STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006845	A. BUILDING: _____ B. WING _____	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE EVANSTON	1300 OAK AVENUE EVANSTON, IL 60201

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S 000	Initial Comments Complaint Investigation 2391493/IL156693	S 000		
S9999	Final Observations STATEMENT OF LICENSURE Violations 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) 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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S9999	Continued From page 1 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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 300.3240 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 evidence by: Based on observation, interviews and record reviews, the facility failed to follow their policies and failed to provide adequate supervision and monitoring of a resident with cognitive impairment and behavior of wandering for one (R1) of four residents reviewed for accidents and supervision.	S9999		

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This deficiency resulted in R1wandering into R2's room, was found on the floor and sustained a comminuted displaced right femoral neck fracture. R1 underwent a surgical procedure called right hip hemiarthroplasty.

Findings include:

R1 is an 81 year-old, female, admitted in the facility on 02/21/2020 with diagnoses of Polyosteoarthritis, Unspecified; Unspecified Diastolic (Congestive) Heart Failure; Paranoid Schizophrenia; Alzheimer's Disease with Late Onset; Anxiety Disorder, Unspecified; Age-Related Osteoporosis without Current Pathological Fracture and Paranoid Personality Disorder.

Incident report dated 02/16/23, R2 allegedly pushed R1. R1 was wandering and went to R2's room. V3 (Certified Nurse Assistant, CNA) heard R2 saying "go to your room." V3 went to R2's room and found R1 on the floor. R1 stated (R2) pushed (R1). R1 was assisted back to (R1's) room and positioned in bed and started complaining of left hip and shoulder pain.

On 02/22/23 at 1:50 PM, V3 was asked regarding incident on 02/16/23 between R1 and R2. V3 stated, "On 02/16/23, (R1) was not assigned to me. It was V11 (CNA) who was assigned to (R1). I went on break at 1:13PM, came back at 1:43PM. When I came back, (V11) was on break. V8 (Registered Nurse, RN) went on break too. It was only me on the floor. There were no other staff on the floor. (R1) was in (R1's) room. I went to another resident's room for assistance. When I came back, I went to the nurses' station, I heard R2 "saying go to your room." When I entered R2's room, I saw R1 on the floor. R2 was standing in

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front of R1. R2 looked upset at R1. I helped R1 up and brought (R1) to (R1's) room and put (R1) to bed. When V8 came back, I told her about the incident."

On 02/22/23 at 3:05 PM, R2 was asked regarding the incident with R1. R2 did not answer. Instead, R2 stated, "It is not a good day today." R2 was observed mumbling with words, unable to keep a conversation and was very confused.

V8 was interviewed on 02/23/23 at 10:36 AM regarding R1 and R2. V8 replied, "On 02/16/23, I was on break. V3 was on the floor, and she told me that she found R1 inside one of the resident's room sitting on the floor. I went to (R1) and did an assessment, took vital signs and assessed for pain. (R1) was touching (R1's) left hip and left shoulder. I gave (R1) pain medication and reported to V1 (Administrator), Social Services, V2 (Director of Nursing), V9 (Nurse Practitioner) and family. V9 ordered for a STAT (immediately) X-ray of the shoulder and hip but V10 (Family Member) wanted R1 to be sent out."

Hospital records dated 02/16/23, Emergency Medicine Note: "R1 presented to the emergency department s/p (status post) altercation and fall. (R1) was in unwitnessed altercation with another NH (nursing home) resident and fell. Was found on the floor." The following diagnostic procedures were performed on (R1), with results:
X-ray of hip: Impression - Findings suspicious for a non-displaced subcapital femoral neck fracture.
CT (computed tomography) of hip without contrast: Impression - Displaced, foreshortened and slightly comminuted proximal right femoral neck fracture.
X-ray femur right: Acute fracture of the right femoral neck.

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S9999	Continued From page 4 (R1) underwent a surgical procedure to repair the fracture called right hip hemiarthroplasty on 02/17/23. Per records also, (R1) had history of left hip fracture following fall s/p ORIF (open reduction internal fixation) in 2019. Progress notes dated 12/20/22, it was documented: "R1 was noted entering another resident's room and rummaging the other resident's stuff. R1 also tried to take away stuff/things from the room. R1 was told that she cannot go in that room and cannot take other resident's personal belongings, but R1 became combative and angry. R1 is unable to understand instructions and redirections, will continue to monitor behavior." Progress notes dated 09/08/22 also documented: "R1 was found sitting on the toilet seat in the common bathroom area, doing nothing. R1 was observed sitting with pants still on. R1 was asked if she's using the toilet to go and needs privacy so door could be closed but R1 replied no and I just want to sit. R1 was told that another resident was waiting to use the bathroom. R1 was assisted back to her room." Progress notes dated 08/23/22 recorded that R1 was observed lying on the bathroom floor by staff. R1 denied falling and stated she was just lying down in order to sleep. She was redirected and reoriented to her room. Staff members were notified to make frequent rounds on R1. V3 (CNA) and V8 (RN) were interviewed regarding R1. 02/22/23 at 1:50PM V3 stated, "(R1) is alert but confused. Unable to find her room. When (R1) is redirected she will say that her room was in	S9999		

