STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145969	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Forest Park	8200 West Roosevelt Road Forest Park, IL 60130

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on observation, interview, and record review the facility failed to implement fall prevention interventions for one of three (R1) residents reviewed for falls. Findings include: R1's diagnosis include but are not limited to Systolic Congestive Heart Failure, Dementia, Anxiety, Alzheimer's Disease, Hemiplegia and Hemiparesis following Cerebral infarction, Osteoarthritis, History of Falling, Glaucoma, and Blindness in One Eye. The facility's List of Incidents includes R1's falls on 8/27/24 and 9/13/24. R1's Fall Risk assessment dated [DATE] notes R1 is at risk for falls. R1's Fall Risk assessment dated [DATE] notes not at risk for falls. R1's Cognitive patterns assessment dated [DATE] identifies R1 as moderately impaired - decisions poor; cues/supervision required. R1's Functional Ability assessment dated [DATE] notes R1 requires partial/moderate assist with toileting hygiene, dressing, personal hygiene, toilet transfer and walking. The facility's Facility Reported Incident documents on 9/13/24 at approximately 5:20AM the nurse was notified that R1 was observed in R1's bathroom, sitting on the floor. Resident noted to have open area to left eyebrow. R1 sent to the hospital for evaluation. R1's hospital records dated 9/13/24 states R1 notable for left maxillary ecchymoses, left eyebrow 2 cm laceration. Repeat CTB, CT C spine without acute injury. No subdural hematoma present. CT face with left cheek soft tissue injury, no fracture, or dislocations. On 10/17/24 at 10:35AM R1 observed in bed, in a gown. A walker observed against the wall, of R1's end of bed, out of R1's reach. On 10/17/24 at 10:46AM V2, CNA, said R1 requires 2 staff to assist her out of bed and into the reclining chair. V2 said R1 requires staff assist with incontinence cares. V2 said I haven't changed her yet today. V2 said that is her walker there (pointed at walker against the wall). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/24 at 9:58AM V7, Certified Nursing Assistant (CNA), said R1 (before her fall on 9/13/24) generally needs one person assist to get to the bathroom and getting out of bed. V7 said R1 would try to get up on her own and she walks without her walker. V7 said for care, V7 makes sure R1 is toileted, because part of the reason she gets up is to use the bathroom. V7 said R1 will try to get up at night when she is wet and tries to get up unassisted. V7 said R1 can be non-cooperative at times and she won't ask for help. On 10/18/24 at 11:30AM V20, CNA, said on 9/13/24 I was giving care to another resident next door to R1. V20 said I heard something in the hall like someone moving a chair. V20 said I went in R1's room and she was on the floor in the bathroom. V20 said I saw R1 at 3:45AM and she was asleep. V20 said I think she slept all night. V20 said when R1 gets up and walks around, we watch her, she does try to get up a lot by herself. V20 said R1 can't see and R1 did not take her walker to the bathroom. V20 said R1 might have been barefoot, the nurse might have put the socks on her after she fell . V20 said on that shift R1 had not been to the bathroom at night. Everyone we watch is a fall risk. V20 said R1 does not use the call light and R1 can't see if the button is not in her hand so R1 isn't able to use it. On 10/17/24 at 1:21PM V3, Registered Nurse (RN), said I saw R1 in bed and then started medication pass. V3 said a CNA told V3 that R1 fell in the bathroom. V3 said R1 was sitting on her buttocks. V3 said R1 went to the bathroom by herself. V3 said we always have to redirect R1 and R1 doesn't like to use the walker. V3 said R1 is safe to ambulate with a walker. V3 said R1 does not remember to use the walker or the call light. On 10/17/24 at 12:04PM V1, Licensed Practical Nurse (LPN), said R1 is confused and R1 walks with a walker. V1 said R1 leaves her walker and ambulates without it. V1 said on 9/13/24 R1 was trying to go to the bathroom. V1 said it is usual for R1 to try to get up, she is confused and will get up and go by herself. V1 said R1 was considered a fall risk and on 9/13/24 R1 had left the walker at the bedside and R1 does not sleep with non-skid socks on, and she was barefoot, I think. V1 said V1 investigated R1's fall on 9/13/24. On 10/17/24 at 2:10PM V5, Director of Nursing, said prior to 9/13/24 R1 has a history of falls. V5 said R1 was at moderate risk for falls on 9/13/24. V5 read the