DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		PLETED
		145928	B. WING				C 101/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				10	21 NORTH CHURCH STREET		
APERION	CARE JACKSONVILLE			J۸	CKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FO	000			
		on #1647284/IL90633- 224, F250, F280, F285,					
		on #1740053/IL90855- 224, F250, F280, F285,					
	Complaint Investigation	on #1740345/IL91159 - F328					
F 152 SS=D	A partial extended su 483.10(b(3)-(7) RIGH REPRESENTATIVE	-	F 1	152			
	adjudged incompeten resident has the right representative, in acc any legal surrogate so the resident's rights to state law. The same-s must be afforded trea to an opposite-sex sp	resident who has not been t by the state court, the to designate a ordance with State law and o designated may exercise the extent provided by sex spouse of a resident tment equal to that afforded ouse if the marriage was n in which it was celebrated.					
		sentative has the right to s rights to the extent those o the representative.					
	rights not delegated to	ns the right to exercise those o a resident representative, evoke a delegation of rights, State law.					
	resident representativ	at treat the decisions of a re as the decisions of the required by the court or					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

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.

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2017 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		145928	B. WING		_	(02/) 01/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
APERION	CARE JACKSONVILLE			1021 NORTH CHURCH STE JACKSONVILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 152	 applicable law. (b)(5) The facility shall representative the right behalf of the resident by the court or delegat accordance with applicable law. (b)(6) If the facility has resident representative taking actions that are a resident, the facility when and in the mann law. (b)(7) In the case of a incompetent under the of competent jurisdict devolve to and are extrepresentative appoint on the resident's behalt representative appoint on the resident's behaver is the extent jurisdict or competent jurisdiction law. (i) In the case of a resident representative representative appoint or court appointment, to make those decision representative's author considered in the extending a the origination of the resident's behaver. (ii) The resident's wish be considered in the extending a three extending a three extendent is a three extendent appointment. (iii) The resident's wish be considered in the extendent is a three extendent is a three extendent is a three extendent. 	dent, in accordance with I not extend the resident at to make decisions on beyond the extent required ted by the resident, in cable law. Is reason to believe that a e is making decisions or e not in the best interests of shall report such concerns her required under State resident adjudged e laws of a State by a court ion, the rights of the resident ted under State law to act alf. The court-appointed e exercises the resident's dged necessary by a court of h, in accordance with State bident representative whose ority is limited by State law the resident retains the right ns outside the ority. hes and preferences must exercise of rights by the	F 152				
	(iii) To the extent prac	ticable, the resident must be					

Facility ID: IL6008650

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	-					FORM	D: 02/14/2017
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			-	(X3) DATE COMP	PLETED
		145928	B. WING				C 101/2017
NAME OF PI	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	CARE JACKSONVILLE			1021 NORTH CHURCH ST	REET		
AFERIOR	CARE JACKSONVILLE			JACKSONVILLE, IL 62	650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 152	Continued From page provided with opportu care planning process This REQUIREMENT by: Based on record revi failed to follow guideli Guardianship & Advo allowed a mentally ill Against Medical Advic residents (R3) review Findings include: A letter from the State Commission, dated 1 September 14, 2016 f was appointed Person for (R3), as guardian the well-being of the v authorized to make fu concerning the ward's placement and person A Progress Note, date "was admittedwith a sepsis, pneumonia ar and possible (history) Traumatic Stress Disc dated 11/01/16, docum (Activities of Daily Liv	e 2 inities to participate in the s. is not met as evidenced iew and interview, the facility ines established by the State cacy Commission and resident to leave the facility ce, for one of 10 adjudicated ed, in a sample of 37. e Guardianship & Advocacy 1/01/16, documents "On the Office of State Guardian n Only Temporary Guardian this office is responsible for ward and is legally undamental decisions is health, medical treatment, nal well-being." ed 11/01/16, documents R3 a (history) of confusion, nd Schizoaffective disorder of abuse and PTSD (Post order)." A Plan of Care, ments R3 has an ADL ing) self-care performance	F 15				
	illness, Schizophrenia and paranoia, impaire to) impaired decision disorganized thinking medications for behave	, uses Psychotropic vior management and "the vision and assistance at					

Facility ID: IL6008650

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CENTER STATEMENT (D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			FORM OMB NC (X3) DATE	0: 02/14/2017 APPROVED 0: 0938-0391 SURVEY LETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING			(
		145928	B. WING		_		01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
APERION CARE JACKSONVILLE				021 NORTH CHURCH ST ACKSONVILLE, IL 620			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 152	Director) stated R3 ha from the police station on 12/16/16. E4 state the way inside the bui belongings. At that p Nurse) attempted to o State Guardian). E4 not going to be stayin police told him he was stated she encourage but R3 kept demandin E4 stated R3 commun writing, so she gave F Medical Discharge for the risks of leaving the and signed the AMA: Discharge form, took facility on foot. Accor was walking to the po the local police depar was on his way to the attempted to reach th R3 needed medical a the facility. E4 stated approximately 4 days told them that R3 was missing person at tha whereabouts were un On 1/30/17 at 11:14 a Guardian Supervisor) decisional capacity to himself, which was ex the State." Z5 stated facility with all the neo- be followed for adjudi of admission. Z5 state	m., E4 (Social Service ad returned to the facility at approximately 1:00 p.m. ed R3 refused to come all lding and requested his bont, E3 (Licensed Practical ontact the OSG (Office of stated R3 indicated he was g at the facility and the s not allowed to return. E4 d R3 to stay at the facility, ng his personal belongings. nicated better through R3 the AMA: Release from m so R3 could understand e facility. E4 stated R3 read Release From Medical his belongings and left the ding to E4, R3 stated he lice department. E4 called tment to inform them R3 station. E4 stated they e OSG to notify them that ssistance and was leaving Z2 (Guardian) called her after R3 left the facility and technically considered a t point, because his known.	F 152				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		145928	B. WING				C 01/2017
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 152 F 157 SS=D	care without prior app prohibits residents fro concluded that the face emergency medical c when R3 returned to t to contact the Guardia whereabouts are curr 483.10(g)(14) NOTIF (INJURY/DECLINE/R (g)(14) Notification of (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications (C) A need to alter trea a need to discontinue treatment due to adve commence a new form (D) A decision to trans- resident from the facil	he and emergent medical proval from the Guardian and proval from the Guardian and proval from the Guardian and proval from the Guardian and proval from the valled for are for R3 on 12/16/16, the facility, rather than trying an. Z5 confirmed that R3's ently unknown. Y OF CHANGES COOM, ETC) Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or		152	2		
	emergency medical c when R3 returned to t to contact the Guardia whereabouts are curr 483.10(g)(14) NOTIF (INJURY/DECLINE/R (g)(14) Notification of (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan- mental, or psychosoc deterioration in health status in either life-thr clinical complications; (C) A need to alter tree a need to discontinue treatment due to advec commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii).	are for R3 on 12/16/16, the facility, rather than trying an. Z5 confirmed that R3's ently unknown. Y OF CHANGES COM, ETC) Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring try; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial eatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the	F	157			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/14/2017 RM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	O. 0938-0391 TE SURVEY IPLETED
		145928	B. WING		0	C 2/01/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZI		
			10	21 NORTH CHURCH STREET		
APERION	CARE JACKSONVILLE		J	ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 157	 all pertinent informatic is available and provid physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r 	the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment I0(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically	F 157			
	 phone number of the This REQUIREMENT by: Based on record revifailed to notify the phy to take Anti-psychotic notify the psychiatrist facility Against Medica nine residents (R3) renotification, in a samp Findings include: 1. The facility policy to Treatment Refusal (number of the second to a medication and/or treatment's medical record the physician was not physician's response. 	titled, "Medication and o date)", documents a resident's refusal of atment must be recorded in cordThe date and time that				

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/14/2017 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		145928	B. WING			02/0	C 01/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
			10	21 NORTH CHURCH STRE	EET		
APERION	CARE JACKSONVILLE			ACKSONVILLE, IL 6265			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page physician each time r A Physician's Order S documents R3 is to re	efused."	F 157				
	Paranoid Schizophrei	isorder with Delusions and nia.					
	documents R3 refuse the following dates: 1 11/23/16, 11/24/16, 1	nistration Record for R3 d to take his Seroquel on 1/15/16, 11/20/17, 11/21/17, 1/25/16, 11/26/16, 11/28/16, 2/01/16 through 12/07/16 12/15/16.					
		contains documented hysician was notified of R3's roquel once, on 12/01/16.					
	On 1/30/17 at 1:51 p. Coordinator) states th medication refusal do physician is to be noti Anti-psychotic Medica	at the facility policy on es indicate that the ified each time a					
	Medical Advice (no da To define the facility's resident and/or legal a discharges him/herse the consent of or an or physician. Policy: It acknowledge the righ him/herself out of the of or an order from the providing that the resi capacity to do soIn questionable as to wh	If from the facility without order from the attending is the policy of the facility to t of a resident to sign facility without the consent e attending physician, ident has the decisional					

