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	IL6014617	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE INTERNATIONAL	4815 SOUTH WESTERN AVE CHICAGO, IL 60609

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S 000	Initial Comments Complaints Investigations 2386812/IL163286 Facility Reported Incident IL163171 of 8/8/23	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)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	S9999	Attachment A Statement of Licensure Violations	

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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:

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 requirements are not met as evidenced by:

Based on interviews and records review, the facility failed to follow its policy and procedures for Fall Prevention by not properly completing a fall risk assessment to determine fall risk factors, failed to target approaches to reduce risks, failed to post fall and quarterly assessments, and failed to not ensure that the residents' care plan addresses each fall, identifies fall risks, and interventions were changed with each fall for three (R1, R5, and R6) out of four residents reviewed for falls. R1 fell on the floor on 06/07/2023 while located inside of her room and sustained a facial bone fracture. R6 sustained a cerebral hemorrhage due to a fall dated 08/08/2023.

Findings Include:

1) Face sheet dated 09/06/2023, documents that R1 is an 81-year-old female with diagnoses not limited to: Cognitive communication deficit, need

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for assistance with personal care, abnormalities of gait and mobility, adult failure to thrive, and generalized anxiety disorder.

R1's MDS (Minimum Data Set) dated 07/28/2023, documents that R1 has a BIMS (Brief Interview for Mental Status) of 06/15 indicating that R1 is severely cognitively impaired. R1's Activities of Daily Living (ADL) Assistance documents that R1 requires total dependence with transfer, locomotion on/off the unit, and dressing, requiring one-persons physical assist. R1 is frequently incontinent of bowel and has an indwelling urinary catheter.

R1's MDS dated 07/28/2023 documents that walking activity for R1 did not occur. Activity with moving from a seated to standing position, turning around, moving on and off the toilet, and surface-to-surface transfer (transfer between bed and chair or wheelchair) also did not occur. R1 utilizes a manual wheelchair, and the activity of walking 10 feet was not attempted due to R1's medical condition or safety concerns.

R1 has a history of recent hospitalizations within recent months as a result of sustaining repeated falls while in the facility. R1's hospital records dated 06/07/2023 documents that R1 had an admitting diagnosis of a facial bone fracture while hospitalized. R1's hospital records dated 08/08/2023 documents that R1 had admitting diagnoses of a head injury and elbow contusion while hospitalized.

On 09/06/2023 at 9:51 AM, V6 (Director of Nursing/DON) stated "A resident's Fall Risk Assessment should be completed at the time of admission, re-admission, after each fall, and quarterly. The purpose of the Fall Risk

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Assessment is to determine the potential risks of falling for the residents and has the components that will determine the risk score of the resident. Nursing staff are responsible for completing the Risk Management Assessment each time a resident sustain's a fall. The Risk Management Assessment serves the purpose of alerting all the department managers. The department managers then have a meeting to discuss the fall and try to determine the root cause of the fall. Nursing staff and restorative staff are responsible for implementing fall preventative interventions based on the fall risk score and care plan of the resident. The resident's care plan should be updated to reflect each fall. The fall care plan interventions should also be updated with different interventions. If a resident falls multiple times, the fall interventions should not remain the same because this indicates that those interventions are not working to prevent the resident from falling."

Progress note dated 09/03/2023 at 1:30 PM documents in part, "FALL-INITIAL OCCURRENCE NOTE- Fall Description: R1 had an un-witnessed fall 09/03/2023 1:30 PM Location of Fall: R1 was observed in room, on the floor, laying on left side with head on the ground. R1 fell out the wheelchair in room while eating lunch on 09/03/2023 1:30 PM. R1 denied pain in her head but was observed with a raised bruise in head on opposites of fall (right side). Actions Taken: R1 was assessed for injuries and writer noted a raised bruised in head on opposite side of the head as well as a smaller bruise on left side of the head."

