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	IL6002489	A. BUILDING _____ B. WING _____	C 04/20/2018

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

(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 State Findings	S 000		
S9999	Final Observations Statement of Licensure Violation: 2 of 2 violations 300.1210b) 300.1210d)6) 300.1220b)3) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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. 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)	S9999		

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These Requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to identify and assess potential hazards/risks and develop interventions to reduce the potential for accidents for 2 of 4 residents (R1, R4) reviewed for accident prevention in a sample of 13. This failure resulted in R1 receiving two second degree burns to her right breast and one second Degree burn to her right arm.

Findings include:

1. R1's Minimum Data Set (MDS) dated 2/5/18 documents in part, R1 having a Brief Interview of Mental Status score of 15, indicating cognition intact. The MDS documents R1 required extensive assistance of one staff person with eating.

Facility Incident Report dated 4/7/2018 at 11:35 AM, documents in part, "(R1) was yelling and upon entry into room writer (V14, Licensed Practical Nurse/LPN) observed resident had reddened area to Right breast and Right upper arm. Resident stated she burned herself with oatmeal and it hurts really bad." Report further documents R1 sustained a burn to her right upper arm which measured 4 by 6 centimeters (cm) and a burn to her right breast area that measured 11.5 cm by 10 cm. There is no depth documented. The report also documents R1 to be alert and oriented but being "drowsy." The Report documents "Resident has predisposing condition

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where she has jerking movements. Resident sleeps completely naked and had no clothes on while eating breakfast (this is a normal thing for this resident)." The Report did not document staff were assisting R1 eating but did document staff entered the room after hearing her yell out.

R1's Nurse's Note dated 4/7/18 at 9:37 AM, documents R1 received a burn to her "Chest - Right breast - 11.5 x (by) 10 cm; Reddened and painful to touch; peeling." The note further documents physician was notified and ordered pain medication and the treatment ordered was "Silvadene cream to areas BID (twice daily) until healed." The report further documents in part, "no change to the Care Plan."

Nurse's Note dated 4/7/2018 at 6:37PM documents in part, "No blistering present at burn site."

On 4/18/18 at 12:15 PM, R1 stated she was in her room and received burns across her right chest and right arm because oatmeal was spilled on her during breakfast. R1 further stated she didn't have a shirt on and she typically sleeps in the nude when she is in bed and was not wearing a shirt when the oatmeal was spilled. R1 confirmed her chest was exposed to the oatmeal and did not have on protective clothing at the time. At the time of the interview, R1 had 2 small burn areas to her right breast, but nothing was noted to her right upper extremity.

Care Plan dated 1/5/2018 and revised on 4/5/2018, documents in part, R1 receiving a regular diet, needing extensive assistance with one person physical assistance with eating and having the following diagnoses: Early-Onset Cerebellar Ataxia, Frederick's Ataxia, muscle

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weakness, and lack of coordination. The Care Plan also documents on 4/9/18 R1 had a burn to her right breast and right upper arm. The intervention listed is to "seek medical attention if skin becomes bloody or infected." The Care Plan did not address R1's eating meals in bed while naked and how staff should address this to prevent risk of injury.

There is no documentation in R1's medical record the facility assess risks versus benefits of R1 eating in bed naked as she has Frederick's Ataxia (a neuro-muscular disorder). There was no documentation in R1's medical record that the facility attempted to discuss these risks with R1.

On 4/18/18 at 1:08 PM, V14, Licensed Practical Nurse (LPN), stated she was the nurse caring for R1 on the date of the incident whereby R1 received 2 burns to her right breast and one to her right upper arm. She stated R1 was in her room lying in bed waiting for her breakfast (asked to have it later than scheduled), and R1 prefers her bedside table to be positioned to the left of her body aligned with the bed. V14 also stated R1 holds her plate and/or bowls on her chest area, while lying in bed, and does not wear clothing when in bed. V14 stated on the day of the incident she heard R1 yelling and went to her room and noticed R1 rubbing her "bare chested" area of her breast that was reddened. She stated the affected area was from "where the nipple starts and across entire right breast leading up to top of chest," and that R1 was trying to wipe off the oatmeal from her chest area.

On 4/18/18 at 1:50PM, V25, CNA, stated she was working on the date of incident involving R1. She stated she took R1's tray into her room and she was awake and she placed the bowl of oatmeal

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on R1's "sternum" area as per R1's request. She stated a few minutes later she heard "screaming down hallway." V25 stated usually R1 doesn't immediately eat when the tray is served to her, as she may take some time before she begins to eat. V25 stated on that day R1 wanted to eat her breakfast as soon as she got her tray.

