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
	IL6008308	A. BUILDING: ______ B. WING ______	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE TOLUCA	101 EAST VIA GHIGLIERI TOLUCA, IL 61369

(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 Licensure Post Visit to Survey Date 9/15/16. Aperion Care Toluca failed to follow their plan of correction for the survey of 9/15/16. Statement of Licensure violations	S 000		
S9999	Final Observations 1 of 3 300.1220b)3) Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. This requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to create care plans for intravenous lines and a wound vacuum device with goals and interventions for three of four residents (R3, R4 and R10) reviewed for care plans in a sample of four. Findings include: The facility care plan policy dated 1/1/2014 documents "...The Interdisciplinary Team	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Develops a comprehensive, individualized care plan based on interdisciplinary team assessments and comprehensive assessments of the resident prior to conference care...when a change occurs in a resident's condition the Resident Care Coordinator is notified by a member of the Interdisciplinary team. The care plan is then reviewed and updated...The Resident Care Coordinator reads report books and makes rounds daily and updates care plans as needed."

1. On 12/8/16 at 9:40a.m. R3 was lying in bed and had an intravenous line in R3's right arm and a wound vacuum device in R3's right groin.
R3's electronic admission record documents R3 was admitted to the facility on 2/14/03 with a readmission date of 12/1/16. R3's electronic care plan last revised on 9/28/15 did not identify R3's intravenous line or wound vacuum device as a focus area with goals and interventions.

2. On 12/8/16 at 9:47 a.m. R4 was sitting in a wheelchair and had an intravenous line port on the right chest.
R4's electronic admission record documents R4 was admitted 11/4/16.
R4's electronic care plan dated 11/17/16 did not identify R4's intravenous line port as a focus area with goals and interventions.
On 12/8/16 at 10:30 a.m. E6 MDS/Care Plans (Minimum data Set) stated R3 and R4's intravenous lines were not care planned and should have been.

3. R10's current electronic Physician's Orders Sheet documents an order for Meropenem (antibiotic) 1 gram, Administer 1 gram intravenously every 12 hours for bacterial infection until 12/9/16.
On 12/8/16 at 8:45 AM, R10 was sitting in R10's room with R10's intravenous medication hanging on an intravenous line pole next to R10. This medication was not currently infusing. At this

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same time, E9 (Licensed Practical Nurse) stated that R10's intravenous line infiltrated earlier that morning so E9 discontinued the line. E9 stated that E2 (Director of Nursing) was going to attempt to place another intravenous line later that day when R10 returned from R10's physician's appointment.
R10's current electronic Care Plan was reviewed and did not document R10's intravenous line and antibiotic as a problem area with goals and interventions.
On 12/8/16 at 10:30 AM, E6 (Minimum Data Set/Care Plan Coordinator) verified that R10's intravenous line was not included on R10's current care plan and that R10's intravenous line should be reflected on R10's care plan.
(B)
2 of 3
300.696a)
Section 300.696 Infection Control
a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.
This requirement is not met as evidenced by:
Based on observation, interview and record review the facility failed to don gloves during repositioning and cares for one of three residents (R3) reviewed for specialty care in a sample of four.
Findings include:
The facility's undated Glove Use-Nursing policy documents "...latex or vinyl gloves will be worn by employees who are not responsible for

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performing examinations, but who may come in contact with blood or body fluids visibly contaminated..."
The facility's undated Infection Control Standard Precaution policy documents, "...gloves will be worn when handling linen soiled with blood, body fluids, secretions, and excretions..."
On 12/8/16 at 9:40 a.m. E2 DON (Director of Nursing) and E7 CNA (certified nursing assistant) were repositioning R3 in bed. E2 pulled down R3's blankets without donning gloves. E7 and E2 grabbed R3's lift sheet to pull and reposition R3 onto R3's left side. R3's lift sheet was visibly soiled with light brown drainage. E7 stated R3's drainage was from R3's wound. E2 picked up a pillow from the floor and placed the pillow on the chair. E2, still with ungloved hand grabbed R3's indwelling urinary catheter tubing and attempted to clip it to R3's gown. E2 then removed a visibly dirty piece of tape from R3's indwelling urinary catheter tubing. E2 continued to hold R3's catheter tubing while E7 positioned R3. E2 continued to place a pillow between R3's legs, pull R3's blankets up and hand R3 the call light. E2 did not wear gloves throughout the duration of R3's cares.
On 12/8/16 at 11:22 a.m. E2 DON verified E2 did not wear gloves the entire duration of R3's cares, and E2 stated that E2 should have worn gloves during the R3's repositioning and cares.
(B)
3 of 3
300.2100
Section 300.2100 Food Handling Sanitation
Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750).
This requirement was not met as evidenced by:
Based on observation, record review and interview the facility failed to keep food covered

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S9999	Continued From page 4 during transportation. This failure has the potential to affect 14 residents (R10, R11, R13, R15, R19, R20, R21, R22, R27, R28, R29, R30, R31 and R32) residing in the facility. Findings include: The facility's undated Meal Service Safety policy documents the following: "The Dietary Department staff will practice safe food handling techniques during meal service... Food is to be covered when being transported outside the kitchen through common areas..." On 12/8/16 at 12:10 PM, the room tray cart was transported out of the dining room to be delivered to residents' rooms. The salads, desserts and cold drinks were not covered during this transportation. On 12/8/16 at 12:20 PM, E3 (Dietary Manager) stated that all food transported out of the cafeteria to the residents' room should be covered. E3 also verified that the salads, desserts and cold drinks were not covered during transportation to residents' rooms during the lunch meal. (AW)	S9999		