



525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • [www.dph.illinois.gov](http://www.dph.illinois.gov)

February 13, 2019

VCorp Agent Services, Inc., Registered Agent  
River Crossing Rehab, LLC  
208 S. LaSalle Street, Suite 814  
Chicago, Illinois 60604

RE: Complaint #: IL 107791, IL 107797  
Survey Date: December 13, 2108  
Docket #: 19-C0042  
Violation Type: B Violation with Fine

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Aperion Care Galesburg.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr  
Division Chief of Quality Assurance  
Office of Health Care Regulations

Enclosure

cc: Administrator

File

Aperion Care Galesburg/December 13, 2018/19-C0042/RcgAgent/kk

PROTECTING HEALTH, IMPROVING LIVES

Nationally Accredited by PHAB

FAC. NAME: APERION CARE GALESBURG

COMPLAINT #: 0107791

LIC. ID #: 0052761

DATE COMPLAINT RECEIVED: 12/05/18 08:03:00

| IDPH Code | Allegation Summary                       | Determination |
|-----------|------------------------------------------|---------------|
| -----     | -----                                    | -----         |
| 105       | IMPROPER NURSING CARE                    | 1             |
| 206       | HOUSEKEEPING                             | 2             |
| 311       | MENUS & MEALS NO VARIETY/SUBST/SMALL AMT | 2             |

☒ The facility has committed violations as indicated in the attached\*  
☐ No Violation

\*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

## Determination Codes

- 
- 1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.
  - 2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.
  - 3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

## COMPLAINT DETERMINATION FORM

FAC. NAME: APERION CARE GALESBURG

COMPLAINT #: 0107797

LIC. ID #: 0052761

DATE COMPLAINT RECEIVED: 12/05/18 09:31:00

| IDPH Code | Allegation Summary   | Determination |
|-----------|----------------------|---------------|
| -----     | -----                | -----         |
| 401       | INVOLUNTARY TRANSFER | <u>1</u>      |

☒ The facility has committed violations as indicated in the attached\*  
☐ No Violation

\*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

## Determination Codes

-----

- 1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.
- 2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.
- 3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH  
STATE OF ILLINOIS

|                                 |   |                       |
|---------------------------------|---|-----------------------|
| THE DEPARTMENT OF PUBLIC HEALTH | ) | Docket No. NH19-C0042 |
| STATE OF ILLINOIS,              | ) |                       |
| Complainant,                    | ) |                       |
|                                 | ) |                       |
| v.                              | ) |                       |
|                                 | ) |                       |
| RIVER CROSSING REHAB, LLC,      | ) |                       |
| D/B/A, APERION CARE GALESBURG,  | ) |                       |
| Respondent.                     | ) |                       |

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED;  
NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF  
VIOLATORS;  
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on December 13, 2018, at Aperion Care Galesburg, 1145 Frank Street, Galesburg, Illinois 61401. On February 13, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

- 1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

- 2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
- 3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

#### NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **\$2,200.00**, as follows:

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)2), 300.1220b)2) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health  
P.O. Box 4263  
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

- (A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.
- (B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or
- (C) Bring an action in circuit court to recover the amount of the penalty.

#### NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

#### NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE  
WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

**Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POChearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.**



Sherry Barr  
Division Chief of Quality Assurance  
Office of Health Care Regulations

Dated this 13th day of February, 2019.

BF300/19-C0042/Aperion Care Galesburg/December 13, 2108/kk

Illinois Department of Public Health

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                               |                                                                                                                          |  |                                                                    |
|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6000434</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/13/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>APERION CARE GALESBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1145 FRANK STREET<br/>GALESBURG, IL 61401</b>                                |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| S 000                                                             | Initial Comments<br><br>Complaint # 1827871/ IL107791-F686 cited<br><br>Complaint # 1827879/ IL107797-F622, F623,<br>F641, F644, F656, F661, F760 cited                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | S 000                                                                         |                                                                                                                          |  |                                                                    |
| S9999                                                             | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)d)2)<br>300.1220b)2)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and<br>procedures governing all services provided by the<br>facility. The written policies and procedures shall<br>be formulated by a Resident Care Policy<br>Committee consisting of at least the<br>administrator, the advisory physician or the<br>medical advisory committee, and representatives<br>of nursing and other services in the facility. The<br>policies shall comply with the Act and this Part.<br>The written policies shall be followed in operating<br>the facility and shall be reviewed at least annually<br>by this committee<br><br>Section 300.1210 General Requirements for<br>Nursing and Personal Care<br><br>b) The facility shall provide the necessary care<br>and services to attain or maintain the highest | S9999                                                                         |                                                                                                                          |  |                                                                    |