Facility ID: IL6008650

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/14/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		145928	B. WING					C 01/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					1021 NORTH CHURCH STREET			
APERION	CARE JACKSONVILLE				JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD B		(X5) COMPLETION DATE
F 157	and administrative sta collaboration with the A Progress Note, date "was admittedwith a sepsis, pneumonia ar and possible (history) Traumatic Stress Disc dated 11/01/16, docur (Activities of Daily Liv deficit, diagnosis and illness, Schizophrenia and paranoia, impaire to) impaired decision disorganized thinking medications for behave resident needs super- times with all decision On 1/25/17 at 2:52 p. Director) stated R3 has from the police station on 12/16/16. E4 states the way inside the bui belongings. E4 states at the facility, but R3 I personal belongings. communicated better gave R3 the AMA: Refe Discharge form so R3 of leaving the facility. signed the AMA: Refe Discharge form, took facility on foot. Accor (Medical Director) afte 1:55 p.m., but did not	cision about an AMA ice) discharge, professional aff are to be consulted in resident's psychiatrist." ed 11/01/16, documents R3 a (history) of confusion, nd Schizoaffective disorder of abuse and PTSD (Post order)." A Plan of Care, ments R3 has an ADL ing) self-care performance history of severe mental a manifested by delusions ed thought process (related making, displays , uses Psychotropic vior management and "the vision and assistance at n making." m., E4 (Social Service ad returned to the facility n at approximately 1:00 p.m. ed R3 refused to come all ilding and requested his d she encouraged R3 to stay kept demanding his E4 stated R3 through writing, so she elease from Medical 8 could understand the risks E4 stated R3 read and ease From Medical his belongings and left the ding to E4, she notified Z1 er R3 had left the building, at	F	157	7			

Facility ID: IL6008650

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUUTIPLE	CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · /	IPLETED
						С
		145928	B. WING		02	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE JACKSONVILLE			21 NORTH CHURCH STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	Continued From page	e 8	F 157			
	policy that addressed	naware the facility had a I the steps which needed to dent leaves the facility AMA.				
F 203 SS=D		OTICE REQUIREMENTS	F 203			
		transfer. Before a facility es a resident, the facility				
	the reasons for the m	he transfer or discharge and love in writing and in a er they understand. The opy of the notice to a Office of the State				
		ns for the transfer or lent's medical record in agraph (c)(2) of this section;				
	(iii) Include in the not paragraph (b)(5) of th	ice the items described in his section.				
	(c) (4) Timing of the r	notice.				
	(b)(8) of this section, discharge required un	d in paragraphs (b)(4)(ii) and the notice of transfer or nder this section must be It least 30 days before the d or discharged.				
	(ii) Notice must be ma before transfer or dis	ade as soon as practicable charge when-				

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 02/14/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(3) DATE SURVEY COMPLETED
		145928	B. WING			C 02/01/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE	
APERION	CARE JACKSONVILLE			021 NORTH CHURCH STREET IACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION E DATE
F 203	 be endangered under this section; (B) The health of individent endangered, under this section; (C) The resident's heat allow a more immediate under paragraph (b)(7) (D) An immediate trans required by the resided under paragraph (b)(7) (E) A resident has not days. (c) (5) Contents of the specified in paragraph include the following: (i) The reason for transferred or dischart (iii) The location to what transferred or dischart (iv) A statement of the including the name, at and telephone number receives such request to obtain an appeal for completing the form at hearing request; 	r paragraph (b)(1)(ii)(C) of viduals in the facility would r paragraph (b)(1)(ii)(D) of alth improves sufficiently to ate transfer or discharge, 1)(ii)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(ii)(A) of this section; or t resided in the facility for 30 e notice. The written notice n (b)(3) of this section must usfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how	F 203			

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2017 1 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		145928	B. WING			(02/0	。 01/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
APERION	CARE JACKSONVILLE			021 NORTH CHURCH ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 203	telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and add developmental disabil C of the Developmental and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individua (c)(6) Changes to the the notice changes pr or discharge, the facil recipients of the notic once the updated infor (c)(8) Notice in advan case of facility closure administrator of the fa- notification prior to the State Survey Agency, Long-Term Care Omb facility, and the reside as the plan for the tra relocation of the reside 483.70(1).	the Office of the State budsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and als with a mental disorder e Protection and Advocacy uals Act. notice. If the information in for to effecting the transfer ity must update the e as soon as practicable ormation becomes available. Acce of facility closure. In the e, the individual who is the acility must provide written e impending closure to the the office of the State budsman, residents of the ent representatives, as well nsfer and adequate	F 203				

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/14/2017 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>				(X3) DATE COMP	SURVEY LETED
		145928	B. WING					C 01/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
					1021 NORTH CHURCH STREET			
APERION	CARE JACKSONVILLE				JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 203	failed to ensure an ap one of one residents of discharge in the samp resulted in R3 who re medications, being pu officers after a behavi released by police an Findings include: The facility policy, title Resident (no date)," of provide safe departur provide continuity of of treatmentComplete and completely, include resident's current phy assessment, medicati is completely describe receiving facility upon "Discharge/Transfer of instructs staff when a physician's order to "of unable to reach attent concern for resident h discharge." A Progress Note, date "was admittedwith a sepsis, pneumonia ar and possible (history) Traumatic Stress Disc dated 11/01/16, docum (Activities of Daily Liv deficit, diagnosis and illness, Schizophrenia and paranoia, impaire to) impaired decision disorganized thinking medications for behavious	iew and interview the facility opropriate transfer of care for (R3) reviewed for involuntary oble of 37. This failure fused to take antipsychotic ut in the care of police for change. R3 was d is now missing. ed "Discharge/Transfer of documents "Purpose: To the from the facility. To care and Transfer Form accurately ding vital signs. Ensure that visical and psycho/social ions and current treatment ed and available to the transfer." The of Resident" policy further resident is leaving without a contact Medical Director if ding physician and there is a health or welfare upon ed 11/01/16, documents R3 a (history) of confusion, nd schizoaffective disorder of abuse and PTSD (Post order)." A Plan of Care, ments R3 has an ADL ing) self-care performance history of severe mental a manifested by delusions ed thought process (related making, displays	F	203	3			

Facility ID: IL6008650

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	S FOR MEDICARE &					O. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			E SURVEY PLETED		
			A. BUILDIN	G		С		
		145928	B. WING		02	2/01/2017		
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		./01/2017		
				1021 NORTH CHURCH STREET				
APERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)		
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETIO		
F 203	Continued From page	<u>- 12</u>	F 20	13				
	times with all decision							
		e Guardianship & Advocacy						
		1/01/16, documents "On						
		the Office of State Guardian						
		n Only Temporary Guardian						
		this office is responsible for						
	the well-being of the							
	authorized to make fu							
	-	s health, medical treatment, nal well-being." The letter						
	further documents, "li	-						
		ty staffis authorized by the						
	Office of State Guard							
	transportation, routine							
		nent, and for hospitalization						
		treatment for (R3). The						
		ian hereby consents to						
	routine emergency ro	spital admission and general						
		the individual ward named						
	herein."							
	On 12/01/16, a Physi	cian's Order documents,						
		ner) notified of resident						
		uel multiple times in the						
	÷ · ·	d of delusional and scattered						
		accusations. (Z4) orders to						
	continue to encourag							
	aggressive to send re	ident becomes agitated or						
	(psychiatric) evaluation							
		1 (Administrator), dated						
		n., documents "(R3) became						
	upset when another r	esident (R5) was attempting						
		room. (R3) pushed (R5)						
		hanged. CNA (E6) attempted						
		bed (E6 - Certified Nursing						
	Accietant) in the tace							
	,	. Police were notified. d. Police did arrest (R3) for						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/14/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		145928	B. WING				C 101/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				10	21 NORTH CHURCH STREET		
AFERION	APERION CARE JACKSONVILLE			JA	ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 203	to press charges." On 1/24/17 at 2:10 p. stated she was worki 12/15/16, when R3 ha R5 and E6. E1 stated as that is the facility's resident to resident a arrested when R5 stat charges against R3 a jail. E1 stated she wo psychiatric evaluation and she did not comm physician's order for a developed physically On 1/30/17 at 1:30 p. stated she informed t night of 12/15/16 that that need to be met of explained to the polic his Seroquel and that due to poor mental he discuss with the polic psychiatric evaluation On 1/25/17 at 12:45 p stated the facility had send R3 out for a psy became violent/aggree that order. Z1 conclut technically does not n resident out for a psy would have been wan stated the facility "sav the police, but that's i needed medical care On 1/30/17 at 11:14 a	Adication and (R5) did want m., E1 (Administrator) ng the floor on the night of ad a physical altercation with d the police were contacted, practice when there is a litercation. E1 stated R3 was ted he waned to press nd R3 was taken directly to buld have sent R3 out for a a, but R3 was arrested first nunicate that R3 had a a psychiatric evaluation if he aggressive behaviors. m., E2 (Director of Nursing) he arresting officers on the R3 had "no medical needs vernight." E2 stated she e that R3 had been refusing R3 had a State Guardian, ealth; however, she did not e that R3 had an order for a b, if he became aggressive. D.m., Z1 (Medical Director) an order on 12/01/16 to rchiatric evaluation if he essive, but failed to act on ded that the facility need an order to send a chiatric evaluation, which ranted in this situation. Z1 w this as a transfer of care to ncorrect, because (R3)	F	203			
	decisional capacity to	stated R3 "lacked the make any decisions for kactly why he was a Ward of					

