STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: ______ B. WING ______	C 03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Final Observations	S9999		

Statement of Licensure Violation:
1 of 1 Violation

300.610a)
300.1210b)
300.1210d)3)
300.1220b)8)
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 300.1210 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

Attachment A
Statement of Licensure Violations

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	IL6002489	A. BUILDING: ______ B. WING ______	C 03/07/2018

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S9999	Continued From page 1	S9999		

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1220 Supervision of Nursing Services

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

8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried

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	IL6002489	A. BUILDING: ____ B. WING ____	C 03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Continued From page 2	S9999		

out.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure appropriately trained competent staff performed reinsertion of gastrostomy tube for 1 of 1 resident (R2) reviewed for gastrostomy tube reinsertion in the sample of 9.
This failure resulted in R2 sustaining a bowel obstruction and perforation secondary to insertion of urinary catheter for gastrostomy tube.

Findings Include:

R2's Electronic Health Record (EHR), dated 1/30/18, documents in part, "Enteral Feeding, Jevity 1.5 milliliters (ml) per hour," via Percutaneous Endoscopic Gastrostomy (PEG) tube, continuous 6:00 PM through 6:00 AM.

R2's Electronic Nurses Notes, dated 1/28/18 at 6:30 PM by V9, Licensed Practical Nurse (LPN), documents in part, "Narrative: CNA (Certified Nurses Assistant) reported to nurse that resident (R2) PEG/g-tube(gastrostomy) came out of

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	IL6002489	A. BUILDING: ______ B. WING ______	C 03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Continued From page 3	S9999		

resident's abdomen. NP (Nurse Practitioner) and DON (Director of Nursing) aware of tube coming out. (Urinary catheter) [20FR{french} 20 cc] inserted. New ordered received per (NP) to hold flushes and feedings until appropriate tube is re-inserted and position verified. Will address tomorrow in AM. POA (Power of Attorney) aware."

On 2/16/18 at 2:20 PM, V15, LPN, stated he hadn't received any specific training for peg/g tubes, "not for a long time." V15 denies ever being inserviced on peg/g tubes.

On 2/16/18, V25, Certified Nursing Assistant (CNA), stated she and V26, CNA, were on the unit when R2's peg/g tube became dislodged. V25 stated she and V26 were getting ready to transfer R2 from the wheelchair to his bed using the full mechanical lift. She stated he had a t-shirt on and she went to remove the t-shirt off from his back and V26 was removing the t-shirt from the front. She stated as V26 was pulling the t-shirt up from his abdomen, his g/peg tube "popped" out of his stomach. V25 stated there was some blood near the insertion site, so she put a towel over it, and she was panicked and went to immediately inform V9, LPN, and he came to assess R2. V25 further stated while R2 was on a feeding tube, the CNAs would assist R2 in the dining room with eating.

On 3/1/18 at 4:10 PM, V26, CNA, stated she was working on the day that R2's peg/g-tube became dislodged and came out. She stated she believed when his t-shirt was removed the peg/g-tube came out. She further stated the g-tube was not secured and was "hanging loose." V26 further stated she had seen R2 "tug at it (peg tube)." She stated she and another CNA

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S9999	Continued From page 4	S9999		

informed V9, LPN, at the time the tube was dislodged.

On 2/16/18 at 2:40 PM, V9, LPN, stated on 1/28/18 at about 6:00 PM, V25 and V26, CNAs, came to let him know about R2's peg/g tube was out. He stated he got a hold of V14, Nurse Practitioner, and was given an order to put in a (urinary catheter) in place of R2's peg/g tube. He stated he wasn't sure of the (urinary catheter) size he put in, and stated he had put in (urinary catheter for G tube) into other residents in previous employment. He stated he has been employed at the facility for about 1 1/2 years, and denies ever having any training at the facility on peg/g tube placement or enteral feedings. V9 stated he only checked for placement at first, and has not had any one-on-one training on any peg/g tubes here at the facility. V9 denied R2 being sent for an x-ray to check for placement after inserting the (urinary catheter). V9 further stated he didn't go back to check the (urinary catheter) for patency because "(R2) was doing fine and eating by mouth." V9 further stated R2 had no complaints of pain, and that the facility has a "BM (bowel movement) protocol." V9 couldn't recall if R2 had any bowel movements during his shift.

On 2/16/18 at 1:00 PM, V15, LPN, stated on 1/29/18 when she came to work, she was told R2's peg/g tube had came out and because R2 was eating and everything was fine, the facility was trying to get him sent out to get a g-tube placement. She stated R2 was eating by mouth, and she would crush his pills and he would take them by mouth. She further stated R2 was on thickened fluids. V15 stated she called the hospital to see when R2 could get a g-tube placement scheduled, and she was told R2 had to go to the hospital where his initial peg/g tube

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Continued From page 5	S9999		

was placed. V15 stated she has not had any training on replacing a peg/g tube with a (urinary catheter) nor any training on enteral feedings.

On 2/16/18 at 12:35 PM, V14, Nurse Practitioner (NP), stated he re-called the date R2's g-tube became dislodged. He stated he received a call from V9, LPN, and he discussed with V9 prior to V9 placing the (urinary catheter) into R2's stomach to keep the site patent, if V9 was comfortable placing the (urinary catheter). V14 stated V9 told him he was comfortable doing the procedure.

On 3/1/18 at 4:22 PM, V14, NP, stated he would expect V9 to have been trained by the facility prior to putting the catheter in R2 when the g-tube came dislodged.

