

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6008015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE MARSEILLES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>578 WEST COMMERCIAL STREET MARSEILLES, IL 61341</b>
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S 000	Initial Comments  Annual Health Survey	S 000		
S9999	Final Observations  Statement of Licensure Violations 1 of 2  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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.  Section 300.1210 General Requirements for Nursing and Personal Care  b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	<p style="text-align: right;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</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>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.</p> <p>These Requirements were not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision and assistance for two of six residents (R68 and R23) reviewed for falls in a sample of 29. This failure resulted in R68 being sent to the hospital for pain and a fractured femur requiring surgery.</p> <p>Findings include:</p> <p>The facility's Fall Prevention Program policy, revised 11-21-17, documents "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls an implementation of appropriate interventions to provide necessary supervision and assistive devices are utilize as necessary...Fall/safety</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>interventions may include but are not limited to: Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet...Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and as addressed on the plan of care."</p> <p>1. R68's Minimum Data Set/MDS assessment, dated 12-26-22, documents R68 is severely cognitively impaired; requires limited assist with one person physical assist for bed mobility and toilet use; requires supervision with one person physical assist for transfers; and is occasionally incontinent of bladder.</p> <p>R68's Fall Risk Assessment, dated 3-3-23, documents R68 is at risk for falls.</p> <p>R68's Progress Note, date 3-3-23, documents: "Resident's roommate (R54) called for help down the hall. CNAs and this nurse entered room and found resident sitting on the floor in front of the toilet, facing the door. Observed resident's left leg pointing outwards in an unusual angle and resident c/o (complained of) severe pain in that leg. Resident denies hitting her head. 911 was called and resident was put on a stretcher to be sent to (local hospital) ER (Emergency Room) for evaluation."</p> <p>R68's Progress Note, dated 3-3-23, documents facility received call from local hospital. "States resident does have a fracture in femur of left leg."</p> <p>R68's Fall IDT (Interdisciplinary Team) note, dated 3-6-23, documents: "Late Entry: Summary of the fall: Resident's roommate called down the hallway for help, stating resident was on the floor in the bathroom. Resident stated 'I was trying to</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>go back to bed after going to the bathroom and fell'...Root cause of fall: Abnormal gait and lost balance while ambulating without assistance."</p> <p>R68's Hospitalist Note, dated 3-7-23, documents "Left Proximal Femur Fracture status post IM (Intramedullary) nailing 3-4-23."</p> <p>On 6-23-23, at 12:20pm, V12 Certified Nursing Assisant/CNA stated the following: It (R68's 3-3-23 fall) happened in the middle of the nightshift. Before this fall with a fracture (R68) had been going independent to the bathroom. (R68) walked herself in there. Not sure if (R68) was supposed to or not...Not sure what (R68's) care plan says. (R68) took herself. I didn't know (R68) was in the bathroom until the roommate (R54) called for help. (V13 CNA) and I went in the room together and (R68) was on the floor in an awkward position. (R68) did not say what happened. (R68) was in so much pain and literally going into shock.</p> <p>On 6-23-23, at 2:37pm, V13 CNA stated the following: (R68) was pretty independent and would ask for help if needed...We heard yelling and the call light had been turned on by the roommate (R54). At that point (R68) had fell in the bathroom. We didn't know (R68) was in the bathroom. Normally (R68) did take herself to the bathroom and if needed help would call...I can't remember what (R68's) chart said or the care plan. It was five months ago. But I would have known if (R68) needed supervision. I can't recall (R68) needing supervision.</p> <p>On 6-23-23, at 10:58am, R54 (R68's roommate) stated: "They do leave (R68) in the bathroom then go do something else. They did that this morning. They'll come back in maybe 10 minutes.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>(R68) is confused. They should probably stay with her."</p> <p>On 6-23-23, at 11:14am, V14 Certified Nursing Assistant/CNA and V15 Physical Therapy Assistant/PTA assisted R68 to walk from a wheelchair to the bathroom toilet. A healed incision line noted to R68's left hip.</p> <p>R68's Progress Note, dated 4-29-23, documents: "Description of fall: resident was transferring from toilet to wheelchair and fell...Investigation of 4/29 fall: resident states was transferring from toilet to wheelchair and fell; forgets to use call light."</p> <p>R68's Interdisciplinary Team/IDT Fall note, dated 5-1-23, documents: "Late Entry:...Summary of the fall: Resident found on the floor of her bathroom sitting on her butt. Resident states she was transferring from the toilet to her wheelchair and fell...Root cause of fall: Transferring unassisted."</p> <p>On 6-23-23, at 11:41am, V14 CNA stated the following: In the mornings (R68) will sit on the toilet for a little bit for a bowel movement then will pull the call light cord when she is finished. This morning (V16 CNA) went to check on (R68) then came to get me to help get (R68) off the toilet. (R68) could walk before the fracture. (R68) is a fall risk. Everyone is really considered to be a fall risk."