

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Final Observations</p> <p>Statement of Licensure Violations: 3 of 3 Violations</p> <p>300.610a) 300.610c)1) 300.1620f) 300.3240a) 300.3300t)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>c) The written policies shall include, at a minimum the following provisions:</p> <p>1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
-------	--	-------	---	--

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 1 of transfers;</p> <p>Section 300.1620 Compliance with Licensed Prescriber's Orders</p> <p>f) The licensed prescriber shall approve the release of any medications to the resident, or person responsible for the resident's care, at the time of discharge or when the resident is going to be temporarily out of the facility at medication time. Disposition of the medications shall be noted in the resident's clinical record.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>Section 300.3300 Transfer or Discharge</p> <p>t) The Department shall prepare resident transfer or discharge plans to assure safe and orderly removals and protect residents' health, safety, welfare and rights. In nonemergencies and where possible in emergencies, the Department shall design and implement such plans in advance of transfer or discharge. (Section 3-418 of the Act)</p> <p>These Requirements are not met as evidenced by:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>Based on interview and record review, the facility failed to provide discharge planning to ensure a safe and orderly discharge to post-discharge care for 2 of 3 residents (R200, R201) reviewed for discharge planning in the sample of 23.</p> <p>R200 was involuntarily discharged to a homeless shelter without discharge planning to ensure appropriate available services for dialysis, surgery consultation appointment and insulin medications for diabetes. Subsequently, R200 was treated in the Emergency Room due to lack of appropriate services. In addition, R201 was involuntarily discharged to a local hotel without medications to treat his mental illness, pain, hypertension and migraines. R200's lack of medications including insulin and lack of coordination to receive dialysis has the likelihood of leading to hospitalization for renal failure and diabetes. This could lead to death. R201's lack of medications and medical monitoring could lead to his psychiatric decline and potential hospitalization.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. R200's Face sheet, undated, documented he was admitted on 1/9/20 and had the following diagnoses: Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease (COPD), Kidney Failure, Diabetes Mellitus, Hyperkalemia (high potassium levels in blood), Hypertension, Lack of Coordination, Other Abnormalities of Gait and Mobility, and Alcoholic Cirrhosis of Liver with Ascites (excess abdominal fluid). <p>R200's Significant Minimum Data Set (MDS), dated 6/4/20, documented R200 required extensive assistance of one-person physical</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 3</p> <p>assistance for bed mobility, dressing, and limited assistance with one-person physical assistance for walking and toileting. The MDS documents R200 balance was "Not steady, only able to stabilize with staff assistance."</p> <p>Incident Investigation Summary dated 6/17/2020 at 3:33 PM, documents R200 received dialysis on 6/17/2020. The incident summary documents V4, Nurse Practitioner (NP), and V11, Social Service Assistant (SSA), were informed by V34, Transportation Driver, that R200 put something in his pocket when he was picked up after his dialysis appointment. The incident summary documents, "2 stubs of marijuana that measured about ¼ inch long and 2 pieces of something like crack cocaine," were found on R200. The incident summary further documents the (city) Police arrived and "did a field test but couldn't confirm the tested product to be crack cocaine. The summary documented the "local Police said there was nothing they could do for the marijuana due to it being legal in Illinois, and (facility) uses federal money for its operation, and it is illegal."</p> <p>R200's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents, dated 6/17/2020, authored by V11 documents, "On the date of transfer or discharge, you will be relocated to (local homeless shelter)."</p> <p>R200's Hospital Admission Emergency Room (ER) Report dated, 6/18/2020 at 11:12PM, documents R200 walks short distances with or without assistance and presented with "cuts on legs that were present on arrival." The ER report also documents R200's medication list to include Lantus insulin and Lispro insulin for his Diabetes Mellitus and Metoprolol for his hypertension. The</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2020
NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL		STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702		
(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) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>ER report documents R200 having fallen in the last 3 months and uses ambulatory aides to assist with walking. The Report states R200 presented to the ER "due to chest tingling," and the tingling reportedly "got a little worse tonight." R200 stated he also feels a little short of breath. R200 reported he has had some chills and hot flashes. The report further documented, "He (R200) stated he is currently homeless" and states "he is waiting on a check from the government to get back into a nursing facility."</p> <p>On 7/22/2020 at 1:27 PM, V1, Administrator, stated due to illegal drugs found on R200, the facility could discharge R200 and stated, "It was a spur of the moment thing." V1 denied having transportation set up or services for R200 to get to and from dialysis at time of discharge and nor did he know if he had been at dialysis after discharge date of 6/17/2020. V1 confirmed R200 had a wheelchair, walker and "can walk some too. (R200) isn't always in a wheelchair." V1 then stated, "I have no idea how (R200) gets to dialysis now."</p> <p>Community Based Dialysis Progress Note dated 6/19/2020 at 10:00AM, documents in part, "Phone call made to (R200's) sister/emergency contact to follow up on pt's (patients) location. She (sister) reports pt has not been located. Informed her ED (Emergency Department) records show pt was there last night at 2255 (10:55PM) c/o (complaints of) chest pain. Pt was discharged however he (R200) informed them he was homeless and would like to sleep in the hospital bed a little longer."</p> <p>On 7/23/2020 at 4:08PM, V23, Dialysis Facility Administrator stated R200's last dialysis treatment was on 6/17/2020. V23 stated she</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 5</p> <p>received a phone call on 6/17/2020 from the facility stating R200 was found behind the dumpster at the dialysis clinic and putting something in his bag. V23 further stated she attempted to call V1, Administrator, for more information but was unable to reach him. V23, stated she was able to reach V4, Nurse Practitioner/NP, who confirmed R200 was discharged from the facility. V23 stated R200 should have had dialysis on 6/19/20. V23 stated on 6/18/2020 she spoke with R200's sister and R200's sister stated she was unaware where R200 was and "was actively still searching."