Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007413	A. BUILDING: _______ B. WING _______	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DEKALB	1212 SOUTH SECOND STREET DEKALB, IL 60115

(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
S 000	Initial Comments Complaint Investigation 2213912/IL147061	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.686d) 300.1210b) 300.1210d)3) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications d) Residents who use antipsychotic medications shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue these medications in accordance with Appendix F. In compliance with subsection 2-106.1(b) of the Act and this Section, the facility shall obtain informed consent for each dose reduction. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:

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.

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to prevent a resident's mental health from declining and failed to implement interventions to keep a resident's behavior from escalating for 1 of 3 residents (R3) reviewed for behavioral health services in the sample of 10. This failure resulted in R3's psychiatric behaviors escalating requiring hospitalization.

The findings include:

R3's Face Sheet dated 5/24/22 shows she was admitted to the facility on 11/12/21 and her diagnoses included, but are not limited to, Anxiety disorder, unspecified, Schizoaffective disorder, bipolar type, Unspecified dementia with behavioral disturbance, major depressive disorder, restless legs syndrome, and seizures.

R3's Minimum Data Set (MDS) dated 2/17/22 shows she has severe cognitive impairment.

R3's Progress Notes include a Psychiatry Note signed at 2:26 PM on 3/23/22 from V16, Psychiatric Physician Assistant (PA). The note

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S9999	Continued From page 2 includes the following: Plan- Med Changes: No medication changes recommended at this time. Continue current treatment plan. Medication List: Quetiapine [antipsychotic], Sertraline [antidepressant], Topiramate [anticonvulsant], Clonazepam [sedative], Buspirone [anxiolytic (anti-anxiety)], Amitriptyline [antidepressant], Divalproex [anticonvulsant and is also used to treat bipolar disorder], Lorazepam [sedative], Haloperidol [antipsychotic], Diphenhydramine [antihistamine], and Ropinirole [dopamine agonist]. Gradual Dose Reduction: Medication does, and duration are appropriate and not duplicitous ...Medications prescribed are medically necessary for treatment of patient's psychiatric diagnosis in accordance with relevant standards of practice ...Gradual Dose Reduction (GDR) is clinically contraindicated at this juncture due to attempted dose reduction likely impairing resident's function and causing psychiatric instability by exacerbating an underlying psychiatric disorder. R3's Medication Administration Record (MAR) for March 2022 shows Amitriptyline, Sertraline (related to major depressive disorder), Topiramate (related to dementia), Divalproex (related to Schizoaffective disorder, bipolar type), Quetiapine (related to Schizoaffective disorder, bipolar type), ropinirole (related to dementia), Buspirone (related to dementia), and diphenhydramine (related to restless legs syndrome), were all abruptly discontinued on 3/26/22. On 5/23/22 at 10:00 AM, V2, Director of Nursing (DON), said R3 has a long psychiatric history. V2 said Hospice stopped R3's medications without family agreement. V2 said she noticed R3's behaviors had increased, and she witnessed R3's	S9999		

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poor impulse control after her psych meds had been discontinued. V2 said R3 was hearing voices and throwing objects. V2 said there should have been a GDR, it is not an acceptable practice to just discontinue psych meds. V2 said R3 had been taking her medications regularly before they were discontinued. V2 said R3 ended up in the hospital due to her behaviors as a result of her medications being discontinued.

On 5/23/22 at 11:15 AM, V11, R3's daughter, said she received a call from the facility about a month and a half ago informing her R3 was acting out and requiring more supervision. V11 said she was told hospice discontinued all of R3's psych medications all at once without her (V11) consent. V11 said she was told the facility did not have enough staff to provide one to one monitoring of R3.

On 5/24/22 at 9:39 AM, V2 said she feels R3's worsening behavior was a direct result of her psych medications being abruptly stopped. V2 said V11, R3's daughter, was not aware everything was going to be discontinued.

On 5/24/22 at 10:46 AM, V12, Physician/Medical Director of Hospice, said psychotropic medications are never abruptly discontinued. V12 said we go by symptoms and behaviors and try to optimize psychotropic medications [for patients]. V12 said if psychiatric medications are abruptly discontinued, it can lead to psychosis and exacerbate symptoms such as aggression, hallucinations, and paranoia with a worsening of psychiatric problems.

On 5/24/22 at 11:46 AM, V1, Administrator, said R3 was sent to the hospital for medication management and stabilization. V1 said it was an

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emergency as R3 had been sitting on her bed and punched the window. V1 said they had been trying to manage R3's medications in house and it did not go well. V1 said it is not the facility practice to abruptly discontinue a resident's psych medications.

R3's Nurses Note dated 3/25/22 at 3:33 PM shows an order was given to discontinue most of R3's medications except for comfort medications and V11 was notified and not in agreement.

R3's Progress Notes show many examples of worsening psychiatric symptoms. "On 3/31/22 at 5:45 AM resident reported feeling lost, scared, and indicated she was hearing voices. On 4/1/22 at 6:41 AM resident continues to exhibit fear, anxiousness, and paranoia, on 4/12/22 at 10:28 PM resident's thinking is scattered and unfocused. She is argumentative with staff and verbally aggressive and mean. On 4/13/22 at 10:24 AM the resident threw the tray on the floor and yelled at her roommate. "

On 4/19/22 at 2:04 PM, Psychiatry note shows R3 "was placed on hospice and some of her medications were stopped. Since that time, it appears her mood has been worsened ...she has had some behaviors where she would get upset and throw herself on the floor, and reports being frustrated and feels helpless and hopeless."

R3's progress notes show "she (R3) was found on the floor on 4/12/22 at 11:30 AM. The Interdisciplinary Team (IDT) met and per their documentation on 4/10/22 at 2:06 PM in R3's progress notes, determined the following: Root cause of fall: Resident with a diagnosis of schizoaffective, major depression, hypertension has been experiencing increased moments of

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S9999	Continued From page 5 anxiety, restlessness, and agitation attempted a self -transfer." R3's Progress Notes show behaviors continued throughout April 2022; "on 4/21/22 at 9:23 PM Nurses Note show she was attempting to get out of bed all day, attempting to bribe staff to leave the building so she can go gamble, on 4/23/22 at 1:43 AM, R3 requesting to call her family, on 4/26/22 at 4:50 PM R3 was on the floor mat next to her bed, on 4/30/22 at 11:30 AM, R3 was found on the floor mat next to her bed. On 5/2/22 at 5:48 AM Behavior/Mood charting shows R3 was attempting to put herself on the floor. Resident verbally aggressive with staff, yelling out, attempting to hit at staff. On 5/4/22 at 3:03 AM Nurses Note documents R3 increasingly agitated hitting staff, yelling at staff and trying to get out of bed, at 3:27 AM resident yelling to staff that "I'm going to kill you" along with other threats and profanities, and at 3:33 AM, R3 accused staff of hitting her and stealing her candy and spit at staff. The Fall-Initial Occurrence Note of 5/4/22 at 10:30 AM shows R3 was again found on the floor mat next to her bed. On 5/4/22 at 3:06 PM, Nurses Note shows R3 hit the window with a boot and destroyed the blinds. R3 was sent to the hospital for evaluation." R3's Care Plan shows a focus initiated on 11/16/21 as follows: "I have the potential to be physically aggressive. I will throw items at others, hit, kick and bite. No new interventions were implemented after 11/16/21. R3's Care Plan shows a focus initiated on 11/16/21 as follows: I am/had potential to be verbally aggressive. I yell/scream at others and use abusive language ...No new interventions were initiated after 11/13/21. "	S9999		

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