STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006399	A. BUILDING: _____ B. WING _____	C 09/01/2021

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APERION CARE MORTON VILLA	190 EAST QUEENWOOD ROAD MORTON, IL 61550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2126197/IL137491	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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.	S9999		

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S9999	Continued From page 2 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on observation, interview, and record review, the failed to accurately assess a resident for a risk of elopement, develop an elopement plan of care for a moderately impaired resident at risk for elopement, provide adequate supervision to prevent a resident's elopements, inform/educate direct care staff of a resident's multiple elopements and elopement risks, and failed to notify the Physician and Administrator of	S9999		

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S9999	Continued From page 3 a resident's elopement for one of three residents (R1) reviewed for elopement in the sample of three. These failures resulted in R1, a moderately cognitively impaired resident with the diagnosis of Dementia, eloping from the facility on 8-25-21 around 11:30 PM, after sunset, proceeding to a two-lane interstate, and being found lying on a concrete barrier on an exit ramp between two lanes of traffic by the police, one mile away from the facility. R1 then eloped into the front parking lot of the facility the following morning (8-26-21 at 7:38 AM) after police returned R1 to the facility earlier that morning (8-26-21 at 2:10 AM). Findings include: The facility's Code Pink: Missing Resident/Elopement policy dated 11-15-18 documents, "All personnel are responsible for reporting a cognitively impaired resident attempting to leave the premises, or suspected of missing, to the charge nurse as soon as practicable. Upon return of the resident to the facility, the Director of Nursing or charge nurse should: 1. Examine the resident for injuries. 2. Contact the attending Physician and report finding and condition of the resident and obtain a Physician's order. 3. Notify the legal guardian/responsible party. 5. Notify the administrator. 7. Complete the incident report indicating when the resident returned and the condition of the resident. 8. Make appropriate entries into the resident's medical record. 10. Complete a new elopement risk assessment and updated plan of care appropriately. 11. Review and update the elopement risk binder." R1's Physician's Order Sheet dated 8-27-21 document R1 with diagnoses of Convulsions,	S9999		

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S9999	Continued From page 4 Insomnia, Major Depressive Disorder, Hallucinations, Disorientation, Epilepsy, Encephalopathy, Lack of Coordination, Cognitive Communication Deficit, Unsteadiness on Feet, Abnormalities of Gait and Mobility, Schizophrenia, Personal history of Traumatic Brain Injury, and Dementia with Behavioral Disturbance. These same orders document R1 requires 24-hour nursing care. These orders also document that R1 receives Depakote for the diagnosis of Epilepsy with convulsion, Donepezil for the diagnosis of Dementia with Behavioral Disturbance, Gabapentin for the diagnosis of Encephalopathy, Levetiracetam for the diagnosis of Epilepsy, Melatonin for the diagnosis of Insomnia, Olanzapine for the diagnosis of Dementia, and Oxcarbazepine for the diagnosis of Epilepsy. R1's History and Physical dated 3-1-21 documents, "Active Problem: Acute Encephalopathy/Dementia with behavioral disturbances/agitation. History of memory/cognitive deficits. According to (R1's) wife, it is significantly worsened. (R1) started having memory loss starting back in 2019. This was first noticed after (R1) crashed his truck and could not get details straight. Also, to be noted (R1) had a longstanding history of being physically abused as a child with memory issues most of his life due to this abuse. (R1) cannot tell me what hospital he is at." R1's Minimum Data Set Assessment dated 8-11-21 documents R1 is cognitively moderately impaired and requires supervision of staff for locomotion on and off the unit and walking. R1's Physician Note dated 6-15-21 and signed by V16 (R1's Nurse Practitioner) documents, "(R1)	S9999		