</p> <p>Social Service Note dated 6/19/20 at 11:29 AM, documented R200 had contacted V11 and asked for the number he should call to appeal his involuntary discharge from the facility because he had lost it. The Note documented V11 gave him the number and asked R200 to come get his belongings.</p> <p>R200's June 2020 Medication Administration Record (MAR) documents R200 receives the following medication for diabetes: Insulin Lispro Solution 100 UNIT/ML (milliliter). Inject 5 unit subcutaneously (sq) before meals; Lantus SoloStar Solution Pen-injector 100 units per milliliter (ml) to inject 5 units sq one time a day; and Glucophage Tablet 1000 milligram (mg), twice daily for diabetes. The POS documented the facility should notify the physician if R200's blood sugar levels were less than 70 and greater than 350.</p> <p>Facility document entitled, "Appointment Reminder," undated, documents R200 having an appointment with vascular surgery on 6/18/2020 at 12:10 PM for his dialysis catheter.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 6</p> <p>R200's June 2020 MAR documents R200 receives Metoprolol Tartrate Tablet 25 mg, 2 tablets twice daily to treat his hypertension.</p> <p>R200's June 2020 documented R200 should receive Nephro-Vite Tablet, 1 mg, daily for kidney failure. The POS documented R200 was receiving dialysis on Monday, Wednesday and Friday weekly. The POS documented the facility should do the following with regarding to R200 receiving dialysis: Obtain Vital Signs, Blood Pressure/Pulse and monitor pre and post dialysis for: altered mental status, lethargy, edema, chest pain, shortness of breath, abdominal pain, nausea, vomiting, unusual itching, bleeding at site, bruises, abnormal muscle cramps, redness, swelling, tenderness, or signs of infection at dialysis site; Observe dialysis catheter (right chest wall) for any signs or symptoms of drainage, redness, bleeding; and Report any abnormal findings to physician and to cover the site with a dressing as needed.</p> <p>R200's Community Survival Skills Assessment, dated 5/27/2020, recommendation: "The resident does not appear to be capable of unsupervised outside pass privileges at this time."</p> <p>Elopement/Unauthorized Leave Risk Review for R200, dated 6/14/2020, documents, R200 "Becomes agitated, confused and/or disoriented or displays consistently poor judgement (i.e., would not be able to safely care for him/herself outside of the facility)."</p> <p>On 7/21/2020 at 2:00 PM, V11, stated she was not sure whether R200 left with his medications at his time of discharge because he was discharged as an involuntary discharge. V11 stated she didn't know because she doesn't do anything with his</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>meds. V11 stated that residents who are discharged Against Medical Advice or Involuntary Discharge don't generally get their medications and she had no idea what happened to R200's medications.</p> <p>On 7/22/2020 at 9:00AM, V7, Receptionist, stated he recalled on 6/17/20 three police officers came to the facility and the facility discharged R200 after that. V7 recalls speaking to R200's sister after R200's discharge and she was not aware of R200's discharge nor his whereabouts. V7 stated R200's sister thought R200 was discharged to the streets. V7 stated R200 was on foot when he left the facility.</p> <p>On 7/28/2020 at 9:28AM, V3, Regional Nurse, stated she would expect the facility to coordinate services such as the care plan with dialysis.</p> <p>On 7/28/2020 at 9:55AM, V3 stated, "I would have assured (R200) had a safe discharge."</p> <p>On 7/28/2020 at 10:10AM, V4, Nurse Practitioner, stated, "I was under the impression you get your medication. I was under impression you get your medication no matter what kind of discharge, except narcotics." When asked by surveyor if she would expect the facility to follow the Plan of Care for R200, V4 stated that would be the expectation. V4 was asked if she was aware the facility failed to provide the plan of care from dialysis and would she have expected the facility to coordinate care with dialysis, and she said she was not aware, and the facility should have the care plan from dialysis.</p> <p>2. R201's Progress Note dated, 6/21/20 at 2:08 PM documented, "Staff and residents report that resident appeared to be in drunken state and was</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 8</p> <p>violent by hitting another resident. The resident that claims to have been hit, guardian asked that the police be called, and charges pressed on him. Writer has moved the resident (R201) to the 3rd floor for safety of that resident. Staff is told that resident cannot come off the 3rd floor currently."</p> <p>The facility's Final Investigation Report for R201's Resident to Resident Abuse, dated 7/13/20, documents, on 6/20/20 at 5:30 PM, R201 had a resident to resident altercation with R203. The Report documented staff witnessed the occurrence and separated the residents. The report documented staff indicated R201 may have been under the influence of alcohol. The report documented R201 was moved to a different floor. The Report documented R201 was involuntary discharged to the community.</p> <p>R201's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents, dated 6/23/20 documented, "Reason: The safety of individuals in this facility is endangered. The Involuntary Discharge Notice documented R201 would be transferred to a local hotel on 6/23/20 with V11 supervising the discharge. The Involuntary Discharge Notice was signed by V1, Administrator. The Involuntary Discharge documents, "Pursuant to Section 483.12(a)(7) of the federal regulations, this facility will provide sufficient preparation and orientation to ensure your safe and orderly transfer or discharge from this facility."</p> <p>On 7/21/20 at 3:19 PM, V1 stated, "We discharged (R201) because he was involved in a resident altercation with (R203). I got a call at home, they told me (R201) was outside smoking and came back in, staff said when he came back,</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 9</p> <p>he seemed intoxicated. He went into (R203)'s room and started messing with her things. She told him to leave. I guess that is when he supposedly hit her. Staff separated them and moved him to the third floor."</p> <p>On 7/22/20 at 1:25 PM, V1 stated, "(R201) had an immediate order of protection placed on him. (R203)'s Power of Attorney (POA) filed the order of protection after (R203) told him about what happened. We cannot accommodate his needs because of the order of protection."