Progress note dated 9/1/2023 at 12:10 PM documents in part, "FALL-INITIAL OCCURRENCE NOTE- Fall Description: R1 had

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S9999	Continued From page 4 an un-witnessed fall 09/01/2023 11:00 AM Location of Fall: R1 room. R1 was found on the floor on 09/01/2023 11:00 AM. R1 states that she is in pain. No injuries observed." Progress note dated 08/14/2023 at 9:15 AM documents in part, "FALL-INITIAL OCCURRENCE NOTE- Fall Description: R1 had an un-witnessed fall 08/14/2023 9:15 AM Location of Fall: R1 was sitting in dining room. R1 was sitting in wheelchair and wanted to go to the bathroom even though she has a foley catheter intact. R1 attempted to walk and fell on 08/14/2023 9:15 AM. R1 verbalized she hit her head. stated " it hurts " " call my son" while moving her head away when the writer attempted to assess R1's head. New injury observed, hematoma left lateral side of head. Actions Taken: R1 was placed in the wheelchair by CNA. The writer assessed R1's L.O.C. and pain level. DON gave verbal orders to transfer R1 out for further evaluation of injuries due to head hematoma." Progress note dated 08/08/2023 at 12:17PM documents in part, "FALL-INITIAL OCCURRENCE NOTE- Fall Description: R1 had a witnessed fall 08/08/2023 12:10 PM Location of Fall: Dining room. Per R1. CNA, R1 was sitting in chair and propelled herself out of chair and was next observed sitting on the floor on 08/08/2023 12:10 PM. Witnessed fall, observed to have struck head; No injuries observed. no injuries observed r/t to current fall. Actions Taken: Post fall evaluation, assist to chair then bed, sent to ER for evaluation. Intervention: PT/OPT eval Restorative eval Safety checks, send to ER for further evaluation." Progress note dated 6/7/2023 at 5:30PM	S9999		

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documents in part, "FALL-INITIAL OCCURRENCE NOTE- Fall Description: R1 had an un-witnessed fall 06/07/2023 5:30 PM Location of Fall: Resident room, at bedside. Staff informed writer R1 was observed on floor next to bedside near dresser drawer laying on left side on 06/07/2023 5:30 PM. R1 statement (if applicable): I was going to the washroom and to get some underwear. No injuries observed. Actions Taken: Intervention: PT/OPT eval Safety checks Other send to local hospital for evaluation and CT scan."

R1's Fall Risk Assessment dated 09/03/2023 inaccurately documents that R1 has a fall risk score of 5, indicating that R1 is not at risk for falls.

R1's comprehensive care plan dated 09/05/2023 does not document and address all of R1's actual falls. R1's care plan also does not document new interventions with each fall as a measure to prevent falls.

Per facility reported incident dated 06/08/2023, R1 sustained a fall which resulted in a fracture to R1s' facial bone while at the facility on 06/07/2023.

R1s' Face sheet does not documents that R1 has a diagnosis of history of falls. R1s' Physician Order Sheet/POS does not document that R1 has an order for fall precautions.

2) On 09/06/2023 at 3:28 PM, R5's electronic health record was reviewed with V42 (MDS Coordinator), during record review, surveyor observed that R5 did not have an updated Fall Risk Assessment. R5's last Fall Risk Assessment is dated 02/24/2023. R5's Fall Risk Assessment

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dated 02/24/2023 documents that R5 has a fall risk score of 14, indicating that R5 is at risk for falls. R5's care plan dated 03/16/2023 documents that R5 is not care planned for being at risk for falls. V42 stated "I do not see a fall risk care plan for R5, R5's care plan should document that R5 is at risk for falls."

Facility Fall Policy dated 11/21/2017, titled "Fall Prevention Program" documents in part, "Guidelines: The Fall Prevention Program includes the following components: Methods to identify risk factors. Methods to identify residents at risk. Care plan incorporates: Identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, preventative measures. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Safety interventions will be implemented for each resident identified at risk. Residents who require staff assistance will not be left alone after being assisted to bath, shower, or toilet. The fall risk interventions will be identified on the care plan. The frequency of safety monitoring will be determined by the resident's risk factors and the plan of care."