On 2/16/18 at 1:40 PM, V7, LPN, stated she has only been employed at the facility for about 3 weeks, and part of her orientation has not included peg/g tube training and/or enteral training. V7 further stated she would not insert any catheter or g-tube should a g-tube become dislodged, because she hasn't been trained to do it.

On 2/16/18 at 12:30 PM, V10, LPN, stated she doesn't recall any training on g-tube replacement, but did have tracheostomy training just day prior. She stated she wouldn't replace any g-tubes of any kind because she has "been told that for a long time. Why we have to send out (R1- another resident)," when any thing happens to her g-tube.

On 2/16/18 at 10:15 AM, V6, LPN, stated it has been a long time since she has had to replace a g-tube (with a urinary catheter) when one is dislodged, and admits to that being many years

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	IL6002489	A. BUILDING: ____ B. WING ____	C 03/07/2018

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APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Continued From page 6	S9999		

ago. V6 further stated she would send any resident that had their feeding tube come out to the hospital for replacement.

On 2/16/18 at 2:35 PM, V5, Assistant Administrator, stated the facility has not done training with regard to enteral feedings and/or placing (urinary catheter) to keep a peg/g tube site patent. V5 further also stated the facility hasn't had any training in 2017 nor up to present date. V5 further stated the nurses were currently being trained as becoming aware of the lack of training on this date.

Training Schedule, dated 2017 provided by the facility, does not list any training and/or inservicing for PEG/G-Tube, including placement for nurses. The facility failed to provide documentation of training for 2018 up to and including date of entrance on 2/16/18. The facility also failed to provide documentation of PEG/G-Tube training for V9, Licensed Practical Nurse (LPN).

The Facility's undated Gastrostomy or Jejunostomy Feedings policy and procedure documents in part, "*Gastrostomy tube can pass through the pyloric sphincter into the small bowel. In addition, you may draw 10-20 cc of air into the syringe. Using stethoscope over mid-gastric region inject air and listen for 'whooshing' sound."

The Facility's undated Tube Feeding - Infusion Pump Method (Closed Container System) policy documents in part, 8. "Checking for Tube Placement: a. Draw 5-10 cc of air into syringe. b. Place stethoscope on the abdomen just above the waist. c. Insert barrel of syringe into g-tube. d. Unclamp tube. e. Gently inject air into port and listen to the stomach for gurgling or growing

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APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Continued From page 7	S9999		

sound. f. If gurgling or growling is observed, continue with tube feeding as ordered. g. If no gurgling or growling is observed, notify physician. DO NOT PROCEED with feeding." The policy further documents in part, that auscultation should not be solely relied upon to check for placement, but to observe for signs and symptoms of misplacement, including "d. If there is a suspicion of feeding tube misplacement NOTIFY PHYSICIAN to request an x-ray to confirm feeding tube placement."

R2's Electronic Nurses Notes, dated 1/30/18 at 3:15 PM, documents in part, New order received per (V14, NP). "Send (R2) to Memorial Medical Center ER (Emergency Room) for PEG tube placement."

R2's H&P electronically signed on 2/6/18, documents in part, "01/30/2018 1813 (6:13 PM), Radiology, states pt (patient) has the tube extended into jejunum - There is a 4 cm (centimeter) balloon blocking the jejunum."

R2's H&P, dated 1/30/18, documents in part, "(R2) presented with complaints of increasing abdominal distention, constipation for 1 week and general feeling of malaise and diaphoresis. (R2) has not had a bowel movement in over one week. (R2) states he has been sweating since his abdomen was noted to get bigger." The H&P further documents in part, "Abdominal pain: All quadrants, The severity is moderate, Characterized as (Cramping/colicky, Continuous). Diagnosis & Plan: Small bowel obstruction/obstipation. (R2) was noted to have a small bowel obstruction in his jejunum secondary to (urinary catheter tubing) catheter insertion."

R2's H&P, dated 2/1/18, documents in part, "(R2)

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APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Continued From page 8 underwent J-Tube (jejunostomy) placement 2 weeks ago in (metropolitan city), surgically. At ECF (extended care facility) has had worsening abdominal pain and constipation. His J tube was noted out 1/28/18 and was replaced with a (urinary catheter tubing). The (urinary catheter tubing) balloon was inflated and left in place. After this patient had worsening abdominal distention and pain and was brought to ED 1/30/18. CT (Computed Tomography) revealed over distention of the balloon in the jejunum causing proximal bowel and stomach dilation. He was admitted to the hospital following this. After multiple enemas and manual disimpaction, he had 4 large BM's (bowel movements)." R2's Operative Report, dated 2/2/18, documents in part, "Postoperative Diagnosis: Iatrogenic gastric perforation." R2's H&P electronically signed on 2/3/18, documents in part, "(R2) had worsening abdominal pain and distention and was brought to the Emergency Department, which revealed over distention of the balloon in the jejunum causing bowel and stomach dilatation." R2's H&P electronically signed on 2/4/18, documents in part, "(R2) transferred to Intermediate Care Unit (ICU)." R2's H&P electronically signed on 2/5/18 document in part, "On 1/28/18 his PEG tube became dislodged and was replaced at nursing home. However, the tip was placed into the jejunum and with inflation created small bowel obstruction which caused diaphoresis with eating. Patient was brought to Emergency Department (ED) on 30 January 2018 and had PEG tube replaced." "(R2) was also found to be	S9999		

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S9999	Continued From page 9 significantly constipated and was given fleets enema and suppositories with minimal response. Surgery with J tube placement. He underwent second Exploratory laparotomy on 2/2/18 to look for a perforated viscus and Esophagogastroduodenoscopy (EGD) which showed a gastric perforation from prior PEG tube." (A)	S9999		