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	procedures governir facility. The written pube formulated by a Formulated by a Formulated by a Formulated consisting administrator, the administrator, the admedical advisory conformedical advisory conformedicies shall comply. The written policies of the facility and shall by this committee, do and dated minutes of Section 300.1210 Genus and Dersonal Comprehensive Resident's guardian of applicable, must device the president's mand psychosocial near resident's comprehensive care includes measurable meet the resident's mand psychosocial near resident's comprehensive care resident's comprehensive care and psychosocial near resident's comprehensive care resident's comprehensive care resident's comprehensive care and psychosocial near resident's comprehensive care resident's comprehensive care resident's comprehensive care and psychosocial near resident's comprehensive care resident's care resid	nave written policies and ang all services provided by the policies and procedures shall Resident Care Policy ag of at least the divisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. Is shall be followed in operating be reviewed at least annually ocumented by written, signed of the meeting.  The meeting is a contract the provided in the meeting is a contract to the meeting.  The meeting is a contract to the provided in the meeting is a contract to the meeting is a contract t					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

EPM611

PRINTED: 07/16/2014 FORM APPROVED

Illinois Department of Public Health

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	practicable level of	independent functioning, and				
1000		e planning to the least				
		ased on the resident's care				
		ment shall be developed with	N TOPOGRAM			
		ion of the resident and the	NO COLOMBIA			
		or representative, as	- Commons			
	applicable. (Section	3-202.2a of the Act)	o-			
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	b) The facility shall p	provide the necessary care	and a second			100
and services to attain or maintain the highest			THE PROPERTY OF THE PROPERTY O			
		, mental, and psychological				
well-being of the resident, in accordance with						
	each resident's comprehensive resident care					
	plan. Adequate and	properly supervised nursing				
		are shall be provided to each				
100	resident to meet the total nursing and personal care needs of the resident.					
	d) Pursuant to subse	ection (a), general nursing				
	care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:					
	Seven-day-a-week b	asis.				
-	G) All pages					
		cautions shall be taken to				
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		all not abuse or neglect a				
	resident. (Section 2-					
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	THESE REQUIREM	ENTS WERE NOT MET AS				
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Illinois Department of Public Health

Based on record review and interview, the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6002661			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
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	measures, assess, plan for 4 of 8 residing for 4 of 8 residing for self-injus ample of 8. This for repetitive self inflicted during two facility bases of the following two facility bases of the following for the following include:  1. R1's Minimum D 3/6/2014, document Anxiety disorder, Described Suicidal Ideations. For the following following for the following f	nent their policy " n and Prevention", safety monitor, supervise and care ents (R1, R2, R4, R8) urious behaviors in the ailure resulted in R1's ed injuries of cutting her wrist ased incidents.  ata Set (MDS), dated as that R1 has a diagnosis of expression, Schizophrenia and R1's MDS documents that she btoms that put R1 at jury. R1's Care Plan, dated ints she has attempted the past and has a eing problem related to R1's Psychiatric Evaluation, to admission to the facility, a history of multiple suicide ttempting to hang herself, walking into traffic.  iew with Z1, R1's Physician, on am, he stated R1 is a her emotional pain by	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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	that R1 left the facil went to the store. F 6:05pm. Nurse's N time documented, E had a razor blade o away. E12, LPN do at 10:00pm R1 was inflicted cut to left w centimeters in lengt.  The Incident Summ 10:00pm documents being sent to the ho to be placed on 15 r R1's room revealed.  R1's Nurse's Notes documented that R a cut to her left wrist.	lity at 5:00pm with a friend and R1 returned to the facility at otes, dated 5/21/2014, no E12, LPN documents that R1 in her person and it was taken cuments in the Nurses Notes found in her room with a self prist approximately 11					
	straight line. R1 was returned.  Incident Summary d documents that R1 I cut to the left wrist. I placed on one to one returned from the horizontal straight line.	s sent to the hospital and lated 5/24/2014 at 9:30pm, had self inflicted razor blade t documents that R1 was e supervision after R1 pospital, and R1 was to have a my outings with family or					
	friends. R1's Nurse's 8:00 am, E2, Director documented that R1 blades on a visit, price E2 documented that she got the razor bla	s Notes, dated 5/26/2014 at or of Nursing (DON) stated she bought the razor or to the 5/21/2014 incident. that she asked R1 where ade as R1's room had been ed that she hid a razor blade					
POLICE DE LA CONTRACTOR	interviewed, E12 stat	ted she does not remember			PPOPINIALIA		

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Illinois Department of Public Health

