STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002646	A. BUILDING: _____ B. WING _____	C 11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MOLINE	430 SOUTH 30TH AVENUE EAST MOLINE, IL 61244

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint # 1726405/IL97815 # 1726437/IL97863	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 300.1010h) 300.1210b) 300.1220b)3 300.2900d)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** **Statement of Licensure Violations**	

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of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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S9999	Continued From page 2 Section 300.2900 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify interventions for a resident that was high risk for elopement and failed to have a system for ensuring door alarms are working correctly during the evening and at night. As a result of this failure R1 eloped from the facility. This also had the potential to affect R3, R4, R5, and R6. Findings include: The facility's Door Alarms policy, no date available, documents, "A safe environment for the the residents and staff will be provided to assure	S9999		

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resident, staff and visitors safety. This will be accomplished by: Setting door alarms at all times; Re-setting door alarms immediately after use."

R1's Electronic Record documents that R1 was admitted to the facility on 10/25/17, and that R1 has the diagnoses of Metabolic Encephalopathy, Central Pontine Myelinolysis, Degenerative disease of the nervous system, and disorientation.

R1's Nurse's note, dated 10/25/17 at 5:39 p.m., document that R1 was restless, agitated, and hard to redirect. The Nurse's note also documents, "(R1) up pacing hall and attempted to exit C hall door two times."

R1's Admission Observation, dated 10/25/17, documents that R1 is oriented to person only, R1 wanders daily, and R1 has behaviors of displaying anger, verbally aggressive, and resistive to cares.

R1's Elopement Assessment, dated 10/25/17, documents that R1 scored a 15 determining that R1 was at risk to elope and should be placed on the Elopement Risk Protocol." The assessment also documents that R1 is physically able to leave the facility, that R1 has signs of compromised decisional capacity and substantially impaired judgement and/or physical status limitations that would place R1 at risk in the community, and that R1 becomes agitated, confused and/or disoriented or displays consistently poor judgement (i.e. would not be able to safely care for himself outside of the facility.

R1's Nurse's notes, dated 10/25/17 at 8:30 p.m., document, "Elopement assessment complete and resident scored high. Therefore, a wander guard

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was placed on the resident for safety."

R1's Brief Interview for Mental status, dated 10/26/17, documents that R1 has a score of eight determining that R1's cognition is moderately impaired.

R1's Electronic record has no documentation of an initial care plan put in place regarding R1's risk for elopement.

On 10/30/17 at 11:05 a.m., E8 (Licensed Practical Nurse) stated, "None of the door alarms went off. (R1) ended up going out D hall exit, and it has two alarms and neither of them went off. If they were going off you would be able to hear them anywhere. I don't know what time we figured out he was missing, but from the video surveillance we found out he left around 5:35 a.m. I would say around 5:15-5:20 a.m., he was sitting in the dining room drinking a soda." E8 also stated, "I saw (R1) up and walking around non stop the whole time I was here (during third shift). He was trying to get out the doors. He opened C-Hall door but never got out the door."

On 10/30/17 at 1:30 p.m., E9 (Registered Nurse) stated, "I called the Code Pink (missing resident) at 6:30 a.m. There were no door alarms going off when they found out (R1) was missing."

On 10/30/17 at 3:45 p.m.,. E6 (Certified Nursing Assistant) stated, "(R1) was wandering throughout the night (during third shift) and trying to go out the doors. No alarms were going off on the D-hall at the time the facility is saying (R1) left."

On 11/1/17 at 5:35 a.m., E5 (Licensed Practical Nurse) stated, "(R1) kept wanting to get out that

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night (during third shift). He was trying all the exits. That night he was wearing a T-shirt and shorts. I did not hear any alarms that's why I said he had to be in the building somewhere."

On 11/1/17 at 6:45 a.m., E4 (Certified Nursing Assistant) stated, "I did not hear any door alarms going off (10/26/16), and believe me they are loud."

