STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Niles	6601 West Touhy Avenue Niles, IL 60714

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** 41156 Based on observation, interview and record review, the facility failed to effectively monitor a newly admitted resident and follow the facility practice of leaving doors open for residents identified to be at risk for falls. This affected one of three residents (R1) reviewed for safety and monitoring. This failure resulted in R1 being found on the floor. R1 was sent to the local hospital and treated for a laceration that required 2 staples, and 6 sutures in frontal scalp laceration and 1 staple left superior lateral scalp laceration. Findings include: R1 had an unwitnessed fall on 3/23/24. Facility Reported incident dated 3/24/24 reads in part: R1 was self-transferring, call night not on, resident found lying on the floor behind the door. Final Report Summary: R1 was admitted to the hospital for unwitnessed fall. R1 received staples to head for laceration to be removes in 7-10 days. After review of resident's medical record and staff interviews, it has been identified that R1 did not call for help when she transferred from the bed and fell on the floor. R1 was observed sleeping prior to the fall. R1 is nonverbal at baseline and could not say what happened. R1 has diagnoses of but not limited to: Parkinson, Anxiety, Insomnia, and cerebral infarction. R1 has a care plan for high risk for fall related to confusion and actual fall due to poor balance dated 3/25/24. R1 has a baseline care plan for risk for falls dated 3/23/24. (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	On 5/15/24 at 1045AM, V10 (Certified Nursing Assistant/CNA) stated she did her rounds beginning of her shift. V10 started in the room closer to the nurse's station and work her way down the hall. As V10 went closer to R1's room, approximately around 11:25 to 11:30PM, the door was shut and V10 tried to open the door, and V10 was having a hard time opening the door (like something was blocking the door). V10 continued to try to open R1's door and pushed it hard enough with V10 strength and then found the resident on the floor. Called and informed the nurse. As we enter, R1's bed is bed one and the one closer to the door. The blue floor mat was also blocking the door, R1 was on top of the mat, and the mat moved and blocking the door and so it was hard to open. Part of her body was on the mat and the head was off the matt and touching the floor. V10 saw blood, and the blood was not pure red, and it was not fresh, it was already dry and brown. Blood stain did not look new, it looked like it been there for a while. V10 informed V9 (Night Shift Nurse) and V7 (PM shift Nurse) were in the nurse's station charting. V9 came right away. After V9 saw R1, and then V7 went to check on R1 also. On 5/15/24 at 11AM, V9 (Nurse) stated that V10 reported to V9 that V10 cannot fully open the door of R1 because R1 was lying on the floor. V9 went and help V10 to fully open the door, both cannot open fully so both slide themselves into the bedroom slightly opened, and found blood on R1 in the head area, on the floor. R1 was away from the floor mat and the bed, lying behind the door like one or two step away from R1's bed. It was a resident blocking the door. Blood was a little bit dry and thick. It was coagulated at the time, Saline solution 4x4 gauze. And after cleaning the site, it started oozing a little bit and so V9 applied pressure. At this time V9 already called 911. R1's blood on the floor was described by V9 as semi liquid, coagulated blood on the floor. 911 came and transferred the resident to the hospital. Fire Department report dated 3/23/24 reads in part: dispatched to a nursing home for a head injury. Upon arrival the crew met a [AGE] year-old female, awake but nonverbal which was her norm. R1 was lying on her side on the floor. The staff stated the fall just happened but unwitnessed. The crew noted dried blood on R1 and the floor. The staff said they bandaged her head right before we arrived. The crew noted a 1-inch laceration with bleeding controlled on the crown of R1's head. On 5/15/24 at 12PM V11 (Paramedic) stated that all V11 can remember what was documented in their report, and it was documented that staff reported the incident just happened, but it was odd because the blood looked dry on R1 and on the floor. Hospital record on 3/24/24 at 12:35AM at ER notes reads in part: large stellate laceration frontal scalp, a second posteriorly. Per EMS, the nursing home stated the fall occurred just prior to their arrival but the patient has dried blood in it appears she may have fallen earlier. She found lying next to the bed just to the side of the pads that were placed near the bed. Hospital record reviewed and documented on 3/24/24 at 3:44AM under laceration repair documentation that R1 had 2 lacerations, on top and back of the head. Frontal scalp 4cm length and 2mm depth. 2 sutures and 6 staples. 1 cm laceration to left superior lateral scalp. On 5/15/24 at 10:45AM, surveyor went to previous room of R1. The door swing opens to the right, bed located at the right side of the wall, bed against the wall. With the door slightly open, the person passing by cannot see a full visual of a resident located in bed one (right side, bed against the wall). For someone to have a good visual of a resident that stays in bed one, the door must be fully open, or for a person to enter/peek the head into the room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/15/24 at 12:50PM, V2 (Director of Nursing) stated that R1 was a hospice resident. V2 asked the nurse how badly the injury was to R1, and the nurse said it was pretty significant wound and was having a hard time to control the bleeding. Instructed to send the resident out to the hospital and then to contact the Nurse Practitioner, grandson, and hospice. V2 expectation is for staff to leave the door open for closer observation of any residents in the unit. To have visual contact and to make sure the mat is in place and bed in lowest position for those who are at risk for fall. V2's expectation is hourly monitoring and as often as possible on a new admission and for at risk for fall residents, and especially those who can't verbalized their needs. Door needs to be open. Staff cannot fully visualized if the door is not fully open. If partially open, we can only see if someone is on the floor. At risk resident needs to have their door fully open. Only resident who has preference and not at risk for fall can have their door shut closed. Fall Prevention Program policy with a revision date of 11/21/17. Purpose: 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. Quality Assurance Program will monitor program to assure ongoing effectiveness. The admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan. 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 and the plan of care.