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
	IL6007207	A. BUILDING: ______ B. WING ______	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE BURBANK	**5701 WEST 79TH STREET BURBANK, IL 60459**

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S 000	Initial Comments Facility Reported Incidents of 1/23/24 IL169503 and 12/29/23 IL169502	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 c) 300.1210 b) 300.1210 d)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 300.690 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the	S9999		

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phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.

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 interview and record review, the facility failed to immediately transfer a resident to the emergency room after a fall that resulted in left hip pain and a fracture; failed to ensure a resident (R6) was not transferred from the floor after a fall

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and complaints of right upper leg pain prior to emergency medical services arriving; and failed to report a final narrative summary of reportable accidents for 2 of 3 residents (R5 and R6). These failures resulted in a surgical delay in treatment (more than 7 hour) for R5 who was experiencing left leg pain and had a fracture. These failures apply to 2 of 4 residents (R5 and R6) reviewed for quality of care in the sample of 14.

The findings include:

1. R5's Fall-Initial Occurrence Note, dated 12/29/23, shows R5 had a fall in the dining room at 1:46 PM and landed on the floor and her left side.

R5's Progress Notes, dated 12/29/23 at 8:44 PM, shows, "Left leg new onset of pain...MD (Medical Doctor) notified of new pain onset, new orders received. x-ray of left leg."

R5's X-ray report shows a reported dated and time of 12/30/23 at 12:10 AM. The report shows R5 had an impacted intratrochanter fracture with varus deformity of the left hip.

R5's Progress Notes, dated 12/30/23 at 7:30 AM, shows, "Resident noted to have pain in left leg with grimaced face. MD made aware and ordered transfer out to hospital for evaluation." (more than 17 hours after R5's fall and 7 hours after receiving x-ray results showing a hip fracture)

R5's Hospital Notes shows she had a left femur cephalomedullary nailing on 12/30/23.

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S9999	Continued From page 3 On 3/8/24 at 11:45 AM, V8 (Registered Nurse) said she did an assessment after R5 fell. V8 said R5 was not complaining of pain, but she also is not able to articulate very well if she is having pain. V8 said she called the physician and he ordered a STAT (Immediate) x-ray of her left leg to make sure there were no injuries. On 3/8/24 at 1:26 PM, V18 (Registered Nurse) said she works from 3:00 PM to 11:00 PM. V18 said on 12/29/23, it appeared R5 was having pain so she called the doctor and he ordered stat x-rays to be done. V18 said she was unsure if x-ray came during her shift. On 3/8/24 at 2:01 PM, V8, Registered Nurse, said when she came in on 12/30/23, she noticed R5 was in pain. R5 was grimacing. V8 said she looked up the x-ray results and it showed a fracture, so she called the physician and sent R5 out to the hospital. V8 said she is not sure when x-ray came, but the nurse should be looking for the results within three hours. V8 said sometimes the x-ray company calls to let the staff know of the results, but sometimes they just fax the report. V8 said it is the nurse's responsibility to follow up on any x-ray results. V8 said she is unsure why R5 was not sent out when the x-ray results were received. On 3/8/24 at 1:54 PM, V2 (Director of Nursing) said if a stat x-ray is ordered, the x-ray company will arrive within 3 hours and she thinks they have 4 hours to read the x-rays and send the report. V2 said typically the x-ray company calls if there is a fracture, but sometimes they just fax the report. V2 said she is not sure why it took so long for the nurse to review the report and send R5 out to the hospital. V2 said sometimes if a resident has had a fall and is having pain, they would not	S9999		

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wait for x-ray results, they would just send the resident to the hospital for evaluation.

The facility's Physician Notification of Laboratory/Radiology/Diagnostic Results Policy, revised on 3/14/18, shows, "STAT or "Same Day" orders will be called to the laboratory service by the nurse who transcribes the order. A nurse is responsible for monitoring the receipt of test results. Test results should be reported to the physician or other practitioner who ordered them...x-ray or other diagnostic tests reveal suspected findings which may require immediate intervention including but not limited to: Pneumonia, New fracture."

2. R6's Admission Record, (dated 3/8/24), shows she was admitted to the facility on 1/18/24, with a fracture of her left upper arm. R6's diagnoses include, but are not limited to, Alzheimer's disease, repeated falls, and syncope with collapse.

R6's Order Summary Report (dated 3/8/24) shows and order from 1/18/24 whereby R6 is to keep a shoulder immobilizer in place.

R6's Care Plan initiated on 1/18/24 shows R6 had an open reduction internal fixation (ORIF) (surgical repair) of her left upper arm bone (humerus) and should keep her shoulder immobilizer in place.

R6's Fall-Initial Occurrence Note, dated 1/28/24, shows R6 had an unwitnessed fall in her room at 8:30 AM and was found lying on the floor. R6 reported pain to her right upper leg at a level of 7 on a 0 to 10 pain scale. R6 was sent to the hospital for evaluation and treatment.

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R6's Nurse's Note, dated 1/28/24 at 8:10 AM, shows R6 was found on the floor near her bedside with complaints of right leg pain. R6 was given pain medication, assisted back to bed, then the physician was notified and R6 was sent to the Emergency Department for evaluation. R6's Progress Note, dated 1/28/24 at 3:00 PM, shows R6 was admitted to the hospital with a diagnosis of closed, non-displaced fracture of her right femur.

On 3/8/24 at 11:29 AM, V8, Registered Nurse (RN), said she was summoned to R6's room after the CNA (Certified Nursing Assistant) found R6 on the floor (on 1/28/24). V8 said she did an assessment of R6, and R6 complained of right hip pain. R6 said she and four staff members rolled a blanket under R6 and used it to lift R6 to her to bed. V8 said she then contacted the physician and was given orders to send R6 to the hospital. V8 said she called 911 and R6 was taken to the hospital by ambulance. V8 said she later contacted the hospital for an update on R6, and was told R6 had a hip fracture and would need surgery.

On 3/8/24 at 12:04 PM, V2, Director of Nursing/DON, said if a resident is found on the floor, the nurse needs to assess the resident and if there is hip pain, they need to leave them on the floor. V2 said when the ambulance, (EMS) emergency medical services arrives, they need to immobilize the resident and transfer them. V2 said staff should not move them because it could "add insult to injury." V2 also said staff should never use a blanket to transfer a patient off the floor; it's not safe and they could drop the person.

On 3/8/24 at 12:06 PM, V2 (Director of Nursing) said that R5 did have a fall that resulted in a

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fracture. V2 said that all falls that result in fractures are reported immediately to IDPH (Illinois Department of Public Health) by the administrator. V2 said that an investigation is done and a final report is given to the administrator to send to IDPH. V2 said that the final report should be sent within 3-5 days. V2 said that she cannot provide any evidence that a final report was sent to IDPH for R5's or R6's fall with fracture. V2 said that the administrator no longer works at the facility, so she does not have access to what he had reported.

The facility's Transfers-Manual Gait Belt and Mechanical Lifts Policy (revised 1/19/18) shows, "...manual lifting is not permitted."

(A)