STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 Complaint Investigation #1647284/IL90633-F152, F157, F203, F224, F250, F280, F285, F309, F406, F490 Complaint Investigation #1740053/IL90855-F152, F157, F203, F224, F250, F280, F285, F309, F406, F490 Complaint Investigation #1740345/IL91159 - F328 A partial extended survey was conducted.	F 000		
F 152 SS=D	483.10(b(3)-(7) RIGHTS EXERCISED BY REPRESENTATIVE (b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. (b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or	F 152		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 152	Continued From page 1	F 152		

delegated by the resident, in accordance with applicable law.

(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.

(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.

(iii) To the extent practicable, the resident must be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 152	Continued From page 2	F 152		

provided with opportunities to participate in the care planning process.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to follow guidelines established by the State Guardianship & Advocacy Commission and allowed a mentally ill resident to leave the facility Against Medical Advice, for one of 10 adjudicated residents (R3) reviewed, in a sample of 37.

Findings include:

A letter from the State Guardianship & Advocacy Commission, dated 11/01/16, documents "On September 14, 2016 the Office of State Guardian was appointed Person Only Temporary Guardian for (R3), as guardian this office is responsible for the well-being of the ward and is legally authorized to make fundamental decisions concerning the ward's health, medical treatment, placement and personal well-being."

A Progress Note, dated 11/01/16, documents R3 "was admitted...with a (history) of confusion, sepsis, pneumonia and Schizoaffective disorder and possible (history) of abuse and PTSD (Post Traumatic Stress Disorder)." A Plan of Care, dated 11/01/16, documents R3 has an ADL (Activities of Daily Living) self-care performance deficit, diagnosis and history of severe mental illness, Schizophrenia manifested by delusions and paranoia, impaired thought process (related to) impaired decision making, displays disorganized thinking, uses Psychotropic medications for behavior management and "the resident needs supervision and assistance at times with all decision making."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 152	Continued From page 3	F 152		

On 1/25/17 at 2:52 p.m. , E4 (Social Service Director) stated R3 had returned to the facility from the police station at approximately 1:00 p.m. on 12/16/16. E4 stated R3 refused to come all the way inside the building and requested his belongings. At that point, E3 (Licensed Practical Nurse) attempted to contact the OSG (Office of State Guardian). E4 stated R3 indicated he was not going to be staying at the facility and the police told him he was not allowed to return. E4 stated she encouraged R3 to stay at the facility, but R3 kept demanding his personal belongings. E4 stated R3 communicated better through writing, so she gave R3 the AMA: Release from Medical Discharge form so R3 could understand the risks of leaving the facility. E4 stated R3 read and signed the AMA: Release From Medical Discharge form, took his belongings and left the facility on foot. According to E4, R3 stated he was walking to the police department. E4 called the local police department to inform them R3 was on his way to the station. E4 stated they attempted to reach the OSG to notify them that R3 needed medical assistance and was leaving the facility. E4 stated Z2 (Guardian) called her approximately 4 days after R3 left the facility and told them that R3 was technically considered a missing person at that point, because his whereabouts were unknown.

On 1/30/17 at 11:14 a.m., Z5 (Office of State Guardian Supervisor) stated R3 "lacked the decisional capacity to make any decisions for himself, which was exactly why he was a ward of the State." Z5 stated the OSG provides the facility with all the necessary guidelines that are to be followed for adjudicated individuals, at the time of admission. Z5 stated that the legal documentation provided by the OSG allows the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 152	Continued From page 4 facility to obtain routine and emergent medical care without prior approval from the Guardian and prohibits residents from signing out AMA. Z5 concluded that the facility should have called for emergency medical care for R3 on 12/16/16, when R3 returned to the facility, rather than trying to contact the Guardian. Z5 confirmed that R3's whereabouts are currently unknown.	F 152		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 157	Continued From page 5	F 157		

(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to notify the physician of a resident's refusal to take Anti-psychotic medication and failed to notify the psychiatrist when a resident left the facility Against Medical Advice (AMA), for one of nine residents (R3) reviewed for physician's notification, in a sample of 37.

Findings include:

1. The facility policy titled, "Medication and Treatment Refusal (no date)", documents "Incidents related to a resident's refusal of medication and/or treatment must be recorded in resident's medical record...The date and time that the physician was notified, as well as the physician's response...Cardiac, psychotropic, oral glycemic, insulin refusal must be reported to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 157	Continued From page 6	F 157		

physician each time refused."

A Physician's Order Sheet dated 11/01/16, documents R3 is to receive Seroquel 300 mg at night for the diagnoses of Schizoaffective Disorder, Psychotic Disorder with Delusions and Paranoid Schizophrenia.

The Medication Administration Record for R3 documents R3 refused to take his Seroquel on the following dates: 11/15/16, 11/20/17, 11/21/17, 11/23/16, 11/24/16, 11/25/16, 11/26/16, 11/28/16, 11/29/16, 11/30/16, 12/01/16 through 12/07/16 and 12/08/16 through 12/15/16.

R3's Medical Record contains documented evidence that R3's physician was notified of R3's refusal to take the Seroquel once, on 12/01/16.

On 1/30/17 at 1:51 p.m., E11 (Care Plan Coordinator) states that the facility policy on medication refusal does indicate that the physician is to be notified each time a Anti-psychotic Medication is refused.

2. The facility policy, titled "Discharge Against Medical Advice (no date)", documents "Purpose: To define the facility's responsibility when a resident and/or legal guardian voluntarily discharges him/herself from the facility without the consent of or an order from the attending physician. Policy: It is the policy of the facility to acknowledge the right of a resident to sign him/herself out of the facility without the consent of or an order from the attending physician, providing that the resident has the decisional capacity to do so...In the event that it is questionable as to whether the resident and/or legal guardian has the decisional capacity to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 157	Continued From page 7	F 157		

make an informed decision about an AMA (Against Medical Advice) discharge, professional and administrative staff are to be consulted in collaboration with the resident's psychiatrist."

A Progress Note, dated 11/01/16, documents R3 "was admitted...with a (history) of confusion, sepsis, pneumonia and Schizoaffective disorder and possible (history) of abuse and PTSD (Post Traumatic Stress Disorder)." A Plan of Care, dated 11/01/16, documents R3 has an ADL (Activities of Daily Living) self-care performance deficit, diagnosis and history of severe mental illness, Schizophrenia manifested by delusions and paranoia, impaired thought process (related to) impaired decision making, displays disorganized thinking, uses Psychotropic medications for behavior management and "the resident needs supervision and assistance at times with all decision making."