</p> <p>R201's Medical Diagnosis section of his June 2020 medical record documents his diagnoses as Schizophrenia, History of Intracranial Injury, Anemia, Edema, Chronic pain, Hyperglyceridemia, Insomnia, Abnormalities of Gait and Mobility. Lack of Coordination, Major Depressive Disorder, Hypertension, Gastroesophageal Reflux Disease, Hemiplegic Migraine.</p> <p>R201's June 2020 POS documented he received the following psychotropic medications for Schizophrenia and Major Depressive Disorder: Divalproex Sodium ER (Extended Release) Tablet 24 Hour, 250 mg, give 1 tablet by mouth in the morning, Divalproex Sodium ER Tablet Extended Release 24 Hour, 500 mg, give 1 tablet by mouth two times per day; Mirtazapine Tablet, 30 mg, 1 tab at bedtime; Olanzapine Tablet, 7.5 mg, 1 tablet by mouth in the morning; Buspirone HCl, 5 mg tablet, 1 tablet by mouth three times a day for anxiety; Bupropion, HCL Extended Release 24 Hour, 150 mg, one tablet daily.</p> <p>R201's June 2020 POS documented he received the following medications for migraines: Sumatriptan, 25 mg as needed for migraines; and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 10</p> <p>Topiramate Tablet, 25 mg, give 1 tablet by mouth two times a day.</p> <p>R201's June 2020 POS documented he received the following hypertensive medications: Amlodipine Besylate Tablet 5 mg, give 1 tablet by mouth at bedtime; Furosemide Tablet, 20 mg, give 1 tablet by mouth one time a day related to Edema; Metoprolol Tartrate Tablet 37.5 mg, give 1 tablet by mouth two times a day and hold for hr (heart rate) < (less than) or = (equal to) 60 or SBP (systolic blood pressure) < or = 110.</p> <p>R201's June 2020 POS documented he received Gabapentin Tablet 800 mg, 1 tablet three times daily related to chronic pain.</p> <p>On 7/28/20 at 10:00 AM, V3 stated the nurses should have given a discharge summary of the medications to R201 upon discharge. V3 stated V26, Licensed Practical Nurse (LPN), should know what R201 was given at discharge.</p> <p>On 7/28/20 at 2:45 PM, V26, LPN, stated "I don't remember discharging (R201), You would think I would remember an Involuntary Discharge, but I don't." When asked, if you would have taken the time to give discharge instructions, a written list of medications and a supply of medications V26 stated, "Yes, you would think I would have remembered that".</p> <p>On 7/24/20 at 12:50 PM, V11, SSA, stated, "It's my fault there wasn't a progress note on (R201)'s discharge and no discharge instructions. I think it was around 1:00 PM. The facility driver (V34) and I took him to a (Local Hotel). He had \$100.00, I think. No discharge assessment was done."</p> <p>On 7/28 20 at 10:10 AM, V4, Nurse Practitioner,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 11</p> <p>stated, "I was under the impression you are to get your meds no matter what kind of discharge, except narcotics, we only give 3 days' worth."</p> <p>On 7/28/2020 at 2:57PM, V44, Pharmacist, stated medications for residents under third party vendor such as Medicaid belong to the resident, and only those medications under Medicare A belong to the facility. Follow-up email dated 7/29/2020 at 8:06AM, written by V44, Pharmacist, stated R200, R201, did not receive Medicare A benefits.</p> <p>After multiple request from the survey team, the facility was not able to provide R201's discharge planning including a list of what medications he was to receive and instructions on how to administer those medications at the time of R201's discharge.</p> <p>As of 7/30/20, the facility had not provided a policy regarding the disposition of medications upon involuntary discharge of residents.</p> <p style="text-align: right;">(A)</p> <p>300.610a) 300.1010g)3) 300.1010h) 300.1210b) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 12</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1010 Medical Care Policies</p> <p>g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following:</p> <p>3) Documentation of the presence or absence of incipient or manifest decubitus ulcers (commonly known as bed sores), with grade, size and location specified, and orders for treatment, if present. (A photograph of incipient or manifest decubitus ulcers is recommended on admission.)</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 13</p> <p>accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.3240 Abuse and Neglect</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 14</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to assess, monitor, and implement progressive interventions to prevent the formation and to promote healing of pressure ulcers for 4 of 5 residents (R209, R213, R214, R219), reviewed for pressure ulcers in a sample of 23. This failure resulted in R209's current pressure injuries/ulcers declining, and she developed two new facility acquired Stage 2 pressure ulcers.</p> <p>Findings include:</p> <p>1. R209's Diagnosis Sheet, not dated, documents R209 has the following diagnoses: Type 2 Diabetes Mellitus with Diabetic Nephropathy. Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation.</p> <p>R209's Minimum Data Set, dated 5/19/2020, documents she is cognitively intact. The MDS documents she has more than one pressure ulcer and is at risk for developing new pressure areas. The MDS further documents R209 requires 2-person extensive physical assist for bed mobility and toilet use.</p> <p>R209's Admission/Re-Admission Assessment, dated 5/19/2020 documents R209 had 3</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2020
NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL		STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702		
(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) COMPLETE DATE
S9999	<p>Continued From page 15</p> <p>unstageable pressure injuries/ulcers with the following measurements: 1) 0.6 centimeters (cm) cm by (x) 0.8 cm x 0.2 cm ulceration to upper buttock with moist slough (dead necrotic tissue) to wound bed; 2) 4.8 cm x 4.0 cm x ulceration to lower buttock with dry eschar (dead tissue) to the wound bed; and 3) 5.0 cm x 2.2 cm x 0.2 cm ulceration to the middle buttock with moist slough to wound bed.</p> <p>R209's Care Plan, dated 5/19/2020, documents R209 has a potential for impairment to skin integrity related to incontinence of stool. R209's Care Plan dated 5/26/2020, documents R209 is resistive to care including turning and repositioning. The Care Plan documents "Allow the resident to make decisions about treatment regime, to provide sense of control. Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care."</p> <p>R209's Braden Scale for Predicting Pressure Ulcer Risk (Braden Scale) dated 5/20/2020, documents R209 was at high risk for pressure ulcers. The Braden Scale documents R209 responds to verbal commands but cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. The Braden Scale documents R209 can make occasional slight changes in body or extremity position but unable to make frequent or significant changes independently and requiring moderate to maximum assistance in moving.