Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145999	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Aperion Care Niles		STREET ADDRESS, CITY, STATE, ZIP CODE: 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** 47304 Based on interview and record review, the facility failed to follow R1's plan of care to provide supervision with meals (eating), ensure R1's assistive mobility device was within reach and ensure R1 was wearing appropriate footwear. R1 who is high risk for falls, was left in the room unsupervised. R1 had a fall incident on 11/13/24 that resulted in subdural hematoma. This past noncompliance occurred from 11/13/24 to 11/15/24. The findings include: R1's Admission record documented initial admitted on 7/12/22 with diagnoses not limited to Other osteomyelitis upper arm, Type 2 diabetes mellitus, Atherosclerosis of coronary artery bypass graft(s), Cognitive communication deficit, Difficulty in walking, Unspecified protein-calorie malnutrition, Metabolic encephalopathy, History of falling, Nontraumatic acute subdural hemorrhage, Essential (primary) hypertension, Solitary pulmonary nodule, Contusion of right front wall of thorax, Other dysphagia, Latent tuberculosis, Hyperlipidemia, Unspecified glaucoma. MDS (minimum data set) dated 11/13/2024 showed R1's cognition was moderately impaired. R1 needs supervision or touching assistance with eating; Substantial / maximal assistance with chair / bed and toilet transfer. On 1/12/25 At 11:40am V9 (REGIONAL NURSE CONSULTANT) informed surveyor that facility created a past noncompliance for R1's fall incident on 11/13/24 and binder was presented to the surveyor. V9 said R1 was identified as high risk for fall, the RCA (root cause analysis) has been identified, and the action plan and plan of correction were in place. On 1/12/25 At 11:45am V2 (DIRECTOR OF NURSING / DON) stated she investigated the fall incident of R1 on 11/13/24 and reported to state agency due to diagnosis of subdural hematoma. V2 said R1 came back from an appointment with son and was served her meal in her room. V2 said fall might have been prevented if R1 was placed by nurse's station or dining room for close supervision. V2 stated R1 was identified as high risk for falls. No surgery was done in the hospital and R1 was readmitted to the facility on [DATE]. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 1/12/25 at 12:48pm V13 (Licensed Practical Nurse / LPN) said he has been working R1 and was the nurse during the fall incident on 11/13/24. He said R1 went out for appointment with son and went back to the facility. V3 said she was served dinner in her room because it was late already. V13 said he was informed by V15 (Certified Nursing Assistant / CNA) that R1 was on the floor. V3 stated he was on the 2nd floor at the time of R1's fall incident. When he was informed, he immediately went to the 3rd floor and saw resident laying on the floor. V13 said there was food sitting on the table. He said walker was farther away from the bed and close to the closet. He said R1 got up from the wheelchair, lost her balance and fell . V13 said there was indication that R1 hit her head against the floor because of the bruise and skin tear on forehead. He Informed the doctor and R1 was transferred to the hospital. V13 stated R1 was admitted in the hospital with diagnoses of subdural hematoma. He stated he can't remember if R1 was toileted, did not check if R1 was wearing a proper footwear. V13 said R1 was high for fall, if R1 was placed near the nurse's station and if walker was accessible or within reach to R1 then fall might have been prevented. On 1/12/25 at 1:11pm V14 (Certified Nursing Assistant / CNA) stated has been working with R1 who can speak minimal English. He said he was working with R1 on 11/13/24. R1 came back from out on pass and was served dinner in her room. V14 said R1 was sitting up in wheelchair, call light was within reach and instructed to call for help. V14 stated he went for his break and was informed that R1 fell and was about to be transferred to the hospital. V14 stated R1 would usually eat in the dining room, and she is high risk for fall. V14 said if resident was placed in the dining room, by the nurse's station, or if R1 had called for help, the fall might have been prevented. On 1/12/25 at 1:59pm V15 (Certified Nursing Assistant / CNA) stated she had worked with R1 but was not the assigned CNA