On 1/25/17 at 2:52 p.m., E4 (Social Service Director) stated R3 had returned to the facility from the police station at approximately 1:00 p.m. on 12/16/16. E4 stated R3 refused to come all the way inside the building and requested his belongings. E4 stated she encouraged R3 to stay at the facility, but R3 kept demanding his personal belongings. E4 stated R3 communicated better through writing, so she gave R3 the AMA: Release from Medical Discharge form so R3 could understand the risks of leaving the facility. E4 stated R3 read and signed the AMA: Release From Medical Discharge form, took his belongings and left the facility on foot. According to E4, she notified Z1 (Medical Director) after R3 had left the building, at 1:55 p.m., but did not contact the facility's Psychiatrist, as instructed in the facility's policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 157	Continued From page 8 E4 stated she was unaware the facility had a policy that addressed the steps which needed to be taken when a resident leaves the facility AMA.	F 157		
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 203	Continued From page 9	F 203		

be endangered under paragraph (b)(1)(ii)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(c) (5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 203	Continued From page 10	F 203		

telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

(c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 203	Continued From page 11	F 203		

Based on record review and interview the facility failed to ensure an appropriate transfer of care for one of one residents (R3) reviewed for involuntary discharge in the sample of 37. This failure resulted in R3 who refused to take antipsychotic medications, being put in the care of police officers after a behavior change. R3 was released by police and is now missing.

Findings include:

The facility policy, titled "Discharge/Transfer of Resident (no date)," documents "Purpose: To provide safe departure from the facility. To provide continuity of care and treatment...Complete Transfer Form accurately and completely, including vital signs. Ensure that resident's current physical and psycho/social assessment, medications and current treatment is completely described and available to the receiving facility upon transfer." The "Discharge/Transfer of Resident" policy further instructs staff when a resident is leaving without a physician's order to "contact Medical Director if unable to reach attending physician and there is a concern for resident health or welfare upon discharge."

A Progress Note, dated 11/01/16, documents R3 "was admitted...with a (history) of confusion, sepsis, pneumonia and schizoaffective disorder and possible (history) of abuse and PTSD (Post Traumatic Stress Disorder)." A Plan of Care, dated 11/01/16, documents R3 has an ADL (Activities of Daily Living) self-care performance deficit, diagnosis and history of severe mental illness, Schizophrenia manifested by delusions and paranoia, impaired thought process (related to) impaired decision making, displays disorganized thinking, uses Psychotropic medications for behavior management and "the resident needs supervision and assistance at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 203	Continued From page 12	F 203		

times with all decision making."
A letter from the State Guardianship & Advocacy Commission, dated 11/01/16, documents "On September 14, 2016 the Office of State Guardian was appointed Person Only Temporary Guardian for (R3), as guardian this office is responsible for the well-being of the ward and is legally authorized to make fundamental decisions concerning the ward's health, medical treatment, placement and personal well-being." The letter further documents, "In the event of an emergency, the facility staff...is authorized by the Office of State Guardian to arrange for transportation, routine emergency room evaluation and treatment, and for hospitalization and general medical treatment for (R3). The Office of State Guardian hereby consents to routine emergency room evaluation and treatment, and for hospital admission and general medical treatment for the individual ward named herein."
On 12/01/16, a Physician's Order documents, "(Z4 - Nurse Practitioner) notified of resident refusal to take Seroquel multiple times in the evening. (Z4) notified of delusional and scattered thoughts and verbal accusations. (Z4) orders to continue to encourage resident to take medication and if resident becomes agitated or aggressive to send resident for a psych (psychiatric) evaluation immediately."
A Progress Note by E1 (Administrator), dated 12/15/16 at 10:39 p.m., documents "(R3) became upset when another resident (R5) was attempting to use adjoining bathroom. (R3) pushed (R5) after words were exchanged. CNA (E6) attempted to redirect, (R3) slapped (E6 - Certified Nursing Assistant) in the face. Police were notified. Guardian (Z2) notified. Police did arrest (R3) for battery due to he does not require medical care,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 203	Continued From page 13	F 203		

is refusing to take medication and (R5) did want to press charges."
On 1/24/17 at 2:10 p.m., E1 (Administrator) stated she was working the floor on the night of 12/15/16, when R3 had a physical altercation with R5 and E6. E1 stated the police were contacted, as that is the facility's practice when there is a resident to resident altercation. E1 stated R3 was arrested when R5 stated he waned to press charges against R3 and R3 was taken directly to jail. E1 stated she would have sent R3 out for a psychiatric evaluation, but R3 was arrested first and she did not communicate that R3 had a physician's order for a psychiatric evaluation if he developed physically aggressive behaviors.
On 1/30/17 at 1:30 p.m., E2 (Director of Nursing) stated she informed the arresting officers on the night of 12/15/16 that R3 had "no medical needs that need to be met overnight." E2 stated she explained to the police that R3 had been refusing his Seroquel and that R3 had a State Guardian, due to poor mental health; however, she did not discuss with the police that R3 had an order for a psychiatric evaluation, if he became aggressive.
On 1/25/17 at 12:45 p.m., Z1 (Medical Director) stated the facility had an order on 12/01/16 to send R3 out for a psychiatric evaluation if he became violent/aggressive, but failed to act on that order. Z1 concluded that the facility technically does not need an order to send a resident out for a psychiatric evaluation, which would have been warranted in this situation. Z1 stated the facility "saw this as a transfer of care to the police, but that's incorrect, because (R3) needed medical care."
On 1/30/17 at 11:14 a.m., Z5 (Office of State Guardian Supervisor) stated R3 "lacked the decisional capacity to make any decisions for himself, which was exactly why he was a Ward of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 203	Continued From page 14 the State." Z5 stated the OSG provides the facility with all the necessary guidelines that are to be followed for adjudicated individuals, at the time of admission. Z5 stated it is the expectation of the OSG that the facility will follow through with any transfer out of the facility, whether it is to the Emergency Room, jail or programming, to ensure the resident's medical needs are going to be met. Z5 stated that the legal documentation provided by the OSG allows the facility to obtain routine and emergent medical care without prior approval from the State Guardian.	F 203		
F 224 SS=K	483.12(a)(1) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN a) The facility must- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility neglected to follow operational policies related to the discharging a resident against medical advice and the emergency medical care of a mentally ill adjudicated resident, as established by the State Guardianship & Advocacy Commission. These failures resulted in staff allowing R3 to leave the facility Against Medical Advice on 12/16/16. As a result of this, R3's whereabouts are currently unknown. These failures resulted in an Immediate Jeopardy and has the potential to affect the other nine adjudicated residents (R1, R2, and R31-R37) currently residing in the facility. While the immediacy was removed on 1/31/17, the facility remains out of compliance at a Severity Level II as the facility instates ongoing Quality Assurance measures to ensure staff are	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 224	Continued From page 15	F 224		

knowledgeable and compliant with the rules set forth by the Guardianship & Advocacy Commission for adjudicated individuals and as the facility continues to develop the programming required for SMI (Serious Mentally Ill) residents.

