STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003511	A. BUILDING: _____ B. WING _____	C 08/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE NILES	6601 WEST TOUHY AVENUE NILES, IL 60714

(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 Investigation of Facility Reported Incident of July 9, 2023/IL162573	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 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**	

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S9999	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to supervise a resident at high risk for falls for 1 of 3 residents (R1) reviewed for falls in the sample of 3. This failure resulted in R1 sustaining a fractured left hip from a fall. The findings include: R1's admission record shows he was admitted to the facility on 3/25/23 and re-admitted 7/13/23 following a hospital stay from 7/9/23 to 7/13/23. The same document shows R1 to have multiple diagnoses including dementia, history of falling, and difficulty in walking. R1's care plan initiated on 3/25/23 documents he is a high risk for falls related to weakness and being non-compliant with using his walker during ambulation. R1's quarterly resident assessment and care screening of 7/4/23 shows he has severe cognitive impairment. The same assessment documents he requires extensive assist of one	S9999		

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S9999	Continued From page 2 person for transfers between surfaces, walking in his room, and walking in the corridor. The facility's final incident report of 7/13/23 shows R1 was in the dining room for activities, attempted to transfer himself, lost balance, and slid to the floor in a supine position (face up). The report shows R1 sustained a left hip fracture. R1's nursing progress note of 7/9/23 documents at 2:35 PM, R1 was on the floor of the dining room, resident complaining of pain in back of his head, noted bump on back of head, left leg pain, no swelling, no change in ROM (range of motion), MD notified, and order for transfer resident to hospital. On 7/10/23, the notes show R1 was admitted to the hospital with a diagnosis of fall with left hip fracture. On 8/12/23 at 9:15 AM, V4 (Activity Aide) said he was working on 7/9/23, and R1 was present in the dining room. V4 said V5 (Certified Nursing Assistant/CNA) was assigned as the monitor and was to watch over the residents. V4 said while conducting activities he had witnessed R1 standing up from his wheelchair, caught him, and placed him back in his chair. V4 said he did not see R1 when he fell. V4 said R1 was a fall risk, and that is why he was in the group. On 8/12/23 at 9:40 AM, V5 (CNA) said she was in the dining room on 7/9/23, assisting another resident with bingo. She said R1 was in the dining room in his wheelchair, he had no pedals on the chair, and his was not able to propel himself. V5 said she was in the corner of the dining room, and was not watching R1, but she believes he was trying to get up on his own, and that is why he fell. She said that was why he needed extra supervision, because he tries to get	S9999		

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S9999	Continued From page 3	S9999		

up by himself. V5 said she did not see him attempting to stand prior to his fall, and V4 never reported to her R1 was trying to stand up on his own. V5 said if V4 had communicated with her regarding R1's attempts to get up, she would have changed what she was doing, or move to monitor him any closer.

On 8/12/23 at 11:30 AM, V7 (Registered Nurse/RN) said when residents are at a high risk for falls, they are placed in the dining room and staff are assigned to watch over them. R1 was a high fall risk, he would try and stand and walk without assistance. V7 said R1 has dementia, and if he gets up once, he will do it again. She said staff should report to each other when a resident tries to get up, and staff should sit with them to ensure they do not fall.

On 8/12/23 at 12:00 PM, V8 (Corporate Nurse) said residents are assessed for fall risk upon admission and fall prevention interventions are based upon their individual needs. She said residents with dementia are re-directed and require close monitoring. The high fall risk residents are placed in activities, and a CNA is to monitor them. If the aide leaves the room, the nurse will take over monitoring the room. V8 said if V4 saw R1 getting out of his wheelchair, he should have communicated that information to V5 so she could move closer to R1 and sit with him.

On 8/12/23 at 9:00 AM, R1 was observed sitting up in a geriatric chair at the nurse's station. He had was alert and confused. He had no complaints of pain per the nurse translating for him while she was feeding him breakfast.

The facility's 11/21/17 policy for fall prevention documents the purpose of the policy is to assure

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S9999	Continued From page 4 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. "A"	S9999		