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 _____	06/18/2015

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

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. Licensure Survey for Subpart S: SMI.	F 000		
F 323 SS=D	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 observation, interview and record review the facility failed to ensure that safety devices were in place, effective and functioning for 1 of 9 residents (R7) reviewed for falls in the sample of 15. Findings include: R7's admission face sheet documents that R7 has diagnoses which include Parkinson's Disease and Schizophrenia, and Dementia. The facility's Accident/incident log documents that R7 has had falls on 4/12/15, 5/25/15 and 6/10/15. All three fall investigations document that the falls occurred while resident was attempting a self transfer. The plan of care which was last updated on 4/8/15 document that R7 "Will attempt dangerous	F 323		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1	F 323		

physical assertions which put him at risk for falls. (i.e. self transferring)."
R7's current care plan documents a personal alarm either pressure or tab variety has been in place since 5/29/15, as an intervention for his repeated falls. Starting 6/10/15 it was to be on R7 at all times.

On 6/15/15, at 1:30 PM, R7 was resting in his room after lunch. His wheelchair was near the end of the bed. R7's personal alarm was on the back of his wheelchair, not attached to resident or his bed in any way.

On 6/16/15 at 1:00 PM, R7 was again resting in his bed after lunch. His personal alarm was again attached to the back of his wheelchair, which was across his room near his closet, not attached to the resident while in bed.

On 6/16/15, at 3:00 PM, E2, (Director of Nursing) stated "He is always taking the alarms off we tell him not to but he laughs and does it anyway. He has even taken his shirt off so he doesn't pull the tab alarm and self transfers to the bathroom or his wheelchair. It should always be on him both in bed and when he is up in his chair, and always out of his reach. I switched him to a pressure pad alarm and added it to the daily tasks for the CNA's to check and document on each shift as of this morning." E2 stated R7's alarm had been changed to a pressure pad alarm for the ease of placing it under him while he is in bed.

On 6/16/15, at 3:00 PM, E7, Certified Nurses Aide (CNA) stated she was not aware that R7 did not have his alarm on, but he should. She also was not aware that his alarm had been changed to a pressure alarm, or that he was supposed to have

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F 323	Continued From page 2 it on all the time. On 6/17/15 at 10:00 AM, R7 was again resting in his bed. R7 was sleeping in his bed, the pressure pad alarm remained on his wheelchair and, was not alarming, when tested it emitted a barely perceptible beep. The Minimum Data Set dated 5/18/15 documents that R7 hallucinates, requires extensive assistance with transfers, is incontinent at times, has poor balance, judgement and safety awareness.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F 356		

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F 356	Continued From page 3 make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to post the nurse staffing on a daily basis and update at the beginning of each shift. This has the potential to affect all 63 residents living in the facility. Findings include: The facility's "Resident Census At The Start Of Shift" form used by the facility did not have the name of the facility documented on it. This form had no 'review' date on it. On 06/15/2014 at 9:30 AM, two "Resident Census At the Start Of Shift" forms were posted on the wall in the facility's entry way. They were dated 6/13/15 and 6/14/15, respectively. The facility did not have this form filled out for the current date. Also, both posted forms did not have the resident census information documented as required. On 6/15/15 at 4:00 PM, E1, (Administrator), stated that the facility tries to keep this information posted daily but they have not been updating it on a shift by shift basis.	F 356		
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	F 458		

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F 458	Continued From page 4 Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to provide 80 square feet of floor space per resident bed for all 32 two-bed resident rooms. This has the potential to affect all 64 residents living in the facility. Findings include: 1. The facility has 32 two-bed resident rooms that can be occupied by 2 residents. According to historical data the room measurements for these rooms provide only 74.5 square feet per bed. All these rooms are certified for Medicaid. 2. R1, R2, R7, R13, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41 and R42 reside in residents' rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16 on A Hall R3, R5, R6, R8, R9, R10, R12, R43, R44, R45, R46, R47, R48, R49, R50, R51, R52, R53, R54, R55, R56, R57, R58, R59, R60, R61, R62, R63, R64, R65 and R66 reside in residents' rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 16 on B Hall. 3. The Resident Census and Conditions of Residents, CMS 672, dated 6/16/2015, documents the facility has 64 residents living in	F 458		

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F 458	Continued From page 5 the facility.	F 458		
F 463 SS=C	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to have a call cord in place for the group toilet room located across from the dining room. This had the potential to affect all 64 residents living in the facility. Findings include: On 06/15/2015 at 11:00 AM the group toilet room was left unlocked and accessible to residents. This toilet room has no call cord to alert the nurse station in the event of a resident need. This group toilet room was left unlocked at various times on all days of the survey. On 06/18/2015 at 2:00 PM, E1, (Administrator), stated that the toilet room is supposed to be kept locked and inaccessible to residents. She stated it is for employees only. 3. The Resident Census and Conditions of Residents, CMS 672, dated 06/16/15, documents that the facility has 64 residents residing in the facility.	F 463		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		

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F 514	Continued From page 6 LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to maintain clinical records in accordance with professional standards and practices in a readily accessible, systematically organized manner for 15 of 15 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15) reviewed for medical record accessibility in the sample of 15. Findings include: 1. The facility's Infection Control Log, dated February 2015, documents R13 was placed on Augmentin due to anterior cruciate ligament (ACL) repair. In March 2015, the Log documents R13 was placed on Keflex for infection to surgical incision. In April 2015, R13 was placed on Keflex due to tooth abscess. In May 2015, the log documents R13 was placed on Azithromycin for a tooth abscess.	F 514		

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F 514	Continued From page 7 R13's Physician Order Sheets (POS), dated February 2015, March 2015, April 2015, May 2015 and June 2015 were reviewed and no antibiotics were documented on the POS. The facilities computer system was also utilized to check for these orders. The electronic orders were not accessible to the survey team. On 6/17/15 at 4:00 PM, E1, Administrator, was asked why the orders for the antibiotics could not be found in the chart or in the computer system and why the charts are hard to navigate in general. E1 stated during interview "Our medical records are a mess. We have been trying to get them straightened out since our switch to the computer in January. We thought we would be able to transfer everything over to the computer but we have not been able to get everything scanned in. So our paper charts/files got messed up and some things did not get filed. We have no medical records person or consultant to help us." 2. Lack of accessibility was was encountered for the other records reviewed during the survey for R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R14 and R15. Physician's Orders and Laboratory Results could not be accessed. In addition, the "paper/hard copy" of these residents did not have the Physician's Orders or Laboratory Results. On 06/18/2015 at 3:00 PM, E2, (Director of Nurses), stated that she was aware that the records are not organized in an ideal manner and are difficult to sort through. E2 stated they have been overwhelmed by this without the benefit of a medical records person.	F 514		