Findings include:
The facility policy, titled "Discharge Against Medical Advice (no date)", documents "Purpose: To define the facility's responsibility when a resident and/or legal guardian voluntarily discharges him/herself from the facility without the consent of or an order from the attending physician. Policy: It is the policy of the facility to acknowledge the right of a resident to sign him/herself out of the facility without the consent of or an order from the attending physician, providing that the resident has the decisional capacity to do so...In the event that it is questionable as to whether the resident and/or legal guardian has the decisional capacity to make an informed decision about an AMA (Against Medical Advice) discharge, professional and administrative staff are to be consulted in collaboration with the resident's psychiatrist."
A letter from the State Guardianship & Advocacy Commission, dated 11/01/16, documents "On September 14, 2016 the Office of State Guardian was appointed Person Only Temporary Guardian for (R3), as guardian this office is responsible for the well-being of the ward and is legally authorized to make fundamental decisions concerning the ward's health, medical treatment, placement and personal well-being." The letter further documents, "In the event of an emergency, the facility staff...is authorized by the Office of State Guardian to arrange for transportation, routine emergency room evaluation and treatment, and for hospitalization

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 224	Continued From page 16	F 224		

and general medical treatment for (R3). The Office of State Guardian hereby consents to routine emergency room evaluation and treatment, and for hospital admission and general medical treatment for the individual ward named herein. The Office of State Guardian shall be notified of routine emergency room treatment or hospitalization by the next working day...In no event shall treatment be withheld from a ward of the Office of State Guardian due to the ward's age, disability, quality of life or legal status."
The facility policy, titled "Staff Obligations to Prevent and Report Abuse, Neglect and Theft (no date)", defines "Neglect" as the "failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident."
A Progress Note, dated 11/01/16, documents R3 "was admitted...with a (history) of confusion, sepsis, pneumonia and schizoaffective disorder and possible (history) of abuse and PTSD (Post Traumatic Stress Disorder)." A Plan of Care, dated 11/01/16, documents R3 has an ADL (Activities of Daily Living) self-care performance deficit, diagnosis and history of severe mental illness, Schizophrenia manifested by delusions and paranoia, impaired thought process (related to) impaired decision making, displays disorganized thinking, uses Psychotropic medications for behavior management and "the resident needs supervision and assistance at times with all decision making."
Nursing Notes, dated 11/16/16, document R3 as having delusions of his coffee "tasting like body fluids...explained that he has worked around death, amputations, murder victims, and lived near a cemetery in the past and he knows what it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 224	Continued From page 17	F 224		

tastes like," after refusing to take his anti-psychotic (Seroquel) the night before. The Electronic Medication Administration Record, documents that R3 started to consistently refuse to take his anti-psychotic medication (Seroquel) on 11/20/16, through 12/15/16. Behavior Monitoring for R3, documents R3 had developed intermittent hallucinations and delusions starting on 11/26/16 through 12/15/16. Nursing Notes, dated 12/01/16, document R3 was having visual hallucinations of snakes coming out of holes in the wall,and continued to refuse to take the Seroquel due to the side effect of an upset stomach.

A Progress Note, dated 12/15/16 at 10:39 p.m., documents "(R3) became upset when another resident (R5) was attempting to use adjoining bathroom. (R3) pushed (R5) after works were exchanged. CNA (E6) attempted to redirect, (R3) slapped (E6 - Certified Nursing Assistant) in the face. Police were notified. Guardian (Z2) notified. Police did arrest (R3) for battery due to he does not require medical care, is refusing to take medication and (R5) did want to press charges."

A Social Service Note, dated 12/16/16, documents "(E4 - Social Service Director) notified of incident and left message with OSG (Office of State Guardian). Resident did return to facility and was in vestibule in between the two doors. (E4) and nurse (E3 - Licensed Practical Nurse) went to speak with resident this afternoon, who stated he was released on his own recognizance and was told to return in February for court. Staff was unaware resident was released and resident states someone gave him a ride back to the facility. Resident stated he...only wanted his belongings. Resident was educated on risks of AMA and resident signed AMA paper. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 224	Continued From page 18	F 224		

stated he planned on returning to police station...Resident left building and began walking towards police station. (E4) contacted police dept. to notify them of situation and request they assist resident. Dispatch stated she would notify police officers that resident was heading in their direction. Nursing staff was able to reach OSG and guardian on call stated that they would contact police department and recommend resident be sent to hospital for (evaluation). It was ensured that resident made it safely to police station."

On 1/25/17 at 2:52 p.m., E4 (Social Service Director) stated R3 returned to the facility from the police station at approximately 1:00 p.m. on 12/16/16. E4 stated R3 refused to come all the way inside the building and requested his belongings. At that point, E3 (Licensed Practical Nurse) attempted to contact the OSG. E4 stated R3 communicated better through writing, so she gave R3 the AMA: Release from Medical Discharge form so R3 could understand the risks of leaving the facility. E4 stated R3 read and signed the AMA: Release From Medical Discharge form, took his belongings and left the facility on foot. According to E4, R3 stated he was walking to the police department. E4 called the local police department to inform them R3 was on his way to the station. E4 notified Z1 (Medical Director) that R3 left the facility AMA at 1:55 p.m. On 1/30/17 at 10:15 a.m., E4 stated she was unaware that the facility had a Policy to follow when a resident left AMA. E4 stated the Director of Nursing (E2) was present in the building on 12/16/16 when R3 wanted to leave, but she didn't get E2 involved because she didn't want to overwhelm R3. E4 stated they attempted to reach the OSG to notify them that R3 needed medical assistance and was leaving the facility,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 224	Continued From page 19	F 224		

but did not consider calling 911 for medical transport to a hospital for treatment. E4 stated she was familiar with the legal documentation provided by the State Guardianship & Advocacy Commission regarding the facility's authorization to obtain emergency medical treatment for R3, but did not act on those instructions. E4 stated Z2 (Guardian) called her approximately 4 days after R3 left the facility and told them that R3 was technically considered a missing person at that point, because his whereabouts were unknown.
On 1/04/17 at 9:24 a.m., E1 (Administrator) stated R3 communicated through reading and writing. E1 stated E4 showed R3 the AMA papers as an "intervention" to attempt to get R3 to come back into the building; however, R3 signed the AMA papers and walked away from the facility.
On 1/25/17 at 11:18 a.m., E3 (Licensed Practical Nurse) stated he was present on 12/16/16 when R3 returned to the facility from the police department. E3 stated R3 told him that the police stated he was not allowed to return to the facility. According to E3, R3 requested his belongings and indicated he was walking back to the police department. E3 stated he attempted multiple times to reach someone at the OSG office and eventually demanded to be put through to talk to someone. E3 spoke with Z3 (OSG On-Call Guardian) and explained that R3 was "not stable, needed medical help and was off his medications." At this point, R3 had been at the facility for approximately 10 minutes, when R3 decided to leave on foot for the police station. According to E3, Z3 stated she would call the police station and let them know what needed to be done with R3. E3 stated E5 (Transportation Aide) was able to catch up with R3 and give him a ride to the police station.
On 12/28/16 at 11:10 a.m., E5 (Transportation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 224	Continued From page 20	F 224		

Aide) stated R3 left the facility on 12/16/16 on foot, to return to the police station. E5 stated he took his truck and was able to get R3 to agree to a ride to the police station. E5 stated he took R3 to the West door of the police station, did not go inside the police station with R3, but watched him enter the building and then E5 left.

On 1/30/17 at 11:14 a.m., Z5 (Office of State Guardian Supervisor) stated R3 "lacked the decisional capacity to make any decisions for himself, which was exactly why he was a ward of the State." Z5 stated the OSG provides the facility with all the necessary guidelines that are to be followed for adjudicated individuals, at the time of admission. Z5 stated that the legal documentation provided by the OSG allows the facility to obtain routine and emergent medical care without prior approval from the Guardian. Z5 concluded that the facility should have called for emergency medical care for R3 on 12/16/16, when R3 returned to the facility, rather than trying to contact the Guardian. Z5 confirmed that R3's whereabouts are currently unknown.

