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 04/09/2024

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

(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 Complaint Investigation 2452588/IL171470	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	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/18/24

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care needs of the resident.

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.

These requirements were not met as evidence by:

Based on observation, interview, and record review, the facility failed to implement planned fall interventions to prevent falls for 1 (R1) of 5 residents reviewed for falls in a sample of 5. This failure resulted in R1 falling, fracturing his right hip and undergoing surgical repair of the fractured hip on 4/2/2024.

Findings included:

Per R1's EHR (electronic health record) R1 was admitted to this facility on 11/7/2024 with diagnoses of Alzheimer's, Chronic Atrial Fibrillation, Weakness and Insomnia. Per R1's MDS (Minimum Data Set) dated 1/23/24 under section C, R1 was assessed with a BIMS (Brief Interview for Mental Status) in which R1 scored 3 out of 15 total, indicating R1 has severe cognitive impairment. This same MDS under section GG, documents R1 as needing substantial/maximum

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assistance from staff for all transferring activities and uses a wheelchair for locomotion about the facility.

A Fall Risk Assessment for R1, dated 4/1/2024, documents R1 is a high risk for falls.

R1's care plan (initiation date of 11/30/23) documents a focus area of: (R1) is at risk for falls related to decreased safety awareness, unsteady gait and medications that may cause dizziness. This same care plan documents the goal of the focus area as: (R1) will not sustain serious injury through the review date (7/15/24) and planned interventions of: Ensure (bedside) recliner is in down position with foot rest down (initiation date 1/4/24), Anticipate and meet (R1's) needs (initiation date 3/10/24), Bed height to be placed where my feet are flat on the floor (initiation date 11/30/23), Educate (R1)/family/caregivers about safety reminders and what to do if (R1) falls (initiation date 11/30/23), Encourage (R1) to participate in activities that promote exercise, physical activity for strengthening and improved mobility (initiation date 11/30/23), Ensure call light is within reach (initiation date 11/30/23), Follow fall protocol (initiation date 3/10/24), Staff to assist (R1) with toileting upon awakening, before and after meals and at bedtime as (R1) allows (initiation date 4/2/24), and (R1) uses chair/bed electric alarm. Ensure the device is in place as needed (initiation date 11/30/23).

On 4/4/2024 at 9:23am, V5 (family) said due to R1's dementia, R1 has increased confusion during the night and attempts to get up without assistance. V5 said the facility implemented a chair/bed pad alarming device to alert staff when R1 attempts to get up without assistance. V5 said she had not seen R1's chair/bed alarm recently

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when she visited R1 about a week before R1's fall.

On 4/4/2024 at 12:30pm, V13 (Registered Nurse/ RN) said R1 uses a chair/bed pad alarm as a safety precaution to help prevent him from getting up and falling. V13 said she has performed safety rounds on R1's hallway and has seen R1's chair/bed pad alarm in his bedside recliner in the past. V13 was asked to point out where R1's chair/bed pad alarm was at, since the alarm pad could not be located in R1's room at the time of this interview. After searching, V13 responded she could not find the alarm.

On 4/9/2024 at 8:45am, V20 (RN) was asked if she could locate R1's chair/bed pad alarm since a search of R1's room could not locate the alarm at the time of this interview. After searching, V20 said she could not find the alarm.

On 4/4/2024 at 12:40pm, V6, V14, V15 (all Certified Nursing Assistants/CNA) said they are the usual day time staff who provide care for R1 and R1 is supposed to have a chair/bed pad alarm on.

On 4/4/2024 at 2:40pm, V7 (CNA) said she, V8 (CNA) and V4 (RN) were the staff providing care for R1 on 3/31/2024 at the time R1 fell. V7 said R1 likes to sleep in his bedside recliner and does not really sleep in his bed. V7 said R1 does not use a chair/bed pad alarm and only uses a call light when R1 needs assistance. V7 said R1 did not have a chair/bed alarm on when he got up and fell the morning of 3/31/2024.

On 4/4/2024 at 2:45pm, V8 (CNA) said she was working with V7 and V4 on 3/31/2024 when R1 fell. V8 said R1 did not have a chair/bed alarm on

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when he fell.

On 4/9/2024 at 8:30am, V4 (RN) said on 3/31/2024, she was working with V7 and V8. V4 said at about 5:00am, she was passing medications when she heard R1 call out for help. V4 said she saw R1 on the floor in the hallway near R1's doorway. V4 said R1 told her he was looking for the bathroom when he fell. V4 said she assessed R1, determined he had a right hip injury due to complaints of pain and sent him to the local hospital ER (Emergency Room) for evaluation. V4 said R1 did not have on a chair/bed pad alarm on 3/31/2024 when he fell.

A facility document titled "Post Fall Investigation", dated 4/1/2024 documents R1 had an unwitnessed fall due to loss of balance when ambulating without staff, had on non-skid socks, and stated to staff at the time of his fall "I was just trying to go to the bathroom." This same document has a place to mark if R1's chair/bed pad alarm was present and if the alarm was sounding at the time of the fall, however this section is left blank and nothing is marked.

On 4/4/2024 at 9:23am, V5 (family) said she received a phone call from V4 (Registered Nurse/RN) on 3/31/2024 at around 6:00am informing her R1 had fell, was complaining of right hip pain and was being sent to the local hospital ER for evaluation. V5 said the ER told her R1 had a fractured right hip and needed surgery to repair the fracture.

Th local hospital ER records dated 3/31/2024 documented R1 was seen for complaints of right hip pain after falling at his nursing home. A CT (Computed Tomography) scan and X-ray of R1's right hip documented R1 had a displaced

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intertrochanteric fracture of right femur and R1 was admitted for surgical management. These same hospital records included a document titled (local hospital) Report of Operation which documented on 4/2/2024, R1 underwent a surgical procedure of Right hip closed reduction with cephalomedullary nail to treat R1's right hip fracture.

The facility "Fall Prevention Policy" dated 11/28/2012, documents the following in part: Purpose: To assure the safety of all residents in the facility. 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. Safety interventions will be implemented for each resident identified at risk. All assigned nursing personnel are responsible for ensuring on-going precautions are put in place and consistently maintained. Fall risk interventions will be identified on the care plan.

On 4/9/2024 at 4:00pm, V1 (Administrator) pointed out R1's chair/bed alarm pad located in R1's room.
(A)