STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009815	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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S 000	Initial Comments Complaint Investgation 2456527/IL176832	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210d)6) 300.3240b) 300.3240c) 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 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	S9999		

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nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)

These requirements were not met as evidence by:

Based on observation, interview, and record review, the facility failed to identify and evaluate potential hazards/risks and implement interventions to ensure safe transfers via mechanical lifts for 1 (R1) of 3 residents reviewed for accident hazards and injuries of unknown origin in the sample of 6. This failure resulted in R1 sustaining injuries of bruising to the tops of both feet and a hematoma under the nail of the right great toe.

Findings include:

R1's Face Sheet documented an initial admission date of 7/23/20 with diagnoses that included unsteadiness of feet, lack of coordination, abnormalities of gait and mobility, adult failure to thrive, and cerebrovascular disease. R1's Minimum Data Set (MDS) dated 8/6/24

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documented a Brief Interview for Mental Status (BIMS) score of 12, indicating R1 had moderate cognitive impairment.

On 8/23/24 at 1:00 PM, R1's right great toenail was black with blood under the nail. R1's feet had greenish yellow bruising to the tops of both feet measuring approximately 3 inches x 3 inches. R1 stated he did not know how his feet had been injured.

R1's Hospice Visit Note dated 7/26/24 documented R1 did not have any bruising to the feet.

R1's Hospice Visit Note dated 7/29/24 documented in part "...Rt. (right) foot and leg was swollen and had bruises present, SNF (Skilled Nursing Facility) reported no falls or injuries for (R1) ..."

R1's Hospice Visit Note dated 8/2/24 documented in part "... Lt (left) foot has a bruise on the top of foot size of a softball circle with purple/green in color. (Right) leg was swollen around ankle bone and had bruises present on top of the foot and side of ankle with purple/green bruise. SNF reported no falls or injuries ... reported these findings to (V2 - Director of Nursing/DON). Pt (patient/R1) is unaware of how or when the bruise occurred ... SN (Skilled Nurse) left a message with person answering (facility) work phone for Nurse on staff to give me a call, as SN needs a report of unknown bruise noted as staff nurses had not document on BLE (Bilateral Lower Extremities) having any bruise. (V7 - Registered Nurse/RN) on staff at SNF was not present during any SNV (Skilled Nurse Visit) and SN was unable to give (V7) report as no staff could find (V7) ..."

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R1's Hospice Visit Note dated 8/5/24 documented in part "...Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V13 - Licensed Practical Nurse/LPN) and (V7) and stated SN needed a incident report since they have no report filled out stating that SNF staff has seen or document pt (R1) having bruises to BLE. Staff is supposed to write up a report stating that bruise are from unknown causes, both (V7) and (V13) voiced understanding..."

R1's Hospice Visit Note dated 8/9/24 documented in part "...Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V5/LPN) and (V2/DON). SN stated hospice needed a incident report since they have no report filled out stating that the SNF staff has seen or document (R1) having bruises to BLE. Staff was suppose to write up a report stating that bruise are from unknown causes, both (V7) and (V13) voiced understanding at last SNV and no report can be found or has been filled out per (V5) and (V2). (sic) Per (V2) a report will be filled out and SN can obtain a copy from them next week ..."

R1's Hospice Visit Note dated 8/12/24 documented in part "...Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V3 - Assistant Director of Nursing/ADON) SN stated hospice needed a incident report since they have no report filled out stating that the SNF staff has seen or document (R1) having bruises to BLE. Staff was suppose to write up a report stating that bruise are from unknown causes, report is filled out but is not signed by any of the nurses yet..."

R1's Hospice Visit Report dated 8/16/24 documented in part "...SN received report from (V17- Hospice Certified Nursing Assistant/CNA)

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that (R1) had bleeding to (right) great toe and bruising noted around toe nail bed. (R1's right) great toe has blood under toe nail bed ... with bruising around nail bed noted. SN spoke with (V2) and (V3) and per them 'assessed toe d/t (due to) Hospice aide (V17/CNA) reported findings to (V2) and (V3)' ... No reports noted of pt (patient) fall or injury noted per staff records. SN is still unable to get report from SNF of bruised noted on 8/2/24 as per (V2) and (V3) 'note is not signed yet'..."

