STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008015	A. BUILDING: _____ B. WING _____	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MARSEILLES	578 WEST COMMERCIAL STREET MARSEILLES, IL 61341

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S 000	Initial Comments Annual Health Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690b) 300.690c) 300.1210b) 300.1210d)6 300.3100d)2 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each	S9999	**Attachment A** **Statement of Licensure Violations**	

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reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.

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:

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

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S9999	Continued From page 2 and assistance to prevent accidents. Section 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These Requirements were NOT MET as evidenced by: Noncompliance resulted in two deficient practice statements: A. Based on observation, interview, and record review, the facility failed to monitor the placement and function of personal alarm bracelets for four of five residents (R33, R57, R69, R176) and failed to ensure appropriate interventions were implemented for a resident assessed as high risk for wandering, provide supervision when a daily wandering, cognitively impaired resident exited the building, failed to ensure that the South East exit door's alarm was enabled and in working condition, failed to recognize the incident of elopement as an elopement and failed to report the elopement occurrence to State Agency, for one of five residents (R43), reviewed for elopement, in a sample of 36. These failures resulted in R43 not being adequately supervised and exiting from the facility on 2/17/22 around 2:00 P.M. Facility staff did not observe R43 exiting the building and were unaware that R43	S9999		

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S9999	Continued From page 3 left the building in winter conditions, for approximately 11 minutes, before another resident alerted staff to the missing resident. Post-incident, R43 was observed via the facility video camera slipping off the sidewalk, falling to her knees and falling against the facility garage, hitting her head, and found laying in the snow within one to two feet of a major river bank, which is located just behind the facility. FINDINGS INCLUDE: 1. The (undated) facility policy, Elopement Risk Assessment, directs staff, "To identify residents who may be potentially at risk for elopement and at risk for harm. To use as a baseline to maintain a secure resident environment. An elopement risk assessment will be performed during the admission process; reviewed/updated quarterly and when there are documented changes in mood or behavior which indicate the potential for elopement. A Social Service Department will conduct the elopement assessment during the admission process, when there is a significant change in mood or behaviors and quarterly. Risk factors will be assessed including the following: Independent ambulation with or without assistance; Pre-admission or history of elopement; Purposeful exit seeking; Restless, aimless pacing; Verbalization of wanting to leave the facility and/or go home; Grabbing doorknob or pushing on exit door; A cognitive impaired individual who is a follower; Inability to differentiate safe from unsafe situations; Diagnosis of Alzheimer's, Dementia, Schizophrenia, Brain Injury; Inability or refusal to follow instructions; Should an elopement risk be determined, interventions will be immediately initiated to protect the resident in a reasonable	S9999		

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S9999	Continued From page 4 manner and as approved by the physician. The Social Service Department will notify Facility Staff and initiate interventions necessary to protect the resident. Interventions include, however, are not limited to the following: Relocation to Secure Unit, Bed Alarm and/ or Chair Alarm, Use sign in/sign out, Psychological Consultation, Personal Alarm Arm or Ankle Bracelet, 15 minute to 1 Hour observations, One - to- One observation, Behavior Management Programs. In the event the assessment was initiated because of an elopement (where the resident's whereabouts are unknown), the elopement will be reported in accordance with the facility's Accident/Incident Unusual Occurrence Policy." The facility policy, Incident/Accidents, dated (reviewed) 1/5/22 directs staff, "The Incident/Accident Report is completed for all unexplained bruise or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident -to-resident altercations. An accident is defined as any happening, not consistent with the routine operation of the facility, that results in bodily injury other than abuse. An incident/accident report will be completed for: All serious accidents or incidents of residents; All unusual occurrences; All unexpected events that occur that cause actual or potential harm to a resident or employee; Leaving premises without authorization. The Director of Nurses, Assistant Director of Nurses, or Nursing Supervisor must notify the following if an actual injury occurs: (State Agency), by phone, within twenty-four hours of the occurrence. The (State Agency) is to be notified of the following: any incident or accident which has, or is likely to have, a significant effect on health, safety or welfare of a	S9999		

