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 02/09/2023

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

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S 000	Initial Comments Complaint Investigation 2391055/IL156165	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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	

PRINTED: 02/23/2023
FORM APPROVED
Illinois Department of Public Health

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S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 interviews and record reviews, the facility failed to prevent an injury for one (R1) of five residents reviewed for accidents and supervision. The facility failed to follow the resident's care plan for bed mobility. This deficiency resulted in R1 being found to have a bump and swelling on the left thigh that required R1 to be transferred to local hospital, then diagnosed with fracture of the left femur. Findings include: R1 was admitted in the facility on 03/01/21 with diagnoses of Dementia in other Diseases Classified Elsewhere, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; Vascular Dementia, Severe, Without Behavioral Disturbance, Mood Disturbance, and Anxiety. Per face sheet also, she was diagnosed with Age Related Osteoporosis without Current	S9999		

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S9999	Continued From page 2 Pathological Fracture on 02/04/23 and Unspecified Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing on 02/06/23. R1's MDS (Minimum Data Set) dated 01/03/23 documented: Sec G: Total dependence on two persons physical assist during bed mobility; transfer; toileting; total dependence from one physical assist during dressing; personal hygiene; bathing. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture R1's Care plan documented: I require assistance with bed mobility related to decreased mobility, dementia - initiated 10/17/22, revision on 01/06/23 - Interventions: Providing assist of 2 persons assist (initiated 10/17/22; revision 01/16/23). According to incident report dated 02/04/23, R1 was noted with left hip swelling and redness. R1 was unable to explain how it occurred. R1 was sent to the emergency room for X-ray. Hospital notified facility that there is a left hip fracture. On 02/07/23 at 3:21 PM, V5 (Registered Nurse/RN) was interviewed regarding R1. V5 replied, "On 02/04/23 around 4:15 PM, V6 (Certified Nurse Assistant/CNA) asked me to check on R1 because he had seen the swelling on the left leg became bigger. He (V6) was the CNA last Friday and he already noticed the swelling which he notified V8 (RN). When he notified her (V8), X-ray was ordered. It was not done, I don't know. When V6 (CNA) told me to check on R1, I noticed swelling on the left thigh	S9999		

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S9999	Continued From page 3	S9999		

and lump on the mid lateral thigh. V6 told me that it got bigger since yesterday. I followed up with X-ray, was told they might be coming late in the evening or early morning. I informed V3 (Assistant Director of Nursing) and V9 (Nurse Practitioner/NP) and ordered for her (R1) to be sent out to the hospital.

On 02/07/23 at 3:46 PM V6 (CNA) was interviewed regarding R1. V6 verbalized, "I worked on 02/03/23, afternoon shift - I came at 3 PM, we are checking the residents around. I set up the dinner for her (R1), she was awake and alert. I repositioned her from the right side to supine and I used the sheet and put a pillow on the back. I did not touch the leg. Did not notice anything. Around 8:30 PM, she (R1) was in supine position. I prepared to change her when I noticed that her left leg was loose and not contracted, no swelling, no bruises or anything. She was not in pain. I called V7 (Licensed Practical Nurse/LPN) and have her (R1) checked. He assessed her (R1) and was told that he had not seen anything relevant. But still, I suggested him to call V8 (RN), the other nurse who is in house. When she (V8) came to the floor, I asked her to assess R1. She (V8 RN) did the assessment, contacted V2 (Director of Nursing) or whoever and ordered a stat X-ray. But no X-ray done. The next day when I came back, afternoon shift, I told V5 that she (R1) was still in the facility, and X-ray was never done. I showed her (V5 RN) that her swelling got bigger. She (V5) called somebody, and she (R1) was sent to the hospital.

On 02/08/23 at 10:30 AM, V8 (RN) was asked regarding R1's left leg. V8 stated, "On 02/03/23 around 7 PM, I got called by V6 (CNA), said that they needed a second opinion for R1. He (V6) said that he found a bump on her left thigh. He

