

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/02/2019
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NAME OF PROVIDER OR SUPPLIER APERION CARE BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701
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S 000	Initial Comments Complaint 1962040/IL110586 F689J	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/17/19
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S9999	<p>Continued From page 1</p> <p>that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to respond to an exit exterior door alarm. As a result, R1, assessed as having poor safety awareness and being severely cognitively impaired, exited through an alarmed door, leaving the facility and grounds (alone and undetected) to a residential property located approximately one eighth mile away. R1 is one of three residents reviewed for supervision and elopement in the sample of three. This failure resulted in R1 leaving the facility undetected at night, being subjected to cold outdoor conditions, and finally being returned from the hospital, hours later by family.</p> <p>Findings include:</p> <p>The facility Face Sheet (current) documents R1 being admitted to the facility from a sister facility on 3/21/19 (same day as elopement) and includes the following diagnoses: Anoxic Brain Damage, Convulsions, Anxiety and Alcoholic Cirrhosis of Liver with Ascites. There is no Care Plan or Minimum Data Set at this time.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>A facility Incident Report undated for R1 documents an Elopement on 3/21/19 as follows: "(R1) missing by staff around 7:15 pm. (R1) had been sleeping in bed. Staff initiated Code Pink within the facility. Unable to locate (R1) in facility, staff canvassed outside grounds. Received call from Fire Department stating they found resident and will transport to (hospital) per protocol." This incident report was not available until 3/26/19.</p> <p>R1's Progress Notes dated 3/21/19 at 6:30 pm document R1 is resting quietly in bed and at 6:50 pm R1 is documented as missing. R1's Progress Notes also dated 3/21/19 documents R1 returning to the facility at 9:50 pm from the hospital with family. The Progress Notes are electronically signed by V3, Registered Nurse (RN).</p> <p>R1's Hospital Records dated 3/21/19 at 8:09 pm, document the following: "Patient (R1) is a 49 year old female with history of cirrhosis, HTN (Hypertension), and dementia presenting to ER (Emergency Room) via EMS (Emergency Response System) after (R1) was found wandering around the streets. Per report, (R1) lives at a nursing home (facility) and somehow got out. The police were called and (R1) was brought to ER. (R1's) only complaint is that (R1's) feet hurt because they were cold while walking around in stockings. Pulse 118, Blood Pressure 143/94 and temperature 98.6."</p> <p>A facility assessment for R1, titled "Elopement Risk Assessment" dated 3/21/19 at 11:50 pm documents R1 with a history of elopement prior to the current admission on 3/21/19. This same assessment documents R1 is at risk to elope and should be placed on the elopement risk protocol and a care plan for elopement is indicated.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>R1's Fall Risk Assessment dated 3/22/19 documents R1 as being a fall risk.</p> <p>A facility report titled "Behavior Safety Checks (every) 15 min's (minutes)" dated 3/22/19 was provided on 3/22/19 at 12:30 pm by V2, Director of Nursing. This report documents 15 minute checks starting on 3/22/19 at 9:49 am through 10:02 am, then beginning again at 12:22 pm. V2 stated "these are the 15 minute checks that I have at this time." V2 acknowledged there is no documentation prior to 3/22/19 for 15 minute checks.</p> <p>On 3/22/19 at 1:30 pm, R1 was reclining in a geriatric chair at the nurse's desk. R1 was alert but non-communicative and unable to answer questions.</p> <p>On 3/22/19 at 2:00 pm, V2 stated R1's safety awareness is poor and R1 is not safe to navigate independently outside the facility. V2 acknowledged that R1 is severely cognitively impaired.</p> <p>On 3/22/19 at 2:05 pm, V12 Regional Director stated the facility did not have a policy on monitoring the door alarms and was not aware of what "the elopement risk protocol" is referring to per R1's Elopement Risk Assessment dated 3/21/19 (as above). V12 stated expectations are that staff would go to the alarm panel at the nurse's desk and check which door is alarming and respond accordingly by checking that door. V12 also stated the facility did not have an overhead announcing system. V1, Administrator also present at this time, confirmed the above statement made by V12.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>On 3/22/19 at 2:10 pm, V3 RN (Registered Nurse) stated the documentation in R1's chart on 3/21/19 was based on estimated times and was unsure what the actual times were when R1 was last seen and noticed as missing on 3/21/19. V3 stated V3 did not remember the alarm going off on 200 exit door and denies turning the alarm off and resetting it. V3 stated "the alarm goes off every time the smokers (residents who smoke) go out to smoke on 400 hall. V3 stated "the residents have a smoke break at 7:00 pm and the alarm constantly rings during this time." V3 stated V3 has reported to V1 about the alarm continually ringing during resident smoke breaks and the potential hazard. V3 stated V1 was notified of R1's elopement and V3 was instructed to place R1 on 15 minute checks. V3 acknowledged the 15 minute checks had not been documented when R1 returned and V3 had not completed an Incident Report on R1's elopement from the facility.</p> <p>On 3/22/19, the facility alarm panel is located centrally at the nursing station which faces the 200 hall. The alarm is a visual and audible system. The alarm panel is labeled with the facility exterior exit door numbers and each door is alarmed separately. The panel will light indicating which door alarm has been activated.