On 4/19/18 at 9:40AM, R1 was lying in her bed with her bedside table to the left side of her body. Her breasts were exposed 2 circular open areas were noted to the upper part of her right breast. The rest of her body is covered by a blanket. V31, CNA, offered R1 her breakfast which consisted of a bowl of oatmeal, hot chocolate, fruit loop cereal, an English muffin with butter and jelly. R1 stated she did not want the oatmeal or the hot chocolate, but requested for V31 to get her 2 bowls of Rice Krispies. V31 stated she would go get her the cereal she requested. When leaving the room, V31 stated she had a towel to cover up R1 while eating, but stated she hadn't provided R1 a clothing protector "not before today."

On 4/19/18 at 9:57AM, V10, LPN, stated R1 is known to sleep and eat in her bed in the nude and that is her "normal routine."

On 4/20/18 at 8:05AM, V15, Certified Nursing Assistant (CNA), stated R1 always eats in the nude while eating in her room.

On 4/20/18 at 8:07 AM, V17, Licensed Practical Nurse (LPN), stated R1 always eats in the nude while in her room and has done this since her first day of admission to the facility. R1's Electronic Face Sheet documents R1 was admitted to the facility on 2/21/17.

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On 4/20/18 at 8:10AM, V24, CNA, stated R1 eats in the nude while in her room, but now since she had the burn, she is allowing the use of a clothing protector.

On 4/20/18 at 8:20AM, V26, CNA, stated R1 does eat nude in her bed when she is in her room, but is now willing to allow for a clothing protector over her chest.

According to Merck Manual website www.merckmanuals.com/burns on 4/20/18, documents "Second-degree burns (also called partial-thickness burns) extend into the middle layer of skin (dermis). Second-degree burns are sometimes further described as superficial (involving the more superficial part of the dermis) or deep (involving both the superficial and the deep parts of the dermis)."

Facility Policy entitled Burns: Emergency Procedures Guidelines, undated, documents in part: "All residents experiencing a burn will be assessed and treated immediately. 4. Assess the burn site to determine the severity and degree of burns. Cover burns as quickly as possible with sterile dressing or a clean cloth. 6. Call paramedics and transfer to hospital. 8. Treat for emotional and physical pain and discomfort. Medicate for pain as ordered by the physician."

2. The MDS dated 3/30/18 documents R4 to be cognitively intact and requires total to extensive assist for all activities of daily living.

The Care Plan dated 3/17/18 no abnormal behaviors from R4 on admission 3/16/18.

On 3/29/18 at 7:05 PM an entry into the Electronic Health Record (EHR) Nurse Notes by

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V10 LPN (licensed Practical Nurse) document "It was reported to writer by staff member resident had bottle of medication in jacket pocket. Writer spoke with resident and stated needed to look in jacket related to resident having medication. Resident became very upset and angry at writer. Yelled at writer 'That's mine you can't take it from me.' Writer removed bottle marked Phenytoin 100 mg cap however contents of bottle is Tramadol and Xanax. Writer stated to resident with staff member present that it was against facility policy for a resident to have any medications prescribed or over the counter while at the facility. Resident continued to be argumentative with staff. Writer notified (V2) DON (Director of Nurses.) Call placed to V13's MD (Physician) office. V35 (MD on call for V13) paged and returned call. Made aware."

R4's Nurse's Notes, dated 4/2/18 at 1:11 PM , written by V10 (LPN) documents V22 (V13's office Nurse), called and "reiterated that (V13) MD had not written narcotic prescriptions in months for resident due to drug screens done at his office."

On 4/17/18 at 3:00 PM, V10 LPN stated she understood that R4's primary physician, V13 MD, refused to order Narcotics for R4 due to past history of having negative drug screens when requesting more Norco and Xanax. V10 stated R4 was a "drug seeker" which they were unaware of until V13 (MD) informed them after this incident. V10 stated the drugs found in the Dilantin bottle on 3/29/18 were Xanax and Tramadol which she determined by checking the imprint of the medications. V10 stated the Xanax was not the same as what was ordered for R4 at the facility and R4 never had an order for Tramadol. V10 stated they were unaware of

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where R4 could have gotten the medications from and was unaware of whether he was self medicating himself or not with the extra Xanax and Tramadol.

