STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012173	A. BUILDING: _____ B. WING _____	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WESTCHESTER	2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154

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S 000	Initial Comments Complaints 2290117/IL142108 2290300/IL142343 2290725/IL142910	S 000		
S9999	Final Observations #1 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3100d)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. 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)	S9999		

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S9999	Continued From page 2 These Regulations were not met as evidenced by: Based on observations, interviews, and record review the facility failed to implement effective supervision and monitoring interventions to prevent avoidable incidents for a cognitively impaired residents with history of wandering in the facility This failure affected 2 residents (R1, R2) reviewed for supervision and avoidable accidents. This failure resulted in R1 sustaining an injury of unknown origin resulting in a acute right intertrochanteric hip fracture, and R2 being able to get outside of the facility using the front entrance and falling outside of the facility without staff knowledge Findings include: R1 is 91 years old with diagnosis including but not limited to Congestive heart Failure, Anxiety, Dementia without behavioral disturbances, Obsessive-Compulsive Disorder, Difficulty walking, Weakness, and Alzheimer's Disease, Vitamin D Deficiency, Anemia. R1's cognitive assessment dated 10/14/21 notes R1 is severely cognitively impaired and did not respond verbally during the survey. On 2/9/22 at 11:08 AM surveyor observed R1 in her bed and no floor matts on the floor or in the room. The surveyor observed R1 is a small, thin, and frail. On 2/9/22 at 11:14 AM V29, Certified Nursing Assistant (CNA), said fall risk residents have floor matts when they are in bed. On 2/9/22 at 11:23AM V18, Registered Nurse (RN), said R1 used to self maneuver herself in	S9999		

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S9999	Continued From page 3	S9999		

her wheelchair in the hallways. V18 said R1 used to be able to stand with assistance from the staff. V18 said on 12/30/22 the family came to visit R1 and they reported they saw a bruise on her. V18 said she went to look at the bruise on R1, R1 did not complain of pain, the bruise was discolored and her knee was swollen. V18 stated she called the doctor and an X-ray was ordered, and when the results arrived found R1 had a fracture and R1 was sent to the hospital. V18 said we don't really know how R1 got the fracture. Prior to the fracture R1 did not try to get up unassisted, and when R1 was in her bed she stayed in bed. V18 said R1 did not know how to get up without assistance. V18 said she was not aware of R1 having had a fall on night shift prior to 12/30.

On 2/9/22 at 1:00PM V2, Director of Nursing, said we were unable to determine how R1 sustained a fracture, so we listed her injury as unknown origin.

On 2/9/22 at 1:53PM observed V18 carrying floor mats in the hallway and placed them on both sides of R1's bed. V18 said R1 is supposed to have floor mats because she is on the falling leaf program.

On 2/9/22 at 3:10PM V12, RN, said he did not see R1 fall. V12 said prior to her fracture, R1 used to wander in her wheelchair by herself. V12 said R1 is unable to do that anymore. V12 said R1 never tried to get herself up and needed 1 person assistance to transfer prior to the fracture.

On 2/10/22 at 9:54AM V8, CNA, stated she has seen R1 wander in the wheelchair in the units. V8 said she had not seen R1 grabbing the rails or trying to get up from her wheelchair in the past.

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S9999	Continued From page 4 On 2/10/22 at 10:03AM V10, RN, said she never saw R1 trying to get up unassisted by staff. V10 said R1 was cooperative, was a known fall risk because of her dementia. On 2/10/22 at 2:52AM V1, Administrator, said after investigating R1's fracture we determined the fracture was caused by R1 using the banister to propel herself. This was our "best determination." On 2/10/22 at 3:13PM V3, CNA, said R1 during care while in the bed R1 would sometimes resist and get still. V3 said during care you have to talk to R1 and reassure her. V3 said she never saw R1 standing unassisted, but had seen her self-maneuvering in her wheelchair. V3 said R1 would maneuver her wheelchair by pedaling her feet. V3 said at times she had seen R1 holding the rails in the hall ways and slowly maneuvering the wheelchair to advance in the hallway. V3 said R1 was not very strong, and was slow and weak, and would not have the strength to move quickly in the wheelchair. On 2/16/22 at 10:59AM via phone interview, V34, Primary Doctor, said I saw R1 before her fracture. I have known for her a long time. V34 said R1 was usually in her wheelchair and she would scooch around in her wheelchair, and she wandered. V34 said R1 has been stable and was not someone who needed a ton of mobility care during the day. V34 said the nurses did not mention any fall had occurred. I was told the family had seen redness and pain in the area and that prompted the X-Ray. V34 said in my experience, fractures can occur from a transfer because the hip breaks from the force when the person sits down. V34 said R1 has osteopenia and she has frail and brittle bones. V34 said if the	S9999		