On 1/25/17 at 12:45 p.m., Z1 (Medical Director) stated if R3 had a change in condition, such as acute onset of aggression, she would have expected a call from the facility. However, Z1 stated the facility does not need an order to send a resident out for a psychiatric evaluation if needed, and that would have been appropriate in this situation. Z1 stated the facility "saw this as a transfer of care to the police, but that's incorrect, because (R3) needed medical care." Z1 stated, "It is the facility's responsibility to ensure the resident is medically taken care of...and no one clearly communicated up front what the real plan for (R3) was" at the time of or after the arrest. Z1 stated, if R3 had Schizophrenia with Delusions, he should not be out living on the streets for his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 224	Continued From page 21	F 224		

own safety and a psychiatric evaluation would have been appropriate.
The Immediate Jeopardy was noted to have started on 12/16/16 when the facility failed to enact their policy. Facility Administrator was notified of the Immediate Jeopardy at 1:40PM on 01/31/17.
The surveyor confirmed through interview and record review that the facility took the following action to remove the Immediate Jeopardy:

1. The facility provided in-service training by the facility's Director of Nursing and Social Service Director to all licensed and unlicensed staff at the nursing home regarding the expectation of the Office of State Guardian regarding routine and emergent medical care for adjudicated individuals, physician notification of change in resident condition, behavior management for new/worsening behaviors and status of resident transfers.

2. The Administrator and Director of Nursing reviewed facility Policy and Procedure on Behavior Management for Agitated Behavior, Change in Condition/Physician Notification Overview Guidelines, Behavioral Management for New or Worsening Behavior Symptoms, Medical Record Documentation and Transfer/Discharge.

3. The Administrator has developed a plan to ensure compliance with Subpart S - SMI State Regulations has been developed and is ongoing. The facility has identified which residents qualify for SMI and what programming would be appropriate for those individuals; however, those programs have yet to be implemented.

4. Additionally, the Director of Nursing will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 224	Continued From page 22 perform a Quality Assurance Audit of all OSG residents weekly for two weeks (or as needed thereafter) to ensure compliance with all reviewed facility policies and that appropriate mental health services are provided.	F 224		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident received psychiatric care following a period of medication refusal, an acute episode of aggressive behavior and an arrest, for one of nine residents (R3) reviewed for medically related social services, in a sample of 37. Findings include: The facility policy, titled "Behavior Management for Agitated Behavior (no date)," documents "In the event staff needs to physically intervene to prevent the resident from harming self or others, techniques to provide interim control will be implemented. Non-violent crisis intervention is a safe, non-harmful behavior management system designed to aid human services in the management of disruptive and assaultive people, even during the most violent moments. When the interim control is used, the physician will be notified and a determination made as to the need for acute mental health services."	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 250	Continued From page 23	F 250		

A Progress Note, dated 11/01/16, documents R3 "was admitted...with a (history) of confusion, sepsis, pneumonia and schizoaffective disorder and possible (history) of abuse and PTSD (Post Traumatic Stress Disorder)."
Nursing Notes, dated 11/16/16, document R3 as having delusions of his coffee "tasting like body fluids...explained that he has worked around death, amputations, murder victim, and lived near a cemetery in the past and he knows what it tastes like, "after refusing to take his anti-psychotic (Seroquel) the night before. The Electronic Medication Administration Record, documents that R3 started to consistently refuse to take his anti-psychotic medication (Seroquel) on 11/20/16. Nursing Notes, dated 12/01/16, document R3 was having visual hallucinations of snakes coming out of holes in the wall, and continued to refuse to take the Seroquel.
On 12/01/16, a Physician's Order documents, "(Z4 - Nurse Practitioner) notified of resident refusal to take Seroquel multiple times in the evening. (Z4) notified of delusional and scattered thoughts and verbal accusations. (Z4) orders to continue to encourage resident to take medication and if resident becomes agitated or aggressive to send resident for a psych (psychiatric) evaluation immediately."
A Progress Note, dated 12/15/16 at 10:39 p.m., documents "(R3) became upset when another resident (R5) was attempting to use adjoining bathroom. (R3) pushed (R5) after works were exchanged. CNA (E6) attempted to redirect, (R3) slapped (E6 - Certified Nursing Assistant) in the face...Police did arrest (R3) for battery due to: he does not require medical care, is refusing to take medication and (R5) did want to press charges."
A Social Service Note the following day, dated 12/16/16, documents E4 (Social Service Director)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 250	Continued From page 24	F 250		

was notified of R3's physical aggression and arrest and E4 left a message with OSG (Office of State Guardian) to keep them updated. There is no documented evidence that E4 made attempts to arrange for a psychiatric evaluation upon R3's release from jail at that time. Progress notes, dated 12/16/16, document R3 ended up returning to the facility that day; however, R3 refused to stay and only wanted to collect his personal belongings. The 12/16/16 Progress Notes, document "(R3) was educated on risks of AMA (leaving against medical advice) and resident signed AMA paper. Resident stated he planned on returning to police station...Resident left building and began walking towards police station."

On 1-25-17 at 10:00 am, E4 (Social Service Director) stated the facility does not currently have a SMI (Serious Mental Illness) program, therefore comprehensive assessments by qualified personnel, SMI individualized treatment plans, psychiatric rehabilitation services, and SMI discharge planning had not been completed for R3. On 1/25/17 at 2:52 p.m., E4 stated they did attempt to reach the OSG (Office of State Guardian) on 12/16/16 to notify them that R3 needed medical assistance and was leaving the facility, but did not consider calling 911 for medical transport to a hospital or arrange for a psychiatric evaluation, as ordered by the physician on 12/01/16.

On 1/25/17 at 12:45 p.m., Z1 (Medical Director) stated stated "It is the facility's responsibility to ensure the resident is medically taken care of...and no one clearly communicated up front what the real plan for (R3) was. Z1 stated, her review of the documentation in R3's medical record indicated "staff handed (R3) off to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 250	Continued From page 25 police and there was no follow up or clear delineation as to where R3 was going to go." Z1 stated no one "clearly communicated up front, what the real plan for (R3) was going to be" after his arrest and a psychiatric evaluation would have been appropriate.	F 250		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 280	Continued From page 26 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 280	Continued From page 27	F 280		

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a resident Plan of Care was updated to reflect the refusal to take anti-psychotic medications for one of nine residents (R3) reviewed for Care Plans, in a sample of 37.

Findings include:

A Physician's Order Sheet dated 11/01/16, documents R3 is to receive Seroquel 300 mg at night for the diagnoses of Schizoaffective Disorder, Psychotic Disorder with Delusions and Paranoid Schizophrenia.

The Medication Administration Record for R3 documents R3 refused to take his Seroquel on the following dates: 11/15/16, 11/20/17, 11/21/17, 11/23/16, 11/24/16, 11/25/16, 11/26/16, 11/28/16, 11/29/16, 11/30/16, 12/01/16 through 12/07/16 and 12/08/16 through 12/15/16.

R3's current Plan of Care (no date), fails to identify R3's frequent refusal of Seroquel as an area of focus, with goals and interventions.