On 4/17/18 at 3:20 PM, V21 Nurse Practitioner (NP) stated R4 was taking Norco before he was admitted to the facility and he ordered the Norco and Xanax for him on 3/16/18, the afternoon of admission to the facility. V21 stated he was unaware of R's narcotics history or any problems prior to that.

On 4/18/18 at 8:30 AM, V13 MD stated he has been caring for R4 for the past 20 years and knows him well. V13 stated R4 had been calling office asking for stronger pain medications and on 4/6/18, the facility called to tell them they would no longer prescribe Narcotics for him as he had been sneaking Tramadol into his room. V13 stated R4, on two separate occasions over the past two years, has had negative drug screens done for Norco and Xanax, both of which he had been filling on a routine basis for him. V13 stated he was unsure where the Norco and Xanax went but assumed he wasn't taking it himself since his screen came back negative. V13 stated he has been able to treat R4's pain with non-narcotic medications and would not order any narcotics for him at this time due to that history unless they could assure him that R4 is actually consuming the medication and not getting drugs elsewhere.

On 4/17/17, V1, Administrator, was unable to provide an investigation on the narcotics in the Dilantin bottle found in R4's coat pocket on 3/29/18 and was unable to say where R4 got the Tramadol and Xanax. V1 was also unable to provide a plan to prevent future occurrences of drug seeking and obtaining medication from

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outside the building. V3 stated the prior DON, V34, took care of the drugs. V3 provided text messages copied from V34 which included a picture of the drugs in the bottle found on R4 and read "these are what we suspected were Tramadol and Xanax. These are what were destroyed." and "There was no narcotic sheet these were his illegally obtained meds (medications)."

On 4/18/18 at 3:00 PM, V3, Assistant Director of Nursing (ADON) stated the facility did not notify their pharmacy and no toxicology tests were done on R4. V3 stated they assumed he got the drugs from an outside source but was unsure as to who it would have been or how they were obtained.

R4's Care Plan, dated 3/17/18, documents a concern dated 3/30/18 of "I am med seeking. I am verbally aggressive. I at times will threaten staff. I fabricate stories. Cares in pairs when giving cares" with the goal being "I will have fewer episodes of behavior through the next review dated (6/14/18.) Interventions documented "Administer medications as ordered" and "Anticipate and meet the resident's needs." The care plan was not revised with interventions to address R4 from obtaining medications that are not his and how staff should address this issue.

Facility Policy entitled Incident/Accident Reports, undated, documents in part, "Policy: The Incident/Accident Report is completed for all accidents or incidents. NOTE: For all medication-related incidents, use Medication Incident Report. 1. An incident/accident report is to include: b. Full written statement and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered, and notification of appropriate parties."

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S9999	Continued From page 10 (B) 300.690a) 300.690b) 300.690c) Section 300.690a)b)c Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This requirement is not met as evidenced by:	S9999		

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S9999	Continued From page 11 Based on interview and record review, the facility failed to timely report to the Illinois Department of Public Health a serious incident for 1 of 4 residents (R1) reviewed for incident and accident reporting in a sample of 13. Finding includes: 1. Facility Incident Report dated 4/7/2018 at 11:35 AM, documents in part, "(R1) was yelling and upon entry into room writer (V14, Licensed Practical Nurse/LPN) observed resident had reddened area to Right breast and Right upper arm. Resident stated she burned herself with oatmeal and it hurts really bad." Report further documents R1 sustained a burn to her right upper arm which measured 4 by 6 centimeters (cm) and a burn to her right breast area that measured 11.5cm by 10 cm. There is no depth documented. The report also documents R1 to be alert and oriented but being "drowsy." Nurses Note dated 4/7/18 at 9:37AM, documents R1 having received a burn to her "Chest - Right breast - 11.5 x (by) 10cm; Reddened and painful to touch; peeling." The note further documents physician was notified and ordered pain medication and the treatment ordered was "Silvadene cream to areas BID (twice daily) until healed." The report further documents in part, "no change to the Care Plan." On 4/19/18 at 3:00PM, V1, Administrator, stated he was not the Administrator on the date R1 sustained the burn, and does not have a report Illinois Department of Public Health was notified of this incident. Facility Policy entitled Incident/Accident Reports, undated, documents in part, "Policy: The	S9999		

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S9999	Continued From page 12 Incident/Accident Report is completed for all accidents or incidents." The Policy documents "the facility will notify "a. The Illinois Department of Public Health, by phone, within twenty-four hours of the occurrence." The Policy documents "i. A narrative summary of the incident is to be sent to the Illinois Department of Public Health within five working days." (AW)	S9999		