STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: _____ B. WING _____	10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	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	Final Observations Statement of Licensure Violation: 1 of 1 Violation Complaint #2045286/IL124553 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 2 seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued From page 3 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) This Requirement is not met as evidenced by: A. Based on observation, interview and record review, the facility failed to develop and implement progressive interventions to prevent falls for 3 of 10 residents (R20, R59, R192) reviewed for falls in the sample of 69. This failure resulted in R59 falling and sustaining a laceration to her head requiring emergency room services and sutures. This failure resulted in R192 falling and sustaining a laceration to his left forehead, requiring emergency room services and treatment. Findings include: 1. On 09/24/20 at 10:15 AM, R59 had 3 band aids to her right upper forehead, a dark shadow noted on band aids, a large hematoma noted around band aids. R59 stated that she fell a few weeks ago and she just had the staples taken out. R59's Care Plan, dated 06/02/2020, documents R59 is at risk for falls related to Alzheimer's disease, incontinence and history of falls. The Interventions documented "Grippy socks on at all times." R59's Care Plan, dated 07/14/2020, documents, "Alarm to bed and chair to alert staff of unassisted transfers."	S9999		

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S9999	Continued From page 4 R59's Minimum Data Set (MDS), dated 8/10/20, documents she has severe cognitive impairment and requires assistance with one staff person for transfers. The MDS documents she is not steady and only able to stabilize with staff assistance with moving on and off toilet and surface to surface transfer (transfer between bed and chair or wheelchair.) R59's Fall Report, dated 09/12/2020, documents that R59 fell on 09/12/2020 and it was unwitnessed. R59's Fall Interdisciplinary Team Note, dated 9/12/2020, documents, "Summary of the fall: (R59) continues on hospice. (R59) was found on floor in room lying beside the bed. She (R59) was bleeding from the forehead. (R59) denied any other pain (range of motion) (within normal limits). (R59) was assisted to bed with assist (of 2 staff). (Nurse Practitioner) notified via phone order received to send to (emergency room). Ambulance was called to transfer resident to (emergency room) at (local hospital) for possible sutures. Large skin tear noted to right forehead. Pressure applied to wound after skin approximated. Bleeding slowed but didn't stop completely before ambulance arrived. (R59) remained alert and oriented with no loss of consciousness noted. Notified (Director of Nurses) and on call about the fall. Notified (Power of attorney) via phone call. Root cause of fall: Alarm was in the wheelchair and was not put in (R59's) bed while she was lying down. Intervention and care plan updated: Educated staff on proper placement of alarm." R59's Health Status Note, dated 09/14/2020 at 2:30 PM, documented, "(R59) noted to be sitting on the floor next to her bed by maintenance after	S9999		

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opening the door for inspection. (R59) fully dressed with cotton socks on. No c/o (complaint of) pain or discomfort. Call light in reach, but not in use. Alert with confusion. Able to make needs known. Wheelchair in reach with brakes unlocked. No injuries noted to head with sutures, and staples present from previous fall. Received 4 abrasions total with wound nurse assessing (and) measuring. Two to spine (and) two to (right) shin. Able to bear weight bilaterally with unsteady gait (and) assist of two."

On 10/14/20 at 10:45 AM, R59 was lying in her bed. There was no bed alarm noted on the bed and the alarm was in her wheelchair (w/c) and not sounding.

On 10/15/20 at 10:00 AM, R59 was sitting up to wheelchair propelling self around her room. R59 was wearing cotton socks without shoes on.

On 10/15/20 at 10:07 AM, V67, Licensed Practical Nurse (LPN), stated, "(R59) should have the wheelchair alarm and bed alarm on at all times and that she should have on appropriate footwear too."

On 10/20/2020 at 11:20 AM, V4, Assistant Director of Nurses (ADON), stated that each manager takes turns and does Angel rounds to check residents to see if they have their appropriate equipment in place, if it is operational and that the resident has their fall precautions in place.

2. R20's Physicians Order summary sheet , dated 10/14/2020, documents she has diagnoses of Multiple Sclerosis and lack of coordination.

R20's MDS, dated 7/3/20, documents she has

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S9999	Continued From page 6	S9999		

moderately impaired cognition. The MDS documents she requires assistance of two staff persons for transfers and toilet use. The MDS documents she has limitations in range of motion in both lower extremities and is not steady, only able to stabilize with staff assistance when moving on and off toilet and surface to surface transfers (transfer between bed and chair or wheelchair).

R20's Care Plan, initiation date of 1/23/20 documents she is at risk for fall/injury from weakness and tiredness related to multiple sclerosis, schizophrenia, dementia and polyneuropathy.

R20's Care Plan Intervention, dated 12/9/15 documents "continue to encourage me to wear gripper socks and continue to remind me to request assistance with transfers." R20's Care Plan Interventions, dated 1/7/16 documented "Offer frequent toileting upon rising, before meals and at bedtime." The last interventions implement on this care plan were dated 4/12/18.