Facility ID: IL6008650

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		145928	B. WING				C 01/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 203 F 224 SS=K	the State." Z5 stated facility with all the neo- be followed for adjudi of admission. Z5 stat the OSG that the facil any transfer out of the Emergency Room, jai the resident's medica Z5 stated that the leg- by the OSG allows the and emergent medica from the State Guardi 483.12(a)(1) PROHIE MISTREATMENT/NE a) The facility must- (1) Not use verbal, me abuse, corporal punis seclusion. This REQUIREMENT by: Based on record revi neglected to follow op the discharging a resi and the emergency me adjudicated resident, Guardianship & Advo failures resulted in stat facility Against Medica result of this, R3's wh unknown. These failu Immediate Jeopardy a affect the other nine a R2, and R31-R37) cu While the immediacy the facility remains ou Severity Level II as the	the OSG provides the cessary guidelines that are to cated individuals, at the time ed it is the expectation of ity will follow through with a facility, whether it is to the l or programming, to ensure and documentation provided e facility to obtain routine al care without prior approval an. AT GLECT/MISAPPROPRIATN ental, sexual, or physical hment, or involuntary is not met as evidenced ew and interview, the facility perational policies related to dent against medical advice redical care of a mentally ill as established by the State cacy Commission. These aff allowing R3 to leave the al Advice on 12/16/16. As a ereabouts are currently ures resulted in an and has the potential to adjudicated residents (R1, rrently residing in the facility. was removed on 1/31/17,		203	3		

Facility ID: IL6008650

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		MEDICAID SERVICES	(X2) MUUT	IPLE CONSTRUCTION		IO. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	APLETED		
						С		
		145928	B. WING		0	2/01/2017		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL				
				1021 NORTH CHURCH STREET				
APERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE		
F 224	Continued From page	a 15	F 2	24				
1 224	-			.24				
	forth by the Guardian	compliant with the rules set						
	-	dicated individuals and as						
		to develop the programming						
		ious Mentally III) residents.						
	Findings include:							
	31 37	ed "Discharge Against						
		ate)", documents "Purpose:						
	resident and/or legal	s responsibility when a						
		elf from the facility without						
	•	order from the attending						
		is the policy of the facility to						
	acknowledge the righ	t of a resident to sign						
		facility without the consent						
		e attending physician,						
		ident has the decisional						
	capacity to do soIn							
		nether the resident and/or e decisional capacity to						
	make an informed de							
		ice) discharge, professional						
		aff are to be consulted in						
	collaboration with the	resident's psychiatrist."						
		e Guardianship & Advocacy						
		1/01/16, documents "On						
		the Office of State Guardian						
		n Only Temporary Guardian this office is responsible for						
	the well-being of the	-						
		undamental decisions						
		s health, medical treatment,						
	-	nal well-being." The letter						
	further documents, "In							
		ty staffis authorized by the						
	Office of State Guard	-						
	transportation, routine	e emergency room nent, and for hospitalization						

If continuation sheet Page 16 of 55

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	COMPLETED			
					с			
		145928	B. WING		02/01/2017			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO				
				1021 NORTH CHURCH STREET				
APERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLE E APPROPRIATE DAT			
F 224	Continued From page	e 16	E 22					
1 224			F 22	4				
		treatment for (R3). The lian hereby consents to						
	routine emergency ro							
		spital admission and general						
		the individual ward named						
	herein. The Office of	State Guardian shall be						
r ł e t	notified of routine em	ergency room treatment or						
	hospitalization by the	next working dayIn no						
		be withheld from a ward of						
		uardian due to the ward's						
		/ of life or legal status."						
		ed "Staff Obligations to						
	•	Abuse, Neglect and Theft (no ect" as the "failure to provide,						
		of, adequate medical care,						
	-	ent, psychiatric rehabilitation,						
		istance activities of daily						
	living that is necessar	ry to avoid physical harm,						
	mental anguish, or m	ental illness of a resident."						
	-	ed 11/01/16, documents R3						
		a (history) of confusion,						
		nd schizoaffective disorder						
) of abuse and PTSD (Post						
		order)." A Plan of Care, ments R3 has an ADL						
		ving) self-care performance						
		history of severe mental						
		a manifested by delusions						
		ed thought process (related						
	to) impaired decision	- · ·						
	disorganized thinking							
		vior management and "the						
		vision and assistance at						
	times with all decision	-						
		I 11/16/16, document R3 as						
					1			
		is coffee "tasting like body						
	fluidsexplained that	is coffee "tasting like body t he has worked around murder victims, and lived						

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			
							C
		145928	B. WING			02/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	CARE JACKSONVILLE			1	1021 NORTH CHURCH STREET		
AFERIOR				J	JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETIO DATE
E 00 4							
F 224			F 2	224	•		
	tastes like," after refu	0					
		uel) the night before. The					
		Administration Record,					
		tarted to consistently refuse					
		otic medication (Seroquel)					
	on 11/20/16, through						
	-	cuments R3 had developed					
		tions and delusions starting					
		12/15/16. Nursing Notes,					
		iment R3 was having visual					
		kes coming out of holes in					
	the wall, and continued to refuse to take the						
	Seroquel due to the side effect of an upset						
	stomach.						
	-	ed 12/15/16 at 10:39 p.m.,					
		ame upset when another					
		empting to use adjoining					
		ed (R5) after works were					
) attempted to redirect, (R3)					
		ed Nursing Assistant) in the					
	face. Police were no						
		rrest (R3) for battery due to					
		nedical care, is refusing to					
		(R5) did want to press					
	charges."						
	A Social Service Note						
	-	cial Service Director) notified					
		essage with OSG (Office of					
		sident did return to facility					
		in between the two doors.					
		Licensed Practical Nurse)					
	· ·	sident this afternoon, who					
		ed on his own recognizance					
		n in February for court. Staff					
		t was released and resident					
	-	e him a ride back to the					
	-	ted heonly wanted his					
		t was educated on risks of					
	AIVIA and resident sig	ned AMA paper. Resident					1

Facility ID: IL6008650

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	S FOR MEDICARE &					0. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED	
			A. BUILDIN	IG			
		145928	B. WING			C	
		145920				01/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
APERION	CARE JACKSONVILLE						
				JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 224	Continued From page	e 18	F 2	24			
	stated he planned on		1 2				
	•	building and began walking					
		n. (E4) contacted police					
		f situation and request they					
		atch stated she would notify					
	-	sident was heading in their					
		aff was able to reach OSG					
		stated that they would					
	•	ment and recommend					
		ospital for (evaluation). It					
		ident made it safely to police					
	station."						
		m., E4 (Social Service					
		eturned to the facility from					
	-	pproximately 1:00 p.m. on					
	-	R3 refused to come all the					
	way inside the buildin	ng and requested his					
	-	oint, E3 (Licensed Practical					
	Nurse) attempted to o	contact the OSG. E4 stated					
	R3 communicated be	etter through writing, so she					
	gave R3 the AMA: Re	elease from Medical					
	Discharge form so R3	3 could understand the risks					
		E4 stated R3 read and					
	signed the AMA: Rele						
		his belongings and left the					
		rding to E4, R3 stated he					
	÷ .	blice department. E4 called					
		tment to inform them R3					
		e station. E4 notified Z1					
	· · · · · ·	at R3 left the facility AMA at					
	-	7 at 10:15 a.m., E4 stated					
		It the facility had a Policy to					
		nt left AMA. E4 stated the					
		E2) was present in the					
	-	when R3 wanted to leave,					
	-	involved because she didn't					
		3. E4 stated they attempted notify them that R3 needed					

Facility ID: IL6008650

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		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · /	IPLETED		
			A. BOILDING			С		
		145928	B. WING		02/01/2017			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/01/2017		
				1021 NORTH CHURCH STREET				
APERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650				
					DECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 224	Continued From page	e 19	F 22	4				
		calling 911 for medical		•				
		I for treatment. E4 stated						
		the legal documentation						
		Guardianship & Advocacy						
		ig the facility's authorization						
	to obtain emergency	medical treatment for R3,						
	but did not act on tho	se instructions. E4 stated						
		her approximately 4 days						
		ty and told them that R3 was						
	-	d a missing person at that						
		nereabouts were unknown.						
		m., E1 (Administrator)						
		ated through reading and						
	-	showed R3 the AMA papers o attempt to get R3 to come						
		; however, R3 signed the						
		ked away from the facility.						
		a.m., E3 (Licensed Practical						
		present on 12/16/16 when						
	R3 returned to the fac							
	department. E3 state	ed R3 told him that the police						
	stated he was not all	owed to return to the facility.						
		requested his belongings						
		walking back to the police						
	-	ed he attempted multiple						
		one at the OSG office and						
	-	to be put through to talk to						
		with Z3 (OSG On-Call						
	needed medical help	ned that R3 was "not stable, and was off his						
	-	point, R3 had been at the						
		tely 10 minutes, when R3						
		oot for the police station.						
		stated she would call the						
	-	them know what needed to						
	-	stated E5 (Transportation						
		ch up with R3 and give him a						
	ride to the police stat	ion.						
		a.m., E5 (Transportation						

