STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002547	A. BUILDING: _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

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S 000	Initial Comments Complaint Investigation: 239101391/IL167460	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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.	S9999		

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S9999	Continued From page 2 These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to place effective fall prevention interventions to include monitoring to reduce or prevent the risk of falling for a cognitively impaired resident with a behavior of getting out of bed unassisted. This affected one of three residents (R1) reviewed for fall prevention. This failure resulted in R1 being involved in a fall incident suffering resulting in a hematoma to the left eye. Findings Include: R1 is an 82-year-old with the following diagnosis: Alzheimer's Disease, Dementia, and Adult Failure to Thrive. A Fall note dated 12/5/23 documents around 4:35 AM R1 was found in R1's room on the floor. The physician was notified and ordered to send R1 out to the hospital for an evaluation. The ambulance arrived around 7:15 AM. R1 was alert but confused. A large hematoma to the left eye was noted. The Fall Occurrence note dated 12/5/23 documents the fall occurred around 4:35 AM. The fall was unwitnessed in R1's bedroom. During rounds, R1 was observed on the floor with a bump to the left eyebrow. R1 was assessed for other injuries none were noted. R1 was safely transferred back into the bed. R1 was unable to give an adequate description of what occurred but stated, "I hurt myself. I didn't mean to hurt myself. I am sorry." R1 has a gait imbalance and is confused. The physician was notified and ordered to send R1 to the emergency room for further evaluation. R1 is alert and oriented per	S9999		

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S9999	Continued From page 3 baseline. There is no documentation of when R1 was last monitored by staff before the fall. The Hospital Records dated 12/5/23 documents R1 presented to the emergency room for an evaluation of a head injury after an unwitnessed fall. R1 has left periorbital edema and bruising. R1 is alert and oriented times one at baseline. A CT (computed tomography) scan of the head and C spine were negative for fractures or brain bleeds. Left periorbital soft tissue swelling is noted. Family is at the bedside and plan to discharge R1 home. The photos submitted by the complainant were reviewed. The second picture of R1 with a hematoma covering the entire left eye. There is a large bump to the upper left eyelid. R1's eye is closed. On 12/6/23 at 2:16PM, V3 (Restorative/Fall Nurse) stated when R1 was initially assessed, R1 was lethargic and would not respond verbally. V3 endorsed a family member was at the bedside during the assessment and endorsed R1 was ambulatory before going to the hospital. V3 reported R1 was a high fall risk because R1 was a new admission, not able to get up and walk, and had decreased cognitive function. V3 stated fall mats were put in place as an intervention. V3 denied R1 was able to follow any directions. V3 endorsed R1 rolled out of the bed onto the floor on the floor mat per the report from staff. V3 stated V3 asked the family member at the bedside if they wanted to put the bed bolsters on at the time of assessment, but the family denied. V3 reported R1 did not need the bed bolsters at that time because R1 was not actively trying to	S9999		

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S9999	Continued From page 4 get out of bed when the assessment took place. V3 stated if V3 was aware that R1 was more active after the assessment, then bed bolsters would have been put into place as an intervention to help prevent any falls. On 12/6/23 at 2:42PM, V2 (DON) stated R1 fell and bumped R1's head. V2 endorsed residents are rounded on every two hours, but when a new admission is in the facility, staff should check on them every time they walk by the room. V2 denied being aware of when the last round was made on R1 before R1 was found on the floor. V2 stated R1 was a high fall risk due to a history of falls, and R1's cognition level. V2 denied being aware of any behavior of R1 continuing to attempt to get out of bed without assistance. V2 stated if a resident is having a behavior where they're getting out of bed constantly, then staff should be making restorative or V2 aware. V2 endorsed the care plan would then be reviewed to see if any additional interventions could be added. On 12/6/23 at 2:52PM, V4 (Nurse) stated R1 was able to roll from side to side in the bed without any assistance. V4 endorsed R1 was a high fall risk based on the history of Dementia and a fall history. V4 reported seeing R1 being taken away by ambulance the morning of the fall. V4 stated there was a large "knot" on R1's left eyebrow that was about the size of a golf ball. V4 endorsed R1 had a habit of staying up all night and sleeping during the day. V4 reported this made R1 higher fall risk because R1 was more active when less staff were in the building for monitoring. On 12/6/23 at 4:32PM, V5 (Nurse) stated R1 was alert to self only and denied R1 being able to follow any directions. V5 endorsed R1 did attempt to get out of bed without assistance on the day of	S9999		