during the fall incident on 11/13/24. V15 said she heard R1 was moaning or something, saw R1 laying on the floor on her stomach , face down with a bruise and some blood on the floor. She said nurse was informed immediately. V15 stated I don't believe R1 had any shoes on because I saw her shoes on the floor. R1 was wearing socks and might have slid. V15 stated R1's walker was by the radiator/ closet and not accessible to the R1. V15 said R1 is high risk for falls. V15 said she is always eating in the dining room. If the resident was in the dining room ,closer to the nurse's station, or maybe if R1 was using a proper footwear, the fall might have been prevented. On 1/12/25 at 2:37pm V3 (ADON / Assistant Director of Nursing) stated has been working in the facility since 2015. V3 stated she was informed by the nurse that R1 fell and had Bruise and skin tear on forehead. V3 said R1 was transferred to the hospital with a diagnosis of a subdural hematoma. She said the initial report was sent to state agency. V3 stated R1 is high risk for falls. The fall could have prevented, if R1 was place in common area like dining room or nurse' station for close supervision. Care plan date initiated on 2/24/23 documented in part: R1 at High risk for falls related to weakness. History of falls on: 5/17/2023, 12/19/2023, 7/15/2024, 11/13/2024. Care plan interventions included but not limited to: R1 to use walker. Ensure R1 is wearing appropriate footwear when ambulating. Care plan date initiated 1/18/24 documented in part: R1 have an ADL self-care/ mobility performance (functional abilities) deficit. Eating: R1's usual performance is supervision. Fall-initial occurrence note dated 11/13/24 documented in part: R1 had an un-witnessed fall in resident room on 11/13/2024 8:00 PM. Forehead bruised. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nurses Note dated 11/14/2024 showed in part: confirmed R1's hospital admission with Admitting Diagnosis: SUBDURAL HEMORRHAGE. R1's CT (computer tomography) head wo contrast result dated 11/13/24 documented in part: Impression: Stable narrow caliber interhemispheric acute subdural hematoma. R1's hospital records by V5 (HOSPITAL PHYSICIAN) history and physical notes dated 11/14/24 documented in part: R1 with mechanical fall in the nursing home. Was found on the floor, fall was unwitnessed. Frontal head contusion and bruising along the left hand and wrist. CT head with slim interhemispheric acute subdural hematoma. R1 is somnolent and complaining of neck pain. Waking up on and off on sternal rub and going back to sleep. Could not answer any of the subjective answer. V4 (Nurse Practitioner / NP) progress note dated 11/20/24 documented in part: R1 was readmitted to the hospital 11/13-11/17 due to a fall, unwitnessed. R1 was found to have interhemispheric SDH (Subdural hematoma). Facility's incident report dated 11/19/24 documented in part: R1 was last observed sitting in wheelchair eating her dinner, stood up, lost her balance, and fell to the floor. R1 had bruise and skin tear on the front / middle of the forehead and was sent to hospital with diagnosis of Subdural Hematoma. Facility's fall prevention policy dated 11/21/17 documented in part: 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. Assistive devices such as walkers and canes will be placed within reach of those residents. The resident will be reminded as needed to call for assistance before attempting to ambulate. Residents who require staff assistance will not be left alone after being Footwear will be monitored to ensure the resident has proper fitting shoes and / or footwear is non-skid. Prior to the survey date of 1/12/25 the facility took the following actions to correct the deficient practice. Surveyor did observation, interview and record review and found the following action plans in place: 1. R1 was supervised by staff every 15 minutes and placed by the common area for close monitoring. R1's log monitoring every 15 minutes from 11/17/24 to 1/11/25. 2. R1 was evaluated by therapy upon readmission on 11/17/24. 3. V2 (DON) and V3 (ADON) in-serviced all staff on the facility's fall policy and individualized interventions. 4. Care plans updated with new interventions. 5. Fall assessment was completed upon readmission on 11/17/24. 6. R1 had no further fall after incident on 11/13/24. (continued on next page)

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