Facility ID: IL6008650

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						IO. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY		
			A. BUILDING			С		
		145928	B. WING	WING				
	ROVIDER OR SUPPLIER	110020		STREET ADDRESS, CITY, STATE, ZIP CODE				
	KONDER OR SOLT EIER			1021 NORTH CHURCH STREET	-			
APERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 224	Continued From page	e 20	F 22	4				
		ne facility on 12/16/16 on						
	,	police station. E5 stated he						
		is able to get R3 to agree to						
		ation. E5 stated he took R3						
		ne police station, did not go						
	·	on with R3, but watched him						
	enter the building and	d then E5 left.						
		a.m., Z5 (Office of State						
) stated R3 "lacked the						
		make any decisions for						
	-	xactly why he was a ward of						
		the OSG provides the						
		cessary guidelines that are to						
	-	icated individuals, at the time						
	of admission. Z5 stat	ded by the OSG allows the						
		ne and emergent medical						
	•	proval from the Guardian.						
		e facility should have called						
		al care for R3 on 12/16/16,						
		the facility, rather than trying						
		an. Z5 confirmed that R3's						
	whereabouts are curr							
		p.m., Z1 (Medical Director)						
		ange in condition, such as						
		ssion, she would have						
		the facility. However, Z1						
		s not need an order to send						
	-	sychiatric evaluation if						
		uld have been appropriate in						
		ted the facility "saw this as a police, but that's incorrect,						
		d medical care." Z1 stated,						
		ponsibility to ensure the						
		taken care ofand no one						
	-	d up front what the real plan						
		me of or after the arrest. Z1						
		izophrenia with Delusions,						

Facility ID: IL6008650

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 02/14/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	SURVEY PLETED
		145928	B. WING			C /01/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE JACKSONVILLE			021 NORTH CHURCH STREET		
				ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224		chiatric evaluation would	F 224			
	started on 12/16/16 w enact their policy. Fa notified of the Immedi 01/31/17. The surveyor confirm record review that the action to remove the I 1. The facility provide facility's Director of Ne Director to all licensed	ardy was noted to have when the facility failed to cility Administrator was ate Jeopardy at 1:40PM on ed through interview and facility took the following				
	Office of State Guardi emergent medical car individuals, physician resident condition, be new/worsening behav transfers.	ian regarding routine and re for adjudicated notification of change in havior management for viors and status of resident				
	reviewed facility Polic Behavior Managemer Change in Condition/I Overview Guidelines, New or Worsening Be	nt for Agitated Behavior,				
	ensure compliance wi Regulations has been The facility has identif for SMI and what prog	individuals; however, those be implemented.				

Facility ID: IL6008650

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION		O. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · /	IPLETED	
						С	
		145928	B. WING		02/01/2017		
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE			
APERION	CARE JACKSONVILLE		1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 224	Continued From page	e 22	F 224				
	residents weekly for t thereafter) to ensure facility policies and th services are provided						
F 250 SS=D	483.40(d) PROVISIO RELATED SOCIAL S		F 250				
	social services to atta practicable physical, i well-being of each res This REQUIREMENT by: Based on record revi failed to ensure a res care following a perio acute episode of aggi arrest, for one of nine medically related soc 37.	provide medically-related ain or maintain the highest mental and psychosocial sident. is not met as evidenced iew and interview, the facility ident received psychiatric d of medication refusal, an ressive behavior and an e residents (R3) reviewed for ial services, in a sample of					
	Findings include:						
	for Agitated Behavior the event staff needs prevent the resident f techniques to provide implemented. Non-vi safe, non-harmful beh designed to aid huma	ed "Behavior Management (no date)," documents "In to physically intervene to rom harming self or others, interim control will be olent crisis intervention is a navior management system an services in the ptive and assaultive people,					
	even during the most interim control is used	violent moments. When the d, the physician will be ination made as to the need					

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		MEDICAID SERVICES	(X2) MULT	TIPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	, <i>'</i>	NG	COMPLETED			
					С			
		145928	B. WING		02/01/2017			
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE			
				1021 NORTH CHURCH STREET				
APERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE COMPLETE			
F 250	F 250 Continued From page 23 A Progress Note, dated 11/01/16, documents R3 "was admittedwith a (history) of confusion, sepsis, pneumonia and schizoaffective disorder and possible (history) of abuse and PTSD (Post Traumatic Stress Disorder)."		F2	250				
	Nursing Notes, dated 11/16/16, document R3 as having delusions of his coffee "tasting like body fluidsexplained 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)							
	document R3 was ha snakes coming out of continued to refuse to On 12/01/16, a Physi "(Z4 - Nurse Practition refusal to take Seroqu	Notes, dated 12/01/16, ving visual hallucinations of holes in the wall, and take the Seroquel. cian's Order documents, ner) notified of resident uel multiple times in the d of delusional and scattered						
	thoughts and verbal a continue to encourag medication and if resi aggressive to send re (psychiatric) evaluation	accusations. (Z4) orders to e resident to take ident becomes agitated or esident for a psych						
	resident (R5) was atte bathroom. (R3) push exchanged. CNA (E6 slapped (E6 - Certifie	ame upset when another empting to use adjoining led (R5) after works were) attempted to redirect, (R3) d Nursing Assistant) in the st (R3) for battery due to: he						
	does not require med medication and (R5) A Social Service Note	lical care, is refusing to take did want to press charges." e the following day, dated E4 (Social Service Director)						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2017 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		145928	B. WING		_		C 01/2017
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
APERION	CARE JACKSONVILLE			021 NORTH CHURCH STI ACKSONVILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 250	arrest and E4 left a m State Guardian) to ke no documented evide to arrange for a psych release from jail at tha dated 12/16/16, docu to the facility that day stay and only wanted belongings. The 12/1 document "(R3) was of (leaving against medi signed AMA paper. Fo on returning to police building and began w station." On 1-25-17 at 10:00 a Director) stated the fat have a SMI (Serious I therefore comprehens qualified personnel, S plans, psychiatric reh- discharge planning ha R3. On 1/25/17 at 2:5 attempt to reach the O Guardian) on 12/16/1 needed medical assiss facility, but did not com medical transport to a psychiatric evaluation physician on 12/01/16 On 1/25/17 at 12:45 p stated stated "It is the ensure the resident is ofand no one clearly what the real plan for review of the docume	hysical aggression and essage with OSG (Office of ep them updated. There is nice that E4 made attempts hiatric evaluation upon R3's at time. Progress notes, ment R3 ended up returning ; however, R3 refused to to collect his personal 6/16 Progress Notes, educated on risks of AMA cal advice) and resident Resident stated he planned stationResident left alking towards police am, E4 (Social Service cility does not currently Mental Illness) program, sive assessments by SMI individualized treatment abilitation services, and SMI ad not been completed for 2 p.m., E4 stated they did DSG (Office of State 6 to notify them that R3 stance and was leaving the nsider calling 911 for hospital or arrange for a t, as ordered by the S.	F 250				

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	-	D HUMAN SERVICES				FORM): 02/14/2017 // APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	LETED
		145928	B. WING		_		C 01/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			10	021 NORTH CHURCH ST	REET		
APERION	CARE JACKSONVILLE		J	ACKSONVILLE, IL 626	650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 250	Continued From page	25	F 250				
F 280 SS=D	police and there was delineation as to when stated no one "clearly what the real plan for his arrest and a psych been appropriate. 483.10(c)(2)(i-ii,iv,v)(3		F 280				
		ticipate in the development f his or her person-centered g but not limited to:					
	including the right to i be included in the pla request meetings and	bate in the planning process, dentify individuals or roles to nning process, the right to the right to request n-centered plan of care.					
	expected goals and o amount, frequency, a	pate in establishing the utcomes of care, the type, nd duration of care, and any o the effectiveness of the					
	(iv) The right to receiv included in the plan o	re the services and/or items f care.					
		e care plan, including the ificant changes to the plan					
		-					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		145928	B. WING			C 02/01/2017	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	 (i) Facilitate the inclusive resident representative (ii) Include an assessive strengths and needs. (iii) Incorporate the recultural preferences in 483.21 (b) Comprehensive C (2) A comprehensive C (2) A comprehensive C (2) A comprehensive C (i) Developed within 7 the comprehensive asticles but is not lime (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the resident and the resident and the resident record if the presence of the resident of the resi	sion of the resident and/or re. ment of the resident's sident's personal and n developing goals of care. are Plans care plan must be- days after completion of ssessment. rerdisciplinary team, that ited to rsician. e with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined	F	280			
	resident's care plan.						

