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
	IL6008650	A. BUILDING: _____ B. WING _____	C 08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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#1945873/ IL# 114743	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d) 6) 300.3240 a) 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. d)Pursuant to subsection (a), general nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

These regulations were not met as evidenced by:
Based on record review and interview, the facility failed to implement effective interventions and provide supervision to prevent injury for multiple falls for 1 of 3 residents (R2) reviewed for falls in the sample of 3. This failure resulted in R2's fall sustaining a laceration to her head which required 5 sutures, and R2's fall sustaining a left hip fracture which required surgery and pinning of her left hip.

Findings include:

R2's Fall Risk Assessment, dated 9/12/18, documents a score of 11 indicating at risk for falls.
R2's Fall Risk Asssessment, dated 9/28/18, documents a score of 14 indicating at risk for falls.
R2's Fall Risk Assessment, dated 2/7/19, documents a score of 15 indicating at risk for falls.

R2's admission Minimum Data Set (MDS), dated 7/17/18, documents that R2 requires extensive

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assistance and two plus physical assistance for bed mobility transfers and toileting.
R2's MDS, dated 10/11/18, documents that R1 requires extensive assistance and two plus physical assistance for bed mobility, transfers and toileting. R2's MDS also documents R2 has severely impaired cognitive skills for daily decision making.
R2's MDS, dated 8/7/19, documents that R2 requires extensive assistance and two plus person physical assistance for bed mobility, transfers and toileting.

R2's Nurses Notes, dated 9/12/18, document that R2 had an unwitnessed fall at 3:45 PM when R2 was found on the floor next to bed. The Notes document that R2 stated that she was attempting to get into bed and slid. R2 noted to have a laceration to forehead. Call light in reach but was not turned on. Res had non-skid socks on foot. The Nurses notes document R2 was sent to the hospital. Nurses notes, dated 9/12/18, document R2 returned at 9:33 PM from the hospital with 5 sutures to forehead.
R2's Fall Interdisciplinary Team (IDT) note, dated 9/13/18, documents root cause of fall: attempting to get out of bed per self to go to supper. Poor safety awareness, Poor visual eyesight. Appears resident was furniture surfing. Interventions: Skid strips to bedside and bathroom, therapy to screen.

R2's Nurses Notes, dated 9/28/18, documents resident had an unwitnessed fall at 1:30 PM when found lying on the floor in room. Appears to have been trying to transfer herself from the bed to the wheelchair. Nurses Notes, dated 9/28/18, Fall IDT note documents root cause as resident was self transferring from her wheelchair to her bed and fell onto the floor. Intervention resident was

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reminded to ask and wait for assistance. Resident's room was rearranged. Staff to assist resident when resident is approaching her room as tolerated. Therapy to screen. MD (Medical doctor) and POA (Power of Attorney) notified.

The Facility's fall incident report, dated 2/7/19 at 2:05 PM, documents an unwitnessed fall with R2 trying to transfer with the help of another resident and fell on her bottom. The form documents no injuries.
R2's Care Plan, dated 3/1/19, documents that R2 is at risk for fall related to severely impaired cognition, unsteady gait, incontinence, medication, non- complaint use call light. Intervention listed are: 2/7/19 therapy to screen, peer resident room moved, remind to use call light, Bright tape placed around call light to remind to use.

R2's Nurses Notes, dated 7/2/19 at 9:55 PM, documents R2 found to be sitting upright on floor next to bed. R2 stated she was trying to get out of bed. R2 had very small laceration to back of the head with minimal bleeding and small hemotoma surrounding the area. Nurses notes document physician via live video regarding incident, send to hospital for CT (computerized tomography) of head. CT results within normal limits.

R2's Care plan documents the intervention dated 7/2/19 documents resident sent to ER (emergency room) for evaluation, therapy will screen upon return, resident will be checked on by staff prior to shift change and after toileting, snack and conversations.

The facility's fall incident report, dated 7/24/19 at 3:45 AM, documents R2 pulled the fire alarm, and slid out of the wheelchair on the floor. R2's

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Nurses note, dated 7/24/19 at 8:59 AM, documents that R2 up in wheelchair at change of shift and yelling "help me."
R2's Nurse's Notes document R2 stated that her leg hurt, and yelled out in pain when leg touched. R2's Nurse's notes document that R2 was sent to hospital for evaluation at 9:18 AM.

R2's hospital x-ray report dated 7/24/19 at 9:40 AM documents acute fracture of Left distal femur with soft tissue swelling, and deformity.

R2's Exam : Hip Pinning Left dated 7/24/19 documents that R2 had left hip nailing done in the Operating room.

R2's Care Plan documents intervention dated 7/24/19: sent to ER for evaluation and treatment. A non slip pad placed in wheelchair will be evaluated upon return from the hospital.

On 8/14/19 at 10:23 AM, V9, R2's primary physician, was interviewed by telephone. V9 stated that reminding a resident with Dementia is an ineffective intervention as they will not remember.

The Facility's Fall Prevention Program policy and procedure, dated 11/28/12, documents the fall prevention program includes the component of immediate change in intervention that were unsuccessful

(A)