</p> <p>R209's Physicians Order Sheet dated 5/20/2020, documents "Santyl Ointment 250 unit/gm apply to the 2 areas on the right rear thigh topically every evening shift for nonstageable wound." R209's</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 16</p> <p>Physician's Order, dated 5/20/20 documents "Silver Sulfadiazine Cream 1 % apply to bottom topically two times a day for wound."</p> <p>R209's Wound documentation dated 5/27/2020, documents R209 had 5 pressure ulcers with the following measurements; 1) Right Thigh distal (situated away from the center of the body) 2cm x 1.8cm x slough; 2) Right thigh proximal 3.0 cm x 4.4 cm (centimeters) x (by) necrosis; 3) Right buttock 5 cm x 2.9 cm x red; 4) Sacrum 2.6 cm x 1.9 cm; and 5) left buttock 9.9 cm x 8.1 cm. There was no documentation there was a change in R209's pressure ulcer treatment even though she now had developed two additional pressure injuries/ulcers. The Wound documentation did not document the Stage of the pressure ulcers, the color, tissue type, exudate (drainage), odor, erythema (redness of skin) and condition of the peri wound.</p> <p>From 5/27 through 6/24/20, the wound documentation was inconsistent. The documentation including the location of the pressure ulcers changed throughout. There was no documentation in R209's medical record throughout this time that V25, R209's Physician, made any changes in treatment orders for R209's pressure injuries/ulcers.</p> <p>R209's Physician Orders, dated 6/24/2020, documents "refer to plastic surgery for wound debridement of right buttocks. Resident was admitted from area hospital with wound. It is becoming worse."</p> <p>R209's Progress Note created by V4, Nurse Practitioner (NP), dated 6/25/2020, documents "Chief Complaint/Reason for this Visit: CHF (congested heart failure), large open wound to</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 17</p> <p>right buttocks." The Progress Note documents "She also has an open wound to her right buttocks. The wound was present when she was admitted from the hospital. The wound is becoming worse. Wound Nurse has been caring for it but states it is now starting to tunnel. She has been using medicated cream and changing dressing daily. She (R209) is unable to transfer herself and is up in her wheelchair for many hours of the day. She (R209) tells me that it does hurt at times. She has no other concerns today."</p> <p>There was no documentation in R209's medical record regarding the facility obtaining services from the plastic surgeon for debridement of R209 pressure ulcers.</p> <p>R209's Wound documentation, dated 7/6/2020, documents pressure injury to the right thigh has tunneling. There was no documentation in R209's medical record that there were any changes in treatment to R209's pressure injuries/ulcers.</p> <p>R209's Wound Clinic Progress Note, dated 7/20/20, documented R209 had a pressure ulcer to her right ischium measuring 2 cm x 2.2. cm by 0.7 cm, a pressure ulcer to her left buttock measuring 10.5 cm x 2.4 cm x 0.1 cm, a pressure ulcer to her coccyx measuring 1.5 cm x 0.3 cm x 0.1 cm and a pressure ulcer to her sacrum measuring 2 cm x 5.6 cm x 0.1 cm. The Progress Note documented that staff were to keep pressure off the pressure ulcers as much as possible and to apply xeroform/border form daily on all pressure areas. In addition, staff were to apply Destin and Silvadene twice daily to the pressure ulcer on her left buttock.</p> <p>R209's Braden Scale for Predicting Pressure Ulcer Risk dated 7/21/2020, documents R209</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 18</p> <p>was at moderate risk for pressure ulcers. The Braden Scale documents R209 responds to verbal commands but cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. The Braden Scale documents R209's ability to walk as being severely limited or non-existent, and R209 not being able to bear own weight and/or must be assisted into the chair or wheelchair. The Braden Scale further documents R209 makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently and requires moderate to maximum assistance in moving.</p> <p>R209's Skin-Pressure/Diabetic/Venous/Arterial Wound Report, dated 7/21/2020, documents R209 had two new facility acquired Stage 2 pressure ulcers with one to her sacrum measuring 2 cm x 5.6 cm by 0.1 cm and one on her coccyx measuring 1.5 cm x 0.3 cm x 0.1 cm. The Report documented that these were first observed on 7/20/20. The report documented R209 had a Stage 3 pressure ulcer to her right ischium measuring 2 cm x 2.2 cm x 0.7 cm with tunneling/undermining of 4.8 cm. This report did not document the pressure injury which was noted on the Wound Clinic Report to her left buttock.</p> <p>R209's Physicians Orders, dated 7/21/2020, documents clean right ischium, coccyx, sacrum with wound cleanser. Apply sterile petrolatum gauze and cover with border foam dressing daily, on evening shift.</p> <p>On 7/22/2020 at 10:20 AM R209 stated, " I can't get the proper care. Can take up to an hour and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 19</p> <p>half to answer the light and get help. Here recently they put me to bed at 12:30 PM. I pulled my light and they answer it and leave. After a while they stopped answering the light. Finally, at 5:00 PM, they were ready to get me up. I have never refused to let them do my treatment. I want to make sure I'm not stuck in the bed all day. It's depressing. I try not to cry. There are days when it is hard to live here. I want to go home but if my infection is not gone and my wounds aren't better, I will be stuck here.</p> <p>On 7/23/2020 at 9:40 AM, R209 was lying on her back in bed. V39 and V18 Certified Nurse's Aides (CNAs) assisted R209 onto her side. V6, ADON was in the room evaluating R209's pressure ulcers. There were multiple deep red creases to R209's back, buttocks and thighs. R209's buttocks and perineal area ranged from fire engine red to dark non blanchable red in color. R209 had a ½ moon shaped deep red non-blanching Stage 1 pressure ulcer and an unstageable pressure ulcer the size of a quarter with 100% slough on her sacrum. V6, ADON, evaluated these two areas, one pressure ulcer measuring 9.6 centimeters squared (cm²). R209 had a pressure ulcer to her right medial thigh approximately the size of a nickel with slough noted in wound bed. V6 measured this pressure ulcer as 7.1 cm². R209 had a Stage 1 pressure ulcer the size of a quarter to her right inner thigh. V6 measured this pressure ulcer as 1.6 cm². R209 had two Stage 2 pressure ulcers, one finger width apart on her coccyx. V6 measured these pressure ulcers as one area measuring 128cm².</p> <p>On 7/23/2020 at 9:40 AM V39 stated that this was the first time coming into R209's room. V39 stated "Coming in to help get her cleaned up."</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 20</p> <p>On 7/23/2020 at 9:45 AM V18 stated, "She pulled the light and said she needed cleaned up." V18 stated she had not repositioned R209 today. V18 stated "She is getting a shower and will get up then."