facility Risk Management report to the surveyor. (Facility would not give the report for review stating the reports are internal records.) V5 read that R1 sustained a laceration to the face. R1's mental status alert x 1 to person. Predisposing environmental factors: no. Pre-disposing physiological: gait imbalance, need to void, vision impaired all selected. Situational factors: wanders. First statement is V20's and the second is V3's statement. V5 said R1 did not have non-skid socks/shoes at the time of the fall. V5 said R1 tends to take off socks and shoes and this increases her risk for falls. V5 said if R1 uses her walker she is safe to ambulate. V5 said R1 is inconsistent with the use of her walker. V5 said the interventions following the fall were to evaluate at emergency room and offer toileting, rounds more frequent, and assist as needed. The surveyor asked V5 what is being done different from before R1's fall that occurred on 9/13/24 to prevent a fall? V5 said I guess we are not doing anything different. On 10/18/24 at 10:32AM V5 said the daily get up list is for residents on dialysis, fall risk , and early birds who get up early. V5 said R1 is an early bird and fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan dated 10/11/23 identifies R1 requires substantial to max assist for toilet transfers and partial assist with toilet hygiene. R1's risk for falls care plan initiated on 8/16/23 and revised on 10/4/24 documents R1 requires assist with ADLs (activities of daily living), Dementia, history of fall, visual deficits, possible medication side effects, incontinence, abnormal gait/mobility, and reduced mobility. Interventions include to add resident to get up list/assist to common area on 4/24/24 and to add R1 to the Falling Leaf Program (9/13/24). Assist with toileting upon awakening, before and after meals, during rounds, before bedtime PRN (8/17/23). Ensure the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair (8/16/23). Ensure the call light is within reach and encourage the resident to use it for assistance as needed. Resident to wear high top gym shoes for additional ankle support (8/21/24). The facility's Document titled Un-witnessed Fall 9/13/24 includes a statement by V20 that V20 did round on R1 at 3:45AM and resident was resting in bed. I checked her for incontinence, noted to be dry. At 5:20AM I was in the room next door. I heard moving around and went into R1's room and observed R1 on the floor. A second statement (DON said is the nurses statement) writer informed by the CNA that resident was observed sitting on the floor in bathroom. Resident sitting on the floor noted with open area to her left eyebrow. Resident assisted back to bed. Non-skid socks applied on both feet. The Fall Committee Meeting Note dated 9/13/24 Summary documents, writer informed R1 sitting on the floor in bathroom. Observed R1 sitting on the floor with laceration to her left eyebrow. R1 verbalized I went to the bathroom to pee and I fell . Contributing factors include Confused, impaired memory, antihypertensive user. Situational factors: using walker and other recent fall. Prior interventions and support provided: non-skid socks/footwear in place (no other intervention marked, options include call light in reach, bed in lowest position, mat at bedside). Comments: Ensure R1 is wearing appropriate footwear when ambulating, to wear proper fitting shoes, on get up list and brought to common area (interventions added April and August 2024). The root cause of the fall determined by team documents R1 is non-compliant with use of assistive device and non-skid footwear. What new interventions were put in place immediately after the fall to prevent further falls? Nonskid footwear (care plan notes this was already a current fall prevention intervention that was previously initiated on 8/16/23). Changes suggested by the team: Sent to hospital for evaluation. Offer toileting during rounds, which was already a current fall prevention in place for R1 and to assist as needed. Facility Fall/Incident Occurrence Assessment and Documentation Guidelines dated 1/4/16 states ensure resident's environment is safe. Fall Prevention Program dated 11/28/12 states the purpose is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Care plan incorporates preventative measures. Standards include safety interventions will be implemented for each resident identified at risk. Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and is addressed on the plan of care. Footwear will be monitored to ensure the resident has proper fitting shoes and footwear is non-skid