**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health

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

TITLE

(X8) DATE

12/31/18

Illinois Department of Public Health

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                     |                                                                                                                          |                          |                                                   |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>IL6000434 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY COMPLETED<br><br>C<br>12/13/2018 |
| NAME OF PROVIDER OR SUPPLIER<br><br>APERION CARE GALESBURG |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1145 FRANK STREET<br>GALESBURG, IL 61401                                        |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| S9999                                                      | <p>Continued From page 1</p> <p>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.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</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 requirements were not met evidenced by:</p> | S9999                                                               |                                                                                                                          |                          |                                                   |

Illinois Department of Public Health

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                                                                                                                          |                                                                    |
|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6000434</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/13/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>APERION CARE GALESBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1145 FRANK STREET<br/>GALESBURG, IL 61401</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S9999                                                             | <p>Continued From page 2</p> <p>Based on record review, and interview, the facility failed to follow hospital readmission order for one of five residents (R1) reviewed for behavioral management in the sample of eight.</p> <p>This failure resulted in R1 having a relapse of symptoms, and threatening harm to others as well as self harm threats requiring re-hospitalization.</p> <p>Findings include:</p> <p>The facility's Behavior Management Program dated 10-30-17 documents, "To establish a system for identifying behaviors and implementing appropriate interventions consistent with the individualized plan of care and to ensure that each resident receives appropriate treatment and services to maintain the highest practicable mental and psychosocial well-being. Services include: Medications prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness."</p> <p>The facility's Admission of Resident policy dated 12-11-18 documents, "To facilitate a smooth transition into a health care environment. To gather comprehensive information as a basis for planning individualized therapeutic care. Using information obtained, contact the attending physician, ensuring that admission ordered cover all aspects of the required care and treatment."</p> <p>R1's Face Sheet documents R1 is a 24 year old that was admitted to the facility on 10-29-18 with the diagnoses of Schizophrenia and Major Depressive Disorder.</p> <p>On 10/31/2018 at 10:03 AM, R1's Nurse's Note</p> | S9999                                                                                     |                                                                                                                          |                                                                    |

Illinois Department of Public Health

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                           |                                                                                                                          |                                                                    |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6000434</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/13/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>APERION CARE GALESBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1145 FRANK STREET<br/>GALESBURG, IL 61401</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S9999                                                             | <p>Continued From page 3</p> <p>documents, "(R1) was talking to himself stating he wants to kill others. This nurse notified (V4/R1's Primary Care Physician). (V4) stated to send (R1) in for a psychiatric evaluation."</p> <p>On 10/31/2018 at 10:33 PM, R1's Nurse's Note documents R1 was transferred to a (behavioral health hospital).</p> <p>Facility's Census Report documents R1 remained at the behavioral health hospital from 10-31-18 to 11-16-18.</p> <p>R1's Behavioral Healthcare System discharge instructions dated 11-16-18 document the following orders: Clonidine 0.1 mg (milligrams) daily at 8:00 PM for the diagnosis of Agitation. Cogentin 2 mg daily at 8:00 PM for the diagnosis of EPS (Extrapyramidal Symptoms). Prolixin 10 mg two tablets daily at 8:00 PM for the diagnosis of Psychosis. Depakote 500 mg three times daily for the diagnosis of Mood. These same discharge instructions document R1 was at low risk of suicide, self injury, and assault after treatment at the behavioral health hospital.</p> <p>R1's Medication Administration Records and Progress Notes dated 11-16-18 to 11-29-18 do not include any documentation of R1 receiving the behavioral health systems orders to administer Cogentin 2 mg daily, Prolixin 10 mg two tablets daily, or Clonidine 0.1 mg daily.</p> <p>R1's Behavioral Note dated 11/29/2018 at 11:30 AM documents, "(R1) is pacing back and forth from his room to the dining room stating he is going to kill himself, and kill other people. (R1) is not easily directed. When trying to speak to (R1), (R1) turns the other way and walks away. Resident refused medication at this time."</p> | S9999                                                                                     |                                                                                                                          |                                                                    |