</p> <p>On 6-23-23, at 12:07pm, V16 CNA stated the following: (V9 CNA) and I put (R68) on the toilet. I told (R68) when (R68) was finished to put her light on and (R68) did. (V14) CNA helped me get (R68) off the toilet.</p> <p>On 6-23-23, at 1:42pm V2 Director of Nursing/DON stated that as per policy residents</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>who are a fall risk or require assistance to shower or toilet should not be left alone in the shower or while on the toilet. R68 required assistance to toilet.</p> <p>2. On 6-20-23, at 10:13am, R23 was in bed with a sling to R23's right arm. R23 stated that the other day R23 fell in the shower. R23 slipped when turning to put the faucet in a different direction and fell onto the wet floor. R23 hurt the back of R23's shoulder and got all bruised up. R23 stated R23 also went to the hospital for a fall.</p> <p>R23's clinical record documents R23 was admitted on 4-19-23 with a right humerus fracture and sling to right arm after multiple falls at home.</p> <p>R23's Fall Risk Assessment, dated 5-5-23, documents R23 is at risk for falls.</p> <p>R23's Minimum Data Set/MDS assessment, dated 4-24-23, documents the following: R23 is moderately cognitively impaired; requires extensive assist with two person physical assist for transfers, dressing, toilet use, and personal hygiene; requires limited assist with one person physical assist for walking in corridor; requires total dependence with one person physical assist for bathing/showers; R23's balance is not steady, only able to stabilize with staff assistance; and R23 has upper extremity impairment on one side.</p> <p>R23's Progress Note, dated 6-10-23 at 1:00pm, documents: "Resident was heard yelling help from the shower room. CNA (Certified Nursing Assistant) checked and resident was sitting on the floor wrapped in towels. (R23) stated (R23) slipped on the wet floor. (R23) also stated (R23) hit her head on the wall when (R23) fell. On inspection redness and hematoma noted to upper</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>part of right side of head. ROM (Range of Motion) WNL (within normal limits), denies any discomfort."</p> <p>R23's Progress Note, dated 6-10-23 at 1:50pm documents: Out of facility with ambulance crew to ER (Emergency Room) for evaluation and treatment d/t (due to)nausea and vomiting after hitting head during fall.</p> <p>R23's Fall IDT note, dated 6-16-23 by V2 Director of Nursing/DON, documents "Summary of the fall: Resident slipped on shower floor and hit her head. Root cause of fall: Resident was let into the shower room by housekeeping and nursing was not aware of her showering. Intervention and care plan updated: Education provided to housekeeping to not let residents into shower rooms or any other locked area without getting approval from nursing."</p> <p>On 6-23-23, at 3:08pm, V2 Director of Nursing/DON stated that housekeeping should not have let (R68) in the shower. (R68) needs someone to stay with her.</p> <p>(A)</p> <p>2 of 2 Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)1 300.1210d)2</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</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>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>These Requirements were not met as evidenced by:</p>	S9999		



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S9999	<p>Continued From page 8</p> <p>Based on observation, interview, and record review, the facility failed to notify the doctor, implement/develop non-pharmacological pain techniques, and administer prescribed pain medication per order for one (R10) of one reviewed for pain in a sample of 29. These failures resulted in R10 having an increase in pain to where he was unable to get out of bed, and was transferred to the hospital for pain control.</p> <p>Findings include:</p> <p>Facility "Pain Management Program," revised 7/6/18, documents "To establish a program which can effectively manage pain in order to remove adverse physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. It is the goal of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program.</p> <p>R10's electronic medical record documents an "actual admission date of 5/11/23" with the following diagnoses: Cellulitis of left lower limb; Multiple Sclerosis; Spastic hemiplegia (affecting one side); chronic pain syndrome; disease of spinal cord; and foot drop."</p> <p>R10's medical record dated 5/15/23 documents R10 is cognitively intact and requires extensive assistance of two plus persons for activities of daily living.</p> <p>R10's current careplan documents R10's admission date as 5/11/23 and has a focus of "I</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>have an ADL/Activities of daily living self-care performance deficit related to multiple sclerosis, spastic hemiplegia, left foot drop, cervical myelopathy, and trigger finger right ring finger pain. I am on pain medication therapy related to multiple sclerosis and cellulitis" with an intervention of "Administer analgesic (pain reliever) medications as ordered by physician. Monitor/document side effects and effectiveness every shift. I have Multiple Sclerosis and spastic hemiplegia" with an intervention of "give medications as ordered; pain management as needed; see physician orders; and provide alternative comfort measures PRN/as needed. I have chronic pain related to Multiple Sclerosis and Cellulitis" with an intervention of "anticipate the residents need for pain relief and respond immediately to any complaint of pain."</p> <p>R10's Medication Administration Record (MAR), dated 5/1-5/31/23, documents the following: dated 5/11/23 "Pain assessment every shift every day and night" where night pain was a 7/10 on a pain scale with 10 being the worst pain; at 6:40pm on 5/11/23 R10 was assessed for pain as pain as 10/10 and was given PRN/as needed "Tylenol 650mg by mouth as needed every 4 hours for mild to moderate pain. R10's ordered Hydrocodone/Acetaminophen 7.5-325mg 1 tablet every 8 hours as needed for severe pain; Cyclobenzaprine 10mg as needed for muscle spasms three times a day; or Diazepam 5mg every 12 hours as needed for muscle spasms" with a start date of 5/11/23 was not given.</p> <p>R10's MAR, dated 6/1-6/30/23, documents the following: dated 6/5/23 pain was assessed as a 4/10, and on 6/18/23 pain was assessed as a 3/10; and was given PRN/as needed "Tylenol 650mg by mouth as needed every 4 hours for</p>	S9999			

