STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145486	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE SPRING VALLEY	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician timely of an unwitnessed fall, for one of one residents (R2), reviewed for physician notification, in a sample of seven. FINDINGS INCLUDE: The facility policy, Physician-Family Notification-Change in Condition, dated (Revised) 11-13-18 directs staff, To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient and effective manner. The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practioner; and notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention. R2's Physician order [REDACTED]. R2's Progress Notes, dated 6/5/2020 at 7:17 P.M. document, (R2) had an unwitnessed fall at 7:00 P.M., in resident's bathroom. Notified by (V22/Certified Nursing Assistant) (CNA) that (R2) had fallen in bathroom and hit head on floor. (R2) bleeding from small laceration to right eyebrow. (R2) said, I went to reach for the door handle of the bathroom door, lost my balance and fell . I hit my head on the floor. Steristrips applied. Bleeding continued so (R2) sent to ER (emergency room). R2's ED (Emergency Department) Note, dated 6/5/2020 documents, ED arrival time 1940 (7:40 P.M.) (R2) brought in from nursing home. On 8/18/2020 at 11:07 A.M., V21/Registered Nurse (RN) stated, I didn't talk to (V24/Physician) after (R2) fell . I messaged him after it was all done. On 8/18/2020 at 12;22 P.M., V24/Physician stated, I was not called and informed that (R2) had fallen and hit (R2's) head. (R2) receives multiple anticoagulant medications and is at high risk for a brain bleed. If I had been called I would have told the facility to send (R2) by ambulance, immediately, to the ER (emergency room).
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify and intervene promptly after an unwitnessed fall for one of three residents (R2), reviewed for falls, in a sample of seven. FINDINGS INCLUDE: The facility policy, Transportation for Residents, dated (reviewed) 11-17-17 directs staff to, Nursing personnel shall promptly arrange ambulance services for residents in the event of an emergency. R2's June 2020 Physician order [REDACTED]. R2's Care Plan, dated April 26, 2020 includes the following Focus and Intervention areas: I am on anticoagulant therapy. Take precautions to avoid falls. R2's Progress Notes, dated 6/5/2020 at 7:17 P.M. document, (R2) had an unwitnessed fall at 7:00 P.M., in resident's bathroom. (R2) had fallen in bathroom and hit head on floor. (R2) bleeding from small laceration to right eyebrow. R2's ED (Emergency Department) Note, dated 6/5/2020 documents, ED arrival time 1940 (7:40 P.M.) (R2) brought in from nursing home. This same document includes, Physician Exam: Right supraorbital, right temporal localized swelling, about 2 CM (centimeters) in diameter each with small laceration above the right eyebrow. Skin: 2 CM lac (laceration) above right eyebrow. Right periorbial ecchymosis with bruising at the right temporal region. On 8/18/2020 at 11:07 A.M., V21/Registered Nurse (RN) stated, I knew (R2) was high risk for falls because (R2) had fallen multiple times at home and (R2) came to us with a [MEDICAL CONDITION]. I really only sent (R2) to the ER because the wound wouldn't stop bleeding. I didn't even realize (R2) was on two anticoagulants (medications). I didn't think about (R2) possibly having a head injury.
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** Based on interview and record review, the facility failed to provide supervision during toileting for one of three residents (R2), reviewed for falls, in a sample of seven. This failure resulted in R2 sustaining a fatal closed head injury, after a fall in the bathroom. FINDINGS INCLUDE: The facility policy, Fall Prevention Program, dated (revised) [DATE] directs staff, 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. Residents who require staff assistance will not be left alone after being assisted to bathe, shower or toilet. R2's Admission Record documents that R2 was admitted to the facility on [DATE]. This same document includes R2's Diagnoses: [REDACTED]. R2's Fall Risk Assessment, dated [DATE] documents that R2 has a history of falls, has balance problems while standing and walking, has decreased muscular coordination and has predisposing disease that place her at high risk for falls. R2's Care Plan, dated [DATE] includes the following Focus/Interventions, I am at risk for fall/injury from weakness and tiredness related to recent hip replacement. Follow facility fall protocol. R2's Minimum Data Set Assessment, dated [DATE] documents under Section G0110 (Activities of Daily Living Assistance), Requires extensive assist of two plus staff for transfers, walking in room and toileting. This same document includes under Section G0300 (Balance During Transitions and Walking), Not steady, only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfers. R2's Progress Notes, dated [DATE] at 7:17 P.M. document, (R2) had an unwitnessed fall at 7:00 P.M., in resident's bathroom. Notified by (V22/Certified Nursing Assistant) (CNA) that (R2) had fallen in bathroom and hit head on floor. (R2) bleeding from small laceration to right eyebrow. (R2) said, I went to reach for the door handle of the bathroom door, lost my balance and fell . I hit my head on the floor. Steristrips applied. Bleeding continued so (R2) sent to ER (emergency