STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145996	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Hillside	323 Oakridge Avenue Hillside, IL 60162

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 - 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** 49740 Based on observation, interview, and record review, the facility failed to provide adequate supervision for three (R4, R3, and R2) of three residents reviewed for supervision. These failures resulted in R4 falling when trying to stand up from his wheelchair unassisted and sustaining a cut on his head that required five stitches; and resulted in the facility failing to keep a resident (R2) safe from being struck by another resident (R3) who has known poor impulse control and behavior of randomly swinging his hands or fists. Findings include: 1. R4 is a cognitively impaired [AGE] year-old former resident, admitted to the facility on [DATE] and discharged on [DATE], with diagnosis listed in part, but not limited to difficulty in walking; lack of coordination; abnormal posture; weakness; history of falling; cataract, left eye; and disorders of psychological development. On 07/03/2024 at 12:14 PM, V10 (CNA) said she considered R4 to be a fall risk. V10 said R4 was sitting in the dining room on 05/09/2024 at about 6 PM, along with one or two other residents while she and the CNA staff were doing rounds, when she saw R4 grip his wheelchair, stand up, fall forward, and crack his head. V10 said she ran to R4 but didn't make it on time. V10 said the staff called 911, and the nurse put pressure on R4's head. V10 said the PM shift staff supervised the two or three residents in the dining area on 05/09/2024 by taking turns looking, checking as they would be going back and forth on their rounds but said no one staff member was on duty exclusively at the dining area. Per the facility daily nursing assignment for 05/09/2024, the PM shift consisted of two nurses and four CNA's. A nursing progress note by V8(LPN), dated 05/09/2024 at 6:45 PM, said V8 was down the hall passing medications when she was notified by staff R4 had fallen in the dining room. V8 said she immediately went to assess R4, whom she observed laying upward on the floor next to his wheelchair and bleeding from his forehead. V8 said R4 told her he was trying to go to his room and hit his head. V8 said she cleaned R4's forehead with normal saline and a small cut was noted. V8, then, applied pressure and wrapped R4's head with gauze, 911 was called, R4 was sent to local hospital, and the physician, director of nursing, and power of attorney were notified. (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 - Actual harm Residents Affected - Few	A nursing progress note by V8, dated 05/09/2024 at 9:32 PM, stated a CT of R4's head was normal and R4 received 5 stitches to his forehead at the hospital. On 07/02/2024 at 2:00 PM, V2 (Director of Nursing) said R4 had fallen a few times, had no safety awareness, and thought he could walk but could not. V2 said on 05/9/2024, R4 wanted to go to the bathroom from the dining room but did not make it. V2 said the dining room fall on 05/09/2024 was witnessed by a CNA, who was across the room and tried to get to him but did not make it. V2 said R4 would try to go to the bathroom, even when he did not need to and needed assistance from staff with a gait belt and a walker. V2 said she was told by the group home R4 came from that he had over 30 falls in the last couple of months at the homw. V2 said she believed R4 needed 1:1 supervision. On 07/02/2024 at 4:24 PM, V1 (Administrator) said on 05/09/2024 R4 was in the dining room wearing an incontinence brief but still had a sensation to go. V1 said R4 stood up and took one step or two. V1 said one CNA was over near room [ROOM NUMBER], near the break room, saw R4 stand, and immediately responded but could not get there quick enough. V1 said the three other CNA's working that shift were doing rounds. V1 said the fall was very quick and the only way to have stopped R4 from falling was to have been right next to him, as in one-to-one care. V1 said someone was always monitoring the dining room where the higher risk residents were. V1 said she would always tell her staff to make sure they were always rotating so that one person was always with the residents in the dining area. V1 also said she viewed the video footage of the dining room area on 05/09/2024 and saw the CNA race toward R4, but it all happened in an instant. On 07/03/2024 at 2:08 PM, V11 (Medical Director) said R4 had an intellectual disability, was very hard to re-direct, adamant he could do things himself, not eating well, unsteady on his feet, and should not be walking on his own. V11 also said he did not think the facility could provide 24/7 care for R4. R4's fall risk assessments, dated 04/29/2024, 05/03/2024, and 05/09/2024, all stated R4 was, at risk for falls, due, in part, to a balance problem while standing and walking, and requiring the use of assistive devices, and intermittent confusion. R4's 72-hour occurrence charting, dated 05/03/2024, interventions in place for R4 are listed as, bed in lowest position; padded mats at bedside; and call light in reach. Also, the note, remove blankets from wheelchair when locomoting is included. Per R4's 72-hour occurrence charting, dated 05/11/2024 (after above fall), interventions in place for R4 are listed as, bed in lowest position; call light in reach; non-skid socks/footwear in place; and behavior monitoring. Also, the note, resident placed with view for safety monitoring is included. Per R4's progress notes, it was noted that R4 fell on [DATE], 05/09/2024, and 05/22/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R4's care plan, dated 05/09/2024, stated he needed help to perform basic daily activities like toilet use, eating, bathing, oral and personal hygiene, and bed mobility, due to spastic quadriplegic cerebral palsy. R4 also was a fall risk. However, the only interventions in