</p> <p>On 3/22/19 at 2:25 pm, the alarm sounded for the exterior emergency exit door on 200 hall at the above panel. There is no differentiating alarm sound for the doors. R1's room is located at the end of the 200 hall next to the emergency exterior exit door. The alarm is manually turned off and reset by staff, only at the panel located at the nurse's station.</p> <p>On 3/22/19 at 3:40 pm, V1 stated "staff probably</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>heard the alarm and thought it was the smokers going out to smoke and just ignored it." V1 acknowledged staff are to respond to all alarms by going to the alarm panel at the nurses station to identify which door is alarming. V1 stated once the alarming door is identified, staff should respond by checking outside that exit door for any resident that might have exited the facility.</p> <p>On 3/22/19 at 2:45 pm, V5 Son/Healthcare Power of Attorney of R1 stated V5 arrived at the facility at 7:20 pm and went to R1's room and R1 was not there. V5 stated V5 spoke to V3 and asked where V5's mother (R1) was. V5 stated it was at this time as V5 recalls that V3 stated they were going to look outside for R1. V5 was unsure of what time the search started inside the facility but felt the facility didn't even know she was missing until V5 arrived. V5 stated R1 was found down the street at someone's house and 911 was called and R1 was taken to the hospital. V5 stated R1 did not have a coat or shoes on. V5 stated V5 recalled telling the facility that R1 did have a history of leaving the previous facility R1 had resided in. V5 also stated the facility was aware that R1 could walk.</p> <p>On 3/26/19 at 10:55 am V4, Paramedic/First Responder stated on 3/21/19, R1 was located at a residential house (approximately one eighth of a mile from the facility) on a street that has a very high traffic volume and a nearby bridge going over railroad tracks. V4 stated the homeowners called 911 at approximately 7:19 pm after R1 walked into their home acting very confused. V4 stated R1 did not have any shoes or coat on when V4 arrived on the scene. V4 stated R1 was very confused and V4 assumed R1 was probably from the facility. V4 stated R1 was taken to the local emergency room per protocol and the facility</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>was informed.</p> <p>On 3/26/19 at 11:15 am, the facility's 200 exterior exit door leads to a grassy area and is located around the side of the building from the front entrance. When exiting the 200 exterior exit door, it is necessary to ambulate around the building in the grassy area to reach an egress to the sidewalk. These sidewalks are uneven and end in gravel. On the opposite side of the facility the sidewalks are uneven and continue around the corner to the high traffic volume street where R1 was located on 3/21/19.</p> <p>On 3/26/19 at 1:50 pm, V7 Certified Nursing Assistant stated V7 was on duty 3/21/19 and was assigned to the 200 hall and helped R1 lay down, but does not recall the time. V7 stated R1 was seen earlier walking with assistance and when V7 went back to check and change R1, R1 was not in R1's room. V7 stated V7 began looking for R1 in the bathroom and then in other rooms on 200 hall. V7 stated V3, (RN) was then notified that R1 was not on 200 hall and they began to look on other halls (100, 300 and 400). V7 stated V7 does not recall the alarm going off on the 200 emergency exit door and denies turning the alarm off at the nursing station.</p> <p>A statement dated 3/22/19 by V6, Certified Nursing Assistant (CNA) and assigned to 200 hall on the evening of 3/21/19, documents that around 7:30 pm, V6 was "bringing in the smokers" (residents who smoke) and was told by V7 that R1 was missing. V6 documents that a search was started in every room and closet. V6 went outside and walked around the building. V6 documents that another staff member (V8 CNA) reported to V6 that V8 saw R1 in a police car as they were driving by. V6 documents that this is</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>when the fire department called and talked with V3 RN. Then the police came and talked with V3 (end of statement).</p> <p>On 3/26/19 at 3:30 pm, the facility video monitoring system was reviewed with V1. The video camera captures R1 dressed in pants and a shirt exiting the facility's 200 emergency exit door unattended at 7:06 pm on 3/21/19. The video captures V7 coming out of a room and looking toward the 200 hall and up toward the nurse's desk at approximately 7:14 pm (8 minutes after the 200 door was opened). V7 then goes back into the same room. At approximately 7:15 pm V7 goes to R1's room. V7 exits R1's room and starts going from room to room and passes the nurse (V3) who is standing at a medication cart. V7 continues to go from room to room and repeats the process until V7 again comes to V3 in the hall at approximately 7:20 pm and converses with V3. Then V7 and V3, both go in and out of rooms. At this time R1's son (V5) enters the hallway and V3 is speaking to V5. It is 7:30 pm (24 minutes after R1 has exited the facility) before V7 and V3 leave the hall, moving toward the nursing station. V3 and V7 do not go out the 200 door to check for R1 during this time review of the video.</p> <p>On 3/27/19 a facility binder titled "Elopement Risk Residents" dated 3/25/19, identifies eight residents being at risk for elopement. R1 is not documented among the eight pictured residents in the above binder.</p> <p>A web-based weather history application for the nearest reporting station documents the temperature in the area on 03/21/19 at 6:56 as being 41 degrees Fahrenheit, winds at 13 miles per hour, and relative humidity at 73%.</p>	S9999		
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