Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001945	A. BUILDING: ______ B. WING ______	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PRINCETON	515 BUREAU VALLEY PARKWAY PRINCETON, IL 61356

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S 000	Initial Comments Complaint Investigation: 2327494/IL164168	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.625n) 300.1210c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.625 Identified Offenders n) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and shall document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents.	S9999	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health

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

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Section 300.1210 General Requirements for Nursing and Personal Care

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to include a resident's criminal sex offense background on the resident care plan and failed to follow a care plan intervention for one (R9) of three residents reviewed for care plans.

Findings include:

The facility's Abuse Prevention and Reporting - Illinois policy, revised 10/24/22, documents "Establishing a Resident Sensitive Environment. For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendations Report into the identified offender's plan of care including the security measures listed.

R9's Criminal History Record, dated 1/16/23, documents R9 is a Registered Identified Sex Offender convicted for indecent liberty of a child in 1979 and 1980.

R9's current Care Plan does not include R9's Identified Offender or Recommendations Report or security measures.

R9's current Care Plan includes a focus of "I reside in a private room r/t (related to) my background and am able to participate in activities of choice as long as activities do not

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interfere or intrude on others." Also included is an Intervention of "Resident's door needs to be kept open r/t his background."

On 9/19/23, at 10:04am, V15 Housekeeping aid stood by R9's door. At this time, R9's door to the hall is closed almost all of the way leaving approximately one to two inches open. V15 stated he has cleaned R9's room many times and that R9's door is usually closed with a just crack open.

On 9/19/23, at 2:57pm, V21 CNA stated that (R9) usually has his door shut on second shift. V21 stated she is unaware that it is on (R9's) care plan to leave the door to his room open.

On 9/20/23, at 1:51pm, V12 MDS (Minimum Data Set)/Care plan Coordinator verified R9's care plan does not incorporate the Identified Offender Report or Recommendations Report, or any security measures listed, with the exception of being in a private room. V12 confirmed that according to the facility's Abuse policy it should be on R9's care plan. V12 stated "I was not aware that that was supposed to be specifically on his care plan."

(C)

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F 000	INITIAL COMMENTS Complaint Investigation: 2327494/IL164168	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to investigate an allegation of a potential misappropriation of resident property for one (R9) of three residents reviewed for criminal activity in a sample of three. Findings include: The facility's Abuse Prevention and Reporting - Illinois policy, revised 10/24/22, documents "Internal Reporting Requirements and Identification of Allegations: "Supervisors shall	F 610		10/1/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 610	Continued From page 1 immediately inform the administrator of person designated to act as administrator in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation." R9's current clinical record, documents R9 as moderately cognitively impaired with diagnoses including Unspecified Dementia, moderate, with Agitation. R9's Criminal History Record, dated 1/16/23, documents R9 is a Registered Identified Sex Offender and was convicted for indecent liberty of a child in 1979 and 1980. On 9/19/23, at 12:03pm, R9 was lying in bed with a personal computer located on a desk against the wall across from the entrance to R9's room. At this time R9 stated he does use the WIFI for Internet on his personal computer and that "there's porn on there, but you don't have to stay on it. You can skip on by it, ya know?" On 9/19/23, at 2:27pm, V1 stated the following: A nurse (V9 Registered Nurse/RN) called me a week ago and said (V21 Certified Nursing Assistant/CNA) reported to (V9) that (V21) suspected (R9) was on a porn site. I asked (V9) if she saw it and (V9) did not. I did not talk to (V21 CNA). At this time, V1 denied doing any investigation for this allegation and was unable to provide any investigation documents. On 9/19/23, at 2:57pm, V21 CNA, stated that V21 walked into R9's room where loud music was	F 610		

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F 610	Continued From page 2 playing and saw R9 on his computer viewing young Chinese girls aged 10 to 12 years old whose dresses were blowing up exposing their underwear. Each time they put a microphone up to their mouths their dress would fly up. What got me was the phone numbers going across the back. V21 stated she reported this to V9 Registered Nurse/RN but is not sure if anything was done. V21 stated that no one from the facility has asked her anything about this occurrence. On 9/19/23, at 3:32pm, V9 RN stated the following: (V21 CNA) told me that (R9) was "watching young girls on porn called 'Chinese Virgins'. I didn't see it." V9 continued to state that (V21) said the Chinese girls looked young but (V21) didn't give me an age. (V21) said the computer screen was flashing "Chinese Virgins," across the screen. "(V21) wasn't explicit in detail, but said it was porn." I reported it to (V1) and have not heard any feedback since.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		10/1/23

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F 656	Continued From page 3	F 656		

required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to develop interventions to address wandering on resident Care Plans for two (R1 and R2) of three reviewed for care plans.

