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
	IL6009815	A. BUILDING: ____ B. WING ____	C 03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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S 000	Initial Comments Facility Reported incident of 03/03/22/IL144758	S 000		
S9999	Final Observations Facility Reported incident of 03/03/22/IL144758 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)2)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 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.	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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S9999	Continued From page 1	S9999		

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:
2)All treatments and procedures shall be administered as ordered by the physician.
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.

These regulations were not met as evidenced by the following:

Based on interview, observation, and record review, the facility failed to implement care plan fall interventions of placing the bed in the lowest position with locked wheels and against the wall for 1 of 3 residents (R7) reviewed for falls in the sample of 10. This failure resulted in R7 falling out of bed, and fracturing her (R7) left hip.

Findings include:

R7's Face Sheet documented an admission date of 06/21/21. R7's Diagnosis List included Unspecified Dementia without Behavior Disturbance, Legal Blindness, and Macular Degeneration.

R7's 03/03/22 Fall Risk Assessment documented a score of 16, indicating R7 was at risk for falls. R7's Care Plan dated 02/06/22 documented a problem area, "I am at risk for falls", Date initiated 6/30/21 with corresponding interventions, "Ensure the bed is in the locked and lowest position, Date

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S9999	Continued From page 2 initiated and Revision date 03/04/22, re arranged room, Date initiated 07/14/21." R7's Minimum Data Set (MDS) dated 02/07/22 documented a Brief Mental Status Score of zero, indicating that R7 was so cognitively impaired that she was rarely or never understood. The same MDS documented that R7 required extensive assistance from at least two staff members for transfers and bed mobility. An Initial Report to IDPH (Illinois Department of Public Health) dated 03/03/22 documented," Description of Occurrence: .. Resident was found in floor between wall and bed on left side. No obvious sign of injury... Emergency Management System (EMS) called for transport to (local emergency room)." A Final Report to IDPH dated 03/10/22 documented, "(R7) returned to facility with hospice consult. Admitted to hospice services on 03/04/22. Will continue current (fall) interventions and ensure that the resident's bed is in the lowest and locked position." R7's Nursing Progress Note dated 03/03/22 at 9:25pm documented, "Description: Resident had an un-witnessed fall 03/03/2022 9:25 PM Location of Fall: Resident room. Resident was found on floor between bed and wall on left side on 03/03/2022 at 9:25 PM. Resident statement (if applicable): Resident has a diagnosis of dementia, unable to interview Resident just yelled out normal cognitive status of resident... EMS called for transport. No obvious sign of injury noted. Unable to determine pain resident has a diagnosis dementia unable to interview." R7's Fall Report dated 03/03/22 documented,"(R7) was found on floor between the wall and bed on the left side. Immediate	S9999		

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S9999	Continued From page 3 action taken: New order received (from R7's Physician) to transport to (emergency room). Intervention: Ensure bed is in the lowest and locked position." R7's Hospital Emergency Room (ER) Physician Documentation authored by V8, Physician, dated 03/03/22, documented, "This 101 year old female presents...with complaints of being found on the floor (following) an unwitnessed fall or crawl, details unknown." A Computerized Tomography (CT) Scan dated 03/03/22 documented, "Acute intertrochantic left hip fracture. Right hip (shows) dynamic screw and intramedulary rod (placement). Old healed right pubic rami fractures." A 03/04/22 Interdisciplinary Team (IDT) Note documented, "Summary of IDT meeting: Recent fall with ER visit and fracture. Fall investigated. Intervention - bed in lowest and locked position against wall." An 03/04/22 Nursing Progress Noted documented, "Patient returned from ER with diagnosis of left hip/femur fracture. Residential hospice to consult." On 03/15/22 at 11:05am, V12, Licensed Practical Nurse (LPN) stated that around 9pm on 03/03/22, V7, Certified Nursing Assistant (CNA), came to her and stated R7 fell. V12 stated when she came into room R7 was on the floor curled up between the wall and the bed, lying on her left side. V12 stated she thinks that the bed was in the lowest position and the wheels were locked. V12 stated R7 had no obvious signs of injury. V12 stated she called EMS and notified R7's Physician and family.	S9999		

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S9999	Continued From page 4	S9999		

