Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: ______ B. WING ______	C 08/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2346544/IL162949: - Past noncompliance - no plan of correction required.	S 000		
S9999	Final Observations Past Noncompliance, no revisit needed. Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken 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. These requirements were not met as evidenced by: Based on interview, observation and record review, the facility failed to monitor and supervise a resident with severe cognitive impairment for 1 of 1 resident (R4) reviewed for supervision in the sample of 5. This failure resulted in R4 missing, last seen at around 11:00AM and discovered entrapped on the elevator at 10:30 PM. This Past Noncompliance occurred from 7/31/23 to 8/1/23. Findings include: R4's Minimum Data Set, dated 7/3/23, documented R4 had severally impaired mental cognition, however, R4 recalls long term memory and not short-term memory but is able to speak	S9999		

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and answer simple questions.

R4's Admission Record, dated 8/10/23, documented R4 had diagnoses of dementia, psychotic disturbance, mood disturbance, anxiety, heart disease and major depressive disorder.

R4's Care Plan, dated 6/20/23, documented, R4 requires assistance with transfers due to being unaware of safety issues and a fall risk with an intervention of a 1-person assistance with transfers, including locomotion on and off the unit. R4's Care Plan documents R4 is incontinent of bowel and bladder, physical addiction to nicotine/smoking and a fall risk due to a medical condition of Dementia with the use of a medication to treat moderate to severe dementia of the Alzheimer type.

R4's Facility documentation, untitled and dated 7/31/23, documents, "On 7/31/23, the facility called a code pink at 20:30 PM, (8:30 PM) after not being able to locate a resident when completing a facility check. Staff verify that the resident was not out on pass. The Administrator was notified and instructed the nurse in charge to notify the police. Resident was in the facility in the small elevator. Fire department, (elevator service company) and Emergency Medical Transport called to the facility. Resident was removed from the elevator at approximately 11:00 PM. Resident refused to go to the hospital, therefore the facility nurse assisted and resident was given food and assisted to his room."

R4's July 2023 Medication Administration Report (MAR) documented the following medications were not given to R4 on 7/31/23 during the 8:00 PM medication administration: Hydralazine HCl,

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10 milligrams (mg) for hypertension with blood pressure not taken; Namenda, 5 mg, for dementia, psychotic disturbance, mood disturbance and anxiety; Lisinopril, 20 mgs, 1 tablet for hypertension; Tamsulosin HCl, 0.4 mg one capsule for benign prostatic hyperplasia. Tamsulosin capsule 0.4 milligram (mg) for benign prostatic hyperplasia. The MAR documented R4 should have vital signs every Monday on the evening shift, and these were not documented as completed. The MAR documented R4 should receive health shake, magic up, ensure or fortified pudding with meals at 5:00 PM and this was not documented as given.

On 8/10/23 at 3:00 PM, V3, Licensed Practical Nurse (LPN), stated R4 is a smoker and will come and go. V3 stated R4 propels himself in his wheelchair, is a smoker and knows when its smoking time. V3 stated R4 answers short questions and has short term memory recall. V3 stated she worked the day of 7/31/23, 2:00PM -10:00 PM. V3 stated R4 has a blood pressure reading scheduled at around 7:30 PM. V3 stated R4 was not found in his room and there was an un-eaten supper tray at his bedside table. V3 stated a search was conducted down stairs where R4 likes to hang out, he was not found. V3 stated, at that point she notified V1, Administrator, that R4 was not to be found in the facility. V3 stated a whole outside ground and building search was performed. The emergency department, fire department, police and Elevator service were all notified and were present in the facility at approximately 9:30 PM. V3 stated at around 10:00 PM, R4 was found located in the elevator, but not retrieved from the elevator until 11:00 PM, by the Elevator Service Company. V3 stated she remained in the building until around 10:30 PM.

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On 8/10/23 at 2:30 PM, V1, Administrator, stated R4 was assessed after the incident. V1 stated R4 refused to go to the hospital and R4's physician was notified on 8/1/23. V2 stated labs were obtained as ordered for 8/1/23 and within normal limits. V1 stated she was at the small elevator door on the 2nd floor. V1 stated R4 did respond after V1 knocked on the elevator door at around 10:00 PM. V1 stated the emergency department stayed at the 2nd floor elevator door and she went down to the basement with the elevator maintenance personnel, where the mechanical issues were addressed. V1 stated they opened the small elevator door and released R4 from the elevator.