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	-	ID HUMAN SERVICES				FORM	MAPPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMF	PLETED
		145928	B. WING				C 101/2017
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	01/2017
	CARE JACKSONVILLE				1021 NORTH CHURCH STREET		
AFERIOR					JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 280	disciplines as determinor as requested by the (iii) Reviewed and reviewed and reviewed and reviewed and reviewed and reviewed and reviewed assessments. This REQUIREMENT by: Based on record revifailed to ensure a residupdated to reflect the anti-psychotic medicar residents (R3) review sample of 37. Findings include: A Physician's Order St documents R3 is to reflect the diagnose Disorder, Psychotic D Paranoid Schizophreit The Medication Adminit documents R3 refuse the following dates: 11/23/16, 11/24/16, 11/29/16, 11/30/16, 12 and 12/08/16 through R3's current Plan of C identify R3's frequent area of focus, with go On 1/30/17 at 1:51 p.	staff or professionals in ined by the resident's needs e resident. Vised by the interdisciplinary ssment, including both the parterly review T is not met as evidenced ew and interview, the facility ident Plan of Care was refusal to take ations for one of nine ed for Care Plans, in a Sheet dated 11/01/16, eceive Seroquel 300 mg at es of Schizoaffective bisorder with Delusions and hia. Inistration Record for R3 d to take his Seroquel on 11/15/16, 11/20/17, 11/21/17, 1/25/16, 11/26/16, 11/28/16, 2/01/16 through 12/07/16 12/15/16. Care (no date), fails to refusal of Seroquel as an als and interventions. m., E11 (Care Plan	F	280			
	area of focus, with go On 1/30/17 at 1:51 p. Coordinator) stated a	als and interventions. m., E11 (Care Plan					

Facility ID: IL6008650

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/14/2017 MAPPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		145928	B. WING		02	C 2/ 01/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
APERION	CARE JACKSONVILLE			1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 280	stated they should ha interventions for R3 re refusal, such as ident how to reapproach R3 comply.	Service Director). E11 ve developed appropriate egarding his medication ifying staff R3 trusted and 8, in attempt to get R3 to	F 28			
F 285 SS=D	FOR MI & MR	ASRR REQUIREMENTS	F 28	5		
	pre-admission screen (PASARR) program u of this part to the max	ate assessments with the ing and resident review nder Medicaid in subpart C imum extent practicable to ng and effort. Coordination				
	PASARR level II dete	recommendations from the rmination and the PASARR a resident's assessment, insitions of care.				
		esident review upon a				
		eening for individuals with a ndividuals with intellectual				
	(1) A nursing facility n January 1, 1989, any	nust not admit, on or after new residents with:				
		defined in paragraph (k)(3) ess the State mental health ned, based on an				

Facility ID: IL6008650

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		145928	B. WING				C 101/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE JACKSONVILLE				021 NORTH CHURCH STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 285	 independent physical performed by a perso State mental health a (A) That, because of the condition of the individual reservices, whether the specialized services; (ii) Intellectual disability of this section intellectual disability of authority has determined the level of services pand (A) That, because of the condition of the individual reservices, whether the specialized services for authority has determined authority has determined the level of services pand (B) If the individual reservices, whether the specialized services pand (B) If the individual reservices for the individual reservices, whether the specialized services for paragraph(k)(1) of this for determinations in the formation of the individual reservices for the specialized services for paragraph(k)(1) of this for determinations in the formation of the specialized services for the spec	and mental evaluation n or entity other than the uthority, prior to admission, the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires or ty, as defined in paragraph n, unless the State or developmental disability ned prior to admission- the physical and mental dual, the individual requires provided by a nursing facility; quires such level of individual requires or intellectual disability. urposes of this section- creening program under s section need not provide the case of the readmission an individual who, after nursing facility, was a hospital.	F	285			

Facility ID: IL6008650

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		145928	B. WING				C 01/2017
NAME OF P	ROVIDER OR SUPPLIER	L	I	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 285	paragraph (k)(1) of th to a nursing facility of (A) Who is admitted to hospital after receivin hospital, (B) Who requires nurs	is section to the admission	F	285	5		
	before admission to the	physician has certified, he facility that the individual s than 30 days of nursing					
	(3) Definition. For pu	rposes of this section-					
		nsidered to have a mental ual has a serious mental 33.102(b)(1).					
	(ii) An individual is co intellectual disability in intellectual disability a or is a person with a r described in 435.1010	f the individual has an as defined in §483.102(b)(3) ^r elated condition as					
	mental health authori disability authority, as significant change in condition of a residen intellectual disability f This REQUIREMENT by: Based on interview a failed to obtain/incorp	applicable, promptly after a the mental or physical t who has mental illness or for resident review. is not met as evidenced and record review, the facility					

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145928	B. WING				C / 01/2017
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 285	three (R10, R11, and reviewed for PASARF 30. Findings include: On 1-25-17 at 3:10 pr Director) stated the fa information to direct th Illness) resident's treat 1. R10's current POS for January 2017 doc 12-15-16 and has dia Schizophrenia, Recur Disorder, and Anxiety R10's PAS/MH (Pre- Health) Level II Notice 12-16-16 states R10 and needs special se Medication monitoring stabilization, instrume training/reinforcemen Rehabilitation activitie Management and illne	resident's plan of care for I R5) of three residents R information in a sample of m, E4 (Social Service acility does not use PASARR he SMI (Serious Mental atment. 6 (Physician's Order Sheet) uments R10 was admitted gnoses including rrent Major Depressive Y. Admission Screen/Mental e of Determination dated is eligible for nursing facility rvices for the following: g, adjustment and/or ental activities of Daily Living t, Mental Health es, Aggression/Anger ess self management.	F	28			
	of the above services 2. R11's POS for Jan was admitted 11-8-16	t include any documentation being offered. wary 2017 documents R11 from another facility with Disorder, Diabetes and					
	1-26-17 at 2:45 pm, w	nclude a Level II PAS. On vhen R11's Level II PAS was I Service Director) called					

Facility ID: IL6008650

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		145928	B. WING				C 101/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 285	R11's previous facility sent. R11's Level II Summa Screening dated 7-2- nursing facility and ne following: Medication and/or stabilization, M activities, Aggression, Incentive program to treatments, and Com activities. R11's record does not that these programs a 3. R5's POS (Physicia 2017 documents R5 w has diagnoses includi	and requested a copy be ary Pre-Admission 15 states R11 is eligible for eeds special services for the monitoring, adjustment lental Health Rehabilitation /Anger management, improve participation in munity re-integration t include any documentation are being offered. an Order Sheet) for January was admitted 10-12-16 and	F	285	5		
F 309 SS=J	Major Depressive Dis R5's OBRA-Initial Scr documents there is a R5 has a mental illnes to be completed. The record documenting r care. 483.24, 483.25(k)(I) F FOR HIGHEST WELL 483.24 Quality of life Quality of life is a fund applies to all care and residents. Each resid facility must provide th services to attain or m	order. een dated 5-20-15 reasonable basis to suspect ss, indicating a PAS needed ere is no PAS screen in R5's ecommendations for R5's PROVIDE CARE/SERVICES BEING damental principle that d services provided to facility lent must receive and the he necessary care and	F	309			

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		145928	B. WING				C / 01/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	483.25 (k) Pain Management The facility must ensu provided to residents consistent with profes the comprehensive pr and the residents' goa (I) Dialysis. The facilit residents who require services, consistent v of practice, the compre- care plan, and the residents preferences. This REQUIREMENT by: Based on record revi- failed to follow operate behavior management identify and anticipate mentally ill resident (F battery on 12/15/16. R3 not receiving the eneeded and lead to R (Against Medical Adv of this, R3's whereab These failures resulted Jeopardy. While the immediacy the facility remains ou Severity Level II as the Quality Assurance me	t with the resident's asment and plan of care.	F	30	9		
	Commission for adjuct	dicated individuals and as to develop the programming					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/14/2017 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		145928	B. WING				C / 01/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1021 NORTH CHURCH STREET		
APERION	CARE JACKSONVILLE			.	JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Findings include: The facility policy, title for Agitated Behavior the event staff needs prevent the resident fit techniques to provide implemented. Non-vis safe, non-harmful beh designed to aid huma management of disru- even during the most interim control is used notified and a determi for acute mental healt be able to manage the members will make even resident and others and call 911 for assistance The facility policy, title Resident (no date)," or provide safe departure provide continuity of or treatmentComplete and completely, include resident's current phy assessment, medicati is completely described receiving facility upon A Progress Note, date "was admittedwith a sepsis, pneumonia ar and possible (history) Traumatic Stress Disc dated 11/01/16, docum (Activities of Daily Live	ed "Behavior Management (no date)," documents "In to physically intervene to rom harming self or others, interim control will be olent crisis intervention is a havior management system n services in the ptive and assultive people, violent moments. When the d, the physician will be ination made as to the need th services. Should staff not e resident's behavior, staff very attempt to protect the nd another staff member will e." d "Discharge/Transfer of locuments "Purpose: To e from the facility. To eare and Transfer Form accurately ding vital signs. Ensure that sical and psycho/social ions and current treatment ed and available to the transfer." ed 11/01/16, documents R3 (history) of confusion, nd schizoaffective disorder of abuse and PTSD (Post order)." A Plan of Care, ments R3 has an ADL ing) self-care performance	F	309			
	deficit, diagnosis and	ing) self-care performance history of severe mental manifested by delusions					

Facility ID: IL6008650

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/14/2017 MAPPROVED D. 0938-0391
STATEMENT AND PLAN O	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145928	B. WING				C /01/2017
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
					1021 NORTH CHURCH STREET		
APERION CARE JACKSONVILLE					JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	and paranoia, impaire to) impaired decision disorganized thinking medications for behar resident needs super times with all decision Nursing Notes, dated having delusions of h fluidsexplained that death, amputations, r near a cemetery in th tastes like," after refu anti-psychotic (Seroq Electronic Medication documents that R3 st to take his anti-psych on 11/20/16. Nursing document R3 was ha snakes coming out of continued to refuse to On 12/01/16, a Physi "(Z4 - Nurse Practitio refusal to take Seroque evening. (Z4) notified thoughts and verbal a continue to encourag medication and if resi aggressive to send ref (psychiatric) evaluatio A Progress Note by E 12/15/16 at 10:39 p.n upset when another r to use adjoining bath after words were excl to redirect, (R3) slapp Assistant) in the face Guardian (Z2) notified battery due to he doe	ed thought process (related making, displays , uses Psychotropic vior management and "the vision and assistance at n making." 11/16/16, document R3 as is coffee "tasting like body the has worked around nurder victims, and lived e past and he knows what it sing to take his uel) the night before. The n Administration Record, tarted to consistently refuse otic medication (Seroquel) 9 Notes, dated 12/01/16, ving visual hallucinations of f holes in the wall, and take the Seroquel. cian's Order documents, ner) notified of resident uel multiple times in the d of delusional and scattered accusations. (Z4) orders to e resident to take ident becomes agitated or esident for a psych	F	309	9		