On 09/23/20 at 12:40 PM, R20's room door was closed and she was yelling "Help me, help me!" At 12:43 PM, R20's room door was opened by R20. R20 was on the floor in the bathroom, with bilateral knees bent up underneath her. R20 had cotton socks on her feet and wheelchair was in front of her. V30, Certified Nurse Assistant (CNA) was alerted and came into room stated to resident, "You can get up." V30 didn't place gait belt on R20 but called out for V31, CNA. Both entered R20's room and closed the door. When V30 and V31 exited the room, R20 was lying in her bed. No nurse was present to assess R20 prior to V30 and V31 getting R20 up off of the floor. V30 stated "She falls all the time and it's

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S9999	Continued From page 7 care planned." On 09/23/2020 at 1:10PM, V30, CNA made V32, LPN, aware of R20 being on the floor. At that time, V32, LPN stated, "She sits on the floor and it is care planned." R20's Progress notes, dated 09/23/2020 at 1:12 PM, V32, LPN documented, "Informed per CNA (resident) on floor per her norm (has been care planned) (resident) with no noted injuries no noted mental status changes (continues) to transfer self (wheelchair) to toilet/bed color fair skin (warm dry) no (signs/symptoms) distress. (Director of Nurses) aware (Minimum Data Set nurse) aware." R20's Care Plan was reviewed and did not address any interventions regarding R20 putting herself on her floor and how staff should address this. R20's Fall risk assessment, dated 09/23/2020, documents that R20 was at risk for falls. R20's Care Plan was not revised until 10/1/20 with progressive interventions to prevent her from future falls. The Intervention documented "It is care planned that she crawls on the floor. Move resident directly closer to desk for better visual of the resident." On 09/30/20 at 11:50 AM V1, Administrator, stated, "A nurse should have assessed her and a fall incident report should have been made out for the 09/23/2020 incident and if the resident is on the floor and it is unwitnessed then an incident report should have been filled out but if staff sees her put herself on the floor then they can just chart it." V1, Administrator, continued, "(R20)	S9999		

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S9999	Continued From page 8 does not have any incident reports for falls from 03/2020 until 09/30/2020." B. Based on observation, interview and record review, the facility failed to assess and implement interventions to provide safe smoking for one of three residents (R9) reviewed for supervision/smoking in the sample of 69. Finding includes: On 10/08/2020 at 10:06 AM, R9 was observed outside smoking without a smoking apron on. V24, Activity Aide, aide was supervising the smoking. R9 was observed to have difficulty holding his cigarette steady in his right hand and dropped ashes on his pants. R9's Admission Record, print date 9/30/2020, documents R9 was admitted 6/4/2015 with diagnoses of Sequelae (a condition which is the consequence of a previous disease or injury) of unspecified Cerebrovascular Disease and abnormalities of gait and mobility. R9's Minimum Data Set (MDS), dated 6/16/2020, documents that R9 is cognitively intact and uses tobacco. R9's Care Plan, dated 6/3/2019, documents, "Focus: I am a smoker. Interventions: Instruct about smoking risks and hazards and about smoking cessation aids that are available. Resident will keep smoking materials in a secured location. Resident will participate in smoking assessments as needed." R9's Smoking Safety Risk Assessment, dated 9/15/20, documents, "Level of supervision: Requires assistance and supervision with	S9999		

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S9999	Continued From page 9 smoking. Comments: Resident needs assistance with smoking, will evaluate a need for a smoking apron." The facility provided document "(R9) Smoking Assessment", dated September/October 2020, given to survey team on 10/6/2020 has 3 facility staff signatures under Need Apron. On 10/6/2020 at 4:30 PM, V3, Social Service Director, (SSD), stated, "I had the Activity people assess (R9) for the need of a smoking apron starting on 9/9/2020. I want to have as many observers give their opinion on if he needs a smoking apron. I need one more persons' signature for the need of an apron for the assessment to be completed." V3 further stated that if she was advised of R9 needing a smoking apron she would get him one and the process would not take weeks to complete. V3 also stated that in relation to R9's smoking apron need assessment the staff did not date the document when they signed it. On 10/08/2020 at 10:55 AM, V24, Activity Aide, stated, "I did not know there was an in-service the other day and that (R9) needed a smoking apron. (R9) does have trouble holding his cigarette with his right hand and he is shaky." On 10/29/2020 at 9:00 AM, V1, stated, "(R9's) smoking apron assessment should not have taken that long to complete." The facility policy and procedure Smoking Safety, dated 1/22/2019, documents, "A Smoking Safety Assessment will be completed to determine the level of assistance and supervision needed during smoking, the ability to carry and store materials, and if a smoking apron is indicated.	S9999		

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S9999	Continued From page 10 The plan of care shall reflect the results of this assessment. This assessment will be completed upon admission, quarterly and with significant change." (B)	S9999		