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 01/06/2021

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

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S 000	Initial Comments Complaint Investigation 2059853/IL129597	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610)a 300.1210b) 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	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. 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 EVIDENCED BY: Based on interview, observation, and record review, the facility failed to use side rails and supervise resident during meal time for 1 of 3 residents (R2) reviewed for falls in the sample of 3. This failure resulted in R2 falling out of bed and sustaining 2 fractures of the cervical spine. Findings include: R2's Medical Records, Diagnoses, documents the following diagnoses: Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, Lack of Coordination, Cerebral Infarction, Repeated Falls, and Alzheimer's Dementia. R2's Care Plan, dated 10/9/20, states Focus: "(R2) is at risk for falls r/t (related to) Gait/balance problems, has history of frequent falls at home. Intervention: (R2) needs a safe environment with: .....Side rails as ordered." Another Focus documented on the 10/9/20 Care Plan is "I have	S9999		

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S9999	Continued From page 2 been assessed to need bedrails. Intervention: I will benefit from side rails to enable bed mobility." R2's Side Rail Assessment, dated 5/21/18, documents the following: Used for positioning, and mobility aid. Use 1/2 right, and left rails. Use to increase bed mobility, increase transfer ability, and increase independence for self care. Physician Order, dated 7/20/20 documents, "Side rails as Enabler." R2's Fall Risk Assessment 1, dated 10/6/20 and 12/26/20, is scored 12 and R2 is documented as "At Risk for Fall." R2's MDS (Minimum Data Set) Section C, dated 11/3/20, documents a Brief Interview Mental Status that is scored a 7 indicating R2's Cognition is Severely Impaired. Section G-Functional Status for Eating (how resident eats, and drinks regardless of skill) indicates that a One Person Physical Assist is required while eating. In R2's Medical Record, the Fall-Initial Occurrence Note documents the following: Resident had an un-witnessed fall 12/20/2020 at 2:47 PM Location of Fall: Residents Room. Staff was alerted to resident room, when residents roommate yelled out for help. Resident was found on floor on her back. Staff had just assisted resident in room and placed her tray on her bedside table over her lap. Residents side rail on right of bed was not put back into place. Residents tray was found on the floor. Resident assessed, vitals WNL (within normal limits), small skin tear to right heal, and resident has raised area to front of forehead. Neuros WNL on 12/20/2020 at 2:47 PM.	S9999		

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R2's Nurse's Notes, dated 12/20/2020 at 3:06 PM, Narrative: Spoke with ER; resident (R2) has a burst C1 fracture and is being sent to (Regional Hospital).

R2's Emergency Room Physician Documentation, dated 12/20/20, states 'Complaint of Patient sitting up eating lunch, and rolled out of bed landing on the front of her head. Diagnoses: Fracture of Cervical Vertebra and other parts of Neck- C1 Burst Fracture and C2 Dens Fracture. Resident transferred to (Regional Hospital) for further care.

R2's CT (Computed Tomography) Spine Report, dated 12/20/20, Impression: Nondisplaced Type II Odontoid Fracture and Burst Fracture of C1.

On 12/24/20 at 2:00 PM, R2 was sitting by the Nurse's Station in a high back wheelchair sleeping and would not respond when aroused. R2 had a bluish green bruise to her forehead with dried abrasions. A cervical collar was in place.

On 12/24/20 at 3:15 PM, V4 (Certified Nurse Aide/CNA) stated that she set R2 up in her bed for lunch and she fell out of bed, knocking over the bed table over. Side rails were not up due to the over the bed table was in place. R2 was left without a person to help her eat so other trays could be passed to other residents. V4 stated that now the staff has to get R2 up in a chair when she eats.

On 12/24/20 at 3:00PM, V3 (Registered Nurse) stated that R2 fell out of bed on Sunday and was sent to the ER. She was placed up in bed to eat as she was able to feed herself. The CNA left R2's room to pass trays to other residents. She

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S9999	Continued From page 4	S9999		

was eating on a over the bed table when she fell out of bed. She is always confused but eats 100% of her meal. Her side rails were not in place due to the over the bed table. Due to the fall R2 received a bruise on her forehead, and a C1 Burst Fracture. R2 requires physical assistance during mealtimes.

On 12/24/20 at 1:30 PM, V2 (Director of Nursing) stated that R2 recently had a fall during lunch and was sent to the ER (Emergency Room). R2 was diagnosed with a fracture of the C1. R2 is very confused and now wears a cervical collar. On 1/5/20 at 8:30 AM, V2 stated that V4 (Certified Nurse Aide) took the tray into R2's room. R2 was in bed so V4 rolled the head of her bed up and put the side rail down because R2 could not reach the table with the side rail up. R2 needs the side rails due to poor positioning control. R2 needs the side rails to be up at all time while she is in bed. R2 also has a wheelchair with special positioning to accommodate R2's needs. V4 left R2 to pass lunch trays to other residents.

On 1/5/21 at 8:51 AM, V7 (Physician) stated that R2 is almost 100 years old and had been declining with her other medical issues. The nursing home is at fault for R2's fall and fracture of C1. V7 stated the side rail should have been up. V7 stated he has talked to the Director of Nurses regarding this issue. R2 is now on Hospice per the family's request.

On 12/24/20, V1 (Administrator) stated that side rail assessments are reviewed quarterly during care plan meeting and are not altered in the system unless changes are made.

R2's Fall IDT (Interdisciplinary Team), dated 12/21/20, Root Cause of Fall: Resident eating in

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S9999	Continued From page 5 Bed. Intervention and Care Plan Updated: Resident should be up in chair for all meals. Fall Prevention Program policy, revised 11/21/17, states the following: Safety interventions will be implemented for each resident identified at risk. Residents will be observed approximately every 2 hours to ensure the resident's is safely positioned in the bed or a chair and provide care as assigned in accordance with the plan of care. " B"	S9999		