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S9999	Continued From page 5 resident." The facility's Elopement Device policy, revised 1-5-22, documents "Purpose: To establish procedures for ensuring personal elopement devices are used in accordance with identified risk, physician orders and to ensure the security system is inspected to identify malfunctions should they occur." This policy also states "Procedure: 7. The anklet or bracelet device will be inspected by nursing personnel once each day by: a. Inspecting the location of the device on the arm or leg. B. Placing the transmitter tester near the anklet or bracelet to test the battery for proper working order. R43's facility Admission Record documents that R43 was admitted to the facility on 12/10/21 from another facility with the following diagnoses: Alzheimer's Disease, Anxiety, Abnormalities of Gait and Mobility, Unsteadiness on feet. R43's Admission Elopement/Unauthorized Leave Risk Assessment, dated 12/10/21 and signed by V9/Social Services Director documents, "(R43) has a a diagnosis of Dementia, Has reported/documented episodes of elopement, Has signs of compromised decisional capacity and substantially impaired judgement and/or physical status limitations that would place the resident at risk in the community." This form also documents, "Elopement Risk decision: (R43) appears to be: At risk to elope and should be placed on the Elopement Risk Protocol. A care plan for Elopement is indicated." R43's Admission Care Plan, dated 12/10/21 includes a care plan for R43's elopement. No intervention to show that a Personal Alarm Bracelet was placed on R43, is included.	S9999		

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S9999	Continued From page 6 R43's Minimum Data Set Assessment, dated 12/17/2021 documents under Section C: Cognitive Patterns- BIMS (Brief Interview for Mental Status) 03:15 (cognitively impaired). This same form documents Section G: Functional Status- able to walk, not steady but able to stabilize without staff assistance. R43's Treatment Administration Records for December 2021, January 2022 and February 2022 show that a Personal Alarm Bracelet wasn't placed on R43 until 2/18/22. R43's Nursing Progress Notes, dated 12/11/2021 at 6:50 P.M. document, "(R43) having increased anxiety, exit seeking, requested (as needed medication) to be increased to (twice daily)." R43's Nursing Progress Notes, dated 12/26/2021 at 12:28 A.M. document, "After supper, (R43) became very fretful and worried about how she was going to get home. (As needed antianxiety medication) given at 6:30 P.M. (R43) wandered hall, crying and worried. Emotional support and reassurance given. (R43) walked with another resident for awhile. (R43) directed to room multiple times. (R43) would only stay a few minutes before wandering into hall again." R43's Nursing Progress Notes, dated 2/10/2022 at 1:55 P.M. document, "Wandering a lot today. Easily redirectable for very short periods." R43's facility CNA (Certified Nursing Assistant) documentation, dated 12/25/2021 through 4/28/2022 document that R43 wanders the facility daily. R43's Nursing Progress Notes, dated 2/17/2022	S9999		

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S9999	Continued From page 7 at 2:20 P.M. and signed by V6/Registered Nurse document, "At (2:00 P.M.) Southeast alarm door went off, a resident (R16) came to the dining room and said (R43) was outside. Staff ran outside and brought (R43) back inside. Full body check done, no bumps, bruises or redness noted. (R43) denies any discomfort anywhere." R43's facility Resident Monitoring form, dated 2/17/22 documents, "February 17, 2022 at 1430 (2:30 P.M.) Sitting in chair, in dining room, smiling." Documentation by facility staff, every 15 minutes from 2:30 P.M. until 5:30 P.M. documents, "Sitting in dining room." Documentation at 1745 (5:45 P.M.) and 1800 (6:00 P.M.) is blank. No further documentation after 6:00 P.M. is present. R43's Nursing Progress Notes, dated 2/18/2022 at 8:09 A.M. and signed by V2/Director of Nurses document, "Summary of Inter Disciplinary Team: (R43) was outside the facility. (R43) was confused and unable to get back into the facility. Upon return inside, vitals (vital signs) were taken and all WNL (within normal limits). Put on 1 to 1 monitoring for the rest of the day and then put on 15 minute checks. Will discuss with family potentially finding a secured dementia unit, for placement." R43's Physician Order Sheet, dated February 2022 document on 2/18/22 at 8:54 A.M., "Placement of code alert (personal alarm) bracelet. Monitor placement and function every shift." R43's Nursing Progress Notes, dated 2/18/2022 at 4:48 P.M. document, "Late appearing bruise from incident of 2/17/22 observed to (R43's) left forehead/temporal area. POA (Power of Attorney)	S9999		