Findings include:

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F 656	Continued From page 4 1. On 9/14/23, between 9:30am and 10:00am, R2 independently ambulated around the locked unit. R2's current Physician Order Sheet/POS documents R2 has diagnoses including Dementia. R2's Minimum Data Set/MDS assessment, dated 8/29/23, documents R2 is severely cognitively impaired. On 9/14/23, at 10:20am, V5 and V6 Certified Nursing Assistants/CNAs identified R2 as one of the wandering residents in the locked unit. R2's current Care Plan does not include any focus or interventions for wandering. On 9/14/23, at 3:37pm, V13 Social Service Director confirmed R1 and R2 are wandering residents who should have had wandering addressed on their care plans. 2) Current Physician order Summary Report indicates R1 has diagnoses that include Unspecified Dementia, Alzheimer's Dementia with Early Onset and Severe Dementia in other diseases with behavioral disturbance. Current Comprehensive Assessment indicates R1 was identified as having wandering behaviors, occurring daily, and intruding on the privacy of others. On 9/14/23 at 10:20am V5 and V6, CNA's identified R1 as a wanderer with behavior of wandering into to other resident rooms and getting into their beds. V5 stated that R1 is difficult to redirect at times and will shake her fist	F 656		

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F 656	Continued From page 5 at staff. Progress Note dated 6/26/23 at 10:12am indicates R1 has chronic wandering behaviors. Progress Note dated 6/27/23 at 8:20am indicates "During morning medication pass, (R1) observed laying in another resident bed under the covers watching television." Progress Note dated 7/7/23 at 7:04pm indicates "(R1) observed in another residents room sleeping on bed." Note indicates staff are "following care plan." Current Care Plan indicates only "Behavior Management" as focus area. Care Plan does not identify wandering as a target behavior and does not identify interventions to address R1's wandering into other residents' rooms and getting into other resident's beds.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete Elopement Risk assessment, failed to include two residents identified as at risk for Elopement in the	F 689		10/1/23

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F 689	Continued From page 6	F 689		

Elopement Risk Protocol and in the facility's Elopement risk binder for two residents (R1 and R2)

Findings include:

The facility's Identification of Elopement Risk policy, undated, documents "Policy Statement: To identify residents that are at risk for elopement. Policy Interpretation and Implementation: 1. Residents will be evaluated for elopement risk on admission and quarterly. 2. The resident's service plan will be modified to indicate the resident is at risk for elopement episodes, if applicable. 3. Interventions to prevent elopement will be entered into the resident's service plan."

1. On 9/14/23, between 9:30am and 9:40am, R2 independently ambulated around the locked unit and then hovered around the exit door of the locked unit.

R2's current Physician Order Sheet/POS documents R2 has diagnoses including Dementia.

R2's Minimum Data Set/MDS assessment, dated 8/29/23, documents R2 is severely cognitively impaired.

R2's Elopement Risk & Community Survival Skill Assessment, dated 8/25/23 and signed by V14 Social Service Director/SSD, is incomplete.

The facility's Elopement binder, located at the nurse's station, does not include R2 on the list of residents identified as Elopement risk.

On 9/14/23, at 3:37pm, V13 SSD stated V14 did

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F 689	Continued From page 7 not complete R2's elopement risk assessment even after receiving further information including R2's diagnosis of Dementia. R2 confirmed that R2 should have been placed on the Elopement Risk Protocol and on the list of residents at risk for elopement in the elopement binder. 2) Current Physician Order Summary Report indicates R1 has diagnoses that include Unspecified Dementia, Alzheimer's Dementia with Early Onset and Severe Dementia in other diseases with Behavioral Disturbance. Current Comprehensive Assessment indicates R1 was identified as having wandering behaviors, occurring daily, and intruding on the privacy of others. Current Social Service Elopement Risk and Community Survival Skills Assessment dated 9/13/23 indicates R1 is at risk to elope and should be placed on the Elopement Risk Protocol and "Care Plan for Elopement is indicated." Current Care Plan indicates only "Behavior Management" as focus area. Care Plan does not identify R1 as an elopement risk and does not identify interventions to address R1's risk of elopement. List of residents identified as "Elopement Risk" included in the Elopement binder at the nurse's station does not include R1. On 9/14/23 at 3:37pm V13, Social Service Director stated R1 should have been included in the Elopement Risk Protocol including being identified on the list of residents identified as Elopement risks and a care plan should have been developed to address managing and	F 689		

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F 689	Continued From page 8 monitoring R1's Elopement Risk.	F 689		