On 03/16/22 at 8:45am, V7 stated she worked the 6pm to 6am shift on Rose Hall, the memory care unit, on 03/03/22. V7 stated she checked on R7 at about 8:00pm, and R7 was already in bed although still awake. V7 stated R7 was wet so she changed R7 clothing and linens, positioned R7 facing the door with a wedge rolled under her front, and a large pillow to her back (facing the window). V7 stated all beds on the Rose Hall are to be in lowest position at night, so she assumes the bed was in the lowest position but does not specifically remember. V7 stated she was in hall at about 9pm, heard a noise, and went into R7's room to find R7 in floor between the bed and the wall, laying on left side. V7 stated R7 had dislodged the pillow behind her. V7 stated R7 was always very fidgety in bed. V7 stated she ran to get V12, who assessed R7 for injuries and called EMS. V7 stated, "Before (R7) got a roommate (R10) a few months back, it was very handy because we would push (R7s) bed up against the wall and put a wedge to her front, this worked great, but when she got a roommate there wasn't enough room, her roommate is also a fall risk and we have to put her bed up against the wall on the long wall where the overhead lights are." V7 stated they don't have that many empty beds on the Rose Hall so she guesses they could not move R7 or R10.

On 3/16/22 at 9:35am, V3, LPN/MDS Coordinator/Care Plan Coordinator, was interviewed in R7's room. V3 stated R7's Care Plan interventions were for the bed to be in the lowest position with the wheels locked. V3 stated the Care Plan intervention, "Rearranged room", which was implemented on 07/14/21, meant that staff had decided to push R7's bed against the wall as a fall intervention. V3 stated this intervention continued until R7 got a roommate,

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S9999	Continued From page 5 R10, in January 2022, who also had an intervention of the bed being against the wall, so R7's bed could no longer be against the wall due to space constraints. On 03/16/22 at 9:45am R7's bed was observed to be parallel to the window, with neither side against the wall. R10's bed was observed against the room's long wall, with the right side of the bed pushed flush against the wall. V3 stated the room had not been rearranged since R7's fall. V3 stated R10's bed was now positioned where, prior to January, R7's had been. On 03/16/22 at 9:50am V3 stated the Interdisciplinary Team (IDT) met on 3/4/22 as a function of the facility's quality assurance program. V3 stated he is a member of this team. V3 stated the team checked the room and bed which were in same position as the night before when the fall occurred. V3 stated the team determined the root cause analysis of the fall was that R7's body movements dislodged the pillow to her back. V3 stated the team also found that the care plan interventions of a low bed with locked wheels, and the bed being up against the wall, were not in place. V3 stated the bed control "had about a one second push until it was all the way down", and the wheels had not been locked. On 03/16/22 at 10:35am, V1, Administrator, stated the IDT team determined that R7 rolled out of bed, and the interventions as outlined above had not been in place. V1 stated when staff made the decision to put R10 in with R7, R7's behaviors had been the main topic of discussion, not fall precautions. V1 stated R7's family wanted R7 to remain in her room. V1 stated staff did not discuss with them the fall intervention of her bed being against the wall as a potential problem.	S9999		

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On 03/17/22 at 12:00pm, V8 (Physician) stated R7 came to emergency room on 3/3/22 at around 10pm. V8 stated R7 was extremely frail and confused, and yelling out in pain, which required the use of Fentanyl for pain control. V8 stated R7's CT scan showed left hip fracture. V8 stated the report that came from the facility was that R7 fell out of bed. V8 stated he had several conversations with the family about end of life care decisions to be made. V8 stated ultimately the family decided on transferring R7 back to the facility on hospice services. V8 stated he was not at all surprised to hear that R7 had passed away. V8 stated it is possible that R7 developed a pulmonary embolism after the fracture, but without an autopsy, the cause of death is impossible to determine.

An 03/11/22 Nursing Progress Note documented, "Called to residents room by family to check pulse. No pulse noted, listened to heartbeat, heard a total of 4 beats then none. Status checked with second nurse (to confirm). Time of death: 0845 am."

R7's Death Certificate dated 03/11/22 documented, "Cause of Death: Alzheimer's (Disease)."

The facility's Fall Prevention Program Policy dated 11/21/17 documented, "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. The Care Plan incorporates..interventions (that) are changed

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S9999	Continued From page 7 with each fall, as appropriate,..(and) preventative measures. Safety interventions will be implemented for each resident identified (as) at risk...The bed locks will be checked to assure they are in the locked position at all times." (B)	S9999		