STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: ______ B. WING ______	C 04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

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S 000	Initial Comments Complaint Investigation: 2491360/IL168947	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 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	S9999		

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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.

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 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

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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.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to developed a resident specific care plan with interventions to address a residents drug use history. This failure resulted in R1 being found unresponsive, non-breathing and was pronounced dead at the hospital. This failure affected R1 out of 8 residents reviewed for comprehensive care plan.

Findings include:

R1 was 33 years old, was admitted to the facility on 10/06/2022 with diagnosis of but not limited to: Anoxic brain damage, Poisoning by unspecified drugs and functional quadriplegia. R1's BIMS Score (Cognition test) was 14 meaning R1 was cognitively intact.

R1's (10/22) admission paperwork from the hospital document in part: Anoxic brain damage secondary to drug overdose.

R1's (10/10/2022 at 2:05 pm) progress note

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documents in part: Resident is a 31 year old, male, Caucasian newly admitted to the facility on 10/06/2022. Resident is alert x3 and he can make his needs known. Resident was diagnosed with anoxic brain injury due to drug overdose. Resident also has protein calorie malnutrition and dysphagia.

R1's (12/4/23) death certificate documents cause of death: drug overdose, due to toxic effects of Fentanyl and Cocaine.

R1's (12/4/2023 at 10:48 am) progress note documents: Upon rounding by staff, resident observed unresponsive and non-breathing. Resident a full code, code blue called, 911 emergency services contacted and CPR (cardio pulmonary resuscitation) initiated with crash cart present. Resident last observed alert and sleeping at approximately 7:50am. CPR continued until Emergency services arrived to facility and transferred resident to the hospital. Nurse Practitioner made aware. Family contacted and made aware.

On 4/13/24 at 9:10 am V10 (Certified Nursing Assistant) said, she is on staff at the facility and has been here little over a year. She remembers R1, was keeping to himself, had an electric wheelchair and spoke to some residents. R1 needed help with putting on clothes, he was smoking cigarettes when it was time for smoke breaks, she did not have a clue or did not see signs of drug use, if she would suspect drug use she would let the nurse on duty and V2 (Director Of Nursing) and V1 (Administrator) know. V10 said, V16 was assigned to him but she was duty on that wing also. V10 asked V16 if if R1 wanted his breakfast tray, sometimes he didn't want anything. V10 said, V16 told her she just checked

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on him earlier and he was sleeping but if V10 could check on R1 because R1 didn't look right. V10 said, she went into R1's room and she went over by the window (R1's bed was by the window) and he didn't respond, he slept with pillow on his face usually, she got closer and noticed his fingertips were purple and it freaked her out because his eyes were open and she never seen anything like that. V10 said, she ran towards nurses station and she yelled called blue and everyone started running, even from different wings to help.

On 4/13/24 at 9:28 am R8 said she was a friend of R1 and they were close. R8 said, she knew something of his history of drug use however she did not suspect R1 to do drugs. R8 said, she never saw R1 doing drugs or talk about drugs. R8 did not know R1 was struggling with drugs. R8 said, she never saw residents doing drugs. R8 said, he passed
on Monday morning and the last time she saw him was Saturday evening and he was his normal self. R8 said, she was supposed to see R1 on Sunday but he never come over to her room.

On 4/15/24 at 10:13 AM with V1 (Administrator), V2 (Director of Nursing) and V12 (Social Service Director) were present for the interview. V1 said, she was here at the facility, little after 9 am, code blue was called, she went there with V17 (ADON), as she was headed down there the nurse started CPR, 911 was called and staff continued CPR, paramedics were doing CPR also even as leaving the facility, Narcan was given but unsure if it was the paramedics or the facility that gave the Narcan. V15 (RN) was R1's assigned nurse. V1 said, she was not aware of R1 cause of death until she was informed by the surveyor. V12 (Social Service Director) said R1

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had history of drug use. V2 said, one of R1's diagnosis were Poisoning by unspecified drugs and it could be drug are pharmaceutical and recreational. V12 was asked what facility had in place for R1 with known history of drug use, V12 said, R1 came with history of drugs and was in no condition to inject any drugs, he was not alert and oriented on admission, he became more oriented with time, R1 made improvements in functional abilities and was able to do more by himself, and he got physical therapy and got stronger. V12 said facility monitors residents and also does constant monitoring, for unusual behavior as needed. V12 said, he believes R1 was care planned for drug use (V12 was provided copy of R1's care plan and asked by surveyor to show where the care plan documents interventions for history of drug use). V12 said, he is not seeing R1 was care planned for drug use, and in hindsight R1 should have been care planned for drug use. V12 said, resident monitoring is based on observation and staff would document if something is observed and increased monitoring if required. V1 said, R1 never presented with active drug use and never facility found any drugs on him. V12 said, R1 had his own phone that he was using. V2 said, is someone comes in and they want to leave something for a resident, it goes first to social service and it is inspected and inventoried. V1 said, if (online food delivery platform system) is delivered or dropped off the facility does not inspect/open residents food, like staff will not open the actual wrapper but will look in the bag. V1 said, if packages come thru the mail they are inventoried so facility can keep track of resident belongings and social service inspects them first.

R1's care plan does not document intervention in place for history of drug use.

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R1's (1/21/23) community assessment documents R1 does not appear to be capable of unsupervised outside pass privileges at this time.

Facility's (11/22, rev.11/17) "Comphrensive Care Plan" policy documents in part: Facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

(A)