</p> <p>On 7/23/2020 at 10:00 AM R209 stated, "Had a bowel movement last night. They cleaned me up and took the dressing off because it was soiled. No one came back in and put another one on. No one has come back in. I have been on my back since they changed me last night."</p> <p>On 7/23/2020 at 10:30 AM V29, Licensed Practical Nurse (LPN), stated, "I have not performed any treatments on (R209) as of yet this morning. I would expect the dressing to be in place. If it (dressing) was removed or came off, I would expect the staff to notify me immediately so I can do the treatment. Moisture and pressure would cause pressure areas and cause them to get worse."</p> <p>On 7/28/2020 at 9:45 V37, Registered Nurse/RN at wound clinic stated "(R209) will continue to have new open areas if the resident is not repositioned."</p> <p>On 7/30/2020 at 12:20 PM V2, Director of Nursing (DON), stated "If the resident refused to turn and reposition or refused treatment, I would expect the staff to document that in the progress notes. I would expect the staff to provide the resident with education discussing the risk versus the benefits so the resident could make an informed decision. Can't say that it wasn't done if not documented, but I would expect it to be documented in the progress if it was done."</p> <p>The Facility was unable to provide documentation</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 21</p> <p>of the education performed with the resident and documentation of the resident's refusals to turn and/or reposition.</p> <p>2) R214's Care Plan, revised on 5/27/2020, documents R214 having blindness, having an Activities of Daily Living (ADL) self-care performance deficient related to Glaucoma, and incontinence. The Care Plan also documents R214 is to lie down after meals. The Care Plan further documents R214 has potential for skin impairment r/t (related to) decreased mobility, fragile skin, incontinence.</p> <p>R214's MDS dated 6/18/2020, documents R214 has moderately impaired cognition and requires extensive assistance of 2 staff persons physical assistance for bed mobility, transfers and toileting. The MDS documented R214 was at risk for pressure ulcers and had one Stage 2 pressure ulcer at the time of this assessment. The MDS further documents R214 having the following diagnoses: Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE) and Chronic Pain.</p> <p>R214's Physician's Order dated 7/18/2020 documents, "Cleanse coccyx with NS (normal saline) or wound cleanser. Apply bordered foam dressing. Change q (every) 3 d (days) et (and) PRN (as needed) for soilage and dislodgement [sic]." There were no other orders for pressure ulcer treatment.</p> <p>On 7/23/2020 at 9:03AM, R214 sat in her room in her wheelchair with her hand on her head moaning. There was a pervasive urine odor in the room. At 9:50AM, surveyor asked V21 and V22, CNAs, when the last time R214 was repositioned and or toileted. V22, CNA, said "ask</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2020
NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL		STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702		
(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) COMPLETE DATE
S9999	<p>Continued From page 22</p> <p>(V20/CNA) and she can tell you how long she (R214) has been up, and I think she has been up since this morning."</p> <p>On 7/23/20 at t 9:05AM, V20 stated R214 was gotten up at 6:30 AM. V20 stated she hasn't had time to change or reposition R214 because she (V20) is too busy giving showers. V20 stated R214 was gotten up because she (V20) must give 17 residents a shower in one day. V20 stated that Corporate changed the schedule for showers whereby afternoons and nights don't do showers and so she hadn't had time to take care of R214. V20 said when she comes in the morning residents are always "wet".</p> <p>On 7/23/20 at 9:55 AM, V20 and V22 stood R214 up. There was dressing on R214's right gluteal dated 7/18/20 and deep red creases were noted to the outer edges of her bilateral buttocks. R214 had an opened pressure ulcer to her coccyx that was not covered with a dressing. There was a pervasive urine odor and V22 stated, "That's her wound, not urine."</p> <p>The Care Plan revised on 7/27/2020, further documents R214 having "pressure ulcer on coccyx and right gluteal r/t (related to) inc (incontinence) of B&B (bowel and bladder)."</p> <p>Facility Wound Log dated 7/28/2020, documents R214 had a new Stage 2 facility acquired pressure ulcer to her "coccyx" with initiation date of 7/23/20. The Wound Log further documents R214 had a facility acquired pressure ulcer to her right upper buttocks measuring 0.4 cm by 0.3 cm with initiation date of 7/23/20.</p> <p>Facility Wound Assessment dated 7/28/2020, documents R214's facility acquired coccyx</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 23</p> <p>pressure ulcer measured 2.1 cm x 1.7cm by 0.1 cm with light exudate and serous drainage. The assessment documented the primary dressing to be a foam dressing and to be on a "turning/repositioning program."</p> <p>R214's Treatment Administration Record (TAR) dated July 29, 2020, documents no treatments for R214.</p> <p>On 7/23/2020 at 10:00AM, V2, Director of Nurse (DON) stated "It (wound) is ordered to be changed every three days and she would have expected the dressing to be changed every 3 days and more often if needed." V2 stated that residents should be toileted at least every 2 hours and more frequent and should be repositioned then as well.</p> <p>3) On 7/23/2020 from 9:15AM, R213 remained in her wheelchair in her room. At 9:30AM, V20 stood R213 up and removed her incontinent brief. R213 had deep white creases and urine was noted dripping from the incontinent brief onto her inner thighs. On R213's right buttock was a red circular mark that remained reddened for greater than five minutes and was not blanchable. When V20 observed R213's buttocks, V20 stated, "That wasn't there this morning when I got her up." At that time, V20 stated she had not repositioned R213. V20 stated that she had been passing trays, doing resident's showers and answering call lights. V20 stated she got R213 up at 7:15 AM.</p> <p>Facility Wound Log dated 7/28/2020 fails to list any reddened area to R213's right upper buttock.</p> <p>Care Plan revised on 1/20/2020, documents R213 having a self-care performance deficit r/t</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 24</p> <p>Dementia and the potential for impairment to skin integrity r/t fragile skin, incontinence, Peripheral Vascular Disease (PVD), and Edema.</p> <p>On 7/23/2020 at 10:00AM, V2, DON, stated, "residents should be toileted at least every 2 hours and more frequent," and should be repositioned then as well.</p> <p>4) R219's Significant Change MDS, 6/22/20, documents R219 is severely cognitively impaired. The MDs documents she requires extensive assistance of two staff persons for mobility, transfers and toilet use. The MDS documents she is at risk for pressure ulcers.