2/6/22 at 12:38PM V5 (Licensed Practical Nurse/LPN) stated, "If a resident is at risk for falls, we will usually use a low bed, we use	S9999		

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S9999	Continued From page 3	S9999		

non-skid socks on the residents, make sure call bell is always in reach, and do close monitoring." V5 stated close monitoring is done more often than the standard monitoring of every 2 hours.

On 2/6/22 at 12:56PM V2 (LPN) stated she was assigned to R1 today (2/6/22). V2 stated R1 can be independent with walking, but R1 has unsteady gait and balance.

On 2/6/22 at 1:30PM V1 (Administrator) stated on 1/10/22 R1 was trying to go to the bathroom. V1 stated R1 will try to independently take herself to the bathroom, and R1 will sometimes use the call light. V1 stated on 1/10/22 the call light was not on. V1 stated, "After investigating the fall we found that the wheelchair locks were not in place." V1 stated R1 slipped trying to get from the bed into her wheelchair to get to the bathroom. V1 stated the fall follow up intervention was to reorient R1, give her education on locking the wheelchair, and to call for help when she wants to get out of bed. Per record review, R1 had no injury related to this fall.

V1 stated regarding R1's fall on 1/12/22 R1 was only wearing regular socks because she had been refusing to wear shoes. V1 stated R1 fidgets often and had been seen fidgeting with the buckle on her wheelchair cushion. V1 stated, "On 1/12/22 R1 was assisted to the bathroom around 1:30PM, I took her around 2:30PM, and the fall occurred at 4:03PM." V1 stated R1 had falls with injuries at home prior to her admission to the facility. V1 stated R1 should still be on 2 hour monitoring by staff. V1 stated R1 was taken to the hospital for evaluation immediately after assessment. V1 stated R1's cognitive assessment score of 6 indicates she is not cognitively intact. While reviewing R1's cognitive

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assessment with the surveyor, the surveyor asked V1 if R1 has memory recall for reminders. V1 stated, "No."

On 2/7/22 at 10:51AM via phone interview V6 (Registered Nurse/RN) stated R1 was noncompliant with care instructions on 1/10/21. V6 stated, "R1 moves according to her whim, R1 is forgetful and does not remember things we tell her. R1 is inpatient and does what she wants." V6 stated when R1 fell R1 was on the COVID unit. V6 stated a CNA is assigned that unit, but they {CNAs} are in and out of the rooms.

On 2/6/22 surveyor observed that the COVID unit is not visible from nurses' stations. V6 stated following R1's fall she told R1 to always use the call light as the new intervention.

On 2/7/22 at 11:36 AM V7 (LPN) stated on 1/12/22 when he saw R1 on the floor, R1 had no shoes on. V7 stated R1 had gait imbalance before her fall, and she said she needed to use the bathroom. V7 stated R1 is always agitated, same as before, and she always needs something.

R1's Fall Risk Assessment date 11/12/21 documents "At risk for falls." This is the only Fall Risk Assessment in R1's record provided to surveyor.

R1's Cognitive Assessment dated 12/31/21, section C, documents R1 not able to recall 3 of 3 questions asked during the assessment. R1's total score is 6 out of 15.

R1's Functional Status Assessment dated 12/31/22, section G, documents R1 requires extensive 1 person assistance for transfer

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S9999	Continued From page 5 between surfaces, walking in the room, dressing, toilet use, and personal hygiene. R1 is only able to stabilize balance with staff assistance. R1's Cognitive Assessment completed on 1/12/22 for section C is the same as on 12/31/22. Review of R1's progress notes from 1/10/22 to 1/12/22 do not include documentation that R1 was noncompliant with cares or interventions. R1's fall notes dated 1/10/22 documented by V6 (RN) document R1 found on floor. Immediate Action Taken educated and reiterate to R1 to always keep wheelchair locked. R1's fall notes dated 1/10/22 at 4:03PM documented by V7 (LPN) document R1 said that she was trying to use the bathroom, but her wheelchair cushion caused her to lose her balance. Review of R1's care plan on 2/7/22 did not include interventions to prevent R1 from falling after investigation of her falls on 1/10/22 and 1/12/22. The facility was unable to provide the surveyor with a copy of the care plan. No documentation was found to address the wheelchair cushion investigated as a cause for the fall. No documentation was provided that R1 was refusing to wear her shoes. R1's Hospital Radiology report exam dated 1/12/22 documents indication patient fell from wheelchair, pain in left arm. Conclusion: Minimally displaced transverse mid radius shaft fracture. B. R2 is 63 years old with diagnoses including but not limited to schizoaffective disorder, bipolar type, polydipsia, urinary tract infection, anxiety	S9999		