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S9999	Continued From page 8 notified and would like a CT (Computerized Tomography) Scan. (R43) going to (local Emergency Room)," R43's Hospital Emergency Room Report, dated 2/18/22 documents, "(R43) presents for a fall that happened approximately 24 hours prior to arrival. Physical Exam: Head- hematoma noted to the left forehead, unable to discern if that is from this recent fall. CT Scan of head and cervical spine negative. Disposition: Return to facility. Follow Head Injury instructions. Return for any worsening of condition." On 4/25/22 at 10:05 A.M., R43 was up ambulating, slowly and independently, throughout the facility SouthEast hallway, mumbling to herself. A personal alarm bracelet was present on R43's left ankle. Facility staff that were assisting other residents repeatedly instructed R43 to have a seat in the South dining room/day room. R43 ignored the instructions and continued to wander. Visualization of the facility South East exit door at that time showed a white piece of standard sized printing paper with the words, "Please remember to reset alarms" taped to the exit door. At that time, V3/Licensed Practical Nurse (LPN) stated, "That's up there to remind staff to turn the door alarms back on, if they go out the door." V3/LPN also stated, "(R43) got out that door sometime in February (2022). I wasn't working that night. (R43) has always been at risk for wandering. (R43) didn't have a code alert (personal alarm bracelet) on at the time. I don't know why she didn't." On 4/26/22 at 10:23 A.M., R43 was lying in bed, attempting to stand by herself. R43 was unable to answer questions and would repeat anything spoken to her.	S9999		

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S9999	Continued From page 9 On 4/26/22 at 11:02 A.M., V4/(R43's) spouse stated, "Someone called me from the facility the night she got out (2/17/22). They told me she had gotten outside and fell and hit her head and knees. They told me they found her in the snow. Thank God (R43) didn't fall in that river. (R43) would have been dead. I don't know why they didn't take (R43) to the E.R. then. She should have been seen by the doctor and tests taken. I finally had to insist, when they called me again, to take her to the E.R. to get a cat scan (CT Scan). No one ever told me about these bracelets (personal alarm bracelet) until after she had gotten out. Seems like (R43) should of had one on, from the start. I know (R43) has tried to get out that door a few times. " On 4/26/22 at 11:10 A.M., V5/(R43's) Family Member stated, "They (facility) called me the night (2/17/22) she fell. It was the nurse (V6/Registered Nurse). She told me (R43) had gotten out the door and they (facility) didn't know (R43) was outside. They told me (R43) didn't have a coat on and it was very cold and snowy that day. When they did find (R43) she had fallen and hit her head. They told me (R43) was laying by the side of the building." On 4/26/2022 at 1:12 P.M., V6/Registered Nurse (RN) stated, "I was the nurse that was working the day that (R43) got out of the building. (R43) had been agitated that day, wandering and going to the doors. (R43) has a history of this. On that day, (R43) got out (of the building) without anyone seeing her. The (South East) door didn't alarm and (R43) didn't have an alarm on. I don't know why. I was down the hallway and I heard another resident (R16) say from the dining room, 'She (R43)'s outside.' (V8/Certified Nursing Assistant)	S9999		

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ran outside and got her. It was cold outside and there was snow on the ground. (R43) only had pants and a sweatshirt on. She didn't have a coat on. (V8/CNA) said (R43) had fallen and she found her on the ground. We changed her clothes and covered her up with blankets. I checked (R43) out and didn't see any injuries. (V2/Director of Nurses) wasn't in the building, so I went to (V1/Administrator)'s office and told her what had happened. I sat with (V1/Administrator) and watched the video recording of it. The time lapse on the video showed (R43) had been outside for 10 to 11 minutes. It showed (R43) sliding off the sidewalk and hitting the building with her head. It showed (R43) back behind the building, within a foot of the river bank. Thank goodness she turned around or (R43) would have slid into the river. R176 is a wanderer and at high risk for eloping and he has a personal alarm bracelet on. I don't know why (R43) didn't have one on, until after she eloped."

