STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E847	A. BUILDING _____ B. WING _____	C 06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE SPRINGFIELD	525 SO MARTIN LUTHER KING DR SPRINGFIELD, IL 62703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS IRI of 5/26/2014 IL/70203 This is a Partial Extended Survey.	F 000		
F 224 SS=K	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is 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. This resulted in an Immediate Jeopardy. While the immediacy was removed on 6-10-2014 at 7:35p.m., the facility remains out of compliance at Severity Level 2 as 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	F 224		6/27/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 224	Continued From page 1	F 224		

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.

0n 5/21/2014 Resident Out On Pass documents that R1 left the facility at 5:00pm with a friend and

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APERION CARE SPRINGFIELD	**525 SO MARTIN LUTHER KING DR SPRINGFIELD, IL 62703**

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F 224	Continued From page 2 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	F 224		

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F 224	Continued From page 3	F 224		

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

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F 224	Continued From page 4	F 224		

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.

The Immediate Jeopardy situation was identified to have began on 6-10-2014 when R1 was identified as having self injurious behaviors during three incidents facility based occurrences. The facility failed to provide identify R1's self injurious behaviors and failed to properly assess, monitor and supervise R1. E1 and E2 were notified of the Immediate Jeopardy on 6-10-2014 at 4:05p.m.

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F 224	Continued From page 5 On 6-10-2014 through interviews, observation and record review, the facility took the following actions to remove the Immediacy: 1. On 6-10-2014, by 7:15p.m., all residents were assessed for self injurious and suicidal ideation. 2. On 6-10-2014, the facility began inservicing all staff on identified and identifying residents for self injurious behaviors and suicidal ideation, updating care plans to address self injurious behaviors and suicidal ideations, perform behavior monitoring for self injurious behaviors and suicidal ideation, resident supervision, updated/revised policies and procedures on room sweeps, body searches, 15 minute checks 1 on 1 supervions and consequences on failure to follow policy and procedures.	F 224		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed 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)	F 323		6/27/14

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F 323	Continued From page 6	F 323		

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.

This resulted in an Immediate Jeopardy.

While the immediacy was removed on 6-10-2014 at 7:35p.m., the facility remains out of compliance at Severity Level 2 as 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.

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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.

0n 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

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F 323	Continued From page 8	F 323		

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

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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,

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F 323	Continued From page 10 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. The Immediate Jeopardy situation was identified to have began on 6-10-2014 when R1 was identified as having self injurious behaviors during three incidents facility based occurrences. The facility failed to provide identify R1's self injurious behaviors and failed to properly assess, monitor and supervise R1. E1 and E2 were notified of the Immediate Jeopardy on 6-10-2014 at 4:05p.m. On 6-10-2014 through interviews, observation and record review, the facility took the following actions to remove the Immediacy: 1. On 6-10-2014, by 7:15p.m., all residents were assessed for self injurious and suicidal ideation. 2. On 6-10-2014, the facility began inservicing all staff on identified and identifying residents for self injurious behaviors and suicidal ideation, updating care plans to address self injurious behaviors and suicidal ideations, perform behavior monitoring for self injurious behaviors and suicidal ideation, resident supervision, updated/revised policies and procedures on room sweeps, body searches, 15 minute checks 1 on 1 supervions and consequences on failure to follow policy and procedures.	F 323		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review	F 497		6/27/14

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of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facilty failed to provide no less than twelve hours of Certified Nursing Assistant (CNA) in-service education per year for 11 of 17 CNA's. This has the potential to affect all 62 residents living in the facility.

Findings include

1. Based on CNA In-Service Records, dated 2013 and 2014, the following CNA's were provided less than twelve hours of CNA in-service education per year based on individual hire dates:

E14 - hired on 2-16-2011, 7 hours of in-servicing from 2-16-2012 to 2-16-2014,
E13 - hired on 11-1-2012, 3 hours of in-servicing from 11-11-2012 to 11-1-2013,
E17 - hired on 11-6-1990, 4.5 hours of in-servicing from 11-6-2012 to 11-6-2013,
E18 - hired on 10-25-2012, 0 hours of in-servicing from 10-15-2012 to 10-25-2013,

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APERION CARE SPRINGFIELD	525 SO MARTIN LUTHER KING DR SPRINGFIELD, IL 62703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 12 E8 - hired on 12-11-2012, 4.5 hours of in-servicing from 12-11-2012 to 12-11-2013, E20 - hired on 5-20-2012, 0 hours of in-servicing from 5-20-2012 to 5-20-2013, E21 - hired on 9-22-2009, 4.5 hours of in-servicing from 9-22-2012 to 9-22-2013, E3 - hired on 6-6-2013, 11.5 hours of in-servicing from 6-6-2013 to 6-6-2014, E22 - hired on 2-8-2011, 4.5 hours of in-servicing from 2-9-2013 to 2-9-2014, E23 - hired on 10-9-2012, 0 hours of in-servicing from 10-9-2012 to 10-9-2013, E24 - hired on 12-20-2004, 3 hours of in-servicing from 12-20-2012 to 12-20-2013, Interview of E2, Director of Nursing, on 6-12-2014 at 1:00p.m., E2 stated that after looking at the CNA In-Service Records, last night, she confirmed that the CNA's, including the ones listed were not provided the required twelve hours of CNA in-service education per year. E2 also stated that she could not find any other records, other than what she had already provided, documenting CNA in-service education/training. 2. The Resident Census and Conditions of Residents, CMS 672, dated 6-6-14, documented that the facilty has 62 residents living in the facilty.	F 497		