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S9999	Continued From page 5 staff is not paying attention or not gentle during a transfer that can cause hip fractures. V34 said he has never seen R1 aggressively resisting cares. V34 said R1 would get around in her wheelchair by taking a couple steps with her legs and then stop to look around. V34 said R1 would place one elbow on the arm of the chair then look around and use her legs to propel her chair forward. V34 said he never saw R1 moving fast. V34 said R1 has upper body weakness and he didn't think she would have the strength to use the rails to push herself in the wheelchair. On 12/30/21 at 2:00PM V1's Progress Notes written by V18, Registered Nurse, note V18 was approached by R1's family member verbalizing swelling on R1's right leg. V18 documented she saw R1's right knee was swollen with bruising on the left foot. Review of R1's X-ray of her right femur dated 1/1/22 notes there is an acute fracture involving the intertrochanteric hip. Review of the facility Investigation Form Summary of Investigation notes "out best determination of the probable cause of the injury of unknown origin could have been due to thrusting herself forward by using the banister to propel herself into an unknown object potentially corner of the end of a wall." R2 is a 79 year old with diagnosis including but not limited to Chronic Diastolic Heart Failure, Depressive Disorder, Hypertension, Difficulty in Walking, Unsteadiness on Feet, Cognitive Communication Deficit, Weakness, Dementia, Insomnia. R2's Cognitive Patterns Assessment dated 11/1/21 notes she has a score of 3, severely impaired. R2's Functional Status Assessment	S9999		

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dated 11/1/21 notes she requires Extensive Assistance for Bed Mobility, Transfer, and Locomotion on and off the unit. R2 was not able to answer surveyor questions appropriately.

On 2/9/22 at 11:30AM V31, Certified Nursing Assistant (CNA) said V2 is known to come out of her room in her wheelchair and needed redirection often.

On 2/9/22 at 2:20PM via phone interview V15, Licensed Practical Nurse (LPN), said she was assigned to R2 on 1/3/22 night shift. V15 said V20, CNA, alerted her that R2 was not in her room, which was not out of the ordinary for her. V15 said she was taking care of another resident and when she came out of that room she saw another staff "frantically waving" from the front entrance. V15 said we usually have security at the front door at night, but we did not that night. V15 said V20, CNA, was the first to find R2 outside. V15 said R2 was outside the building on the ramp; R2 had exited the building and fallen outside. V15 said R2 was wearing an electronic monitoring device but the alarm for the wander guard was not sounding. V15 said if you press on the front doors for 15 seconds the doors will open. V15 said R2 got past the 2 set of doors before getting outside. V15 said she had last seen R2 about 1:30AM or 1:40AM in her bed in her room.

On 2/9/22 at 2:41PM V13, Social Services, said prior to 1/3/22 she cannot remember the last time she tested R2's electronic monitoring device. V13 said she did not document the testing before.

On 2/10/22 at 9:52AM V8, CNA, said I am not sure if there is a list with residents who wear electronic monitoring device. R2 is at risk for

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wandering, she always says she wants to get to the door. V8 said I don't know if R2 has ever gotten to the front door, outside, or if she has fallen. V8 said she would be notified if these things had happened.

On 2/10/22 at 11:30AM via phone interview V33 (Receptionist) said R2 sometimes gets to the front door and is redirected back to the unit. V33 said if the electronic monitoring device goes off she contacts maintenance to turn it off. V33 said she has not been made aware than any resident has eloped out of the building.