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S9999	Continued From page 4 and V7 checked it but unsure what had happened. I went to her room, I assessed her and saw a bump on her left thigh, upper part, like the size of about three to four centimeters. The site was not warm, no discoloration. He (V6) said she (R1) does not have the bump the day before. Now that he was changing her, he noticed it. Also, when he (V6) tried to lift her legs up to check for movements, she (R1) made a sound like she was guarding the leg. I notified V3 (Asst Director of Nursing) via text. She called, said that she talked to V9 (Nurse Practitioner) and a stat X-ray need to be done." R1's progress notes documented the following: 02/04/23: V6 (CNA) asked me (V5 RN) to check on patient's (R1) left leg as he had noticed yesterday that the leg was hypermobile and a lump was found on the thigh, which was reported to V3 (Assistant Director of Nursing/ADON) and V9 (Nurse Practitioner) yesterday, and they had ordered a left thigh X-ray stat (immediately) that was not still done today. Upon assessment of the area, left leg was swollen and bump was still present, and had gotten larger as observed by V6. X-ray company was contacted for an update and status, still unknown if today or tomorrow so as per advice of V3 and V9, R1 was sent out to the hospital. Hospital Records Emergency Department dated 02/04/23 documented: Chief Complaint: Leg swelling. Imaging: CT (Computerized Tomography) lower extremity without contrast left. Impression: Oblique fracture of the mid femoral diaphysis with displacement and angulation. Imaging: XR (X-Ray) Femur Left. Impression: Oblique fracture of the left femur with angulation and displacement.	S9999		

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S9999	Continued From page 5 On 02/08/23 at 12:02 PM, V3 (ADON) was interviewed regarding R1 and left left leg swelling. V3 replied, "When she was in the facility, she never had fall incidents. She is alert, oriented to person, bed bound, total care. She went to the hospital last weekend due to fracture. They texted me Friday evening, 02/03/23 about her (R1) having a bump on the left thigh. I asked V8 (RN) if she had fallen, or if bruise was noted. I notified V9 (NP) right away and ordered a stat X-ray. I was home, then Saturday, 02/04/23, I received a text that X-ray was not done so me and V9 decided to send her (R1) to the hospital for further evaluation. The cause of her (R1) fracture - she has a wound, and we reposition her every two hours. She has contractures on both legs. Because of her poor nutrition and Osteoporosis, when staff reposition her, maybe it could cause a break in the bones, like a spontaneous fracture. Staff should be gentle when repositioning her. Two staff is needed, pull the draw sheet gently and put a wedge pillow on her back. As much as possible, avoid pushing R1 while turning. I expect staff to provide two person assists during repositioning for bedbound residents and use minimum force/pushing on residents while turning. R1's POS (Physician Order Sheet) dated 11/08/22 recorded: Turn and reposition while in bed (refer to clock schedule). Offload heels at all times, every two hours for wound treatment. R1's progress notes documented the following: 11/25/22: Weekly Skin observations: R1 has a wound in the sacrum area. R1'S progress notes dated 02/06/23 documented: After discussing and investigating resident has	S9999		

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S9999	Continued From page 6 protein calorie malnutrition. Anemia, osteoporosis labs: RBC (red blood cells) 3, 32, Hgb (hemoglobin) 9; calcium 8.6; sacrum pressure ulcer, resident (R1) is turned and repositioned often that increases her risk for fracture even with minimal impact. Resident (R1) does not have any known fall incident. On 02/08/23 at 12:27 PM, V9 (NP) was interviewed regarding R1 and incident on 02/04/23 causing a fracture. V9 verbalized, "I have been taking care of her (R1) since admission. She is alert to herself, she has Dementia. She has a different language, never talk to me, unable to follow commands. She is bed bound, total care, dependent on staff. She was found to have femoral fracture on the left hip. Cause: we need to turn her every two hours because of the sacral wound, she has Osteoporosis. Looks like she has spontaneous fracture, maybe during turning and repositioning it happened. Because there was no fall incident at all. Her legs have contractures, immobile and does not move at all. I am sure staff are in-serviced on how to turn residents properly. I expect staff that they received proper training and education related to turning repositioning." On 02/08/23 at 12:49 PM, V10 (Admissions Director/Administrator in Training) mentioned during interview, "I am finishing up interviewing everyone involved in her (R1) care and also looking into the results with her (R1) diagnosis of Osteoporosis, Anemia, lower levels of Calcium. Last 02/03/23, around 1 PM, wound care did a full assessment on her, no bruises, no redness, no bump. They also did wound treatment. V6 observed the bump in the evening. He reported it to the nurse. The nurse reported it to V9, and stat X-ray was to be taken. Cause of her (R1) fracture	S9999		

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- it came back like an oblique fracture, could be caused by Osteoporosis. And with her being turned and repositioned every two hours, likely could have break her bones."

02/08/23 at 1:00 PM, V1 (Administrator) was also asked regarding R1 and the cause of her fracture. V1 stated, "She has fracture on the femur, left. She is bedbound. She is elderly, 92 years old, has Osteoporosis, a lot of comorbidities. She was not in pain. She is being repositioned frequently, for wound, which is every two hours or during peri care. Possibly during movement of resident (R1) from side to side, which should be done in a proper way, and should be performed by two persons for assist. We actually did annual competency last Thursday 02/03/23, turning and repositioning is part of the skills they need to be trained well. I expect my staff to be cautious during provision of care, if they need proper training on certain skills, let facility know and we can provide the needed training."