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S9999	Continued From page 5 was seen today. Staff state that he keeps saying that he wants to go home. His wife did take him home for only four days, but he had a wrench threatening which scarred the grandchildren. He can have violent outbursts and is anxious. Trazodone was recently started for him for sleep. He keeps telling provider he wants to go home and is anxious and depressed due to this. He says if he is not discharged, he will leave through the window. He states he is not sleeping well due to the facility. Delusional material expressed: Wants to go home and cannot remember he cannot. Memory immediate: Appears impaired. Memory/Recent: Appears impaired." R1's Nurse's Note dated 6-8-21 at 6:11 AM documents, "(R1's) wife called facility and informed this nurse that (R1) had called her several times in a span of a few minutes, and that (R1) was 'very agitated and threatening to either break out of facility or commit suicide'. When asked if he had any means to carry out this threat, wife denied this, but she did state that she is aware that he can possibly break out through the bedroom window. This nurse did go and assess (R1) after getting off the phone with his wife, and (R1) was resting in bed, denied any suicidal ideation, and stated that he did not plan on breaking out of facility." R1's Elopement/Unauthorized Leave Risk Review dated 7-23-21 and signed by V9 (Social Service Director) documents, "Is there a history of wandering/elopement and/or does the resident verbalized a strong desire to leave? Yes. Signs of compromised decisional capacity and substantially impaired judgement and/or physical status limitations that would place the resident at risk in the community: Yes. Verbalizes a serious/strong intent to leave the facility in the	S9999		

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absence of an appropriate discharge plan: No. Not at risk to elope at this time and placement on Elopement Risk Protocol is not indicated."

R1's Comprehensive Care Plan dated 4-30-21 through 8-25-21 does not include a Care Plan with interventions to prevent R1 from eloping from the facility.

R1's Police Event Report dated 8-26-21 at 12:28 AM and signed by V12 (Local County Police Deputy) documents, "12:28 AM Caller: (V11/Community Witness). Male (R1) lying on concrete barrier between turn lanes on ramp to Broadway from I (Interstate)-155 South bound. Wearing orange shirt and camouflage hat. First arrive 12:42 AM out with (R1) a quarter of mile from I-155 interstate. (R1) states, 'Out on foot checking corn'."

A website Accuweather.com states the weather on 8-25-21 in Morton, Illinois reached a high of 92 degrees Fahrenheit (F) and a low of 70 degrees F with scattered storms. This same website states a sunset time of 7:44 PM.

R1's Initial Report to the State Agency dated 8-26-21 at 12:03 PM and signed by V1 (Administrator) documents, "Date of Occurrence: 8-26-21. Time of Occurrence 8:00 AM. Diagnosis: Unspecified Dementia and Schizophrenia. Description of Occurrence: (R1) exited facility, was redirected, and came back to facility. (Local Police) department was present. Action Taken: Door codes changed, medications reviewed, and (R1) on checks. (V6/R1's Family Member) and (V7/R1's Physician) notified.

R1's Social Service Note dated 8/26/2021 at 09:33 documents, "(R1) exited facility this

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S9999	Continued From page 7 (morning) to return home. (R1) believes that his wife needs his assistance. (R1) was cooperative and re-entered facility with (Local Police) Department. Medications reviewed and resident on frequent checks. Restorative nurse and social services to contact (R1's) wife regarding returning to home." R1's Progress Notes dated 8-25-21 from 10:00 PM through 8-26-21 at 9:00 AM do not include any documentation of R1's multiple elopements that occurred after 10:30 PM on 8-25-21, and do not include documentation of V1 or V7 being notified of R1's elopements from the facility. On 8-27-21 at 9:35 AM, R1 walked to his room independently from the outside back of the building courtyard. R1 walked to his room and sat on the edge of his bed. R1 was dressed in construction clothing (work boots, jeans, and an orange long sleeve shirt) and was wearing a construction hat. R1 stated, "I want to go home. I left out of here the other night through the window around 11:00 PM. I walked the highway towards my home. It was dark out. A police officer picked me up around 1:00 AM and took me to my home where my wife lives. It was hot out, but I survived. I think my wife is having an affair with her ex-boyfriend. If I find out I will beat her to death. I am twitching now. My step dad beat me all the time so I feel like if I go off, I will hurt somebody bad. My wife tells me I have to live here because I cannot remember things. I will find a way out of here. I will live homeless in the woods where nobody can find me. Somebody screwed down a chunk of wood in the window seal so that I cannot open the window. I will break the window out if I have to." On 8-27-21 at 11:30 AM V6 (R1's Family	S9999		