Illinois Department of Public Health

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        |                                                                                                                          |                          |                                                      |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>IL6000434 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>12/13/2018 |
| NAME OF PROVIDER OR SUPPLIER<br><br>APERION CARE GALESBURG |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1145 FRANK STREET<br>GALESBURG, IL 61401                                        |                          |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                      |
| S9999                                                      | Continued From page 4<br><br>R1's Nurse's Note dated 11/29/2018 at 11:56 AM documents, "(R1) continues to pace, curse, and state he is going to kill himself, and others. (V2/Director of Nursing) stated to send (R1) for a psychiatric evaluation at this time."<br><br>R1's Communication Progress Note dated 11/30/2018 at 12:31 PM, documents, "Advised (R1's Power of Attorney/V10) that an emergency involuntary transfer discharge is being issued for (R1) due to the fact that (R1's) needs cannot be met in this facility. (R1) refuses to take his medications, and (R1's) physician states that (R1) needs a more secure environment."<br><br>On 12-11-18 at 11:20 AM, V13 (Pharmacy Accountant) stated, "The facility has never ordered Clonidine 0.1 mg, Cogentin 2 mg, or Prolixin 10 mg for (R1) from this pharmacy."<br><br>On 12-11-18 at 12:00 PM, V2 (Director of Nursing) stated, "The admitting nurse (V15/Registered Nurse) did not get orders from the behavioral healthcare when (R1) was re-admitted to the facility (11-16-18). (V15) assumed the medication orders in the computer, prior to (R1) being sent to the psychiatric unit, were the medications ordered for (R1) upon (R1's) return. It was miscommunication on our part. We (the facility) should have made sure we had the orders from the behavioral healthcare and ensured (R1) received the medications ordered by the behavioral healthcare facility. (R1) was sent to the behavioral health system to stabilize (R1), and we should have made sure we followed their orders when (R1) was re-admitted. I know someone in this building received the behavioral health orders from (V4/R1's Primary Care Physician) on 11-21-18, but (R1's) | S9999                                                                  |                                                                                                                          |                          |                                                      |

Illinois Department of Public Health

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                               |                                                                                                                          |  |                                                                    |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6000434</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/13/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>APERION CARE GALESBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1145 FRANK STREET<br/>GALESBURG, IL 61401</b>                                |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| S9999                                                             | <p>Continued From page 5</p> <p>medications were still not started."</p> <p>On 12-11-18 at 12:30 PM, V1 (Administrator) stated, "When (R1) was re-admitted to the facility on 11-16-18 the nurse (V15/Registered Nurse) should have ensured (R1's) medication orders, and treatment orders were obtained from the behavioral healthcare system that discharged (R1), or from (R1's) physician."</p> <p>On 12-11-18 at 10:55 AM, V4 (R1's Primary Physician) stated, "When (R1) was sent for a psychiatric evaluation on 10-31-18 and re-admitted to the facility on 11-16-18, the facility should have made sure (R1) received the medications ordered from the psychiatric hospital. (R1) was sent to the psychiatric hospital to manage his behaviors and stabilize him. I was not notified that (R1) had never received the medications ordered from the psychiatric hospital. I saw (R1) several days after he was re-admitted to the facility on 11-16-18 due to (R1) having behaviors, but was never told that his medication ordered by the behavioral hospital were not being given. I am not a psychiatric doctor and tried my best to stabilize (R1). The facility should have ensured they followed the psychiatric hospital's discharge instructions to keep (R1) stabilized, which could have prevented (R1) from having the same behaviors that lead up to the involuntary discharge."</p> <p>On 12-11-18 at 1:30 PM, V17 (Assistant Hospital Administrator) stated, "(R1's) Hospital progress notes document we (the hospital) were in constant contact with (V2/Director of Nursing). When we sent (R1) back to the facility, R1's behaviors were stable. (R1's) orders were sent to</p> | S9999                                                                         |                                                                                                                          |  |                                                                    |

Illinois Department of Public Health  
STATE FORM