On 1/30/17 at 1:51 p.m., E11 (Care Plan Coordinator) stated a resident's refusal of medication should be Care Planned by either

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 280	Continued From page 28 herself or E4 (Social Service Director). E11 stated they should have developed appropriate interventions for R3 regarding his medication refusal, such as identifying staff R3 trusted and how to reapproach R3, in attempt to get R3 to comply.	F 280		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an	F 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 285	Continued From page 29	F 285		

independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 285	Continued From page 30	F 285		

paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to obtain/incorporate PASARR (pre-admission screening and resident review)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 285	Continued From page 31	F 285		

recommendations in resident's plan of care for three (R10, R11, and R5) of three residents reviewed for PASARR information in a sample of 30.

Findings include:

On 1-25-17 at 3:10 pm, E4 (Social Service Director) stated the facility does not use PASARR information to direct the SMI (Serious Mental Illness) resident's treatment.

1. R10's current POS (Physician's Order Sheet) for January 2017 documents R10 was admitted 12-15-16 and has diagnoses including Schizophrenia, Recurrent Major Depressive Disorder, and Anxiety.

R10's PAS/MH (Pre-Admission Screen/Mental Health) Level II Notice of Determination dated 12-16-16 states R10 is eligible for nursing facility and needs special services for the following: Medication monitoring, adjustment and/or stabilization, instrumental activities of Daily Living training/reinforcement, Mental Health Rehabilitation activities, Aggression/Anger Management and illness self management.

R10's record does not include any documentation of the above services being offered.

2. R11's POS for January 2017 documents R11 was admitted 11-8-16 from another facility with diagnoses of Bipolar Disorder, Diabetes and Hypertension.

R11's record did not include a Level II PAS. On 1-26-17 at 2:45 pm, when R11's Level II PAS was requested, E4 (Social Service Director) called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 285	Continued From page 32 R11's previous facility and requested a copy be sent. R11's Level II Summary Pre-Admission Screening dated 7-2-15 states R11 is eligible for nursing facility and needs special services for the following: Medication monitoring, adjustment and/or stabilization, Mental Health Rehabilitation activities, Aggression/Anger management, Incentive program to improve participation in treatments, and Community re-integration activities. R11's record does not include any documentation that these programs are being offered. 3. R5's POS (Physician Order Sheet) for January 2017 documents R5 was admitted 10-12-16 and has diagnoses including Schizoaffective Disorders, Generalized Anxiety Disorder, and Major Depressive Disorder. R5's OBRA-Initial Screen dated 5-20-15 documents there is a reasonable basis to suspect R5 has a mental illness, indicating a PAS needed to be completed. There is no PAS screen in R5's record documenting recommendations for R5's care.	F 285		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 33	F 309		

well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25
(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to follow operational policies related to behavior management and failed communicate, identify and anticipate the medical needs of a mentally ill resident (R3), upon his arrest for battery on 12/15/16. These failures resulted in R3 not receiving the emergent psychiatric care he needed and lead to R3 leaving the facility AMA (Against Medical Advice) on 12/16/16. As a result of this, R3's whereabouts are currently unknown. These failures resulted in an Immediate Jeopardy.
While the immediacy was removed on 1/31/17, the facility remains out of compliance at a Severity Level II as the facility instates ongoing Quality Assurance measures to ensure staff are knowledgeable and compliant with the rules set forth by the Guardianship & Advocacy Commission for adjudicated individuals and as the facility continues to develop the programming

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 34	F 309		

required for SMI (Serious Mentally Ill) residents.

Findings include:
The facility policy, titled "Behavior Management for Agitated Behavior (no date)," documents "In the event staff needs to physically intervene to prevent the resident from harming self or others, techniques to provide interim control will be implemented. Non-violent crisis intervention is a safe, non-harmful behavior management system designed to aid human services in the management of disruptive and assultive people, even during the most violent moments. When the interim control is used, the physician will be notified and a determination made as to the need for acute mental health services. Should staff not be able to manage the resident's behavior, staff members will make every attempt to protect the resident and others and another staff member will call 911 for assistance."
The facility policy, titled "Discharge/Transfer of Resident (no date)," documents "Purpose: To provide safe departure from the facility. To provide continuity of care and treatment...Complete Transfer Form accurately and completely, including vital signs. Ensure that resident's current physical and psycho/social assessment, medications and current treatment is completely described and available to the receiving facility upon transfer."
A Progress Note, dated 11/01/16, documents R3 "was admitted...with a (history) of confusion, sepsis, pneumonia and schizoaffective disorder and possible (history) of abuse and PTSD (Post Traumatic Stress Disorder)." A Plan of Care, dated 11/01/16, documents R3 has an ADL (Activities of Daily Living) self-care performance deficit, diagnosis and history of severe mental illness, Schizophrenia manifested by delusions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 35	F 309		

and paranoia, impaired thought process (related to) impaired decision making, displays disorganized thinking, uses Psychotropic medications for behavior management and "the resident needs supervision and assistance at times with all decision making."
Nursing Notes, dated 11/16/16, document R3 as having delusions of his coffee "tasting like body fluids...explained that he has worked around death, amputations, murder victims, and lived near a cemetery in the past and he knows what it tastes like," after refusing to take his anti-psychotic (Seroquel) the night before. The Electronic Medication Administration Record, documents that R3 started to consistently refuse to take his anti-psychotic medication (Seroquel) on 11/20/16. Nursing Notes, dated 12/01/16, document R3 was having visual hallucinations of snakes coming out of holes in the wall, and continued to refuse to take the Seroquel.
On 12/01/16, a Physician's Order documents, "(Z4 - Nurse Practitioner) notified of resident refusal to take Seroquel multiple times in the evening. (Z4) notified of delusional and scattered thoughts and verbal accusations. (Z4) orders to continue to encourage resident to take medication and if resident becomes agitated or aggressive to send resident for a psych (psychiatric) evaluation immediately."
A Progress Note by E1 (Administrator), dated 12/15/16 at 10:39 p.m., documents "(R3) became upset when another resident (R5) was attempting to use adjoining bathroom. (R3) pushed (R5) after words were exchanged. CNA (E6) attempted to redirect, (R3) slapped (E6 - Certified Nursing Assistant) in the face. Police were notified. Guardian (Z2) notified. Police did arrest (R3) for battery due to he does not require medical care, is refusing to take medication and (R5) did want

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 36	F 309		

to press charges." R3's progress notes contain no further documentation, until R3 returned to the facility upon his release from jail 12/16/16.
On 1/24/17 at 2:10 p.m., E1 (Administrator) stated she was working the floor on the night of 12/15/16, when she heard a noise from the 200 Hall. E1 observed R5 running down the hall after being shoved by R3 for using the adjoining bathroom. Immediately after the incident, E1 stated R3 de-escalated, went straight to his room and "laid down in his bed like nothing happened." E1 stated the police were contacted and came to the facility to question R3. E1 stated R3 would not answer the policemen's questions directly and R3 was arrested. E1 stated she informed the police that R3 was a "Ward of the State" and offered to send the legal documentation from the OSG (Office of State Guardian) with them, but declined. After R3 was taken to the local police department, E1 asked the oncoming nurse to contact the physician and OSG regarding R3's arrest. E1 stated she would have sent R3 out for a psychiatric evaluation, but R3 was arrested first and she did not communicate the need for R3 to have a psychiatric evaluation to the police department.
On 1/30/17 at 1:30 p.m., E2 (Director of Nursing) stated she informed the arresting police on the night of 12/15/16 that R3 had "no medical needs that need to be met overnight." E2 stated she explained to the police that R3 had been refusing his Seroquel and that R3 had a State Guardian, due to poor mental health; however, she did not discuss with the police that R3 had an order for a psychiatric evaluation, if he became aggressive. E2 stated it was mentioned that they would have "preferred" R3 be sent to the hospital for a psychiatric evaluation, rather than being arrested. E2 stated nothing was discussed with the police