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S9999	Continued From page 8 Member) stated while crying, "On Wednesday night 8-25-21 (R1) left the facility unattended. (R1) had left me a message on my phone at 11:30 PM that he had left the facility and was walking home. I did not get the message until after 1:00 AM. On 8-26-21 around 1:00 AM a Tazewell County police deputy was knocking on my door and stated they had (R1) and dropped him off at my house. The deputy told me that (R1) was found lying on a concrete median on an off ramp on I (Interstate)-155 South. (R1) was drenched in sweat because the weather was very humid. It had also stormed that night. (R1) told me that he left out of the window at the facility and that he was not going back to the facility. (R1) said he would commit suicide first. I called the facility and V14 (CNA/Certified Nursing Assistant) answered the phone. I stated to (V14), 'Are you missing (R1) from your facility?' I heard (V14) drop the phone and I heard running. (V10/Registered Nurse) then got on the phone and stated, 'Is (R1) a resident here?' I stated back to (V10), 'What kind of question is that?' (V10) then said that I would have to bring (R1) back to the facility as there was no one available to pick (R1) up at my house. (V10) stated that she did not know (R1) was missing from the facility. I live in Delavan, Illinois which is 21 miles from the facility. I then called the Tazewell Sheriff's office and a deputy picked (R1) up from my house and took (R1) back to the facility. (R1) was admitted to that facility because he was becoming increasingly confused and was having major behaviors at home. (R1) was also having seizure after seizure which was causing (R1) to lose brain function. (R1) is not safe to leave the building without staff, especially at night. (R1) could get lost or fall. I should not have to worry about (R1). (R1) had falls at home, prior to his admission, and had fell backwards, ripping the	S9999		

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top of his scalp off, which required sutures. I have told staff over and over that (R1) was threatening to leave the facility through the window. (R1) knew how to remove the window in his room. The facility should have made sure (R1) was safe."

On 8-27-21 at 2:55 PM, V11 (Community Witness) stated, "On 8-26-21 around 12:30 AM I was leaving Morton on south I-155. When I went on an exit ramp, I saw a male gentleman lying on a concrete median. It had been raining right before I saw him. The male looked unsafe, so I called the police to report this immediately. Where I saw this male, it was around two to three miles from (the facility)."

On 8-27-21 at 11:50 AM, V10 (RN) stated, "On 8-26-21 around 1:00 AM I got a phone call from (V6) that (R1) was at her home. I was not aware that (R1) was gone out of the facility. The last time staff saw (R1) was around 10:00 or 10:20 PM on 8-25-21. (V6) told me that the police had brought (R1) to her house and (R1) was found on an interstate. I told (V6) to bring him back to the facility. Around 2:10 AM a Tazewell County police deputy brought (R1) back to the facility. I do not know how (R1) got out of the facility. No alarms were going off. I did not chart anything about this incident in (R1's) progress notes. I did not notify (V1/Administrator) or (V7/R1's Physician) about (R1) leaving the facility unattended. I notified the manager on call (V15/Licensed Practical Nurse/LPN) about the incident. (R1) kept telling me he was going to go home after the police brought him back to the facility."

On 8-28-21 at 11:15 AM, V15 (LPN) stated, "On 8-26-21 around 1:30 AM, (V10) called me and reported that (R1) had eloped from the facility and

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ended up at his wife's house. (V10) told me that the police brought (R1) back to the facility. I told (V10) to make sure (R1) is observed continuously. Later on that day, sometime after 8:00 AM, (R1) was found in the front of the building parking lot without staff presence. Staff should have been watching (R1) continuously, so I am not sure how (R1) got back outside without being noticed. That morning I texted (V1) and (V2/Director of Nursing) that (R1) had eloped. I am not sure if (V1) and (V2) thought my text was from (R1's) elopement in the morning. (V1) and (V2) must not have realized that (R1) had eloped earlier that morning (prior evening)."

