STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145180	A. Building B. Wing	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Chicago Heights	490 West 16th Place Chicago Heights, IL 60411

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45395 Based on interview and record review, the facility failed to follow their change of condition policy by not effectively communicating to a resident's physician the extent of the injury related to a fall, including the resident experiencing extreme pain because of a visible leg deformity after a fall. This failure applied to one (R4) of six residents reviewed for quality of care and resulted in R4 not being sent out to the hospital emergently for assessment after a fall and not being provided with any pain medication while experiencing 10/10 pain as a result of the injury. Findings include: R4's face sheet shows R4's past medical history not limited to epilepsy, anxiety, pain in thoracic spine, and personal history of (healed) traumatic fracture. MDS (Minimum Data Set assessment) summary dated 11/28/2022 showed R4 is cognitively intact, requires supervision with activities of daily living and requires setup help only with locomotion and mobility. R4's care plan last revised on 01/18/2023 showed he is at risk for falls. Last documented fall was on 01/05/2023 with injury, left wrist fracture. Reviewed final incident report completed by V1 (Administrator) dated 02/23/2023 that showed R4 had a fall on 02/16/2023. Time of occurrence is documented as n/a and that R4 was transferred to the emergency room for evaluation due to complaint of pain to left leg. X-ray revealed left tibia and fibula fracture. Reviewed R4's nursing progress notes and noted the following: Note dated 2/15/2023 23:27 showed R4 was horse playing with peer, fell and sustained injury to the lower limb above the ankle. Cold compress applied and the Dr. (doctor) notified. Orders received for R4 be sent to the hospital. Note dated 2/16/2023 00:45 showed R4 was picked up by emergency medical services. Note dated 2/16/2023 01:03 showed R4 was taken to a different hospital than previously ordered because he was in so much pain. Note dated 2/16/2023 10:15 showed R4 was being evaluated for diagnosis of left fibula and tibia fractures. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 03/27/2023 at 2:33 PM, R4 said on the night of 02/15/2023 while in R7's room, he was walking towards the nightstand and said his pant leg got caught on the bed frame of R7's bed which caused him to fall to the floor. He then said while trying to free his leg, he heard a cracking sound. R4 said another resident helped him get up off the floor and into a wheelchair then went to the central nurse's station and told an unknown nurse. R4 said the nurse told him his leg is probably broken then called an ambulance service, not 911 like he asked. R4 proceeded to say that he was in excoriating pain and begged multiple times for staff to call 911. R4 said it took about 3.5 hours from the time of fall for the ambulance to pick him up. R4 added that all he received for his pain was a cold pack. Reviewed R4's ambulance transport treatment summary dated 02/16/2023 showed facility notified ambulance service on 02/15/2023 at 11:33 PM and on 02/16/2023 at 12:39 AM, R4 was received by emergency medical staff while sitting in a wheelchair in the hall near room. R4 was observed with extreme left ankle swelling, redness, and general swelling from knees to ankle. R4 reported pain at 10/10. R4 was secured onto a stretcher then left facility enroute to specific hospital ordered by his primary physician. R4 left facility at 12:47 AM. Summary also showed that during transport, R4 started experiencing more pain and could no longer tolerate such a long transport, so R4 was taken to the nearest hospital where upon arrival, R4 could no longer bend leg. Reviewed R4's hospital records dated 02/16/2023 that stated he arrived in the emergency department at 01:16 AM via emergency medical services from the facility post fall. Per his record, R4 stated the incident happened around 10:15 pm and he rated his pain upon arrival at 10/10. R4 was admitted to the hospital with closed fracture of distal tibia, closed fracture of distal fibula, closed fracture of proximal fibula which required surgical intervention. On 03/27/2023 at 2:25 PM, R7 said she and R4 were in her room the night he fell and broke his leg. She said R4 went to run from [her] then tripped and fell to the floor. R7 added that at first, she thought R4 was playing with her until he started complaining of pain to his leg and ankle. R6 then said after about five minutes or so, she looked at R4's leg and saw that it was swollen so she went to get the nurse. R7 said they (doesn't remember names) got him up, told him to lay down, then put ice on his leg. She added that an hour later, R4's leg was swollen even more, and that he was asking to go to the hospital. On 03/29/2023 at 10:15 AM, V17 (Certified Nursing Assistant) said she walked in around 11:00 PM for her shift on the night R4's incident occurred. She said other aides told her that R4 fell on second shift. She said that she could hear R4 yelling out profanities and saying he hit his foot. On 03/29/2023 at 2:44 PM, V18 (Licensed Practical Nurse/LPN) said on 02/15/2023 that she was working second shift on the central unit and saw staff pushing R4 in a wheelchair sometime before 11:00 PM. She said that they were coming from the west wing heading to the east wing, where R4 resided. She then said V15 (Registered Nurse) came to her station and said she (V15) was just told by R4 that he fell in his room. V18 (LPN) told V15 about what she saw previously then headed up front near the double doors with V15. V18 then said she saw R4 sitting in a wheelchair and his leg was swollen. V18 added, I think I called the doctor and told him R4 fell and said he needs to get sent out. She added that V15 gave R4 an ice pack, then she (V18) left the facility and went home. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 03/29/2023 at 3:02 PM, V21 (Licensed Practical Nurse) said around 11:00 PM during change of shift report to V15 (RN), an aide brought R4 to the east side and said he fell . V21 said we asked what happened, R4 said he fell and wanted a pain pill. She then said that she finished giving report to V15 then left to go home. V21 added that she did not assess R4 nor give him any pain medication. On 03/27/2023 at 3:27 PM, V15 (Registered Nurse) said that she was just coming in, that it was after 11PM. She then said some aides brought R4 in a wheelchair to her while she was at the east nurse's station. V15 added that staff and R4 told her to call 911. She continued to state that R4 said he fell in his room. When V15 asked how R4 fell , he refused to tell. V15 then said she saw his right leg was deformed looking and swollen, then took resident in the wheelchair to the central nurse station where she and another nurse assessed R4 and placed a cold compress on his leg. V15 said she next contacted V9 (Director of Nursing/DON) then called the doctor who said transfer resident to his hospital. V15 then said she called the ambulance service and was told it would take approximately two hours. When asked why 911 wasn't called given the condition of R4's leg, V15 said, I don't know what to say, I was new and didn't call 911 because I had already called the ambulance service. V15 added that she did not administer any pain medication to R4 because she was told he already received some. On 03/27/2023 at 3:43PM, V2 (Assistant Director of Nursing/ADON) said after a fall occurs, her expectations are for the nurse to do an immediate risk management assessment immediately after. She then said when there's visible and obvious injury, nursing staff should call 911 immediately, and not the ambulance service. On 03/28/2023 from 4:14 PM - 4:29 PM, V16 (Medical Doctor) said regarding R4's incident on 02/15/2023 that the facility contacted him about the fall and said, it doesn't look good. V16 told the facility to send R4 to the hospital then added that the level of emergency determines whether a resident is sent out 911. V16 added that what a nurse tells him is subjective so if the extent of R4's injury had been described in more detail and if his complaints of extreme pain were communicated to him, he would have ordered 911 be called and for pain medication to be administered immediately. V16 then said at this time, knowing R4's reported pain level at the time of incident, the nurse misjudged the timeframe R4 had to wait for the ambulance and the nurse should have understood the significance of the resident having to wait two plus hours for the ambulance to arrive. Reviewed R4's physician's orders that showed transfer resident to hospital emergency room for medical evaluation and treatment (ordered 02/15/2023) and acetaminophen tablet give 2 - 325 milligram tablets every 6 hours as needed for pain (ordered 09/02/2022). Reviewed R4's medication administration record for February 2023 that showed acetaminophen was not administered to him on 02/15 or 02/16/2023. Reviewed condition change policy last revised 11/13/2018 that showed the purpose is to ensure that medical problems are communicated to the attending physician and responsible parties in a timely, efficient, and effective manner. The policy also showed that the facility will consult with the resident's physician or authorized designee when there is: an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly. A need to alter treatment significantly includes to commence a new form of treatment to deal with a problem.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45395 Based on interview and record review, the facility failed to follow their policy and procedure for pain management by not informing the resident's physician that the resident was experiencing 10/10 pain after a fall and failed to administer any pain medication after the resident verbalized being in pain. This failure applied to one (R4) of six residents reviewed for pain management and resulted in R4 experiencing severe pain (10/10) without any interventions to address R4's pain for over two hours, while waiting for hospital transport. Findings include: R4's face sheet shows R4's past medical history not limited to epilepsy, anxiety, pain in thoracic spine, and personal history of (healed) traumatic fracture. Minimum Data Set (MDS) summary dated 11/28/2022 showed R4 is cognitively intact, requires supervision with activities of daily living and requires