V5 (RN) also mentioned during interview, "R1 is alert, oriented, non-verbal; bed bound. Since she is bed bound, we have to do the turning schedule while in bed. When we do turn her, we do log rolling, one assist but if there are available staff, we have two assists. But since she is small, one person can do the turning."

V8 (RN) was also asked regarding R1's turning and repositioning. V8 stated, "She (R1) is bedbound, we do turn and repositioning on her every two hours. I have done the turning before with CNA. She never had incidents of fall during my shift. Very difficult to move her legs because it is flexed, bent but it can be moved by staff. When we do the turning and repositioning: she does

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S9999	Continued From page 8 have a flat sheet under her lower back. Me and the CNA are on both sides, rolled her to the side where she is going to be moved. The CNA will pull the sheet towards her, I am on the other side holding her back and legs and move her back towards me." V6 (CNA) also verbalized, "Her (R1) legs are contracted. When turning, I pull the sheet towards me, unfortunately since we are short of staff, I always do the turning by myself, and she is turned to the other side. Same thing during changing of briefs. She has contracted legs and arms." On 02/07/23 at 3:03 PM, V4 (CNA) was also asked regarding R1's turning and repositioning. V4 replied, "I am her usual CNA. Most of the time, she is in bed. During changing of incontinent brief, she can hold the halo attached to bed while I change the brief and reposition her. She helps me in turning. Most of the time, I am the only one turning and changing her. When I changed her, I give her a little push on the back, and she holds the halo. When repositioning, I grab the draw sheet and pull it towards me and turn her to the other side and put the pillow under the back." V11 (CNA) also verbalized, "We turn and reposition her (R1) every two hours. I call other CNA to help me in turning. We pull that sheet under her bottom. We pull together the flat sheet towards us, she is a heavy set. We turn her to the other side. We roll her body together to the other direction. We hold the shoulders and the hip and push it together so she could go to the direction we want to." On 02/08/23 at 1:49 PM, V2 (Director of Nursing)	S9999		

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S9999	Continued From page 9 was asked regarding R1 and prevention of injury on bed bound residents. V2 stated, "She (R1) is being turned and reposition every two hours and as needed because of the pressure ulcer on the sacral area. Very high risk for fractures when turned. She is bedbound. There should be two persons assist, one on each side of the bed, use a draw sheet to turn to the other side while the other person putting the pillow on the back and between the knees to maintain comfort. We have to offload the heels with a pillow. My expectations on staff in preventing fractures or injuries on bedbound residents are to expect them to work as a team, help each other and report to the nurse, to us, if there are changes in functional level. There should be proper endorsements between nurses and CNAs. Report to me ASAP (as soon as possible) on any changes observed on a resident. Staff has to follow the facility procedures when turning a resident." Facility's procedure titled "Turning Patients Over In Bed", undated, documented in part but not limited to the following: Turning A Patient The following steps should be followed when turning a patient: Get as close to the person as you can. You may need to put a knee on the bed to get close enough to the patient Place one of your hands on the patient's shoulder and your other hand on the hip. Standing with one foot ahead of the other, shift your weight to your front foot (or knee if you put your knee on the bed) as you gently pull the patient's shoulder toward you. Then shift your weight to your back foot as you gently pull the person's hip toward you. You may need to repeat steps 4 and 5 until the patient is in the right position.	S9999		

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S9999	Continued From page 10 Facility's checklist titled "Bed Mobility and Positioning Competency" dated 08/2012, documented in part but not limited to the following: Performance Criteria: 1. Turning in bed a. Assess resident's ability to turn b. Lower head of bed as appropriate c. Turning a resident toward you i. Cross the resident's arms over his/her chest ii. Cross the leg near you over the far leg iii. Raise side rail on opposite side of bed as appropriate iv. Lower the rail on the side of the bed towards where the resident will be turning v. Place one hand on the resident's far shoulder and the other on the resident's far hip vi. Gently roll the resident toward you d. Turning a resident away from you i. Cross the resident's arms over his/her chest ii. Cross the leg near you over the far leg iii. Place one hand on the resident's near shoulder and the other on the resident's near hip iv. Gently roll the resident away from you v. If the side rail is up, ensure that the side rail is padded to prevent injury 3. Logrolling a. Ensure assistance of 2 to 3 persons b. Move the person as a unit to keep the spine straight "A"	S9999		