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what time the razor blade was taken away from R1. E12 stated that she did a body search on R1 at that time. On 6/11/2014 at 2:13pm E13, Certified Nursing Aide, (CNA) was interviewed in regards to the incidents of 5/21 and 5/24/2014. E13 stated that she was made aware R1 had a razor blade on her person from another resident at the facility. E13 stated that she could not recall who took the razor blade from R1. E13 stated that later in the evening R1 turned on her call light. E14, CNA answered the call light and R1 had out her left wrist. E13, CNA stated that it was end of shift and room search was done. E13 stated there were no razor blades found at that time. E13 stated that R1 did end up giving staff a box of seven razor blades. E13 stated that was a total of nine razor blades. With one blade still missing as the box contained ten blades. Nurse's Notes, dated 5/21/2014 failed to document there had been any room searches or body search on S/21/2014.  Per interview with E2, DON on 6/12/2014 at 1:27 PM, she stated that R1 "is very with it, and better at hiding things than anybody else at the facility, because she is fat. "E2 reports that R1 was placed on 1:1 from 5/24/2014-61/12014. E2 stated that Kna placed on 15 minute checks after the first incident on 5/21/2014, and after the second incident was when the 1:1 was initiated. E2 stated that croporate reports when residents on 15 minutes checks and out of facility they are not liable for the resident. Documentation on the 15 Minute Check Sheet documents that R1 was on 15 minute checks 5/25/5/29/2014.  Incident Summary, dated 6/5/2014 at 7:05pm documents that R1 was found with a cord	

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	wrapped around her hospital and admitted	r neck. R1 was sent to the ed.	oosaa.vaa.aaooonnier en mengriji			
	behavior symptoms emergency, safety initiated., A search of conducted, including objects and removed document checks ewithin visual close attimes as determined medical doctor until evaluation indicates  2. Interview of E2, E2 stated R1, R2, Resuicidal ideation and The 15 Minute Check provided by E10, CNR2 and R8 were not from 2:15p.m to 6:15 not have a 15 Minute noted that R1 did not	nts that in the event there are which indicate a suicide interventions will be promptly of residents room will be g clothing for any harmful . Initiate a monitoring form or every 15 minutes and stay occess of the resident at all by the charge nurse and				

#### IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Aperion Care Center (Formerly known as Springfield

DATE AND TYPE OF SURVEY: 06/17/2014

IRI of 5/26/2014/IL70203

300.610a)

300.1210a)

Care Center)

300.1210b)

300.1210d)6)

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 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.

- 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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

## THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on record review and interview, the facility neglected to implement their policy "Suicide Observation and Prevention", safety measures, assess, monitor, supervise and care plan for 4 of 8 residents (R1, R2, R4, R8) reviewed for self-injurious behaviors in the sample of 8. This failure resulted in R1's repetitive self inflicted injuries of cutting her wrist during two facility based incidents.

The facility continues to educate staff, evaluate and monitor the effectiveness of the facility policies and procedures and provide inservice training on identifying residents for self injurious behavior and suicidal ideation, resident supervision, room sweeps, body searches, fifteen minute checks, 1 on 1 supervision to include consequence of failure to follow policy and procedures, updating care plans to address self injurious behaviors and suicidal ideation and behavior monitoring for self injurious behavior and suicidal ideation.

## Findings include:

1. R1's Minimum Data Set (MDS), dated 3/6/2014, documents that R1 has a diagnosis of Anxiety disorder, Depression, Schizophrenia and Suicidal Ideations. R1's MDS documents that she has behavioral symptoms that put R1 at significant risk for injury. R1's Care Plan, dated 3/26/2014, documents she has attempted self-harmful acts in the past and has a psychosocial well-being problem related to suicidal ideations. R1's Psychiatric Evaluation, dated 3/1/2014 prior to admission to the facility, documents R1 has a history of multiple suicide attempts including attempting to hang herself, slitting her wrist and walking into traffic.

Per telephone interview with Z1, R1's Physician, on 6/10/2014 at 10:00 am, he stated R1 is a "cutter" and relieves her emotional pain by causing physical pain to herself.

On 6/6/2014 at 9:45 am E12, Licensed Practical Nurse (LPN) was interviewed in regards to incidents with R1. E12 stated that R1 was admitted with the behaviors of cutting her wrist and attempting to kill herself by walking into traffic.

On 5/21/2014 Resident Out On Pass documents that R1 left the facility at 5:00pm with a friend and went to the store. R1 returned to the facility at 6:05pm. Nurse's Notes, dated 5/21/2014, no time documented, E12, LPN documents that R1 had a razor blade on her person and it was taken away. E12, LPN documents in the Nurses Notes at 10:00pm R1 was found in her room with a self inflicted cut to left wrist approximately 11 centimeters in length.

The Incident Summary Form dated 5/21/2014 at 10:00pm documents the interventions for R1 after being sent to the hospital and returning. R1 was to be placed on 15 minute checks and a sweep of R1's room revealed a box of razor blades.