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another area. (R1) walks in the hallway all the time. (R)1 goes from one resident's room to another. When (R1) goes to another room, (R1) refuses to be redirected. (R1) wants to stay in that room. But calmly speaking to (R1) will make her go to her room. Sometimes, (R1) understands me but most of the time, (R1) is confused. When I am not busy, I assist (R1) during walking and redirect to (R1's) room. There are times that I attend to other residents' needs, that I am not able to follow (R1).
On 02/16/23, I was the only one on the floor, the other staff were on break. We have to monitor here to check if (R1) is in (R1's) room and not wandering around all the time." At the same time V8 (RN) mentioned, "(R1) is alert to person, to self only. She has a wandering history and is physically aggressive. She walks in the hallways, enters other residents' rooms but we were able to redirect her right away. On 02/16/23, I was on my break. R1 is a wanderer and needs to be monitored. We don't have a specific timing for her monitoring. Whenever I see R1 go out in her room, I redirect her. CNAs know about R1's behavior as well. That time, when I asked V3, she said she was inside one of the residents' room. She just heard something and went to room and saw her R1 on the floor. If there was another CNA on the floor, the incident should have been prevented. I was on break, V11 (CNA) and V12 (CNA) were also on break. It was only V3 working on the floor at the time. V11 was supposed to come back from break but she did not."

On 02/22/23 at 3:09 PM, V4 (RN), V5 (RN) and V6 (RN) were interviewed regarding monitoring R1. V4 stated during interview, "(R1) is alert, oriented to person. (R1) has a behavior of wandering. We try to redirect (R1), offer food, offer snack, engage in activities and ongoing

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monitoring - rounds every now and then. (R1) has a behavior of going inside other residents' rooms and taking stuff and stuff from nurses' station. (R1) is very confused. During breaks, I make sure that two staff are present on the floor. Like if I am going for a break, I endorse residents who wanders around for monitoring. I heard about the incident that she was allegedly pushed by (R2) when she wandered, and she fell on the floor. The nurse was on break and was only notified after the break. (R2) has a withdrawn behavior, resistive to care, does not want to talk to anyone, (R2) will just ask what (R2) needs. He does not wander. He probably got agitated when he saw (R1) in his room because he is not familiar with (R1). That is why I always make sure that one staff is at the station or roaming around the floor/hallway to monitor (R1). She is our number one priority and she usually sleeps in other residents' bed. And the other residents get agitated with her." V5 also mentioned, "I usually ask CNAs regarding break times. There should be one nurse and one CNA on the floor. If I am going to take a break, both CNAs should be on the floor. R1 is confused, violent for no reason. She wanders a lot. Sometimes she goes from one room to another, we have to prevent it because it makes other residents agitated. Whenever I am working on the floor, I will be at the station, do my rounds randomly and have CNA or CNAs do rounds. Usually, CNAs are there to catch (R1), redirect (R1) back to (R1's) room. (R2) is someone not used in hurting people. (R2) has no behavior with me. (R2) is usually in (R2's) room. I think (R2) got agitated when (R1) was in (R2's) room." V6 also stated, "When we take breaks, there should be two staff on the floor while the other one is taking a break. Never leave one staff on the floor. (R1) is a wanderer. We redirect (R1), reorient to go back to

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S9999	Continued From page 7 (R1's) room. (R1) will follow you. Then after 20 minutes, she will wander again, so just redirect her." On 02/23/23 at 11:29 AM, V9 (Nurse Practitioner) was interviewed regarding R1. V9 stated, "She is alert to self and to regular staff, disoriented due to Dementia. She does have a history of agitation. She does wander, walks steady. She wanders in the hallways, staff always do a redirection. On 02/16/23, I was told that she went to R2's room. (R2's) room is very close to nurses' station. (R1) should have been stopped by staff from entering the room. She should have been monitored and supervised whenever she is not in her room." V1 was also asked regarding expectations on staff in preventing falls and injury. V1 replied, "Staff presence, staff should be visible in the hallway all the time to redirect residents who wanders. If residents have behavior like wandering, identify the triggers. Ideally, there should be at least two staff monitoring residents if other staff went on breaks. If there is only one staff, they are trained to call assistance from supervisors and restorative aides." R1's care plan on Wandering/Elopement, date initiated 11/15/2021 documented: Intervention: Make rounds/room checks per facility protocol to minimize chance of unauthorized leave. R1's care plan on impaired cognitive function possibly related to diagnosis of Alzheimer's, Dementia, Paranoid Personality disorder., Anxiety disorder; Insomnia, revision date 01/18/23: Intervention: Cue, redirect and supervise as needed (revision date 01/25/21).	S9999		

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S9999	Continued From page 8 R1's care plan on risk for injury or fall related to dementia, insomnia, impaired mobility, poor safety awareness, osteoporosis, osteoarthritis, wandering behavior, date initiated 03/18/2020: Intervention: Resident has Dementia and has episodes of confusion, redirection provided and redirected to go to her room (date initiated 08/22/22). Facility's policy titled "Fall Prevention Program" revision date 11/21/17, documented in part but not limited to the following: 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 Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Facility was requested to present policy on "Wandering/Elopement" but facility has no exiting policy. A	S9999		