On 2/10/22 at 11:49AM V11, Maintenance, said the electronic monitoring device were serviced recently with the alarm radius being reset so that the alarm will sound when a electronic monitoring device is detected in the vicinity. V11 said he has not been made aware that any resident has gotten out of the facility.

On 2/10/22 at 12:57PM V1, Administrator, stated if a resident falls or gets out of the facility, the staff should be aware it.

On 2/10/22 at 1:07PM V2, Director of Nursing, said staff should be aware R2 got outside and is at risk to do it again.

On 2/10/22 at 1:21PM V24, Regional Nurse, said he was notified when R2 fell outside. V24 said R2 normally wheeled up and down the hallways in her wheel chair. V24 said R2 got past the 2 sets of front doors. V24 said he does not know if the electronic monitoring device door alarm was working in the middle of the night. V24 said I expect staff to know R2 is at risk for falls and has gotten out of the facility.
Progress Notes for R2 written by V15, LPN, state

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S9999	Continued From page 8 at 2:05AM Resident had an unwitnessed fall on 1/3/22 outside on ramp to facility front entrance. CNA found R2 sitting on the ground outside. Blood Pressure 150/90, Temperature 95.4, and Pulse 110. At 2:10AM V15 documented electronic monitoring device on R2's wrist but system not alarmed at entrance R2 exited. R2's Fall Risk Assessment dated 1/1/22 notes R2 is not at risk for falls. No other Fall Risk Assessment was provided. R2's initial Fall Initial Occurrence Note written by V15 notes R2 said I'm cold and she had been outside about 5 minutes. R2's Elopement Leave Risk Review dated 12/3/21 notes R2 is at risk to elope. R2's care plan for cognitive function initiated on 7/24/18 notes she has poor logic, poor ability to understand cause and effect, poor judgement, awareness, insight focus, and poor impulse control. (A) #2 Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and	S9999		

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S9999	Continued From page 9 procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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 Regulations were not met as evidenced by: Based on interviews and records reviewed, the facility failed to follow their policy and ensure all staff had met the Covid Vaccination requirements	S9999		

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S9999	Continued From page 10 or an approved Covid Vaccine exemption. This failure had the potential to cause Covid 19 infections in 5 residents (R17, R18, R19, R20, and R21) who have contracted Covid 19 at the facility in the last 4 weeks. Findings include: On 2/15/2022 at 3:30 PM V1 (Administrator) states the only documentation that they have for Staff Vaccination compliance are the requests for exemption forms. V1 states she will check with corporate for any approvals and declination forms. On 2/17/2022 at 11:50 AM V1 states the corporate office approves exemptions. V1 states the facility only has 2 exemptions from people that currently work at the facility. Those were forwarded to surveyor. V1 states the approvals are on the Covid 19 Vaccine Declination forms. Review of Covid 19 Vaccine Declination form for the 2 staff (V35 and V36) provided on 2/16/2022 and dated on 2/16/2022 documents all listed reasons for declination. There is no statement of approval on the request for exemption or declination forms. All of staff members filled out the exemption request form, but no further action was noted by the facility. There was no approval of a medical exemption with documentation from a physician. On the Religious exemptions, only one had a religious leader sign off on request, but there was no evidence of an approval Anyone who requested an exemption was able to work. There were 5 requests for exemptions and 2 staff V35 and V36 (nursing staff) are still employed at	S9999		

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S9999	Continued From page 11 the facility. V35 and V36 have been working at the facility since they requested an exemption in October. V1 via email on 2/16/22 documents that 5 residents (R17, R18, R19, R20, R21) have contracted Covid-19 at the facility in the last 4 weeks. The facility's Employee-Vendor Covid-19 Vaccinations policy dated 2/11/22 documents the following: 2. Religious Exemption Employees may also seek a religious exemption if the vaccination conflicts with a sincerely held religious belief and practice. An employee seeking a religious exemption must complete a Request for Religious Exemption Form, which can be obtained from and returned to, the Human Resources Department. Once a Religious Exemption is approved, the employee must complete COVID-19 Vaccination Declination Form, which will be provided by Human Resources. (A)	S9999		