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 37	F 309		

regarding what would happen to R3 upon his release from jail.
On 12/29/16 at 7:05 p.m., Z9 (Police Officer) stated he responded to a call from the facility regarding a "resident out of control." Z9 stated they were not going to arrest R3, but was told by the facility that R3's "mental capacity was o.k. (R3) could come and go as he pleased" and R5 wanted R3 arrested. Z9 stated they would not have arrested R3 if they had known R3 had a State Guardian.
On 1/25/17 at 2:52 p.m., E4 (Social Service Director) stated she was informed on the morning of 12/16/16 that R3 had been arrested the night before. E4 did attempt to reach the OSG to notify them that R3 had been taken to jail. E4 stated that R3 returned to the facility from the police station at approximately 1:00 p.m. on 12/16/16. E4 stated R3 refused to come all the way inside the building and requested his belongings. At that point, E3 (Licensed Practical Nurse) attempted to contact the OSG. E4 stated R3 communicated better through writing, so she gave R3 the AMA: Release from Medical Discharge form so R3 could understand the risks of leaving the facility. E4 stated R3 read and signed the AMA: Release From Medical Discharge form, took his belongings and left the facility on foot. According to E4, R3 stated he was walking to the police department. E4 called the local police department to inform them R3 was on his way to the station. E4 notified Z1 (Medical Director) that R3 left the facility AMA at 1:55 p.m. On 1/30/17 at 10:15 a.m., E4 stated they attempted to reach the OSG to notify them that R3 needed medical assistance and was leaving the facility, but did not consider calling 911 for medical transport to a hospital for treatment. E4 stated Z2 (Guardian) called her approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 38	F 309		

4 days after R3 left the facility and told them that R3 was technically considered a missing person at that point, because his whereabouts were unknown.

On 1/25/17 at 11:18 a.m., E3 (Licensed Practical Nurse) stated he was present on 12/16/16 when R3 returned to the facility from the police department. E3 stated R3 told him that the police stated he was not allowed to return to the facility. According to E3, R3 requested his belongings and indicated he was walking back to the police department. E3 stated he attempted multiple times to reach someone at the OSG office and eventually demanded to be put through to talk to someone. E3 spoke with Z3 (OSG On-Call Guardian) and explained that R3 was "not stable, needed medical help and was off his medications." At this point, R3 had been at the facility for approximately 10 minutes, when R3 decided to leave on foot for the police station. According to E3, Z3 stated she would call the police station and let them know what needed to be done with R3. E3 stated E5 (Transportation Aide) was able to catch up with R3 and give him a ride to the police station.

On 12/28/16 at 11:10 a.m., E5 (Transportation Aide) stated R3 left the facility on 12/16/16 on foot, to return to the police station. E5 stated he took his truck and was able to get R3 to agree to a ride to the police station. E5 stated he took R3 to the West door of the police station, and watch him enter the building and left.

On 1/04/17 at 9:24 a.m., E1 (Administrator) stated she thought R3 would be coming back to the facility, but expected to hear from the guardian or police before R3's return. On 1/30/17 at 12:57 p.m., E1 stated, "Due to the short time frame, of about twelve and 1/2 hours from R3's arrest (on 12/15/16) to when R3 returned to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 39	F 309		

facility (on 12/16/16), I can't answer the question as to who/when staff should have followed up with the police department regarding (R3's) status" following his arrest. E1 stated she was "shocked" at how quickly R3 was released from jail and they were not prepared when R3 returned to the facility.

On 1/25/17 at 12:45 p.m., Z1 (Medical Director) stated if R3 had a change in condition she would have expected a call, but the facility does not need an order to send a resident out for a psychiatric evaluation, if needed. Z1 stated the facility "saw this as a transfer of care to the police, but that's incorrect, because (R3) needed medical care." Z1 stated she would expect the facility to determine up front, "is his medical care going to be met at the time of arrest." Z1 stated "It is the facility's responsibility to ensure the resident is medically taken care of...and no one clearly communicated up front what the real plan for (R3) was. Z1 stated, her review of the documentation in R3's medical record indicated "staff handed (R3) off to the police and there was no follow up or clear delineation as to where R3 was going to go. Z1 stated no one "clearly communicated up front, what the real plan for (R3) was going to be" after his arrest.

On 1/30/17 at 11:14 a.m., Z5 (Office of State Guardian Supervisor) stated R3 "lacked the decisional capacity to make any decisions for himself, which was exactly why he was a ward of the State." Z5 stated the OSG provides the facility with all the necessary guidelines that are to be followed for adjudicated individuals, at the time of admission. Z5 stated it is the expectation of the OSG that the facility will follow through with any transfer out of the facility, whether it is to the Emergency Room, jail or programming, to ensure the resident's medical needs are going to be met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 40	F 309		

Z5 stated that the legal documentation provided by the OSG allows the facility to obtain routine and emergent medical care without prior approval from the Guardian. Z5 concluded that the facility should have called for emergency medical care for R3 on 12/16/16, when R3 returned to the facility, rather than trying to contact the Guardian. Z5 confirmed that R3's whereabouts are currently unknown.
The Immediate Jeopardy was noted to have started on 12/15/16 when R3 refused to take ordered antipsychotic medications. Facility Administrator was notified of the Immediate Jeopardy at 1:40PM on 01/31/17.
The surveyor confirmed through interview and record review that the facility took the following action to remove the Immediate Jeopardy:

1. The facility provided in-service training by the facility's Director of Nursing and Social Service Director to all licensed and unlicensed staff at the nursing home regarding the expectation of the Office of State Guardian regarding routine and emergent medical care for adjudicated individuals, physician notification of change in resident condition, behavior management for new/worsening behaviors and status of resident transfers.

2. The Administrator and Director of Nursing reviewed facility Policy and Procedure on Behavior Management for Agitated Behavior, Change in Condition/Physician Notification Overview Guidelines, Behavioral Management for New or Worsening Behavior Symptoms, Medical Record Documentation and Transfer/Discharge.

3. The Administrator has developed a plan to ensure compliance with Subpart S - SMI State

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 309	Continued From page 41 Regulations has been developed and is ongoing. The facility has identified which residents qualify for SMI and what programming would be appropriate for those individuals; however, those programs have yet to be implemented. 4. Additionally, the Director of Nursing will perform a Quality Assurance Audit of all OSG residents weekly for two weeks (or as needed thereafter) to ensure compliance with all reviewed facility policies and that appropriate mental health services are provided.	F 309		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 328	Continued From page 42	F 328		

receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to follow physician's orders and failed to monitor oxygen saturation levels for two (R7 and R8) of three residents reviewed for oxygen therapy, in a sample of 37.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 328	Continued From page 43	F 328		

On 1-26-17 at 10:35 am, E2 (DON/Director of Nursing) stated it is facility policy that if a resident is receiving oxygen therapy, SP02 (oxygen saturation levels) should be monitored every shift.

