	-	ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES					). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
							C
		146064	B. WING				01/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE DECATUR			2	650 NORTH MONROE STREET		
APERION	CARE DECATOR			D	ECATUR, IL 62526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI TAG	Х	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
1/10					DEFICIENCY)		
F 000	INITIAL COMMENTS		F	000			
	Complaint #1563436	/IL78252 - F315					
		/IL78262 - No Findings					
F 315			F	315			
SS=G	RESTORE BLADDER	۲.					
	Based on the residen	t's comprehensive					
		ity must ensure that a					
	resident who enters t						
	÷	not catheterized unless the					
		dition demonstrates that					
		ecessary; and a resident bladder receives appropriate					
		es to prevent urinary tract					
		ore as much normal bladder					
	function as possible.						
		is not met as evidenced					
	by:	is not met as evidenced					
	· ·	n, interview and record					
		ed to obtain orders for					
		ges and maintenance care					
	and failed to ensure l	•					
		In for one(R1) of three In catheters in a sample of					
		Ited in R1 not having his					
	urinary catheter chan						
		nary tract infections and the					
	catheter adhering to I	R1 internally.					
	Findings include:						
	On 06/30/15 at 0.20 /	AM, R1's medical record lists					
		cle Weakness, Difficulty with					
	Walking, Depressive						
	Neoplasm of Prostate, and Urinary Retention.						

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

TITLE

(X6) DATE

PRINTED: 07/07/2015

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
146064			B. WING			C 07/01/2015		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET	<u> </u>		
APERION	CARE DECATUR			1	DECATUR, IL 62526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 315	Continued From page 1		F	315	5			
	Continued From page 1 On 06/30/15 at 10:15 AM R1 stated, "My urinary catheter was not changed from October of last year until the other day when my doctor changed it. I told the nurse in November that I didn't want her to change it, I wanted my Urologist to change it. I never heard anything else about it. They never said anything about it and I'm not a doctor, I didn't know how sick I could get if it wasn't changed. They don't clean it. I do when I take a shower. They've never shown me how to clean it properly. When the doctor removed it, it hurt like hell, they couldn't get it out. We pulled on it for almost an hour. When it finally came out, it had a bunch of tissue on it the doctor said, and it bled like hell. I don't ever want that to happen again. It's still sore." R1's Physician Orders dated 01/05/15, documents, "Keflex 500 milligrams by mouth twice a day for ten days for urinary tract infection, Probiotic one tablet by mouth twice a day for fifteen days for prophylaxis." R1's Physician Orders dated 02/04/15, documents, "Ceftin 500 milligrams by mouth twice a day for ten days for urinary tract infection, Probiotic twice a day for fifteen days for prophylaxis." R1's Physician Orders dated 06/26/15, documents, "Bactrim DS 800-160 milligrams by mouth twice a day for five days." On 07/01/15 at 9:05 AM, Z1(R1's Urologist), stated, "Yes (R1's) urinary catheter should have been changed every four weeks. I can attribute							

If continuation sheet Page 2 of 5

PRINTED: 07/07/2015

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/07/2015 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146064	B. WING		_	C 07/01/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
APERION CARE DECATUR				2650 NORTH MONROE STI DECATUR, IL 62526	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315			F 315				

Facility ID: IL6005508

If continuation sheet Page 3 of 5

	-	ID HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA					E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED		
		146064	B. WING	B. WING		C 07/01/2015		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
APERION	CARE DECATUR				2650 NORTH MONROE STREET			
	1			0	DECATUR, IL 62526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
E 046		•						
F 315		AM, E6(Licensed Practical	F :	315				
		ary catheters should be						
		and catheter care every						
	On 07/01/15 at 11:30	AM, E4(Licensed Practical						
		ary catheters are changed						
	monthly and catheter shift."	care is performed every						
		AM R1's medical record did						
	not contain a Physicia urinary catheter or ca	an's Order for a indwelling theter maintenance.						
		AM, R1's Care Plan dated ontain interventions for neter.						
		AM , R1's Care Plan dated ontain interventions for g urinary catheter.						
		AM, R1's medical record Order dated 05/15/15, Foley shift and as needed.						
	were reviewed from 1	AM, R1's Nurses Notes 0/29/14 through 06/25/15, urinary catheter change.						
	-	r Evaluation dated 06/11/15 "3. Frequency of Catheter as needed."						
	Coordinator/MDS), pr Rounding Sheets date	PM, E3(Minimum Data Set ovided R1's Physician ed 03/03/15 and 04/30/15. rders for R1 to be seen by state pain, chronic						

Facility ID: IL6005508

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PRINTED: 07/07/2015

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/07/2015 // APPROVED ). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
146064		146064	B. WING			C 07/01/2015		
NAME OF P	ROVIDER OR SUPPLIER	l	<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CO	DDE		
APERION	CARE DECATUR				650 NORTH MONROE STREET DECATUR, IL 62526			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
F 315	indwelling catheter, u prostate hypertrophy( verified that the order no appointment was s R1 to be seen 06/26/ On 07/01/15 2:15 PM documented Physicia "Schedule follow up v pain." On 07/01/15 2:15 PM documented Physicia "Schedule follow up v related to BPH with u On 07/01/15 at 2:45 F on 05/04/15 documer appointment for urina nothing about catheter the facility would have appointment regardin	rine retention and benign (BPH). At that time E3 s were put in R1's chart but scheduled until 05/4/15, for 15 by Urologist. I, R1's medical record in Order dated 03/03/15, with Z1 regarding prostate I, R1's medical record in Order dated 04/30/15, appointment with urology rinary retention." PM, Z2 stated, "(R1's) record nts, (R1) facility called for rry retention and BPH, it says er change or prostate pain. If e mention the need for	F	315				

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