

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2019
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NAME OF PROVIDER OR SUPPLIER APERION CARE OAK LAWN	STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453
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S 000	Initial Comments Statement of Licensure Violations Complaint investigations: 1992076/IL110620	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/09/19

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S9999	<p>Continued From page 1</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>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.</p> <p>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)</p> <p>Based on observations, interviews, and record reviews, this facility failed to develop and implement appropriate measures to minimize the risk of falls for one resident (R3) out of 4 reviewed for risk for falls in a sample of 5. This failure resulted in R3 sustaining an upper arm fracture requiring hospitalization.</p> <p>Findings include:</p> <p>On 4/3/19 at 1:00pm, R3 is observed left side lying at the edge of the bed. There are bed bolsters on each side of R3's bed and a floor mat on the left side of bed. On 4/5 at 10:30am, R3 is observed left side lying at the edge of the bed. Throughout this survey, this surveyor did not</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>observe R3 move any extremity. This surveyor did not observe any side rails on R3's bed.</p> <p>On 4/4/19 at 1:30pm, V7 LPN (licensed practical nurse) stated that after a fall, residents are assessed head to toe for any injuries. V7 stated that if the fall was unwitnessed, then neurological checks are initiated.</p> <p>On 4/5/19 at 10:30am, R3 stated that R3 does not know how R3 hurt left arm.</p> <p>On 4/5/19 at 11:00am, V6 CNA (certified nurse aide) stated that R3 does not move. V6 stated that residents that can move in bed have bed bolsters and floor mats. V6 stated that residents should be positioned in the middle of the bed to prevent a fall.</p> <p>On 4/9/19 at 10:30am, V3 ADON (assistant director of nursing) stated that R3 is not able to reposition self in bed. V3 stated that after R3's fall, floor mats were put in place. V3 stated that R3 tends to favor lying on left side. V3 stated that residents should be positioned in the center of the bed to prevent a fall occurring.</p> <p>On 4/9/19 at 3:20pm, V11 (attending physician) stated that R3 was not able to move extremities. V11 stated that in V11's opinion it is highly unlikely that R3 moved and fell out of bed.</p> <p>Review of the medical record notes R3 with diagnoses including: stroke with paralysis affecting right dominant side, left hand contracture, high blood pressure, heart failure, vascular dementia, and gastrostomy tube. On 3/16/19, R3 was re-admitted with head injury and displaced fracture of left upper arm.</p>	S9999		

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Review of R3's BIMS (brief interview of mental status), dated 3/5/19, notes R3's score is 3 out of 15.

Review of R3's fall risk assessment, dated 2/28/19, notes R3 is not at risk for falls.

Review of R3's fall occurrence, dated 3/5/19, notes R3 was observed lying on the left side of bed on R3's left side. Facility investigation determined R3 rolled out of bed which resulted in a fall related injury.

Review of R3's hospital medical record, dated 3/16/19, notes R3 was admitted to the hospital with a closed head injury, large hematoma to forehead, and left upper arm fracture.

Review of R3's falls care plan notes R3 is at risk for falls related to impaired mobility, weakness, dementia, stroke with right sided paralysis, and left hand contracture. Interventions identified include: encourage and educate R3 to use call light pad by using chin/cheek to press, frequent round check, and check/change for incontinence. After fall on 3/5/19, R3's care plan was updated to include hourly monitoring for placement in bed.

Review of R3's bed mobility care plan, dated 2/22/18, notes R3 requires assistance with bed mobility due to immobility. Interventions identified include: bilateral half side rails, provide encouragement, and provide assistance as tolerated.

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(B)