setup help only with locomotion and mobility. Facility submitted final incident report completed by V1 (Administrator) dated 02/23/2023 that showed R4 had a fall on 02/16/2023. Time of occurrence is documented as n/a and that R4 was transferred to the emergency room for evaluation due to complaint of pain to left leg. X-ray revealed left tibia and fibula fracture. Documented actions taken by facility included pain management offered. On 03/27/2023 at 2:33 PM, R4 said on the night of 02/15/2023 while in R7's room, he was walking towards the nightstand and said his pant leg got caught on the bed frame of R7's bed which caused him to fall to the floor. He then said while trying to free his leg, he heard a cracking sound. R4 said another resident helped him get up off the floor and into a wheelchair then went to the central nurse's station and told an unknown nurse. R4 said the nurse told him his leg is probably broken then called an ambulance service, not 911 like he asked. R4 proceeded to say that he was in excoriating pain and begged multiple times for staff to call 911. R4 said it took about 3.5 hours from the time of fall for the ambulance to pick him up. R4 added that all he received for his pain was a cold pack. R4's care plan showed he is at risk for pain related to chronic bilateral thoracic back pain, last revised on 12/05/2022. Interventions showed to monitor/record/report to nurse resident complaints of pain or requests for pain treatment and notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Date Initiated: 09/02/2022. Reviewed R4's physician's orders that showed transfer resident to hospital emergency room for medical evaluation and treatment (ordered 02/15/2023) and acetaminophen tablet give 2 - 325 milligram tablets every 6 hours as needed for pain (ordered 09/02/2022). Reviewed R4's medication administration record for February 2023 that showed acetaminophen was not administered to him on 02/15 or 02/16/2023. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 03/27/2023 at 3:27 PM, V15 (Registered Nurse) said that R4 informed her that he fell in his room. She added that R4's leg was deformed looking and swollen so she placed a cold compress on his leg. V15 added that she did not administer any pain medication to R4 because she was told he already received some. On 03/29/2023 at 10:15 AM, V17 (Certified Nursing Assistant) said she walked in around 11:00 PM for her shift on the night R4's incident occurred. V17 then said other aides told her that R4 fell on second shift, then she could hear R4 yelling out profanities and saying he hit his foot. On 03/29/2023 at 3:02 PM, V21 (Licensed Practical Nurse) said around 11:00 PM during change of shift report to V15 (RN), R4 said he fell and wanted a pain pill. She then said that she finished giving report to V15 then left to go home. V21 added that she did not assess R4 nor give him any pain medication. Reviewed R4's ambulance transport treatment summary dated 02/16/2023 at 12:39 AM that showed R4 was received by emergency medical staff while sitting in a wheelchair in the hall near room. R4 was observed with extreme left ankle swelling, redness, and general swelling from knees to ankle. R4 reported pain at 10/10. Summary also showed that during transport, R4 started experiencing more pain and could no longer tolerate such a long transport so R4 was taken to the nearest hospital. Reviewed R4's hospital records dated 02/16/2023 that stated he arrived in the emergency department at 01:16 AM via emergency medical services from the facility post fall. Per his record, R4 stated the incident happened around 10:15 pm and he rated his pain upon arrival at 10/10. R4 was admitted to the hospital with closed fracture of distal tibia, closed fracture of distal fibula, closed fracture of proximal fibula which required surgical intervention. On 03/28/2023 from 4:14 PM - 4:29 PM, V16 (Medical Doctor) said regarding R4's incident on 02/15/2023 that the facility contacted him about the fall and said, it doesn't look good. V16 added that if the extent of R4's injury had been described in more detail and his complaints of extreme pain had also been communicated to him, he would have ordered 911 be called and for pain medication to be administered immediately. V16 then said, at this time, knowing R4's reported pain level at the time of incident, the nurse misjudged the timeframe R4 had to wait for the ambulance and the nurse should have understood the significance of the resident having to wait two plus hours for the ambulance to arrive. Reviewed pain management program policy last revised 07/06/2018 that showed the purpose is to establish a program which can effectively manage pain to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. The policy also showed the goal is to promote resident comfort, to preserve and enhance resident dignity and facilitate life involvement through an effective pain management program. The pain medication used shall be appropriate for the population served with standards to initiate a pain assessment protocol when a change of condition occurs that requires pain control. The policy added that a resident's physician will be notified of the resident's complaints of pain not relieved by comfort measures, including pain medications.