1. R7's current POS (Physician's Order Sheet) for January, 2017 documents R7 has diagnoses of Chronic Obstructive Pulmonary Disease, Congestive Heart Disease and Lung Cancer.

R7's January POS documents R7 is to have oxygen "3 liters continuously via nasal cannula every shift related to chronic obstructive pulmonary disease".

R7's November MAR (Medication Administration Record) documents R7's SP02 was checked consistently from November 1 through November 6, 2016. From November 7 through November 30, R7's SP02 was checked only 18 of the 72 times required.

R7's December 2016 MAR documents R8's SP02 was checked 14 of the 72 times required when R8 was present in the facility.

R7's January 2017 MAR documents R7's SP02 was not checked at all until 1-25-17.

On 1-24-17 at 9:20 am, R7 was up in a wheelchair in room with R7's oxygen set at 2 liters per nasal cannula. On 1-26-17 at 8:50 am, R7 was up in a wheelchair in room with the nasal cannula on. R7's oxygen was located on the back of R7's wheelchair and was set at 0.5 liters and not turned on. R7 stated R7 has been up in her wheelchair since before breakfast and no one had adjusted it in that time frame. R7 stated at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 328	Continued From page 44	F 328		

times R7 is short of breath.

On 1-26-17 at 11:50 am, E10 (LPN/Licensed Practical Nurse) verified R7's oxygen was off and at the wrong setting. E10 stated the following: R7 was up in the wheelchair all morning and E10 had not checked R7's oxygen. The facility nursing staff is responsible for connecting R7's oxygen tubing, setting the rate and turning on the flow. SP02 levels are to be completed every shift and as needed on all residents requiring oxygen therapy.

R7's MDS (Minimum Data Set) dated 10-20-16 shows R7 has a BIMS (Brief Interview for Mental Status) of 15 out of 15.

On 1-26-17 at 8:50 am, R7 stated R7 had been up in R7's wheelchair since before breakfast and had not adjusted any of her oxygen settings that day. R7 could not remember who had administered R7's oxygen that morning and failed to turn it on.

2. R8's current POS (Physician's Order Sheet) for January 2017 documents R8 has Emphysema and has an order for oxygen at 2-3 liters per nasal cannula as needed, checking oxygen saturation level every shift.

R8's November 2016 MAR (Medication Administration Record) documents R8's SPO2 (oxygen saturation level) was checked consistently November 1, 2016 through November 5, 2016. From November 7 through November 30, 2016, R8's SP02's were completed only 21 out of the 72 times required.

R8's December 2016 MAR documents R8's SP02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 328	Continued From page 45 was checked only 22 of the 93 times required. R8's January 2017 MAR documents R8 did not have any SP02 monitoring until 1-25-17. On 1-26-17 at 2:00 pm, E11 (Care Plan Coordinator) stated there was a mix up in how the orders on the computer were put in along with a computer update. E11 stated that is why the SP02 levels were not completed every shift as they should have been. On 2/01/17 at 3:30 p.m., E1 (Administrator) stated SPO2 levels are to be monitored every shift for residents with the diagnosis of Chronic Obstructive Pulmonary Disease and who are receiving oxygen therapy.	F 328		
F 406 SS=E	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.	F 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 406	Continued From page 46	F 406		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide required mental health services for 24 of 24 residents (R3, R5, R7, R8, and R10 through R30), reviewed identified by the facility as being SMI (Serious Mental Illness), in a sample of 37.

Findings include:

On 1-25-17 at 10:00 am, E4 (Social Service Director) confirmed there were 24 residents (R3, R5, R7, R8, and R10 through R30) she had determined were SMI. E4 stated they presently do not have an SMI program, therefore comprehensive assessments by qualified personnel, SMI individualized treatment plans, psychiatric rehabilitation services, and SMI discharge planning have not been completed for the 24 SMI residents.

1. R10's current POS (Physician's Order Sheet) for January 2017 documents R10 was admitted 12-15-16 and has a including Schizophrenia, Recurrent Major Depressive Disorder, and Anxiety.

R10's PAS/MH (Pre-Admission Screen/Mental Health) Level II Notice of Determination dated 12-16-16 states R10 is eligible for nursing facility and needs special services for the following: Medication monitoring, adjustment and/or stabilization, instrumental activities of Daily Living training/reinforcement, Mental Health Rehabilitation activities, Aggression/Anger Management and illness self management.

R10's record does not include any documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 406	Continued From page 47	F 406		

of the above services being offered.

2. R11's POS for January 2017 documents R11 was admitted 11-8-16 from another facility with diagnoses of Bipolar Disorder, Diabetes and Hypertension.

R11's Level II Summary Pre-Admission Screening dated 7-2-15 states R11 is eligible for nursing facility and need special services for the following: Medication monitoring, adjustment and/or stabilization, Mental Health Rehabilitation activities, Aggression/Anger management, Incentive program to improve participation in treatments, and Community re-integration activities.

R11's record does not include any documentation that any specialized SMI rehab is being offered.

R11's Admission MDS (Minimum Data Set) dated 11-15-16 documents R11 scores a 15 out of 15 on the Brief Interview for Mental Status screen.

On 1-16-17 at 2:30 pm, R11 stated he was not aware of any special mental health services being offered by the facility nor had he attended any programming activities.

3. R5's POS (Physician Order Sheet) for January 2017 documents R5 was admitted 10-12-16 and has diagnoses including Schizoaffective Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder.

R5's OBRA-Initial Screen (Omnibus Budget Reconciliation Act) dated 5-20-15 documents there is a reasonable basis to suspect R5 has a mental illness, indicating a PAS needed to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 406	Continued From page 48 completed. There is no PAS screen in R5's record nor is there any evidence of specialized rehab being offered. 4. R8's POS documents R8 was admitted 7-28-16 with diagnosis of Schizoaffective Disorder. R8's MDS (Minimum Data Set) dated 1-12-17 shows R8 has a 15 out of 15 score on the BIMS (Brief Interview for Mental Status). On 1-25-17 at 9:10 am, R8 stated she was not aware of any mental health programming offered at the facility. 5. R7's POS documents R7 was admitted 11-29-15 with a diagnosis of Major Depression with Psychosis. R7's MDS dated 10-26-16 documents R7 has a 15 out of 15 score on the BIMS (Brief Interview for Mental Status). On 1-26-17 at 8:50 am, R7 stated she has not been offered any mental health services/classes or programming while at the facility.	F 406		
F 490 SS=D	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 490	Continued From page 49	F 490		

Based on record review and interview, the facility's Administration failed to ensure a one of 24 residents (R3) reviewed, who met the requirement for SMI (Serious Mental Illness) attained their highest practicable level of mental and psychosocial well-being. Administrative staff failed to follow physician's orders instructing R3 to have a psychological evaluation in the event of agitation or physical aggression and failed to identify R3's need for medical care after an acute change in mental condition. These failures resulted in R3, who refused to take antipsychotic medications, being arrested on 12/15/16 after a behavior change and taken to jail, instead of receiving psychiatric care. R3 was released by police and is now missing.