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2017 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		145928	B. WING		_	(02/	C 01/2017
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			1	021 NORTH CHURCH STI	REET		
APERION	CARE JACKSONVILLE		J	ACKSONVILLE, IL 620	650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	no further documental facility upon his releas On 1/24/17 at 2:10 p. stated she was workin 12/15/16, when she h Hall. E1 observed R8 being shoved by R3 fb bathroom. Immediate stated R3 de-escalate and "laid down in his E1 stated the police w the facility to question not answer the police R3 was arrested. E1 police that R3 was a ' offered to send the leas OSG (Office of State declined. After R3 was department, E1 asked contact the physician arrest. E1 stated she a psychiatric evaluation have a psychiatric evaluation have a psychiatric evaluation that need to be met o explained to the polic his Seroquel and that due to poor mental he discuss with the polic psychiatric evaluation E2 stated it was ment "preferred" R3 be sen psychiatric evaluation	3's progress notes contain tion, until R3 returned to the se from jail 12/16/16. m., E1 (Administrator) ng the floor on the night of eard a noise from the 200 5 running down the hall after or using the adjoining ely after the incident, E1 ed, went straight to his room bed like nothing happened." were contacted and came to n R3. E1 stated R3 would men's questions directly and stated she informed the 'Ward of the State" and gal documentation from the Guardian) with them, but as taken to the local police d the oncoming nurse to and OSG regarding R3's would have sent R3 out for on, but R3 was arrested first nunicate the need for R3 to aluation to the police m., E2 (Director of Nursing) he arresting police on the R3 had "no medical needs vernight." E2 stated she e that R3 had been refusing R3 had a State Guardian, ealth; however, she did not e that R3 had an order for a , if he became aggressive. ioned that they would have	F 309				

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						O. 0938-039	
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION G	· · ·	E SURVEY PLETED	
			A. BOILDIN	<u> </u>		С	
		145928	B. WING		02	2/01/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
	CARE JACKSONVILLE			1021 NORTH CHURCH STREET			
AFERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 309	Continued From page	e 37	F 3	09			
		d happen to R3 upon his					
	release from jail.						
		p.m., Z9 (Police Officer)					
		to a call from the facility					
		out of control." Z9 stated					
	, , , , , , , , , , , , , , , , , , , ,	o arrest R3, but was told by					
		mental capacity was o.k.					
		go as he pleased" and R5 Z9 stated they would not					
		ney had known R3 had a					
	State Guardian.						
	On 1/25/17 at 2:52 p.	.m., E4 (Social Service					
	-	was informed on the morning					
	of 12/16/16 that R3 h	ad been arrested the night					
		pt to reach the OSG to notify					
		en taken to jail. E4 stated					
		ne facility from the police					
		ely 1:00 p.m. on 12/16/16. I to come all the way inside					
		ested his belongings. At					
	that point, E3 (Licens	÷ ÷					
		the OSG. E4 stated R3					
		through writing, so she					
	gave R3 the AMA: Re						
		3 could understand the risks					
		E4 stated R3 read and					
	signed the AMA: Rele						
		his belongings and left the					
	-	rding to E4, R3 stated he blice department. E4 called					
		rtment to inform them R3					
		e station. E4 notified Z1					
	-	at R3 left the facility AMA at					
	,	7 at 10:15 a.m., E4 stated					
		ach the OSG to notify them					
		cal assistance and was					
		ut did not consider calling 911					
		to a hospital for treatment.					
	⊥ ⊢4 stated 72 (Guardi	an) called her approximately	1			1	

Facility ID: IL6008650

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				PRINTED: 02/14/2017 FORM APPROVED OMB NO. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145928	B. WING		C
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE
APERION CARE JACKSONVILLE			1021 NORTH CHURCH S	STREET
			JACKSONVILLE, IL 6	52650
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORF	R'S PLAN OF CORRECTION (X5) RECTIVE ACTION SHOULD BE COMPLETION RENCED TO THE APPROPRIATE DATE DEFICIENCY)
R3 was technically com at that point, because H unknown. On 1/25/17 at 11:18 a.1 Nurse) stated he was p R3 returned to the facil department. E3 stated stated he was not allow According to E3, R3 re and indicated he was w department. E3 stated times to reach someon eventually demanded t someone. E3 spoke w Guardian) and explaine needed medical help a medications." At this p facility for approximate decided to leave on foo According to E3, Z3 sta police station and let th be done with R3. E3 s Aide) was able to catch ride to the police statio On 12/28/16 at 11:10 a Aide) stated R3 left the foot, to return to the po took his truck and was a ride to the police stati to the West door of the him enter the building a On 1/04/17 at 9:24 a.m stated she thought R3 the facility, but expecte guardian or police befor at 12:57 p.m., E1 state	e facility and told them that asidered a missing person his whereabouts were m., E3 (Licensed Practical present on 12/16/16 when lity from the police I R3 told him that the police wed to return to the facility. equested his belongings walking back to the police I he attempted multiple he at the OSG office and to be put through to talk to <i>ri</i> th Z3 (OSG On-Call ed that R3 was "not stable, and was off his point, R3 had been at the ly 10 minutes, when R3 of for the police station. ated she would call the nem know what needed to stated E5 (Transportation in up with R3 and give him a in. a.m., E5 (Transportation e facility on 12/16/16 on blice station. E5 stated he able to get R3 to agree to tion. E5 stated he took R3 e police station, and watch and left. n., E1 (Administrator) would be coming back to	F	309	

Facility ID: IL6008650

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			0.00				
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED		
			A. BUILDIN	IG	с		
		145928	B. WING				
	OVIDER OR SUPPLIER	140520		STREET ADDRESS, CITY, STATE, ZIP COD	02/01/2017		
	OVIDER OR SUPPLIER						
APERION	CARE JACKSONVILLE			1021 NORTH CHURCH STREET			
				JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE		
F 309	Continued From page	e 39	F 3	09			
		I can't answer the question					
		should have followed up					
		ment regarding (R3's)					
	• •	arrest. E1 stated she was					
		ckly R3 was released from					
	jail and they were not	prepared when R3 returned					
	to the facility.						
		o.m., Z1 (Medical Director)					
		ange in condition she would					
	•	but the facility does not					
	need an order to send						
		n, if needed. Z1 stated the					
	•	transfer of care to the rrect, because (R3) needed					
		ated she would expect the					
		p front, "is his medical care					
		e time of arrest." Z1 stated					
		oonsibility to ensure the					
		taken care ofand no one					
	clearly communicated	d up front what the real plan					
	for (R3) was. Z1 state						
		s medical record indicated					
		to the police and there was					
		delineation as to where R3					
		stated no one "clearly					
	(R3) was going to be	nt, what the real plan for					
		a.m., Z5 (Office of State					
		stated R3 "lacked the					
		make any decisions for					
		kactly why he was a ward of					
		the OSG provides the					
		cessary guidelines that are to					
		cated individuals, at the time					
		ted it is the expectation of					
		lity will follow through with					
		e facility, whether it is to the il or programming, to ensure					