place for R4 were to remove blankets from R4's wheelchair when he was moving about, added on 05/03/2024; a toileting program, added on 05/09/2024; fall risk assessments; non-skid footwear when up; and therapy, as ordered. No intervention to monitor R4 more closely, like one-to-one monitoring, due to his impulsivity and belief that he could stand up and do things by himself was noted in his care plan. 2. R3 is a cognitively impaired [AGE] year-old former resident, admitted to the facility on [DATE] and discharged on [DATE], with diagnosis listed in part, but not limited to seizures; schizophrenia; vascular dementia; schizoaffective disorder, bipolar type; drug-induced dystonia; and drug-induced sub-acute dyskinesia. R2 is a [AGE] year-old cognitively impaired resident, admitted on [DATE], with diagnosis listed in part, but not limited to acquired absence of left and right feet; schizoaffective disorder; anxiety disorder; cognitive communication deficit; insomnia; weakness; and tobacco use. On 06/27/2024 at 12:43 PM, R2 said on 04/29/2024, she was sitting down on her wheelchair, coming in from a smoke break, waiting for the second door to open, when R3 came alongside her on his wheelchair and tried to pass her up. R2 said she grabbed the handle of R3's wheelchair and said, hey, wait a minute, and R3 socked her right arm, so, she let go of R3's wheelchair and R3 took off ahead of her. R2 said she then reported the incident to the nurse. R2 said she did not get a bruise, but her right arm was sore for a few days, had her arm examined, and was given two Tylenol's. R2 said R3 was always moving around, circling, with everybody, as if he was fighting people, going to the TV and pointing at it, like he had a gun. R2 said she would ignore him, afterwards. R2 said the staff would just let R3 wheel around the facility, expecting the residents to understand. R2 said she did not think the staff were equipped to handle R3, with his state of mind. On 07/02/2024 at 2:35 PM, V9 (Former Director of Maintenance and Housekeeping) said, he was the one accompanying the residents on 04/29/2024 during their smoke break and was holding the outside door open while they were moving in. V9 said R2 was first in line, R3 was second and, before he knew it, R3 had passed R2 up and was first. V9 said he did not see anything happen because he was holding the door, checking to see which smokers were still outside and which were inside, but remembered that R3 was behind R2, and then he saw R3 trying to go around R2, R2 trying to reach for R3's wheelchair, then R3 passing R2 up. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/2/2024 at 3:56 PM V1 (Administrator) said R3 was independent, did not need an escort, would toilet himself, and had involuntary movements; which were a regular thing for him, to be moving his arms around. V1 said when they would notice R3 was having involuntary movements, they would separate him from his peers. V1 said, sometimes, when R3 had those issues, he would go in circles on his wheelchair and, when he would do that, they would take him away from the residents, with a staff member, to an area where he could go in circles, and not bother anyone. V1 said staff would also take him out to the patio, when the weather permitted, and let him de-escalate, or they would sit him at a table with coffee or pop and help him focus on what he wanted. Regarding the incident with R2, V1 said R3 tried to race past R2 and grabbed her wheelchair. V1 said one-to-one supervision was a higher level of care than what the facility could offer because they were sub-acute, but if needed, they would pull administrative staff or nurses to help. V1 said she saw the 04/29/2024 video footage from the cameras and saw V9 holding the door open and moving his head back and forth, looking outside then inside. V1 also said she saw the inside door in the vestibule propped open so the residents could move themselves in. V1 said V9 didn't even know anything had happened. Then, V1 said she heard V9 say something, and R3 was in front of R2. V1 said she did not see anything on the video, no striking, no commotion, nor indicators of escalation. V1 said everything was fine outside and added V9 also saw nothing. V1 said she viewed cameras with views from two angles to the location of the alleged incident, saw the second camera at different speeds, and did not see anything. V1 said she even asked R3 if he hit R2, and he said, no, adding, for me, it was a situation of, 'he said, she said.' On 06/27/2024 at 12:00 PM, V1 said R3 was transferred out to a behavioral unit. V1 said R3's interventions became with a shorter length of effectiveness. V1 said the psych doctor was consulted because R3 needed a higher level of psych care. V1 said the facility sent R3 to the local behavioral health facility. R3's care plan, dated 05/15/2024, states R3 has the potential to be physically aggressive during care, most likely due to dementia, schizophrenia and bipolar diseases, has a history of harm to others, and poor impulse control due to difficulties adjusting to new places. R3 also has a behavior problem, randomly swinging his hand or fist at others with no intent or purpose. Interventions in place to address R3's behaviors include behavior monitoring/location monitoring for 72 hours; monitor for behaviors and re-direct; and analyze times of day, places circumstances, triggers, and what de-escalates behavior. Per R3's MDS, dated [DATE], Cognitive Patterns section, R3 had a short-term memory problem, had severely impaired cognitive skills, inattention, and disorganized thinking. In addition, his care plan stated he had poor impulse control and would randomly swing his hands or fists with no intent or purpose. On 04/29/2024 the facility placed the Director of Maintenance and Housekeeping to care for the residents that were on a smoking break. There was no clinical staff, with knowledge of R3's care planned behaviors monitoring R3 during the above incident while on smoke break.