On 8/10/23 at 3:15 PM, V5, Certified Nurse Aide, CNA, stated R4 takes all four scheduled smoke breaks, as R4 is aware of the smoking scheduled times. V5 stated she worked the day of the incident on 7/31/23 from 2:00 PM to 10:00 PM; however, she had the first half of the hall and R4 resides at the back end of the hall. V5 stated she saw R4 propel himself in his wheelchair and down the elevator but she did not follow-up to check on R4's whereabouts.

The facility's entitled form, "Smoking Times," undated, documented the following smoke times: 9:15 AM, 11:00 AM, 3:00 PM and 6:00 PM.

On 8/14/23 at 9:40 AM, V8, Activity Aide, stated R4 requires supervision. V8 stated the activity staff go to his room and assist R4 from the 3rd floor down to 2nd floor for smoking times and activities. V8 stated R4 enjoys doing activity's; however, R4 will come down the elevator unassisted by himself. V8 stated she worked the day of 7/31/23. V8 stated R4 was assisted down

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S9999	Continued From page 5 at 9:30 AM smoke break. V8 stated after the smoke break the activity department serves morning coffee which R4 enjoys. V8 stated R4 arrived on the 2nd floor for 2nd smoke break at around 11:00 AM but that is the last she saw R4. V8 stated she worked until 5:00PM. V8 stated at 3:30 PM, during 3rd scheduled smoke break she realized R4 did not come down to smoke. V8 stated she did not go look for R4. On 8/14/23 at 10:04 AM, R3 stated that R3 does not smoke; however, he walks a lot down the hall and uses the elevator from the 3rd floor to the 2nd floor. R3 stated R4 uses a wheelchair, as he tries to propel himself, but it's hard for him. R3 stated he has assisted R4 to the elevator by pushing him in his wheelchair many times, and seen other residents assist him as well. On 8/14/23 at 10:15 AM, R5 stated R4 smokes along with him. R5 stated R4 can get himself in his wheelchair and take himself down to the 2nd floor for smoke breaks. R5 stated he heard about the incident with R4 and was wondering why R4 never returned to his room for a long time. R5 stated R4 can get in his wheelchair by himself, but he rolls along in his wheelchair slow, so other residents have help to push R4 to the elevator. On 8/14/23, at 2:00 PM, V9, CNA stated she was assigned to care for R4. V9 stated R4 is known to get up on his own into his wheelchair and take himself to the elevator as he likes to be downstairs. V9 stated at scheduled smoking times and activities the activity aide or the CNA retrieves R4 and assist him downstairs. V9 stated the last scheduled smoke break is at 6:30 PM. V9 stated, "I should have checked on (R4), but did not check on him or his whereabouts and should have." V9 stated supper is delivered and served	S9999		

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on the 3rd floor around 5:30-5:45PM. V9 stated about 8:00 PM, is when V9 was informed by V11, Licensed Practical Nurse to do a search inside and outside of the facility building for R4 with V10, CNA. V9 stated, she took the 3rd floor and V10 took the 2nd floor and R4 was not found. V9 stated V3 had notified V1, then the fire department, police department and elevator inspector service had all arrived at the facility.

On 8/15/23 at 11:56 AM, V2, Director of Nursing, DON stated R4 should be supervised and checked on every 2-3 hours.

On 8/15/23 at 2:00 PM, V1 stated she did not have a policy for resident requiring supervision/monitoring and she is aware R4's scheduled medication for 8:00P was not marked as given on the Medication Administration Record. V 1 stated, she couldn't find documentation that physician was informed of the medications R4 did not receive.

On 8/21/23 at 2:57 PM, V28, R4's physician, stated he recalls receiving a call on 7/31/23 that R4 was trapped in an elevator but stated he was not informed R4 missed his scheduled 8:00 PM medication. V28 stated if informed he would asked the nurse the status of R4's vital signs (blood pressure/heart rate) and if vital signs were his normal range limit, would have given telephone orders to resume his normal medication the following day at scheduled time of 8:00 AM.

On 8/23/23, at 9:10 AM, V16, Elevator Company Maintenance, stated he was called out to this facility due to a trapped resident (R4) and informed he is to continue weekly monitoring of the elevator functioning. V16 stated he was

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called out on 7/31/23 around 11:00 PM. V16 stated he went to the basement to check the coding issue of the elevator, went back upstairs, and opened the elevator door to the small elevator, and R4 was sitting in a wheelchair. V16 stated R4 was happy to see V16. V16 stated if the elevator by chance, has too many buttons pushed at one time, can shut off the memory to the elevator and shut it down. In this case V16 was unsure what happened but was present when the small elevator door was opened and R4 was sitting in a wheelchair and retrieved by the emergency department.

(B)