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 03/04/2022

NAME OF PROVIDER OR SUPPLIER: APERION CARE OAK LAWN

STREET ADDRESS, CITY, STATE, ZIP CODE: 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: 2290774/IL142962 2290938/IL143165 2291471/IL143859 Facility Reported Incident of January 13, 2022/IL142864 Facility Reported Incident of January 25, 2022/IL143459	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610 a) 300.1210 d)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 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: 3) Objective observations of changes in a	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

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 03/04/2022

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
S9999	Continued From page 1	S9999		

resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to follow their pain policy by not reassessing and documenting a new onset of pain, administrating and documenting pain medication for one (R1) of three resident reviewed for pain management. This failure resulted in ineffective pain management for R1. R1 said R1experienced pain 10/10 for over 3.5 hour after rolling from the bed and sustaining a right femur fracture.

The findings include:

R1 was admitted to the facility on 11/10/20 with a diagnosis of paraplegia, assault by shotgun, hypertension, and vascular dementia without behavioral disturbances. R1's brief interview for mental status score dated 11/21/21 documents a score 15/15 is which indicates cognitively intact.

R1's progress note dated 1/24/22 at 5:56pm: Resident complaints of pain and crackling sound to right knee upon lifting leg. No swelling noted at this time. Pain medication given. V19 (MD) notified.

R1's progress note dated 1/25/22 at 9:35am documents: Resident stated to writer (V2 Director of Nurses/DON) that R1 had a fall in R1's room, the evening of 1/24. Resident reported that R1

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 03/04/2022

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
S9999	Continued From page 2	S9999		

was sleeping and attempted to roll over in bed and rolled too far. Resident stated that R1 got self off the floor, back into bed, and transferred self in to R1's wheelchair. Resident, then went to nursing station to report complaints of pain. Head to toe assessment performed, ROM performed, all extremities moved within normal limits, with a complaint of pain to right knee. Resident rates the pain 10/10. NP (Nurse Practitioner) contacted and informed resident compliant. Order received for x-ray of right hip, femur, tibia, and fibula. Order placed with local x-ray company.

R1's hospital record dated 1/25/22 documents: Resident reports last night R1 was experiencing neuropathic pain in the right thigh and angled self near the edge of the bed and slept on R1's left side to alleviate R1's pain. This morning R1 woke up on the ground with pain to right lower extremity. R1 is unsure of how R1 fell to the ground but believes R1 fell off the bed. Patient notes that trauma was focused over right lower extremity and denies head or losing consciousness. Patient was able to pull self off the ground, back up into bed. Patient had imaging done at nursing home that confirmed fracture. Patient is unable to detail where the fracture was. R1 received Tylenol but continues to rate the pain as a 10/10. X-ray Femur dated 1/25/22 documents acute spiral fracture of the distal right femur

On 2/25/22 at 12:09pm, R1 who was alert and oriented at time of interview, said R1 was experiencing neuropathic pain prior to bed and eventually fell asleep. R1 said R1 rolled off R1's bed and heard a crack when R1 hit the floor. R1 said R1 was able to get self back in bed and pulled R1's call light. Two staff answered the light and R1 informed them that R1 fell but R1

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 03/04/2022

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
S9999	Continued From page 3	S9999		

reported the staff did not believe R1. R1 said the nurse gave R1 Tylenol at that time and R1 did not receive any other pain medications after that until R1 was at the hospital. R1 said R1 had pain for almost 2 days and R1's pain was 10/10. R1 said R1 did not want to the return to the facility after the way they treated R1.

On 2/25/22 at 11:34am, V2(DON) said R1 reported that R1 had fallen and was experiencing pain to R1's right leg. V2 said when she attempted to do range of motion to right leg, R1 yelled out in pain and V2 stopped assessment. V2 said she observed swelling to the right upper leg and informed V20(Nurse Practitioner). V2 said she informed V30 (Nurse). V2 said she did not administrator any pain medication. V2 said she would expect the nurse to assess the pain. Document the pain assessment, document medication given and if it was effective. V2 said she did not see that documentation in R1's medical record.

On 2/24/22 at 3:31pm, V30(Nurse) said R1 will usually request Tylenol in the morning, but she is unclear if she gave R1 Tylenol on 1/25/22. V30 said R1 denied any pain or discomfort during her shift. V30 said pain would be documented in R1's progress notes.

R1's progress notes does not document any pain or follow up assessments between fall note 1/24/22 at 6:56pm through 1/25/22 at 9:35am. R1's medication administration record for January 2022 does not document any as needed pain medications given on 1/24/22 or 1/25/22.