R1's Hospice Visit Note dated 8/20/24 documented in part "...brusied noted to Rt. great toe with dried blood under nail bed. SN reported SN findings to (V7/RN). SN still does not have report from 8/2/24 as it still not signed by RN...MD is aware of SN and CNA reporting SNF to (State Agency)."

R1's Electronic Medical Record (EMR) documented two progress notes on 8/11/24 that had been struck out citing incorrect documentation:

R1's struck out progress note dated 8/11/24 at 1:58 AM documented in part "Note Text: (R17) Follow up assessment completed. Bruising to top of left, right foot...reddish purple bruising noted..." The note documents Strike Out Reason: Incorrect Documentation and Strike Out date: 8/14/24 09:05 (am).

R1's struck out progress note dated 8/11/24 at 9:25 AM documented in part "Note Text (R17) Follow up assessment completed. Bruising to top left of right foot...No skin issues noted. No Bruising noted. No s/s (signs/symptoms) of infection noted to site. No swelling noted." The note documents Strike Out Reason: Incorrect

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Documentation and Strike Out date: 8/14/24 09:05 (am).

On 8/23/24 at 10:59 AM, V4 (Hospice RN) stated R1 had bruising found on 8/2/24 to the top of both feet about the size of a softball. V4 said she had reported the bruising to V2 (DON) when V4 found the bruising. V4 said that on 8/5/24, V4 had returned to the facility and V7 (RN) and V13 (LPN) said they were not aware of R1 having any injuries. V4 stated that on 8/9/24, she told V2 that V4 would need a report on the bruises because the staff could not tell V4 how R1 was injured and there was no documentation of the bruising in R1's medical record. V4 then stated that on 8/16/24, R1 was found to have bleeding and a hematoma under the right great toenail with surrounding bruising to the toe. V4 said the facility was not able to explain how R1's right great toe was injured. V4 said she had asked the facility several times for a report on R1's injuries of unknown origin but none had been provided.

On 8/23/24 at 11:31 AM, V2 (DON) said staff would use the mechanical lift to transfer R1 when R1 was not feeling strong enough to stand for transfers. V2 said she thought the injuries to R1's feet had been caused by staff hitting R1's feet on the bar of the mechanical lift.

On 8/27/24 at 11:00 AM, V16 (CNA) stated that the facility had several "agency staff who don't care," and will hit resident's feet on the bar of the mechanical lift when transferring them. At the same time of this interview with V16, this surveyor observed a dark red substance that appeared to be dried blood on the center bar and central cross bar of the mechanical lift.

On 8/27/24 at 11:11 AM, V1 (Administrator)

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verified the dark red substance found on the mechanical lift looked like blood.

R1's Report to (State Agency) dated 8/28/24 documented in part "...Interviews with staff revealed that resident is tall, a maximum assist, dependent with care. Resident is transferred by 2 staff or at times has had to use a (mechanical lift). Staff stated (R1) has bumped feet on (mechanical lift) before. Staff interviews revealed that resident has been observed to also attempt to self transfer, pulls rolling wheelchair toward him...Interview with (R1) revealed that (R1) was unable to tell me what happened but he could tell me he was alright and having no pain in feet..."

The facility's revised 10/24/22 Abuse Prevention and Reporting - (State) policy documented in part "...Employees are required to report any incident, allegation or suspicion of potential abuse ... they observed, hear about, or suspect to the administrator, or to an immediate supervisor who must immediately report it to the administrator...Upon learning of the report, the administrator...shall initiate an incident investigation...Injuries of Unknown Source...For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an "injury of unknown source." An injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was not observed by any person other source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury...or the number of the injuries observed at one particular point in time...If classified as an "injury of

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S9999	Continued From page 7 unknown source," the person gathering the facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party..." (B)	S9999		