R1's Nurse's Notes dated 5/24/2014 at 9:30pm, documented that R 1 was found in her room with a cut to her left wrist measuring 4-41/2 inches in length running from hand toward the elbow in a straight line. R1 was sent to the hospital and returned.

Incident Summary dated 5/24/2014 at 9:30pm, documents that R1 had self inflicted razor blade cut to the left wrist. It documents that R1 was placed on one to one supervision after R1 returned from the hospital, and R1 was to have a body search after any outings with family or friends. R1's Nurse's Notes, dated 5/26/2014 at 8:00 am, E2, Director of Nursing (DON) documented that R1 stated she bought the razor blades on a visit, prior to the 5/21/2014 incident. E2 documented that that she asked R1 where she got the razor blade as R1's room had been searched. R1 reported that she hid a razor blade on her body.

On 6/10/2014 at 2:28 pm E12, LPN was interviewed, E12 stated she does not remember what time the razor blade was taken away from R1. E12 stated that she did a body search on R1 at that time. On 6/11/2014 at 2:13pm E13, Certified Nursing Aide, (CNA) was interviewed in regards to the incidents of 5/21 and 5/24/2014. E13 stated that she was made aware R1 had a razor blade on her person from another resident at the facility. E13 stated that she could not recall who took the razor blade from R1. E13 stated that later in the evening R1 turned on her call light. E14, CNA answered the call light and R1 had cut her left wrist. E13, CNA stated that it was end of shift and room search was done. E13 stated there were no razor blades found at that time. E13 stated that R1 did end up giving staff a box of seven razor blades. E13 stated that was a total of nine razor blades with one blade still missing as the box contained ten blades. Nurse's Notes, dated 5/21/2014 failed to document there had been any room searches or body search on 5/21/2014.

Per interview with E2, DON on 6/12/2014 at 1:27 PM, she stated that she would have done a body search on R1 on 5/21/2014 based on her history. E2, DON stated that R1 "is very with it, and better at hiding things than anybody else at the facility, because she is fat." E2 reports that R1 was placed on 1:1 from 5/24/2014-6/1/2014. E2 stated that R1 was placed on 15 minute checks after the first incident on 5/21/2014, and after the second incident was when the 1:1 was initiated. E2 stated that corporate reports when residents on 15 minutes checks and out of facility

they are not liable for the resident. Documentation on the 15 Minute Check Sheet documents that R1 was on 15 minute checks 5/25/-5/29/2014.

Incident Summary, dated 6/5/2014 at 7:05pm documents that R1 was found with a cord wrapped around her neck. R1 was sent to the hospital and admitted.

Facility Policy Suicide Observation and Prevention documents that in the event there are behavior symptoms which indicate a suicide emergency, safety interventions will be promptly initiated., A search of residents room will be conducted, including clothing for any harmful objects and remove,. Initiate a monitoring form or document checks every 15 minutes and stay within visual close access of the resident at all times as determined by the charge nurse and medical doctor until medical psychiatric evaluation indicates it is no longer necessary.

2. Interview of E2, DON, on 6-9-2014 at 6:45p.m. E2 stated R1, R2, R4 and R8 were admitted with suicidal ideation and were on 15 minute checks.

The 15 Minute Check Sheets, not dated but provided by E10, CNA, on 6-9-2014, documented R2 and R8 were not provided 15 minute checks, from 2:15p.m to 6:15p.m. on 6-9-2014. R4 did not have a 15 Minute Check Sheet. It was also noted that R1 did not have 15 Minute Check Sheets for 5-22-2014, 5-23-2014 and 6-2-2014 through 6-4-2014.

#### THIS WILL BE ACCOMPLISHED BY:

- 1. The facility will review and implement policies and procedures to ensure close monitoring of all residents, to keep all residents free from neglect as possible.
- 2. Staff will be educated through directed in-service, on the identification of residents with self-injurious behaviors and/ or suicidal ideation, their Care Plans and Monitoring Forms, reporting of behaviors, new and/ or revised policies and procedures as well as consequences for failing to perform monitoring check forms.
- 3. Any/All new incidents will be reviewed and discussed at "Morning Meeting" to ensure the appropriateness of interventions put in place, the implementation of other interventions if deemed necessary and to ensure Care Plans are updated accordingly.
- 4. Revise facility's Suicide Observation and Prevention Policy, to ensure general and/or individualized supervision of all residents and keep resident free from harm to self and/or others as much as possible. The revisions should include but not limited to:
  - a) 15 minute Checks and Consequences for failure to perform checks
  - b) 1 on 1 Supervision
  - c) Room Sweep/Searches
  - d) Body Searches
- 5. The Administrator and Director of Nurses will monitor Items I through IV listed above to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of the Imposed Plan of Correction.

LJK/7/16/2014