</p> <p>R219's Current Care Plan, undated, documents she has diagnoses of Urinary Incontinence, Fracture of T9-T10 Vertebra and contractures of the right and left knees. R219's Care Plan Focus, initiation date of 4/10/19, documented "I have a potential for impairment to skin integrity r/t (related to) fragile skin, incontinent, Seizures and ASA (aspirin) use."</p> <p>On 7/23/20, from 8:54 AM to 10:30 AM, based on 15-minute observations, R219 was in her room sitting in a specialized chair watching T.V. There was a mechanical lift sling/pad under R219. R219's knees were contracted. At 9:11 AM, V11, Social Service Assistant and V39, CNA were in R219's room. V39 was asked when R219 had been checked for incontinence and repositioned last. V39 stated that would have been around 7:00 AM when R219 was placed in the specialized chair. V39 went to the hall and brought back a mechanical lift. V11 and V39 hooked R219's sling to the mechanical lift and attempted to move R219 to R219's bed. The mechanical lift noted to rise both up and down to</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 25</p> <p>what appeared to this surveyor the right heights. V39 stated the lift was not raising high enough and disconnected R219 from the sling. V11 and V39 left the room with the mechanical lift.</p> <p>On 7/23/20 at 9:29, V40, Rehab Director, V11, and V41, Medical Records, returned to R219's room with a different mechanical lift. These staff members attempted to use the lift again and stated the lift was not going high enough. The lift rose to the same level as prior lift and staff again stated the lift was not raising high enough to get R219 over the chair arms of the chair. The staff then brought in a new battery to try on the lift. The lift was then checked again, and staff continued to say the lift was not rising high enough to transfer R219.</p> <p>On 7/23/20 at 9:43 AM, R219 was restless in chair, fidgeting, reaching for the floor and end of chair. R219 attempting to scoot forward and move R219's legs were off the end of the chair. V41 instructed R219 to move back in chair.</p> <p>On 7/23/20 at 9:45 AM, V41, V11 and V29, LPN, all entered R219's room stating they were going to reposition R219. They used the mechanical lift sling to pull R219 up into chair. All 3 staff agreed that a resident should be checked for incontinence and repositioned every two hours. V11 stated that R219 was last checked for incontinence and change of position at 7:00 AM by V39.</p> <p>On 7/23/20 at 10:06 AM, V2, DON, V6 DON, V42 LPN, and V43 CNA entered R219's room. R219 was moved in R219's chair to the side of the bed as the staff discussed how they would move R219. V43 left the room and came back with the same mechanical lift from the hall that had been</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 26</p> <p>used previously. R219's lift sling was hooked to the lift and R219 was raised in the air. The mechanical lift again raised to the height it had been raised before. V2 and V6 stated the lift was not going high enough again. V43 then stepped in at 10:15 AM, three hours and 15 minutes after R219's last incontinence check, and stated: "Yes, it is." V43 then maneuvered the lift and chair to allow R219 to be able to be transferred from the front of the chair instead of over the chair arms and into the bed. This surveyor asked if R219 was wet. V2 (DON) stated, no as the disposable brief did not turn color to show it is wet. The surveyor requested to observe R219's skin. R219 was rolled on R219 left side. R219 had deep indentations noted to her bilateral upper legs into the buttocks area around the edges of the disposable brief, both areas were noted to be red in appearance.</p> <p>Facility's Pressure Ulcer Prevention Policy, dated 11/28/2012 with revisions on 1/15/18 documents "Purpose: to prevent and treat pressure sores/pressure injury." The Policy documented "2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures." The Policy documented "5. Turn dependent resident approximately every two hours or as needed and position the resident with pillows or pads protecting boney prominence as indicated." It documents "7. Whenever possible, encourage resident to change position at regular intervals as able to promote circulation. Wheelchair resident may be instructed to shift weight from one buttock to the other. 8. If redness does not disappear within 30 minutes the turning schedule may be shortened to 1 hour. Maintain clean/dry skin during daily hygiene measures. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. May use lotion on dry</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 27</p> <p>skin. Change bed linen per schedule and whenever soiled with urine, feces, or other material. Turn dependent residents approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. Whenever possible, encourage resident to change position at regular intervals as able to promote circulation. Wheelchair residents may be instructed to shift weight from one buttock to the other. If redness does not disappear within 30 minutes the turning schedule may be shortened to one hour."</p> <p style="text-align: right;">(B)</p> <p>300.610a) 300.1210b) 300.1210d)3) 300.1220b)7) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 28</p> <p>the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 29</p> <p>nursing services of the facility, including:</p> <p>7) Coordinating the care and services provided to residents in the nursing facility.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to develop and implement person-centered interventions to address residents' behavioral health care needs for 2 of 3 residents (R200, R222) reviewed for behavioral health in the sample of 23. This failure resulted in R222 hallucinating, having delusions and refusing medications which resulted in psychiatric hospitalizations three times in five months.</p> <p>Findings include:</p> <p>1.R222's Electronic Medical Record (EMR) dated 8/2020 documents Diagnosis as Paranoid Schizophrenia, Major Depressive Disorder and Anxiety.</p> <p>R222's only Behavior Health Note, dated 3/2/20,</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 30</p> <p>written by, V36, Licensed Clinical Social Worker from a Behavioral Health Consultant Group, "(R222) is a 64 year old Caucasian female who was seen at the nurse's desk on her hall at the nursing home. Nursing Home staff report that (R222) believes she is pregnant and will be having a baby boy in September, and they have confirmed multiple times that she is not pregnant. Staff report that (R222) has been refusing psychotropic medication, and the writer witnessed her walking in the hall, shouting 'They said I'm Schizophrenic and I'm not. I don't need you crazy people'. The writer introduced herself and described her role and encouraged (R222) to talk about what is bothering her so the writer can assist her. (R222) reported 'you can't help me, I'm sorry,' and started pacing the hallway. She is alert and oriented X (times) 2, intense eye contact. Speech is loud, mood is grandiose. Insight, judgement and impulse control impaired. She denies suicidal ideation/homicidal ideation, displays response to internal and external stimulus. She is recommended for individual therapy and psychiatric services. Prognosis is limited. ASSESSMENT and PLAN document, Schizoaffective disorder, bipolar type. PLAN: Cognitive Behavior Therapy/Dialectical Behavior Therapy (CBT/DBT) skills training to assist in managing moods and symptoms. Individual therapy to stimulate cognition, help develop healthy coping skills, and learn psychoeducation. Psychiatric diagnostic evaluation. Follow up as needed (prn)."