Findings include:

The facility policy, "Change in Condition Physician Notification Overview Guidelines (1/01/2014)," document "These guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed and physician notification is based assessment findings and is to be documented in the medical record. 2. Medical care problems are communicated to the attending physician in a timely, concise, and thorough manner. Nurse Responsibilities - The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgement requires immediate medical intervention."

The facility policy, titled "Discharge/Transfer of Resident (no date)," documents "Purpose: To provide safe departure from the facility. To provide continuity of care and treatment...Complete Transfer Form accurately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 490	Continued From page 50	F 490		

and completely, including vital signs. Ensure that resident's current physical and psycho/social assessment, medications and current treatment is completely described and available to the receiving facility upon transfer." The "Discharge/Transfer of Resident" policy further instructs staff when a resident is leaving without a physician's order to "contact Medical Director if unable to reach attending physician and there is a concern for resident health or welfare upon discharge."

A letter from the State Guardianship & Advocacy Commission, dated 11/01/16, documents "On September 14, 2016 the Office of State Guardian was appointed Person Only Temporary Guardian for (R3), as guardian this office is responsible for the well-being of the ward and is legally authorized to make fundamental decisions concerning the ward's health, medical treatment, placement and personal well-being." The letter further documents, "In the event of an emergency, the facility staff...is authorized by the Office of State Guardian to arrange for transportation, routine emergency room evaluation and treatment, and for hospitalization and general medical treatment for (R3). The Office of State Guardian hereby consents to routine emergency room evaluation and treatment, and for hospital admission and general medical treatment for the individual ward named herein."

A Progress Note, dated 11/01/16, documents R3 was admitted with the diagnoses of confusion, sepsis, pneumonia, schizoaffective disorder and possible (history) of abuse and PTSD (Post Traumatic Stress Disorder). A Plan of Care, dated 11/01/16, documents R3 has an ADL (Activities of Daily Living) self-care performance deficit, diagnosis and history of severe mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 490	Continued From page 51	F 490		

illness, Schizophrenia manifested by delusions and paranoia, impaired thought process (related to) impaired decision making, displays disorganized thinking, uses Psychotropic medications for behavior management and "the resident needs supervision and assistance at times with all decision making."
The Electronic Medication Administration Record, documents that R3 was to receive the anti-psychotic medication, Seroquel 300 mg (milligrams), nightly and started to consistently refuse to take the Seroquel on 11/20/16. Nursing Notes, dated 12/01/16, document R3 was having visual hallucinations of snakes coming out of holes in the wall, and the physician was contacted.
A Physician's Order dated 12/01/16 documents, "(Z4 - Nurse Practitioner) notified of resident refusal to take Seroquel multiple times in the evening. (Z4) notified of delusional and scattered thoughts and verbal accusations. (Z4) orders to continue to encourage resident to take medication and if resident becomes agitated or aggressive to send resident for a psych (psychiatric) evaluation immediately."
On 1/24/17 at 2:10 p.m., E1 (Administrator) stated she was working the floor on the night of 12/15/16, when R3 had a physical altercation with R5 and E6 (Certified Nursing Assistant). E1 indicated this was the first time R3 had displayed any aggression, since his admission on 11/01/16. According to E1, the police were contacted, as that is the facility's practice when there is a resident to resident altercation. E1 stated R3 was arrested when R5 stated he waned to press charges against R3 and R3 was taken directly to jail. E1 stated she would have sent R3 out for a psychiatric evaluation, but R3 was arrested first and she did not communicate the need for R3 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 490	Continued From page 52	F 490		

have a psychiatric evaluation to the police department. On 1/31/17 at 1:40 p.m., E1 stated she has never had a resident arrested from a facility before and did not have any written protocols/policies to guide staff on what to do in this situation. E1 stated R3 was still considered the responsibility of the facility, since R3 was adjudicated and had not been discharged.
A Progress Note by E1 (Administrator) following the 12/15/16 incident, at 10:39 p.m., documents "(R3) became upset when another resident (R5) was attempting to use adjoining bathroom. (R3) pushed (R5) after words were exchanged. CNA (E6) attempted to redirect, (R3) slapped (E6 - Certified Nursing Assistant) in the face. Police were notified. Guardian (Z2) notified. Police did arrest (R3) for battery due to he does not require medical care, is refusing to take medication and (R5) did want to press charges."
On 1/30/17 at 1:30 p.m., E2 (Director of Nursing) stated she was present in the building on the evening of 12/15/16 and informed the arresting police officer that R3 had "no medical needs that need to be met overnight." E2 stated she explained to the police that R3 had been refusing his Seroquel and that R3 had a State Guardian, due to poor mental health; however, she did not discuss with the police that R3 had current order for a psychiatric evaluation, if he became aggressive.

A Social Service Note the day after R3 was arrested, dated 12/16/16, documents "Resident did return to facility...(E4) and nurse (E3 - Licensed Practical Nurse) went to speak with resident this afternoon, who stated he was released on his own recognizance...Staff was unaware resident was released and resident states someone gave him a ride back to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 490	Continued From page 53	F 490		

facility. Resident stated he...only wanted his belongings. Resident was educated on risks of AMA and resident signed AMA paper. Resident stated he planned on returning to police station...Resident left building and began walking towards police station. (E4) contacted police dept. to notify them of situation and request they assist resident."

On 1/25/17 at 2:52 p.m., E4 (Social Service Director) stated R3 returned to the facility from the police station at approximately 1:00 p.m. on 12/16/16. E4 stated R3 refused to come all the way inside the building and requested his belongings. E4 stated R3 communicated better through writing, so she gave R3 the AMA: Release from Medical Discharge form so R3 could understand the risks of leaving the facility. E4 stated R3 read and signed the AMA: Release From Medical Discharge form, took his belongings and left the facility on foot. According to E4, R3 stated he was walking to the police department. E4 called the local police department to inform them R3 was on his way to the station. E4 notified Z1 (Medical Director) that R3 left the facility AMA at 1:55 p.m. On 1/30/17 at 10:15 a.m., E4 stated they attempted to reach the OSG to notify them that R3 needed medical assistance and was leaving the facility, but did not consider calling 911 for medical transport to a hospital for treatment. E4 stated she was familiar with the legal documentation provided by the State Guardianship & Advocacy Commission regarding the facility's authorization to obtain emergency medical treatment for R3, but did not act on those instructions. E4 stated Z2 (Guardian) called her approximately 4 days after R3 left the facility and told them that R3 was technically considered a missing person at that point, because his whereabouts were unknown.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE JACKSONVILLE	1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650

(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 490	Continued From page 54 On 1/25/17 at 12:45 p.m., Z1 (Medical Director) stated the facility had an order on 12/01/16 to send R3 out for a psychiatric evaluation if he became violent/aggressive, but failed to act on that order. Z1 concluded that the facility technically does not need an order to send a resident out for a psychiatric evaluation, which would have been warranted in this situation. Z1 stated the facility "saw this as a transfer of care to the police, but that's incorrect, because (R3) needed medical care."	F 490		