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S9999	Continued From page 10  mild to moderate pain. R10's ordered Hydrocodone/Acetaminophen 7.5-325mg 1 tablet every 8 hours as needed for severe pain; Cyclobenzaprine 10mg as needed for muscle spasms three times a day; or Diazepam 5mg every 12 hours as needed for muscle spasms" with a start date of 5/11/23 was not given. R10's MAR further documents no PRN Hydrocodone was given on 6/5-6/7/23 and 6/18/23. On 6/6/23 Cyclobenzaprine was given twice and Diazepam was given once. On 6/18/23 Cyclobenzaprine was given once and Diazepam was not given.  R10's nurses note, dated 6/7/23 at 3:04am by V7 RN/Registered Nurse, documents "Shortly after the writer arrived on duty, resident verbalized he was having pain. PRN (as needed) Norco 7.5/325mg (milligrams) not yet available from pharmacy. At 7:17 PM, I gave resident prn Valium 5 mg. and prn Flexeril 10 mg. When I later gave room mate his scheduled meds, (R10) became upset wanting to know when his "Norco would be coming". He was slamming things around in his room and cussing. He then called his son who called me about the Norco. I informed his son what meds I had given him while we wait for the Norco to arrive. Ordered med is NOT available in facility PIXUS system. I phoned pharmacy and was informed the script had been filled and would be in the next delivery we receive. I informed resident. He then came to the south dining room and watched a movie with another resident till about midnight. He returned to his room. A short time ago I heard resident cussing and slamming things at his bedside. He then came to the dining room as facility phone rang at 2:40 AM. Resident had called 9-1-1 to go to hospital. I printed appropriate paperwork. A police officer came to facility prior to ambulance and spoke with the resident until ambulance arrived. Resident stated	S9999		

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S9999	<p>Continued From page 11</p> <p>"you're a Liar" to me. Left via ambulance at 2:49 AM. I phoned (local hospital) ER and let the nurse know (R10) was enroute and what prn meds I had given. (R10) took his phone with him and informed me his son knew he was gong to the hospital.</p> <p>"Local" Pharmacy "Patient Dispense History" documents "Hydrocodone 7.5-325mg tablet 7 day supply was delivered on 5/11/23, 6/6/23, and 6/19/23.</p> <p>On 6/20/23 at 10:30am, R10 was in his room in an electric wheelchair, alert and oriented, left foot red and swollen, and two 1/4 siderails on his bed to assist with mobility. R10 stated he is not getting his pain medications and over the last month he has had multiple days no pain medication available; He had three consecutive days no pain medications (6/5-6/7/23), went into withdrawals, and was sent out to the hospital for pain control. On 6/18/23 stated he did not get pain meds (vicodin but got them today 6/20/23) because they had to wait for them to come in. R10 stated his pain is a 7 but when he did not get his pain meds it was a 10/10, and he did not get out of bed those days. "I have been taking Vicodin (norco) for a long time and I see a pain doctor in Morris. The staff are aware my pain medication was not here and they did not do anything about it."</p> <p>On 6/23/23 at 10:58 AM V2 Director of Nursing/DON stated "We did not stock Norco in our Cubex/pixis or in our emergency medications prior to the incident with (R10) on 6/7/23 so there was none on hand to give to him; I am aware (R10) went to the hospital due to pain on 6/7/23 ; I am not sure why we never had it here and why</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6008015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2023</b>
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S9999	<p>Continued From page 12</p> <p>he went three days without it. If a person admits in the afternoon it can be the next day about 6pm before we get their medications; I am not sure why they deliver at 6pm every day; yes pharmacy can come multiple times a day and have before; and if we order/call for stat (immediate) medications they can get it to us in an hour. Quite frankly I am looking for a new pharmacy; ours comes from Burr Ridge about an hour away; I do not know if we utilize a local pharmacy for medications that aren't here, we never have since I have been here (March 2023)." V2 verified R10 did not get any Norco on 5/11/23, 6/5-6/7/23, and 6/18/23 due to no 7.5-325 Norco available in the facility but verified there was 5-325mg Norco available in their Cubex/pixis during those dates.</p> <p>On 6/23/23 at 11:19am V2 stated "What we had in stock was the Norco 5/325mg and (V10) is taking the 7.5/325mg tablets. I have a call to our pharmacy rep to see about a stat pharmacy to utilize, and none of the staff was aware of a local pharmacy to deliver medications." At that same time, V2 verified no nurse called R10's physician to obtain a different pain medication order, or to implement any nonpharmacological pain interventions.</p> <p>(B)</p>	S9999		