On 11/1/17 at 9:45 a.m., E10 (Certified Nursing Assistant) stated, "Early in the night (during third shift), (R1) was very confused on why he was in the facility, and then he started getting more and more anxious about an appointment he had in the morning. He was worried he was going to miss it so he was up and down frequently. He attempted to go out the C-Hall exit a couple of times. I took him to the dining room to watch the television. He would still get up and he was walking around on his own real quickly like he was trying to do something. Sometime between 5:30 and 6:00 a.m. he was still sitting in the dining room. Then when I gave report after 6:00 a.m. I realized he wasn't sitting in the same spot. So I went and checked his room. (R1) wasn't there. So I told the nurse and she called Code Pink. Then everyone started looking for (R1). He ambulates independently. No door alarms were going off when he left. (R1) was wearing a T-shirt, shorts, and socks (no shoes) the last time I saw him."

On 11/1/17 at 2:30 p.m., E12 (Certified Nursing Assistant) stated, "He was really anxious that night (during second shift) rushing around confused. He was confused not knowing where he was. He requires supervision at times for his safety, but the rest of the time he is independent. He is not safe to make decisions on his own. That is why we have to supervise him because he

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doesn't make safe choices."

On 11/1/17 at 2:50 p.m., E9 (Registered Nurse) stated that R1 had poor cognition, he was confused, and not able to make safe decisions on his own.

On 11/2/17 at 9:40 a.m., E3 (Assistant Director of Nursing) confirmed that an initial care plan was not put into place when R1 was identified as being an elopement risk.

On 10/30/17 at 1:45 p.m., Z3 (Police Station Records Clerk) stated, "The facility called the police department at 7:27 a.m. and reported a missing person. At 6:25 a.m. the police department responded to a welfare check. The caller (Z4 Citizen) said he picked (R1) up. (R1) told (Z4) that he wanted a ride home. When (Z4) headed towards the highway, (R1) got extremely confused, and asked (Z4) to be let him out. So (Z4) let him out and called the police."

On 10/31/17 at 11:20 a.m., Z2 (Police Officer) stated, "(Z4 Citizen) dropped (R1) off at a retail store then called us. We picked (R1) up walking towards the highway. (Z4) picked up (R1) approximately one mile from the facility. (R1) was only wearing gym shorts, a T-shirt, and socks with no shoes. His indwelling urinary catheter was disconnected and he had urine all over him. He was freezing cold. It was 38 degrees Fahrenheit that morning. (R1) was so cold I put him in my police car and drove him to the fire department. They took him to the hospital. (R1) was confused the whole time." The location that Z2 picked R1 up from was a highly trafficked 35 mph road directly off of a four lane 45 mph highly trafficked road.

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On 11/1/17 at 2:15 p.m., Z4 (citizen) stated, "(R1) waved me down at an intersection behind a local elementary school. When he got in the car with me he was confused and having troubles talking. He told me he was cold. He was only wearing a T-shirt, shorts, and no shoes. He smelled like urine also. I did get out of him that he was needing a ride home. We drove around looking for his house for about 20 minutes. He continued to be confused and got anxious about the situation. I offered to take him to the police station, and he told me to just let him out. That is when I took him to the retail store. I dropped him off and called the police. I left before the police arrived." The location that Z4 picked R1 up in was a 20 mph school zone neighbor hood area. In order for R1 to get to this location, R1 would have crossed the high trafficked 30 mph road directly in front of the facility.

R1's Emergency Room Physician notes, dated 10/26/17 at 7:41 a.m., document, "(R1) was found wandering the streets this morning by the police department after 'escaping' from a nursing facility. (R1) is slurring words, does not respond appropriately to questions, and unable to provide a reliable history." The Physician's notes also documents in the physical examination that R1 had a low temperature of 97.5 degrees Fahrenheit, and that R1 was disoriented to time and place.

A facility investigation, no date available, documents, "E1 (Administrator) received notification from E2 (Director of Nursing) on 10/26/17 at approximately 6:50 a.m. that R1 was missing and that a Code Pink (missing resident) had been been initiated at the facility." The investigation also documents, "Upon notification of the local police department we were informed

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that R1 had been picked up by the police and that he was being transported to the hospital." The investigation also documents, "A facility wide inspection was conducted of all exit doors and alarms. Upon inspection it was discovered that D-wing door did not alarm properly."

On 10/30/17 at 9:45 a.m., Z1 (R1's Brother) stated, "(R1) doesn't have his mind. He is not able to make his own decisions. He was up and down constantly not knowing where he was, and the facility knew they needed to watch him."