On 4/26/22 at 1:36 P.M., V8/Certified Nursing Assistant (CNA) stated, "I've been a CNA for three years now and have worked at (the facility) since November 2021. I work day shift and I am usually assigned to the south halls. I've known (R43) since she was admitted. (R43) is a wanderer. (R43) is very confused. (R43) is usually up walking around and goes to the doors, often. Me and another CNA, I can't remember which one, went to change a resident. All of a sudden we heard (R54) yelling and saying, '(R43) is outside'. (R54) said she saw (R43) back behind the building, facing the river. I ran out the (South East hallway) door. We never heard an alarm go off when (R43) went outside and it didn't go off when I went outside. Somebody said later it had been turned off. It was cold outside and there was snow on the ground. When I saw (R43) she ran

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from me, towards the river. I was yelling at her to stop and then I slipped and almost fell down the bank. I was so scared. I don't know how to swim and I thought we were both going to drown. I saw (R43) fall when she turned back towards me and land on her knees. (R43) got up by herself and then slipped again and hit her head on the garage. When I finally got to (R43), I pulled her back inside. (R43) had jogging pants on and a black sweater. (R43) had shoes on, but not a coat. (R54) was cold and wet when I brought her back in. I changed her clothes and covered her up with blankets."

On 4/27/22 at 10:10 A.M., V6/Registered Nurse stated, "I don't know why I charted in (R43)'s chart that the alarm was going off when (R43) left the building. The alarm didn't go off, that's why we didn't know (R43) was outside. (R54) was in the dining room and saw (R43) out behind the building and alerted us."

On 4/27/22 at 10:22 A.M., V9/Social Services Director (SD) stated, "I've been doing this job for five to six months. I don't have a degree in social work. I don't have any college degree. I'm learning as I go. I am responsible for doing the elopement risk assessment when a new resident is admitted. If a resident is high risk (for elopement) they get a (personal alarm bracelet) put on. The doors have a sensor on them and when a resident with a (personal alarm bracelet) goes toward the doors, they lock down. (V15/Business Office Manager) keeps the alarms locked up in her office. I'm not sure what the nurse's do if they need one (alarm) when (V15/BOM) isn't here. I was here the day when (R43) went out the door. We didn't hear an alarm go off. We couldn't put an alarm on (R43) that day, after (R43) went outside. (V15/BOM) wasn't

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S9999	Continued From page 12 here to give us one." On 4/27/22 at 11:37 A.M., V1/Administrator stated, " I was in my office on a telephone call when (R43) went out the door. We did not hear an alarm go off. (R43) exited the facility out the South East door. One of the CNAs saw (R43) and went and got her. I did not notify the state (State Agency) of the incident. (R43) didn't leave the grounds, so I didn't consider it (the incident) an elopement. I wasn't aware the alarm on the South East door wasn't working." On 4/27/22 at 11:48 A.M., V2/Director of Nurses (DON) verified that the facility Elopement Risk Assessment defined an elopement as, "where the resident's whereabouts are unknown." V2/DON also verified that (R43)'s exit out the facility South East door would be called an elopement, as the facility staff did not know that (R43) had left the building and another resident (R54) alerted staff to her whereabouts. V2/DON verified that R43 was assessed on admission and was at high risk for eloping and a personal alarm bracelet should have been placed at that time. V2/DON stated, "A (personal alarm bracelet) was placed on (R43) on 2/18/22. 2. On 4-25-22, at 9:55 A.M., R33 was ambulating near an exit door with a personal alarm bracelet noted to R33's left ankle. R33's current Care Plan documents R33 is an elopement risk/wanderer and includes an intervention of wearing a (personal alarm) to left ankle, dated 2-7-22. R33's Medication Administration Records/MARs and Treatment Administration Records/TARs, dated February - April 2022, do not include any	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008015	A. BUILDING: _____ B. WING _____	04/29/2022