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S9999	Continued From page 6 disorder, unspecified dementia, history of falling. On 2/6/22 at 9:59AM the surveyor observed R2 to ambulate out of the bathroom and return to her bed. On 2/6/22 at 10:48AM V4 (CNA) stated R2 is independent with toileting and walking. On 2/6/22 at 2:37PM V8 (LPN) stated on 1/25/22 one of the CNAs told V8 that R2 went to the bathroom and then fell in the bathroom. V8 stated after she assessed R2 she left the room and then R2 fell again at the bedside. V8 stated R2 had been seen frequently before the first fall because R2 kept coming out of the room. V8 stated the second time R2 fell on 1/25/22 was not more than 35 minutes after the first fall. V8 stated R2 was changing herself because she had been incontinent of urine and lost her balance. V8 stated R2 was being treated for a urinary tract infection when V8 worked on 2/2/22 which can make a resident have increased urinary urgency and change their mental status. V8 stated R2 is able to walk independently and can toilet herself. On 2/6/22 at 2:57PM V1 (Administrator) stated R2's falls are related to her behavior of polydipsia resulting in R2's sodium levels changing. V1 stated R2 is noncompliant with her care. V1 stated following R2's fall on 1/25/22 the intervention was to reinforce R2's fluid orders and draw labs. V1 stated, "I expect staff to follow policies." On 2/7/22 at 11:36 AM V7 (LPN) stated R2 is independent with her toileting needs and he is not aware of R2 having any behaviors. R2's Fall Risk Assessment date 1/25/22	S9999		

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documents R2 is "not at risk for falls." This is the only Fall Risk Assessment provided to the surveyor.

R2's Cognitive Assessment dated 1/14/22, section C, documents R2 not able to recall 2 of 3 questions asked during the assessment. R2's total score is 10 out of 15, indicating impaired cognition.

R2's Health Conditions Assessment dated 1/14/22, section J, documents R2 has had a prior fall.

R2's Functional Status Assessment dated 1/14/22, section G, documents R2 requires limited assistance of 2 persons for transfer between surfaces and limited assistance walking and dressing. R2 requires extensive assistance with personal hygiene.

R2's care plan initiated on 7/2/20 documents R2 is low risk for falls related to ability to self ambulate. Intervention initiated on 2/15/20 documents to follow facility fall protocol. Care plan initiated on 2/15/20 documents R2 has cognitive deficit related to short term memory issues.

R2's care plan revised on 10/29/21 documents R2 had an actual fall on 5/13; 7/5/20; 8/6/20; 8/19/20; and 12/8/20. January 2022 falls were not included, and no interventions were updated following a fall which occurred on 1/6/20.

R2's care plan initiated 12/28/21 documents R2 requires assistance to dress upper and lower body due to dementia and weakness.

Interventions initiated on 10/29/21 document R2

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S9999	Continued From page 8 requires assistance with dressing, personal hygiene, toilet use, and transfers. R2's Progress Notes dated 1/3/22 document R2 got up from toilet but felt dizzy and fell. No care plan intervention was listed. Facility Fall Prevention Program policy, effective date 11/28/12, documents as follows: 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. Guidelines: The Fall Prevention Program includes: Care plan incorporates: address each fall; intervention are changed with each fall, as appropriate. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall. Footwear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid. (B)	S9999		