room). The facility form, Incident Witness, dated [DATE], from V22/CNA documents, I assisted (R2) to the bathroom with (R2's) walker, positioned (R2) in front of the toilet with the walker in front of (R2). I left the bathroom to give (R2) some privacy and as I was removing (R2's) roommate's dinner tray, I turned around and (R2) was on the floor. It happened in a few seconds. (R2) sat up and I noticed a laceration to (R2's) eyebrow and it was bleeding so I called (V21/Registered Nurse) (RN). R2's ED (Emergency Department) Note, dated [DATE] documents, ED arrival time 1940 (7:40 P.M.) (R2) brought in from nursing home. States (R2) was using walker and went to bathroom and turned to the right side trying to grab doorknob. The doorknob was too far away and (R2) fell on to the floor hitting the right side of (R2's) face on the ground. This same document includes, Physician Exam: Right supraorbital, right temporal localized swelling, about 2 CM (centimeters) in diameter each with small laceration above the right eyebrow. Skin: 2 CM lac (laceration) above right eyebrow. Right periorbial ecchymosis with bruising at the right temporal region. This document concludes with, (R2) presents with mechanical fall at the nursing

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

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) home. Normal neurological exam. Has bruising to the right temporal region and right suproribital region. There is a small laceration at the right eyebrow. (R2) is experiencing some facial pain but not in acute distress at this time. Takes Aspirin. CT (Computerized Tomography) of head reveals large right subdural hematoma. Contacting (Regional Trauma Center) for stat (immediate) transfer. R2's hospital Facial Bones CT, dated [DATE] at 8:36 P.M. document, Impression: Right-sided facial trauma involving zygomatic arch, maxillary sinus and orbital wall and rim. Maxillary sinus fracture involves gas outside the lumen of the sinus indicating an open fracture due to its involvement with sinuses. [MEDICAL CONDITION]. R2's hospital Brain/Head CT, dated [DATE] at 8:36 P.M. document, Ventricles: mass effect upon the right lateral ventricle related to the acute hemorrhage. [MEDICAL CONDITION]: There are several regions of acute hemorrhage. The acute hemorrhage has significant mass effect with dimensions of 7.5 CM AP (anterior to posterior) X 2.4 CM medial to lateral and extending nearly 8.7 CM craniocaudally. Midline shift: 5 MM (millimeters) right to left. Impression: Acute on chronic right subderal hemorrhage resulting in right-to-left midline shift. Additional acute blood within the sylvian fissure on the left with the inferior posterior left anterior fosa. Multiple facial fractures. R2's (Regional Trauma Center) Discharge Summary, dated [DATE] documents, (R2) was transferred after suffering a ground level fall at her nursing home. (R2) had been taking dual anti-platelet therapy. (R2's) imaging at the first hospital demonstrated a large subdural hematoma and subarachnoid hemorrhage as well as several orbital fractures. (R2's) mental status markedly declined prior to transport, so (R2) was intubated prior to arrival to (Regional Trauma Center). On arrival to (Regional Trauma Center), (R2's) sedation and paralytic was reversed. (R2's) exam did not improve with reversal or Mannitol. (R2's) POA (Power of Attorney) was consulted. (R2) apparently would never have wanted heroic measures to keep (R2's) self alive. Neurosurgery offered that surgery for [REDACTED]. (R2's) POA elected for comfort measures to be initiated. (R2) was extubated. (R2) expired at 0400 (4:00 A.M.) on [DATE]. R2's Certificate of Death documents, Cause of Death: Subdural Hematoma, Subarachnoid Hemorrhage and Ground Level Fall (from injury on [DATE] at 7:00 P.M.). On [DATE] at 9:50 A.M., V21/Registered Nurse (RN) stated, I was working on [DATE] (2020). It was around 7:00 (P.M.) and (V22/Certified Nursing Assistant) came and got me and said (R2) had fallen in the bathroom and hit (R2's) head. I went into the bathroom and (R2) was sitting up, on the floor. (R2) had a small laceration above (R2's) right eyebrow. (R2) said was alone in the bathroom and had reached to try and shut the door and fell and bumped head on the sink. I did ROM (range of Motion) on (R2). We helped (R2) up and set resident on the toilet. I put steri strips on the wound. I sent (R2) to the ER (emergency room) because the wound kept bleeding. On [DATE] at 10:04 A.M., V22/Certified Nursing Assistant (CNA) stated, I had came into work at 6:00 (P.M.) that night ([DATE]). I got bumped to that hall. I usually work A Hall. I remember it was the first call light of the night. (R2) wanted to use the bathroom. I walked beside (R2) and (R2) used walker. (R2) said she felt unsteady. When we got to the bathroom, (R2) said was fine from here. When I left, (R2) was standing in front of the toilet. I stepped out of the bathroom, but was still in the room. I was cleaning up (R2's) roommate's dinner tray and I heard a loud thud. I found (R2) in the bathroom, on the floor. (R2) was bleeding from face. (R2) said had reached for the door and fell , tripping on walker. (R2) said thought hit head on the sink. I told (R2) not to move and I ran and got the nurse (V21). We helped (R2) back up. (R2) had a bump protruding above right eye and a cut above eyebrow. I didn't know (R2) couldn't be left alone in the bathroom. I feel so bad about all of this.