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S9999	Continued From page 5 admission. V5 reported redirecting R1 back to bed, but R1 did not follow directions and kept attempting to get out of bed. V5 stated R1 was then put in a wheelchair and taken into the nurse's station for closer monitoring. V5 endorsed R1 is a high risk for falls because R1 does not have good mobility and has a decreased cognition level. V5 reported if a new resident does not want to stay in the bed, then staff should get them up and set them in an area where more staff is available to monitor them. V5 stated V2 or the restorative department should be made aware of the behavior so new interventions can be put in place. On 12/7/23 at 8:05AM, V6 certified nursing assistant (CNA) stated V6 was assigned to R1 the day before the fall. V6 endorsed on this day R1 kept hanging R1's feet off the side of the bed where R1 would be half in the bed and half out of the bed. V6 reported other staff would be calling for help from R1's room because they caught R1 attempting to get out of bed without any help. V6 stated the nurse staff decided to put R1 in a wheelchair and take R1 to the dining room to be monitored more closely. V6 denied R1 being able to follow any directions. V6 stated when residents continue getting out of the bed, staff bring them to an area that has more people to be more closely monitored. V6 endorsed telling the nurse that R1 kept getting out of bed but is unaware if the nurse told anyone else to put in further interventions. V6 reported R1 is a high fall risk because R1 was confused and could not stand alone. On 12/7/23 at 10:31AM, V7 (CNA) stated R1 was found in R1's room on the floor but V7 was not able to remember an exact time R1 was found. V1 reported sometime between 2AM and 4 AM R1 was found on the floor mat. V7 endorsed staff	S9999		

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S9999	Continued From page 6 was checking on R1 every two hours but they would try to check on R1 every hour. V7 reported R1 would hang R1's legs over the side of the bed and staff would reposition R1 back in the bed. V7 endorsed R1 was able to move without assistance in the bed. V7 denied R1 was able to explain how the fall occurred because R1 is confused. V7 stated V9 (Nurse) knew R1 kept trying to get out of bed and was moving around a lot that night. V7 endorsed staff would put R1 back to sleep when they found her attempting to get out of bed alone and direct R1 to stay in bed. V7 reported R1 would get back in bed when redirected but when checked on again, R1 would be attempting to get out of bed alone. V7 denied R1 followed the direction to stay in bed. V7 denied remembering when V7 rounded last on R1. On 12/7/23 at 11:00AM V1 (Administrator) stated R1 was able to move from side to side in the bed alone. V1 endorsed the fall was unwitnessed. V1 reported R1 was a high fall risk due to being a new resident and having bouts of confusion. V1 stated the staff was still trying to assess R1's baseline because R1 was a new resident. V1 stated if R1 was not at the previous baseline that R1 was admitted at, then that should have been reported to the next nurse or V2 to follow up with the physician and the care plan should have been reviewed for any new intervention needed. On 12/7/23 at 1:50PM, V8 (Primary Physician) stated R1 had intermittent confusion probably due to being in a new environment along with generalized weakness. V8 endorsed sometimes residents are more confused after coming to a new facility when they have dementia, and the confusion can be worse until they get settled into a new place. V8 stated, "with these types of	S9999		