On 8-27-21 at 11:05 AM, V9 (Social Service Director) stated, "I came in yesterday and was told by (V15/LPN/Licensed Practical Nurse) that (R1) had left the facility. I spoke to his wife yesterday and she was very angry and stated that (R1) needs more supervision. I am not sure when (R1) left or how (R1) got out of the facility. All I know is that (R1) got out of the facility unattended and the police had to bring him back. I know in the past, (R1) would threaten to break windows and leave the facility. (R1) did not have an elopement Care Plan and interventions developed until yesterday (8-26-21) after (R1) had left the facility. (R1) needs supervision at all times due to confusion and would not be safe to leave the building unattended."

On 8-27-21 at 12:00 PM, V1 (Administrator) stated, "(R1) was found outside in the front parking lot by V13 (Therapist) yesterday (8-26-21) at 7:38 AM. The staff did not know that (R1) had gotten out of the facility unattended. I watched the security cameras and saw (R1) leave out the front door unattended at 7:36 AM. I was not aware of (R1) making statements about wanting

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S9999	Continued From page 11 to leave the facility through the window. I was not notified that (R1) had left the building unattended at night on 8-25-21 and was found on an interstate (on morning of 8-26-21). I also did not know that a police deputy had brought (R1) back to the facility. I definitely should have known that (R1) was making threats to leave the building and that (R1) left the building unattended. (R1) is not safe to leave the building without supervision." On 8-27-21 at 1:00 PM, V2 (Director of Nursing) stated, "I know sometime in April 2021 (R1) had threatened to get out of his window to leave the facility. I was not aware that (R1) had eloped Wednesday night 8-25-21 and that the police brought him back. (V10) should have notified me immediately of this incident. (R1) has short term memory loss and would have been unsafe to walk home or leave the facility without staff assistance. (V8/Care Plan Coordinator) did not create or implement a Care Plan with interventions regarding (R1's) elopement attempts or regarding (R1) stating that he was going to leave the facility through the window. (V8) did not create an elopement care plan with interventions due to (R1's) elopement/unauthorized leave risk reviews indicating (R1) is not at risk for elopement. The elopement/unauthorized leave risk reviews dated 4-29-21 and 7-23-21 were not accurately coded and should have identified that (R1) is at risk for elopement." On 8-27-21 at 9:25 AM, V3 (CNA/Certified Nursing Assistant) stated, "I work here four days a week. I know (R1) does not want to be here. (R1) always says he wants to go home. I am not aware of (R1) ever leaving the building unattended or eloping from the building. (R1) is not an elopement risk. (R1) walks	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MORTON VILLA	190 EAST QUEENWOOD ROAD MORTON, IL 61550

(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
S9999	Continued From page 12 independently. Whenever I do my rounds every two hours, I check on (R1). (R1) is not on any supervised checks that I am aware of. (R1) is confused and would be unsafe to leave the building alone. (R1) would not know where to go or what to do if he left the building. There is an interstate close by that would be very dangerous if (R1) walked on it." On 8-27-21 at 9:50 AM, V4 (Registered Nurse/RN) stated, "I heard from other staff that (R1) eloped from the building a few days ago. I was not here when (R1) left the building. (R1) has short term confusion. (R1) is usually well mannered. I am not aware of (R1) needing any increased supervision and I do not know what door (R1) left out of." On 8-27-21 at 10:05 AM, V5 (CNA) stated, "I have worked at the facility full time for around three years. I am the staff responsible for (R1) today. I am not aware of (R1) ever leaving the building unattended by staff. (R1) is not on frequent checks or anything. (R1) is confused and is not safe to leave the building without staff. There is too much traffic outside and (R1) gets confused easily. (R1) would not know where he was if he left. On 8-27-21 at 2:20 PM, V7 (R1's Physician) stated, "(R1) is not safe to leave the facility without staff. (R1) is definitely not safe to walk outside at night without assistance. (R1) requires supervision of staff. The facility has not even informed me of (R1) elopements." (A)	S9999		