</p> <p>R222's Care Plan Focused Problem, dated 3/10/20, documented "I have been diagnosed with psychiatric diagnoses and may benefit from skills training. I require attention in the priority skilled areas: self-maintenance, ADLS hygiene, dressing, grooming, care of personal space, diet</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 31</p> <p>and nutrition, personal safety, social skills and symptom management." The Goal documented "I will engage in skills training addressing 2x per week." The Interventions documented "Encourage resident to practice skill regularly. Emphasize detailed instructions, modeling, repetition, or role playing in reality-based scenarios. Introduce skill gradually, with clear explanations, Offer appropriate behavior incentives, positive feedback and reinforcement for practicing skill."</p> <p>R222's Care Plan Focused Problem, dated 3/11/20 documented "I have a behavior problem delusion r/t (related to) schizophrenia. I think I'm pregnant and I'm having a baby boy." The Care Plan interventions documented "Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet the resident's needs. Care givers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and or unacceptable to the resident."</p> <p>There was no documentation in R222's medical record that the facility implemented cognitive behavioral therapy/dialectical behavioral therapy, or any other recommendations made by V36 on 3/2/20 to address R222's behavior health needs.</p> <p>There is no documentation in R222's medical record of the facility's implementation of skills training for R222.</p> <p>The Facility's Petition for Involuntary/Judicial</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 32</p> <p>Admission dated 4/21/20 documented R222 was sent to hospital because she was experiencing visual hallucinations, seeing God and angels, delusional thinking (i.e. thinking she is pregnant), refusing medication, combative with staff, yelling disruptive and not easily redirect.</p> <p>R222's Petition for Involuntary/Judicial Admission, dated 6/24/20, documented she was sent to hospital due to experiencing visual hallucinations, seeing God and angels, thinking that she is pregnant with multiple babies, refusing medications, combative with staff, yelling and disruptive and not easily redirected.</p> <p>R222's Discharge Instructions from Hospital, dated 7/1/20 document "Follow up with Psychiatrist at (Facility). Take medications as prescribed. If you experience side effects, please notify clinical provider. Avoid use of alcohol or illicit drugs."</p> <p>There is no documentation in R222's medical record that she is being seen by a Psychiatrist. There was no other documentation from the Behavioral Health Consultant Group that R222 was seen after her hospitalization on 6/24/20.</p> <p>R222's Medication Administration Record (MAR) dated July 2020 documents R222 refused Buspirone (an antianxiety medication), 30 milligrams (mg) every AM and Hydroxyzine (antihistamine), 50 mg every AM on 7/2/20 and 7/3/20. R222 refused her Levothyroxine which should be given daily, 16 days in July 2020. R222 refused Omeprazole (medication to treat Gastroesophageal reflux disease) which should be given daily, 20 days in July. R222 refused Torsemide, a diuretic, to be given daily, 9 days in July. R222 refused her AM dose of Quetiapine</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 33</p> <p>(an antipsychotic medication), 9 days in July. She refused her PM dose of Quetiapine, 11 days in July.</p> <p>There was no documentation in R222's Care Plan or medical record that the facility attempted to implement progressive interventions to address R222's refusal of medication.</p> <p>The Petition for Involuntary/Judicial Admission, dated 8/3/20 documented she was having visual hallucinations, claiming to be raped in April by her angels, claiming to be pregnant with twins, being physically and verbally aggressive with staff and other residents.</p> <p>R222's Progress Note, written by V19 Social Service Director (SSD) dated 8/3/20 at 12:29 PM documents, "Receptionist brought resident to SS (Social Service) office and she told writer that she (R222) was raped. Writer spoke with resident and she stated that she was raped four months ago by three different men. Writer asked her if she knew who raped her and she said Vurt and Burt and writer asked her what was the third person name and she called me illiterate b**** and that she is not going to talk to me anymore. Resident stood up and grabbed writer and shook writer and writer said let's go talk to Director of Nurses (DON) and Assistant Director of Nurses (ADON) so you can tell them what happen. Writer took her to DON office and writer notified Administrator."</p> <p>R222's Progress Note written by V2 Director of Nurses (DON) dated 8/4/20 document, on 8/3/20 "Writer was made aware of a situation by social service regarding resident. Resident became violent with social service grabbing and shaking her. This is when the writer took over the inquiry. Resident claims to have been raped in April.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 34</p> <p>Resident told writer that three guardian angels raped her and now she is pregnant with twins. When writer attempted to ask questions regarding the rape the resident became belligerent. Resident repeatedly states that the three guardian angels came in her room through the window and attacked her. While attempting to complete a skin assessment, resident became angry and agitated, stating she was done talking about this. Resident told writer 'you're not going to touch me, get out of my room.' Writer exited the room. Facility contacted Police Department regarding the rape allegation. A police officer came to interview the witness around 11 am."</p> <p>On 8/4/20 at 11:20 AM, V19 Social Service Director (SSD) was asked if (R222) was put on any type of behavioral programming when she returned from the last hospital admission on 7/1/20. V19 stated, "No, but she (R222) spoke with (V36, Licensed Clinical Social Worker from Behavioral Health Consultant Company)." V19 stated "I usually work from 5:00 PM to 10:00 PM, so I normally text (V11 Social Service Aide) or email her to let her know what needs to be done the next morning, and sometimes I'm on the meeting with speaker phone. I've said in the phone calls on the morning meetings, I ask them "What are we going to do about (R222)?" I have been working with V4 Nurse Practitioner (NP) on behaviors by "keeping an eye on this person, I should have documented it probably, but I didn't."</p> <p>On 8/10/20 at 12:00 PM, V3, Corporate Registered Nurse (RN) Consultant stated, "Interventions should have been put into place to ensure (R222) took her medications." At 2:27 PM, V3 stated R222 has not been seen by a psychiatrist or psychologist while residing in the facility.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020	
NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL		STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702		
(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) COMPLETE DATE
S9999	<p>Continued From page 35</p> <p>2. R200's Face sheet, undated, documented he was admitted on 1/9/20 and had the following diagnoses: Schizophrenia, Bipolar Disorder and Major Depressive Disorder,</p> <p>R200's Care Plan Focused Problem, dated 1/10/20, documented "I have diagnosis of depression or is at risk for depression." The Interventions documented "Administer medications as ordered by physician, encourage participation in activities of choice and interest, encourage sharing feelings of loss, encourage socialization." R200's Care Plan Focused Problem, dated 3/26/20 documented "I have a history of criminal behavior. I have demonstrated stability during the admission screening process and does not appear to present at risk. Fits criteria for an 'identified offender.'" The Interventions documented "Evaluate the resident's ability to control impulses. If substance abuse is suspected, utilize appropriate blood/urine testing, limit setting, counseling and consequences." R200's Care Plan Focused Problem, dated 5/14/20 documented "I have a mood problem r/t (related to) DX (diagnosis) of Schizophrenia, Bipolar disorder." The Interventions documented "Behavior health consults as needed (psycho-geriatric team, psychiatrist etc.)"</p> <p>Progress Note authored by V36, Licensed Clinical Social Worker (LCSW), dated 3/9/2020, documents, R200 was seen for chief complaint of anxiety and was referred by V25, Medical Director. The progress note documented R200 has chronic anxiety disorder and with a recommendation for: "Plan BCT (Behavior Change Technique) /DBT (Dialectical Behavior Therapy) skills training to assist in managing</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2020
NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL			STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702		
(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) COMPLETE DATE	
S9999	Continued From page 36 moods and symptoms individual and group therapy to help develop healthy coping skills and stimulate cognition." There was no documentation in R200's medical record that the facility implemented V36's recommendations which she made on 3/9/20. R200's Community Survival Skills Assessment, dated 5/27/2020, recommendation: "The resident does not appear to be capable of unsupervised outside pass privileges at this time." Social Services notes, written by V11, Social Service Assistant (SSA), dated 6/10/2020, documents "Writer met with (R200) to see how things are going. He (R200) is doing well. He has not exhibited any criminal behavior since admission." Elopement/Unauthorized Leave Risk Review for R200, dated 6/14/2020, documents, R200 "Becomes agitated, confused and/or disoriented or displays consistently poor judgement (i.e., would not be able to safely care for him/herself outside of the facility)." Social Services note dated 6/17/2020 1:10 PM, documents: "Writer (V11) spoke with resident (R200) to let him know that he needs to stop asking other residents and staff members for cigarettes and food. Resident denied that he is asking staff and other residents for items he states that he has money of his own and that he can buy the things that he needs. Writer informed him that this type of behavior will not be tolerated and if he keeps this up, he will be giving an involuntary discharge (IVD). He is doing this on a daily basis and when staff question him about it, he denies."	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 37</p> <p>R200's Care Plan was not updated with progressive interventions to address R200 asking staff and residents for money.</p> <p>Incident Investigation Summary dated 6/17/2020 at 3:33 PM, documents R200 received dialysis on 6/17/2020. The incident summary documents V4, Nurse Practitioner (NP), and V11, Social Service Assistant (SSA), were informed by V34, Transportation Driver, that R200 put something in his pocket when he was picked up after his dialysis appointment. The incident summary documents, "2 stubs of marijuana that measured about ¼ inch long and 2 pieces of something like crack cocaine," were found on R200. The incident summary further documents the (city) Police arrived and "did a field test but couldn't confirm the tested product to be crack cocaine. The summary documented the "local Police said there was nothing they could do for the marijuana due to it being legal in Illinois, and (facility) uses federal money for its operation, and it is illegal."</p> <p>7/23/2020 8:30 AM, V11, Social Service Assistant stated that there were no behavioral services for residents. She said there were no services such as alcohol programing or counseling services. She said the facility used to have some classes such as anger management and/or things like how to do socialization.</p> <p>The facility Policy and Procedure for Behavior Management Program dated 11/28/12 documents "To establish a system for identifying behaviors and implementing appropriate interventions consistent with the individualized plan of care and to ensure that each resident receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being.</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
---	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 38</p> <p>Guidelines include Services: Mental health rehabilitative services and behavior management program for Mental Illness (MI) and Intellectual Disabilities (ID) may include, but are not limited to: Consistent implementation during the resident's daily routine and across settings, of systemic plans which are designed to change inappropriate behaviors; Medications prescribed to change inappropriate behavior to alter manifestations of psychiatric illness; Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal); Development, maintenance and consistent implementation across settings of those programs designed to teach individuals the daily living skills they need to be more independent and self-determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skills, health, drug therapy, mental health education, money management, and maintenance of the living environment; Crisis intervention service; Individual, group, and family psychotherapy; Development of appropriate personal support network; and Formal behavior modification programs."</p> <p>(B)</p>	S9999		
-------	--	-------	--	--