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S9999	Continued From page 7 residents, staff should keep them near the nurse's station with a low bed, and if they have anyone available to be sitting with them while they're awake, then they should be doing so." V8 denied being aware of R1's behavior of getting out of the bed unassisted before the fall. V8 endorsed if V8 was made aware of the behavior a psych consult would have been ordered to see if they could have evaluated R1 to manage the behavior with medication. On 12/7/23 at 2:12PM, V9 (Nurse) stated V7 found R1 on the floor mat next to the bed. V9 reported R1 had a bump to the left forehead. V9 reported when R1 was asked what happened the only thing R1 could say was "I'm sorry I hurt myself." V9 endorsed the fall happened around 4 AM. V9 stated R1 was a high fall risk due to being a new resident and being confused. V9 endorsed the night of the fall R1 kept sitting up at the edge of the bed. V9 reported while doing rounds, V9 would lay R1 back down to try to get R1 to sleep. V9 stated V9 repositioned R1 two or three times before the fall. V9 endorsed being assigned to R1 on the 2 PM to 10 PM shift and the 10 PM to 6 AM shift. V9 stated during the evening shift, R1 was in a wheelchair sitting by the nurse's station because R1 kept trying to get out of bed alone during the dayshift. V9 reported putting R1 back to bed because staff did not want R1 falling asleep and falling out of the chair. V9 was not able to answer how the left eyebrow bump occurred if R1 fell onto the floor mat next to the bed. V9 stated there is a possibility R1 fell off the mat when R1 fell out of bed. V9 reported if a resident is having a behavior where they are trying to get out of bed unassisted then it should be passed onto the next nurse or to the restorative department. V9 endorsed the restorative department would put in new	S9999		

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S9999	Continued From page 8 interventions for a resident, and they are in charge of putting in interventions unless it is an emergency situation. V9 reported V9 could have called V2 to get access to the bed bolsters that night, but staff instead kept redirecting R1 back to sleep. V9 stated R1 would go back to sleep for an unknown amount of time before getting up again. V9 endorsed the size of the bump on the left eyebrow was about the size of a walnut and it did grow a "little bit" bigger by the end of the shift. V9 denied remembering the time R1 was last rounded on before the fall. V9 stated between V7 and V9 they were attempting to round on R1 every hour. The Admission Hospital Records dated 11/19/23 document R1 was admitted to the hospital for Acute on Chronic Encephalopathy Versus Worsening Dementia and Adult Failure to Thrive. R1 is alert and oriented times one at baseline and is able to follow one step commands with reinforcement. R1 has decreased balance, upper extremity/lower extremity strength, and impaired cognition. The Admission Observation dated 11/30/23 documents R1 arrived from the hospital with a diagnosis of Failure to Thrive. R1 is total dependence for bed mobility, transfers, and all ADL (activities of daily living) care. The skin assessment documents the only skin alteration is to the sacrum, which is a small, excoriated area. The Fall Risk Assessment dated 11/30/23 documents R1 is at risk for falls due to intermittent confusion, history of falls, medical history, and being chairbound. The Fall Risk Assessment dated 12/5/23 documents R1 is still at risk for falls for the same reasons listed as above.	S9999		

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S9999	Continued From page 9 The SBAR Communication Form dated 12/5/23 documents R1 fell, and a "bump" is noted in the skin evaluation, but is not documented where on the body. The Brief Interview for Mental Status dated 12/4/23 documents the score as zero (severe cognitive impairment). The Care Plan dated 12/4/23 documents R1 is at high risk for falls related to a decrease in strength and endurance, gait/balance problems, incontinence, and adult failure to thrive. All interventions were documented on 12/4/23. There are no interventions documented before the fall addressing R1's behavior of continuously attempting to get out of bed. There is no documentation on the care plan regarding what kind of monitoring R1 requires as a high fall risk actively attempting to get out of bed. The IDT Fall Committee Meeting dated 12/5/23 documents during rounds, R1 was observed on the floor mat with a bump to the left eyebrow. Contributing physiological factors to the fall are documented as gait imbalance, incontinence, weakness, confused, impaired memory, forgets to use call light, and declining cognitive skills. The root cause of the fall was determined to be R1 rolled out of the bed onto the floor mat. Interventions in place at the time the fall were floor mats. The policy titled, "Fall Prevention Policy," dated 11/21/17 documents, "Standards: ... All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained ...Inform family of risk factors and reinforce interventions as needed ...	S9999		

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S9999	Continued From page 10 In addition to the use of Standard Fall Precautions, the following interventions may be implemented for residents identified at risk: the resident will be checked, approximately every two hours, or as according to the care plan, to assure they are in a safe position. The frequency of safety monitoring will be determined by the resident's risk factors in the plan of care." (B)	S9999		