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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaints: 2024848/IL124085 2024853/IL124091 2024821/IL124060 F 580 D F 684 D F689 G	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		9/10/20

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

Electronically Signed | 09/10/2020

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.

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: 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	F 580	Aperion Care Spring Valley Provider # 145486/0053611 Cycle Date: 8/20/20 Survey Date: 8/20/20 Survey Type: Complaint Plan of Correction F580 Please accept the following as the facility□s credible allegation of compliance. The Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: DON has inserviced all direct care staff on notification to physician with change of condition.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 injury and has the potential for requiring physician intervention." R2's Physician Order Sheet, dated June 2020 includes the following medications: Clopidogrel (anticoagulant) 75 MG (milligrams) by mouth one time daily and Aspirin EC (Enteric Coated) (anticoagulant) 81 MG by mouth two times daily. 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 580	How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: All direct care staff have been inserviced on notification to physician with change of condition Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON will randomly monitor notification to physician with change of condition weekly for 4 weeks, or as needed. Observations noted during monitoring will be discussed with the QA Committee. Concerns will be discussed among the members, a plan of action is devised, and past plans of actions evaluated by Quality Assurance Committee, for 3 months or as needed.	
F 684	Quality of Care	F 684		9/10/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 SS=D	Continued From page 3 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 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 Sheet includes the following medications: Aspirin EC Enteric Coated) (anticoagulant) 81 MG (milligrams) by mouth two times daily and Clopidogrel (anticoagulant) 75 MG by mouth one time daily. 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	F 684	Aperion Care Spring Valley Provider # 145486/0053611 Cycle Date: 8/20/20 Survey Date: 8/20/20 Survey Type: Complaint Plan of Correction F580 Please accept the following as the facility's credible allegation of compliance. The Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: DON has inserviced all direct care staff on notification to physician with change of condition. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4 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 fractured hip. 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 684	The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: All direct care staff have been inserviced on notification to physician with change of condition Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON will randomly monitor notification to physician with change of condition weekly for 4 weeks, or as needed. Observations noted during monitoring will be discussed with the QA Committee. Concerns will be discussed among the members, a plan of action is devised, and past plans of actions evaluated by Quality Assurance Committee, for 3 months or as needed.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 689	perion Care Spring Valley	9/10/20

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 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) 11-21-17 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 4/26/2020. This same document includes R2's diagnoses: Orthopedic Aftercare, Displaced Fracture of Greater Trochanter of Right Femur, Unsteadiness on Feet, Lack of Coordination and Abnormalities of Gait and Mobility. R2's Fall Risk Assessment, dated 4/26/2020 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 4/26/2020 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."	F 689	Provider # 145486/0053611 Cycle Date: 8/20/20 Survey Date: 8/20/20 Survey Type: Complaint Plan of Correction F689 Please accept the following as the facility's credible allegation of compliance. The Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: DON has inserviced all direct care staff on accidents and incidents and supervision and assistance as needed. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: All direct care staff have been inserviced on accidents and incidents and supervision and assistance as needed. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON will randomly monitor accidents and	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 R2's Minimum Data Set Assessment, dated 5/8/2020 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 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)." The facility form, Incident Witness, dated 6/5/2020, 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 6/5/2020 documents, "ED arrival time 1940 (7:40	F 689	incidents weekly for 4 weeks, or as needed. Observations noted during monitoring will be discussed with the QA Committee. Concerns will be discussed among the members, a plan of action is devised, and past plans of actions evaluated by Quality Assurance Committee, for 3 months or as needed.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

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 onto 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 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 6/5/2020 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. Intracranial hemorrhage."

R2's hospital Brain/Head CT, dated 6/5/2020 at 8:36 P.M. document, "Ventricles: mass effect upon the right lateral ventricle related to the acute hemorrhage. Intracranial hemorrhage: There are several regions of acute hemorrhage. The acute hemorrhage has significant mass effect with

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

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 6/6/2020 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 (R2's) significant head bleed, (but surgery) would likely not provide a meaningful recovery. (R2's) POA elected for comfort measures to be initiated. (R2) was extubated. (R2) expired at 0400 (4:00 A.M.) on 6/6/2020.

R2's Certificate of Death documents, "Cause of Death: Subdural Hematoma, Subarachnoid Hemorrhage and Ground Level Fall (from injury on June 5, 2020 at 7:00 P.M.)."

On 8/18/2020 at 9:50 A.M., V21/Registered

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

Nurse (RN) stated, " I was working on June 5 (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 8/18/2020 at 10:04 A.M., V22/Certified Nursing Assistant (CNA) stated, "I had came into work at 6:00 (P.M.) that night (6/5/2020). 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."