On 11/2/17 at 10:45 a.m., Z5 (R1's Brother) stated, "When I picked (R1) up from the hospital that morning (10/26/17) he was very upset and confused. He is not conscious enough to make safe decisions obviously it was 38 degrees Fahrenheit that day and he walked outside in a T-shirt, shorts, and no shoes. That shows he can't make safe decisions for himself."

On 11/1/17 at 10:10 a.m., E1 stated, "I called the police to report a missing person, and they told me they currently had (R1) in the ambulance. I didn't follow up with the police. I'm not sure where he got picked up at." E1 also stated, "When we screened (R1) a few weeks before coming to the facility we noticed they had a one on one with (R1) and he was agitated about being in the hospital." E1 stated, "(10/26/17) he exited from the D-hall exit door. The door alarm is supposed to continually alarm until it's reset, but the alarm did not do that. If the door alarm had been working properly this could have alerted staff sooner that (R1) was gone, and they could have caught him before leaving the grounds. (R1) could only have gone to the left out the D-wing exit door because to the right is blocked off. The fence goes for a little ways then it opens to the

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woods. He could have gone into the woods, but if he went into the woods he would have gotten hurt. Video surveillance showed that R1 left the building at 5:37 a.m."

On 11/1/17 at 12:40 p.m., E11 (Medical Director) stated, "The facility's doors and alarms should be functioning properly to protect the residents and prevent this from happening."

On 10/30/17 at 11:35 a.m., E7 (Maintenance Director) tested the administrative wing exit door alarm by opening the door. The door alarm was not functioning correctly. E7 attempted the door alarm eleven times, and three out of the eleven times the door chirped softly one time and then stopped without being reset with a code. E7 confirmed the alarm was not working correctly. At this time, E7 verified that the only door alarm in the facility that the wanderguards would set off an alarm is the front entrance/exit. On 11/1/17 at 10:10 a.m., E1 verified that R3, R4, R5, and R6 have access to the administrative wing hallway exit, and they independently ambulate.

On 10/30/17 E1 provided a list of residents who were elopement risks. The list included R3, R4, R5, and R6.

On 11/1/17 at 10:45 a.m., in the presence of E7, the D-hall exit door opens up to a chain link fence with a wooded drop off ravine on the other side of it. If a person turns left out the door the chain link fence lasts approximately 45 feet before its broken down and opens up to the wooden ravine area. The wooden ravine area is approximately 245 feet long with the last 145 feet of the wooded drop off containing large cement blocks and large downed trees. Continuing around the facility, the facility property has about 240 feet of neighboring

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fencing. After the fencing ends it is about 300 feet to the highly trafficked road with a 30 mph speed limit and multiple cars were passing continuously. (A)
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300.1230k)

Section 300.1230 Direct Care Staffing

k) Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. (Section 3-202.05(e) of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to meet the minimum required Registered Nurse hours for two of four selected days. This has the potential to affect all 93 residents in the facility.

Findings include:

The facility's Direct Care Staffing policy, documents, "Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be

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S9999	Continued From page 11 used to satisfy the remaining 75% of the nursing and personal care time requirements." On 11/6/17 E2 (Director of Nursing), provided and verified nursing schedules for 10/17/17-10/31/17, which document the actual hours scheduled worked by Registered Nurses, and Licensed Practical Nurses. On 11/16/17 E1 (Administrator) provided a list from 10/21-11/5/17 documenting the census for each day and the number of residents requiring either skilled or intermediate care for each day. Based on the average number of skilled and intermediate care residents residing in the facility on 10/22/17 and 10/29/17 the facility should have had the following: 10/22/17: 230.3 hours of Direct Care Staff and 23.03 hours of Registered Nurses; 10/29/17 242.9 hours of Direct Care Staff and 24.29 hours of Registered Nurses. The nursing schedules, dated 10/17/17-10/31/17, document that on 10/22/17 there was 16 hours of Registered nurse hours, and on 10/29/17 there was 8 hours of Registered Nurse hours. On 11/6/17 at 10:25 a.m., E2 stated that on 10/22/17 there were only two Registered nurses scheduled for a total of 16 hours, and that on 10/29/17 E2 was the only Registered Nurse working the floor for a total of eight hours. The facility data sheet, dated 10/30/17 and signed by E1 (Administrator), documents that 93 residents reside in the facility. (B)	S9999		