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/14/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		145928	B. WING					C 101/2017
NAME OF P	ROVIDER OR SUPPLIER			(STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 309	 Z5 stated that the leg, by the OSG allows the and emergent medica from the Guardian. Z should have called for for R3 on 12/16/16, w facility, rather than try Z5 confirmed that R3' unknown. The Immediate Jeopa started on 12/15/16 w ordered antipsychotic Administrator was not Jeopardy at 1:40PM of The surveyor confirm record review that the action to remove the I The facility provide facility's Director of ND Director to all licensed nursing home regardi Office of State Guardi emergent medical car individuals, physician resident condition, be new/worsening behavitransfers. The Administrator reviewed facility Polic Behavior Managemer Change in Condition/I Overview Guidelines, New or Worsening Be Record Documentation The Administrator 	al documentation provided e facility to obtain routine al care without prior approval 25 concluded that the facility r emergency medical care when R3 returned to the ving to contact the Guardian. 's whereabouts are currently ardy was noted to have when R3 refused to take c medications. Facility tified of the Immediate on 01/31/17. ed through interview and e facility took the following Immediate Jeopardy: ed in-service training by the ursing and Social Service d and unlicensed staff at the ing the expectation of the ian regarding routine and re for adjudicated notification of change in shavior management for viors and status of resident	F	309				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED C		
		145928	B. WING) 01/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
APERION	CARE JACKSONVILLE				021 NORTH CHURCH STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 F 328 SS=D	The facility has identifi for SMI and what prog appropriate for those programs have yet to 4. Additionally, the D perform a Quality Ass residents weekly for the thereafter) to ensure of facility policies and the services are provided 483.25(b)(2)(f)(g)(5)(f FOR SPECIAL NEED (b)(2) Foot care. To en- proper treatment and and good foot health, (i) Provide foot care a with professional stant to prevent complication medical condition(s) a (ii) If necessary, assiss appointments with a carranging for transpor appointments (f) Colostomy, ureter The facility must ensu- require colostomy, ure services, receive such professional standard	 developed and is ongoing. ied which residents qualify gramming would be individuals; however, those be implemented. birector of Nursing will urance Audit of all OSG wo weeks (or as needed compliance with all reviewed at appropriate mental health . b)(i)(j) TREATMENT/CARE S nsure that residents receive care to maintain mobility the facility must: nd treatment, in accordance dards of practice, including ons from the resident's and t the resident in making qualified person, and tation to and from such pstomy, or ileostomy care. re that residents who eterostomy, or ileostomy care. re that residents who eterostomy, or ileostomy care. re that residents who eterostomy, or ileostomy care. 		309	DEFICIENCY)		
	(g)(5) A resident who	is fed by enteral means					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		145928	B. WING				C 101/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 328	receives the appropria to prevent complic including but not limit diarrhea, vomiting, de abnormalities, and na (h) Parenteral Fluids. administered consiste standards of practice physician orders, the person-centered care goals and preference (i) Respiratory care, in and tracheal suctionin that a resident who no including tracheostom suctioning, is provide professional standard comprehensive perso residents' goals and p this subpart. (j) Prostheses. The far resident who has a pr and assistance, consis standards of practice, person-centered care and preferences, to w prosthetic device. This REQUIREMENT by: Based on observatio review, the facility fail orders and failed to m levels for two (R7 and	ate treatment and services ations of enteral feeding ed to aspiration pneumonia, ehydration, metabolic isal-pharyngeal ulcers. Parenteral fluids must be ent with professional and in accordance with comprehensive plan, and the resident's s. ncluding tracheostomy care ng. The facility must ensure eeds respiratory care, ny care and tracheal d such care, consistent with ls of practice, the in-centered care plan, the preferences, and 483.65 of acility must ensure that a rosthesis is provided care istent with professional	F	328			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		145928	B. WING				C / 01/2017
	ROVIDER OR SUPPLIER		•	10	TREET ADDRESS, CITY, STATE, ZIP CODE 021 NORTH CHURCH STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 328	Nursing) stated it is fa is receiving oxygen the saturation levels) shoued 1. R7's current POS for January, 2017 doe of Chronic Obstructive Congestive Heart Dis R7's January POS doe oxygen "3 liters contine every shift related to pulmonary disease". R7's November MAR Record) documents F consistently from Nover 30, R7's SP02 was clitimes required. R7's December 2016	am, E2 (DON/Director of acility policy that if a resident herapy, SP02 (oxygen huld be monitored every shift. (Physician's Order Sheet) cuments R7 has diagnoses e Pulmonary Disease, hease and Lung Cancer. bouments R7 is to have nuously via nasal cannula chronic obstructive (Medication Administration R7's SP02 was checked rember 1 through November mber 7 through November necked only 18 of the 72 MAR documents R8's SP02 e 72 times required when	F	328	DEFICIENCY)		
	was not checked at a On 1-24-17 at 9:20 at wheelchair in room w liters per nasal cannu R7 was up in a wheel cannula on. R7's oxy back of R7's wheelch and not turned on. R7 her wheelchair since						

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		145928	B. WING				C / 01/2017			
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>				
				1	1021 NORTH CHURCH STREET					
APERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 328	times R7 is short of b On 1-26-17 at 11:50 a Practical Nurse) verifi at the wrong setting. R7 was up in the whe had not checked R7's nursing staff is respon oxygen tubing, setting flow. SP02 levels are and as needed on all therapy. R7's MDS (Minimum shows R7 has a BIMS Status) of 15 out of 19 On 1-26-17 at 8:50 ar up in R7's wheelchair had not adjusted any day. R7 could not rer administered R7's oxy to turn it on. 2. R8's current POS for January 2017 doc and has an order for nasal cannula as nee saturation level every R8's November 2016 Administration Record (oxygen saturation level November 5, 2016. F	reath. am, E10 (LPN/Licensed ied R7's oxygen was off and E10 stated the following: eelchair all morning and E10 s oxygen. The facility nsible for connecting R7's g the rate and turning on the e to be completed every shift residents requiring oxygen Data Set) dated 10-20-16 S (Brief Interview for Mental 5. m, R7 stated R7 had been since before breakfast and of her oxygen settings that member who had ygen that morning and failed (Physician's Order Sheet) uments R8 has Emphysema oxygen at 2-3 liters per ded, checking oxygen shift. MAR (Medication d) documents R8's SPO2 vel) was checked er 1, 2016 through From November 7 through R8's SP02's were completed	F	328						
	R8's December 2016	MAR documents R8's SP02								

Facility ID: IL6008650

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		145928	B. WING				01/2017
NAME OF PF	ROVIDER OR SUPPLIER		ł		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
APERION	CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 328 F 406 SS=E	R8's January 2017 M have any SP02 monit On 1-26-17 at 2:00 pr Coordinator) stated th orders on the comput computer update. E1 SP02 levels were not they should have bee On 2/01/17 at 3:30 p. stated SP02 levels at shift for residents with Obstructive Pulmonar receiving oxygen ther 483.65(a)(1)(2) PROV SPECIALIZED REHA (a) Provision of service rehabilitative services physical therapy, spe occupational therapy, rehabilitative services intellectual disability of intensity as set forth a in the resident's comp facility must- (1) Provide the require (2) In accordance with required services from	of the 93 times required. AR documents R8 did not oring until 1-25-17. m, E11 (Care Plan here was a mix up in how the er were put in along with a 1 stated that is why the completed every shift as n. m., E1 (Administrator) re to be monitored every in the diagnosis of Chronic ry Disease and who are apy. /IDE/OBTAIN B SERVICES ess. If specialized e such as but not limited to ech-language pathology, respiratory therapy, and for mental illness and or services of a lesser at §483.120(c), are required orehensive plan of care, the ed services; or in §483.70(g), obtain the in an outside resource that is		328	В		
	and is not excluded fr	ed rehabilitative services om participating in any a care programs pursuant to 6 of the Act.					

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2017 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		145928	B. WING		_		C 01/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
APERION	CARE JACKSONVILLE			021 NORTH CHURCH STI ACKSONVILLE, IL 620			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 406	by: Based on interview a failed to provide requi for 24 of 24 residents through R30), reviewe being SMI (Serious M 37. Findings include: On 1-25-17 at 10:00 a Director) confirmed th R5, R7, R8, and R10 determined were SMI do not have an SMI p comprehensive asses personnel, SMI individ psychiatric rehabilitati discharge planning ha the 24 SMI residents. 1. R10's current POS for January 2017 doc 12-15-16 and has a ir Recurrent Major Depr Anxiety. R10's PAS/MH (Pre-A Health) Level II Notice 12-16-16 states R10 i and needs special set Medication monitoring stabilization, instrume training/reinforcement Rehabilitation activitie Management and illne	is not met as evidenced and record review, the facility ired mental health services (R3, R5, R7, R8, and R10 ed identified by the facility as lental Illness), in a sample of am, E4 (Social Service here were 24 residents (R3, through R30) she had . E4 stated they presently rogram, therefore asments by qualified dualized treatment plans, ion services, and SMI ave not been completed for B (Physician's Order Sheet) uments R10 was admitted heluding Schizophrenia, ressive Disorder, and Admission Screen/Mental e of Determination dated is eligible for nursing facility rvices for the following: g, adjustment and/or ental activities of Daily Living t, Mental Health es, Aggression/Anger	F 406				

Facility ID: IL6008650

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		145928	B. WING				C /01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1	021 NORTH CHURCH STREET		
APERION	CARE JACKSONVILLE						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
TAG F 406	Continued From page of the above services 2. R11's POS for Jan was admitted 11-8-16 diagnoses of Bipolar I Hypertension. R11's Level II Summa Screening dated 7-2- nursing facility and ne following: Medication and/or stabilization, M activities, Aggression Incentive program to treatments, and Com activities. R11's record does no that any specialized S R11's Admission MDS 11-15-16 documents on the Brief Interview On 1-16-17 at 2:30 pr aware of any special offered by the facility programming activitie 3. R5's POS (Physicia 2017 documents R5 v	e 47 being offered. uary 2017 documents R11 from another facility with Disorder, Diabetes and ary Pre-Admission 15 states R11 is eligible for eed special services for the monitoring, adjustment dental Health Rehabilitation /Anger management, improve participation in munity re-integration t include any documentation SMI rehab is being offered. S (Minimum Data Set) dated R11 scores a 15 out of 15 for Mental Status screen. m, R11 stated he was not mental health services being nor had he attended any s. an Order Sheet) for January was admitted 10-12-16 and ing Schizoaffective Disorder,		406	DEFICIENCY)	ATE	
	R5's OBRA-Initial Scr Reconciliation Act) da there is a reasonable	een (Omnibus Budget ated 5-20-15 documents basis to suspect R5 has a ing a PAS needed to be					