3) R6 is 62 years old, recently admitted on 05/17/2023 and was transferred to the hospital on 08/08/2023 due to fall. R6 has left foot and right leg below the knee amputation per diagnosis information.

Progress notes dated 08/08/2023 for R6 by V10 (Licensed Practical Nurse) documents as follows: R6 fell on his wheelchair where he sustained laceration on the back of the head. R6 was sent to hospital. Staff of the hospital informed V10 that

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S9999	Continued From page 7 R6 needs to be transferred to another hospital due to acute brain bleed. Notes dated 08/09/2023 for R6 by V10 documents that R6 was admitted for cerebral hemorrhage. Progress notes dated 07/14/2023 for R6 by V33 (Licensed Practical Nurse) documents that R6 had a prior fall that also hit his head and was transferred to the hospital. R6 fall risk assessment documents that R6 was assessed on 05/17/2023 (admission assessment) and 08/08/2023 (due to fall with injury). No fall risk assessment was done on 07/14/2023 fall incident. Per Minimum Data Set dated 08/08/2023, R6 needs 1-person extensive physical assistance for bed mobility and transfers. R6 needs wheelchair for locomotion and is non ambulatory. Care plan for R6 reads that R6 is at risk for fall initiated on 05/18/2023 and revised on 05/26/2023. R6 fall care plan goal is to have interventions in place to address risk for falls. All interventions in the care plan of R6 were all dated 05/18/2023. Except, the following interventions: R6 will have laboratory drawn dated 07/14/2023 and to transfer R6 to emergency room for evaluation dated 08/08/2023. V6 (Director of Nursing) on 09/06/2023 at 01:25 PM stated that for every fall there should have been fall risk assessment including the fall of R6 on 07/14/2023. The purpose of fall risk assessment is to determine if resident who fell are at risk of fall. Based on fall risk assessment, proper protocol and interventions must be initiated.	S9999		

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S9999	Continued From page 8 V33 (Licensed Practical Nurse) on 09/07/2023 at 11:47 AM stated that she may have witnessed the fall and that R6 can wheel himself in a wheelchair and was not seen as ambulatory. R6 needs more help as time goes by. V42 (Minimum Data Set Coordinator) on 09/07/2023 at 12:21 PM stated that each fall needs to be care planned so that staff will know what intervention to implement to prevent a fall. After reviewing full care plan of R6, V42 said, "I don't see any intervention for R6's fall on 07/14/2023 and that the correct intervention is something in place that the facility staff can do to prevent a fall to the resident. Drawing of labs is not an intervention that can prevent R6 from falls." V10 (Licensed Practical Nurse) on 09/07/2023 at 2:35 PM stated R6 fell inside his room and was first seen by a CNA (Certified Nursing Assistant) that she cannot remember her name. R6 sustained a dime size laceration at the back of his head. R6 was transferred to the hospital, that later transferred into another hospital because R6 has cerebral hemorrhage. V10 stated that she does not know what interventions are needed for R6 to prevent falls because she did not check the care plan. V48 (Nurse Practitioner) on 09/08/2023 at 09:25 AM stated that R6 needs redirection and was not always oriented although he appears to be every day. R6 had history of multiple falls in the past. R6's fall on 08/08/2023 resulted to cerebral hemorrhage that means bleeding in the brain that affects a person's motor ability. Fall Prevention Program dated 11/21/2017 as revised, reads: The purpose is to assure the	S9999		

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S9999	Continued From page 9 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 devises are utilized as necessary. Care plan incorporates the following: Identification of all risk/issue, address each fall, interventions are changed with each fall, and preventative measures. A fall risk assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. (A)	S9999		