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S9999	Continued From page 13 monitoring of the placement or function of R33's personal ankle alarm. 3. On 4-25-22, at 11:35 A.M., R57 was seated in a wheel chair near the South Hall nurse's station with a personal alarm bracelet noted to R57's ankle. R57's current Care Plan documents R57 is an elopement risk/wanderer and includes an intervention of wearing a (personal alarm) to the ankle. R57's Medication Administration Records/MARs and Treatment Administration Records/TARs, dated February - April 2022, do not include any monitoring of the placement or function of R57's personal ankle alarm. 4. On 4/28/22 at 9:10 A.M., V69 was laying in bed. A personal alarm bracelet was present of R69's ankle. R69's current Care Plan documents that R69 wanders aimlessly and has a diagnosis of Alzheimer's Disease. This same care plan includes an intervention of a personal alarm bracelet to the ankle. R69's Medication Administration Records, dated February 2022, March 2022 and April 2022 document staff as only checking R69's personal alarm bracelet daily, instead of the facility required twice daily. 5. On 4/28/22 at 9:48 A.M., R176 was ambulating near the North Hall nurse's station. A personal alarm bracelet was present on R176's ankle. R176's current Care Plan documents that R176 is	S9999		

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S9999	Continued From page 14 an elopement risk/ wanderer and includes an intervention for a personal alarm bracelet, which was initiated on 4/19/22. R176's Medication Administration Record, dated April 2022 does not include monitoring for the placement or function of R176's personal alarm bracelet until April 27, 2022. On 4-27-22, at 12:25 P.M., V2 Director of Nursing/DON stated the following: There are no TARs for (R33). There is no order for monitoring of (R33's) personal alarm for placement and function (which would trigger it on the TAR) and there should be. It should be documented somewhere, but it isn't. At that time, V2/DON also verified that R57, R69 and R176's personal alarm bracelets were not being monitored for place or function, as recommended. B. Based on observation, interview and record review, the facility failed to implement appropriate fall interventions to prevent a fall for one of eight residents (R57), reviewed for falls, in a sample of 36. FINDINGS INCLUDE: The facility's Fall Prevention Program, revised 1/5/22, documents to assure the safety of all residents in the facility. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. R57's Fall Risk Assessment, dated 4/15/22, documents that R57 is at risk for falls. R57's Progress Notes, dated 4/15/22 at 10:45pm,	S9999		

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S9999	Continued From page 15 documents that R57 was in southwest hallway in wheelchair and she bent forward attempting to pick something off floor when she fell out of her wheelchair hitting her head, staff was nearby at linen cart, resident noted to have hematoma forming on left forehead above eye, ice applied, neuro checks initiated and within normal limits for resident (R57). Resident (R57) assisted off floor and toilet and assisted back to bed. R57's Current Physician Order Sheet, documents that R57 take Clopidogrel Bisulfate 75mg daily for Atherosclerotic Heart Disease. R57 also has a diagnosis of an Aortic Aneurysm of unspecified site without rupture. On 04/25/22 11:35am, R57 has purple, blue, back eyes. R57's forehead is also purplish black and stated that it hurts above her left eye. R57 was unable to give specific details about how she received the bruising to her face. On 4/26/22 at V3, Licensed Practical Nurse, stated that R57 has leaned forward to pick up items that are on the floor for years. V3 verified that R57's current care plan does not have safety interventions in place for R57 leaning forward in her wheel chair to pick items off the floor that are not there. V3 also stated that R57 should have been sent to the emergency room for an evaluation, due to the head injury. On 4/29/22 at 11:00am, V14, RN, stated that any resident that is on an anticoagulant (blood thinner) should automatically be sent to the emergency room for an evaluation, with any type of head injury. (A)	S9999		