Facility ID: IL6008650

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		145928	B. WING	3. WING		C 02/01/2017	
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1021 NORTH CHURCH STREET		
APERION	ON CARE JACKSONVILLE				JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490 SS=D	record nor is there an rehab being offered. 4. R8's POS docume 7-28-16 with diagnosi Disorder. R8's MDS (Minimum I shows R8 has a 15 or (Brief Interview for Me On 1-25-17 at 9:10 ar aware of any mental R at the facility. 5. R7's POS docume 11-29-15 with a diagn with Psychosis. R7's MDS dated 10-2 15 out of 15 score on for Mental Status). On 1-26-17 at 8:50 ar been offered any men or programming while 483.70 EFFECTIVE ADMINISTRATION/R 483.70 Administration A facility must be adm enables it to use its re efficiently to attain or	no PAS screen in R5's y evidence of specialized nts R8 was admitted s of Schizoaffective Data Set) dated 1-12-17 ut of 15 score on the BIMS ental Status). n, R8 stated she was not health programming offered nts R7 was admitted osis of Major Depression 6-16 documents R7 has a the BIMS (Brief Interview n, R7 stated she has not hal health services/classes e at the facility. ESIDENT WELL-BEING h. inistered in a manner that esources effectively and maintain the highest mental, and psychosocial		400	6		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		145928 B.				C 02/01/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
APERION	APERION CARE JACKSONVILLE				1021 NORTH CHURCH STREET JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 490	facility's Administratio 24 residents (R3) revi requirement for SMI (attained their highest and psychosocial wel failed to follow physic have a psychological agitation or physical a identify R3's need for change in mental con resulted in R3, who re medications, being ar behavior change and receiving psychiatric of police and is now mis Findings include: The facility policy, "CI Notification Overview document "These gui ensure that: 1. All sig status are thoroughly notification is based a to be documented in 1 Medical care problem attending physician in thorough manner. Nu nurse should not hesi physician at any time her judgement require intervention."	ew and interview, the n failed to ensure a one of iewed, who met the Serious Mental Illness) practicable level of mental I-being. Administrative staff ian's orders instructing R3 to evaluation in the event of aggression and failed to medical care after an acute dition. These failures efused to take antipsychotic rested on 12/15/16 after a taken to jail, instead of care. R3 was released by sing. nange in Condition Physician Guidelines (1/01/2014)," delines were developed to prificant changes in resident assessed and physician issessment findings and is the medical record. 2. Is are communicated to the a timely, concise, and urse Responsibilities - The tate to contact the attending for a problem which in his or es immediate medical	F	490				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 02/14/2017 M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
		145928	B. WING				C / 01/2017	
NAME OF P	ROVIDER OR SUPPLIER		I	STF	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
	CARE JACKSONVILLE			102	1 NORTH CHURCH STREET			
AI ERIOR				JA	CKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 490	and completely, inclu resident's current phy assessment, medicat is completely describ receiving facility upor "Discharge/Transfer of instructs staff when a physician's order to "d unable to reach atten concern for resident h discharge." A letter from the State Commission, dated 1 September 14, 2016 was appointed Perso for (R3), as guardian the well-being of the authorized to make fu concerning the ward's placement and perso further documents, "In emergency, the facilit Office of State Guard transportation, routine evaluation and treatm and general medical Office of State Guard routine emergency ro treatment, and for ho medical treatment for herein." A Progress Note, date was admitted with the sepsis, pneumonia, s possible (history) of a Traumatic Stress Dise dated 11/01/16, docu (Activities of Daily Liv	ding vital signs. Ensure that visical and psycho/social itions and current treatment ed and available to the in transfer." The of Resident" policy further resident is leaving without a contact Medical Director if ding physician and there is a nealth or welfare upon e Guardianship & Advocacy 1/01/16, documents "On the Office of State Guardian in Only Temporary Guardian this office is responsible for ward and is legally undamental decisions is health, medical treatment, nal well-being." The letter in the event of an ty staffis authorized by the ian to arrange for e emergency room nent, and for hospitalization treatment for (R3). The ian hereby consents to	F	490				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039	
AND PLAN OF CORRECTION					· · · ·	COMPLETED	
						С	
		145928	B. WING	·	02/01/2017		
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	E		
				1021 NORTH CHURCH STREET			
APERION	CARE JACKSONVILLE			JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 490	illness, Schizophrenia and paranoia, impaire to) impaired decision disorganized thinking medications for behave resident needs super times with all decision The Electronic Medic documents that R3 we anti-psychotic medicat (milligrams), nightly a refuse to take the Set Notes, dated 12/01/10 visual hallucinations of holes in the wall, and contacted. A Physician's Order of "(Z4 - Nurse Practition refusal to take Seroop evening. (Z4) notified thoughts and verbal a continue to encourag medication and if resi aggressive to send re (psychiatric) evaluatio On 1/24/17 at 2:10 p. stated she was working	a manifested by delusions ed thought process (related making, displays , uses Psychotropic vior management and "the vision and assistance at n making." ation Administration Record, as to receive the ation, Seroquel 300 mg ind started to consistently roquel on 11/20/16. Nursing 6, document R3 was having of snakes coming out of the physician was lated 12/01/16 documents, ner) notified of resident uel multiple times in the d of delusional and scattered accusations. (Z4) orders to e resident to take ident becomes agitated or esident for a psych	F 49				
	indicated this was the any aggression, since According to E1, the that is the facility's pro- resident to resident a arrested when R5 sta	Nursing Assistant). E1 e first time R3 had displayed e his admission on 11/01/16. police were contacted, as actice when there is a ltercation. E1 stated R3 was ited he waned to press and R3 was taken directly to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2017 APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145928	B. WING		_	(02/) 01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
APERION	CARE JACKSONVILLE			1021 NORTH CHURCH STF JACKSONVILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	she has never had a facility before and did protocols/policies to g this situation. E1 stat the responsibility of th adjudicated and had in A Progress Note by E the 12/15/16 incident, "(R3) became upset w was attempting to use pushed (R5) after word (E6) attempted to red Certified Nursing Assi were notified. Guardi arrest (R3) for battery medical care, is refus (R5) did want to press On 1/30/17 at 1:30 p. stated she was prese evening of 12/15/16 a police officer that R3 need to be met overn explained to the polici his Seroquel and that due to poor mental he discuss with the polici for a psychiatric evalu aggressive. A Social Service Note arrested, dated 12/16 did return to facility(Licensed Practical Nu resident this afternoor released on his own r unaware resident was	aluation to the police /17 at 1:40 p.m., E1 stated resident arrested from a not have any written yuide staff on what to do in ed R3 was still considered he facility, since R3 was not been discharged. (1 (Administrator) following at 10:39 p.m., documents when another resident (R5) e adjoining bathroom. (R3) rds were exchanged. CNA irect, (R3) slapped (E6 - stant) in the face. Police an (Z2) notified. Police did r due to he does not require ing to take medication and s charges." m., E2 (Director of Nursing) nt in the building on the and informed the arresting had "no medical needs that ight." E2 stated she e that R3 had been refusing R3 had a State Guardian, ealth; however, she did not e that R3 had current order lation, if he became	F 490				

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DATE SURVEY COMPLETED			(VO) M	(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT O
	CO,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			CORRECTION	
С			1			
02/01/2017	c	B	B. WING	145928		
	EET ADDRESS, CITY, STATE, ZIP CODE	STRE			ROVIDER OR SUPPLIER	NAME OF PF
	1 NORTH CHURCH STREET	1021				
	CKSONVILLE, IL 62650	JAC			CARE JACKSONVILLE	APERION
(X5) COMPLETIO DATE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	FIX	IE PRE TA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(EACH DEFICIENC	(X4) ID PREFIX TAG
		490	F	e 53	Continued From page	F 490
				ted heonly wanted his	facility. Resident stat	
				t was educated on risks of		
				ned AMA paper. Resident		
				building and began walking	stated he planned on	
				n. (E4) contacted police		
				f situation and request they		
					assist resident."	
				.m., E4 (Social Service	On 1/25/17 at 2:52 p.	
				eturned to the facility from	-	
				approximately 1:00 p.m. on	· ·	
				R3 refused to come all the		
				ed R3 communicated better	way inside the buildin	
					through writing, so sh	
				al Discharge form so R3		
				risks of leaving the facility.		
				nd signed the AMA: Release	E4 stated R3 read an	
					From Medical Discha	
				ne facility on foot. According		
				vas walking to the police		
				them R3 was on his way to	department. E4 calle	
				ed Z1 (Medical Director) that		
				A at 1:55 p.m. On 1/30/17 at		
				they attempted to reach the	-	
				nat R3 needed medical	OSG to notify them th	
				eaving the facility, but did not		
				for medical transport to a		
				t. E4 stated she was familiar		
				entation provided by the		
				-	-	
				reatment for R3, but did not		
					act on those instruction	
				r approximately 4 days after		
				d told them that R3 was	-	
				d a missing person at that		
				Advocacy Commission s authorization to obtain reatment for R3, but did not ons. E4 stated Z2 approximately 4 days after d told them that R3 was	State Guardianship & regarding the facility's emergency medical tr act on those instructio (Guardian) called her R3 left the facility and technically considered	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/14/2017 M APPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145928	B. WING				C / 01/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		0 11 20 11
APERION CARE JACKSONVILLE					1021 NORTH CHURCH STREET		
					JACKSONVILLE, IL 62650		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	On 1/25/17 at 12:45 p stated the facility had send R3 out for a psy became violent/aggre that order. Z1 conclu technically does not r resident out for a psy would have been war stated the facility "sav	b.m., Z1 (Medical Director) an order on 12/01/16 to vchiatric evaluation if he essive, but failed to act on ided that the facility need an order to send a chiatric evaluation, which rranted in this situation. Z1 w this as a transfer of care to ncorrect, because (R3)	F	490			

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