

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2014
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NAME OF PROVIDER OR SUPPLIER APERION CARE SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 525 SO MARTIN LUTHER KING DR SPRINGFIELD, IL 62703
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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)</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview, the facility</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>On 5/21/2014 Resident Out On Pass documents</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>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 4-4 1/2 inches in length running from hand toward the elbow in a straight line. R1 was sent to the hospital and returned.</p> <p>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.</p> <p>On 6/10/2014 at 2:28 pm E12, LPN was interviewed, E12 stated she does not remember</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>Incident Summary, dated 6/5/2014 at 7:05pm documents that R1 was found with a cord</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>wrapped around her neck. R1 was sent to the hospital and admitted.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(A)</p>	S9999		

IMPOSED PLAN OF CORRECTION

Care Center)

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)
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 R1 was found in her room with a cut to her left wrist measuring 4-4 1/2 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 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.

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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