Facility policy titled: Pain Management Program reviewed 4/1/21 documents: It is the goal of the facility to facilitate resident independence.

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 03/04/2022

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
S9999	Continued From page 4	S9999		

Promote resident comfort. Preserve and enhance resident dignity and facilities life involvement. The pain management program includes documentation of pain assessment and monitoring; Pain medication shall be appropriate for the population served; medications for the control or relief of anxiety related to pain. Pain assessment protocol will be initiated under any of the following situations: a change in the resident's condition occurs to require pain medications; Resident receives routine pain medication or pain not controlled. Documentation of assessment and the resident response to the pain management plan will be made with each assessment.

"B"

Statement of Licensure Violations II of II:
300.610 a)
300.1210 b)
300.1210 d)3), 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

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 03/04/2022

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
S9999	Continued From page 5 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 interview and record review the facility failed to develop a plan of care to reduce or prevent the risk of falling with interventions to include supervision and monitoring for 1 of 3 residents (R2) reviewed for fall prevention. This failure resulted in R2 having an unwitnessed fall sustaining a closed non-displaced right femoral neck fracture. The findings include:	S9999		

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 03/04/2022

NAME OF PROVIDER OR SUPPLIER: APERION CARE OAK LAWN
STREET ADDRESS, CITY, STATE, ZIP CODE: 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
S9999	Continued From page 6 R2 R2 had the diagnosis of dementia with behavior disturbance, anxiety, and hypertension. Hospital paperwork dated 1/10/22 documents: R2 is below baseline level requiring increased physical assist for transfers and mobility. Physical Therapy Treatment dated 1/6/22 documents: R2 requires extensive hand-on for functional transfers. R2 remains confused, unable to follow commands consistently. R2 was unable to take steps or ambulate at this time. R2 demonstrate flexed forward posture with decrease balance and posterior lean with fatigue. R2's mobility remains limited due to decreased cognition/safety awareness/confusion, generalized decondition, decrease balance and activity tolerance. Suggested support at discharge: physical assist, close contact for safety and constant supervision. On 2/22/22 at 2:12pm, V12 (Therapy Director) said, we didn't evaluate R2. I briefly reviewed R2's hospital package. R2 was fall risk. Close contact and constant supervision mean R2 needs someone with R2 with him at all times for any transfers. On 2/22/22 at 2:37pm, V3 (Nurse) said, when R2 arrived, R2 was placed in bed and instructed to use call light with understanding. R2 had a fall within thirty minutes of arrival. R2 was discharge to the hospital. I did not receive in report that R2 was a fall risk, nor did I read R2's entire hospital package. On 2/23/22 at 11:40am V2 (DON) said, R2 was in the facility for 15-20 min before R2 was found on the floor. I can't remember R2 ambulation status. I determined, R2 was a fall risk based on reading	S9999		

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 03/04/2022

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
S9999	Continued From page 7 the hospital paper after R2's fall. I expect the nurse to read the hospital paper on admission and to put in necessary intervention to prevent falls. On 2/23/22 at 2:41pm, V21 (CNA) said, I helped transfer R2 to the bed off the stretcher with the EMTs. R2 was alert to self. I got R2 situated, told R2 if R2 need anything to use the call light. It was no way to determine if R2 knew how to use a call light. That would take more than an hour to determine that. I walked away, heard something, turned around, R2 was on the floor at the foot of the bed. It seemed like R2, took a couple steps, and fell. Progress noted dated 1/13/21 documents: Resident is alert to self. Fall event dated 1/13/22 documents: R2 was sitting on R2's buttock with back against the wall supported by the palms of R2's hands. R2 complained of right hip pain. R2 stated, "I don't know what happened." Fall event dated 1/13/22 documents: R2 was disoriented but with normal limits, predisposing physiological factor: gait imbalance, functional loss, forgets to use call light, resident was standing, predisposing situation factor: ambulation with assist. Hospital paperwork dated 1/13/22 documents: R2 has dementia, does not know where R2 is, recall falling, date, year or time. R2 had an unwitnessed fall in R2's room resulting in a closed nondisplaced right femoral neck fracture. Facility policy titled Fall Prevention Program revised 11-21-17 documents: Under purpose: To assure the safety of all the residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk for falls	S9999		

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 03/04/2022

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
S9999	Continued From page 8 and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Each resident will be screened by a specialist therapist at the time of admission, quarterly, after each fall, as appropriate, and with significant change in the resident's mental and functional abilities. "A"	S9999		