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APERION CARE PEORIA HEIGHTS	1629 GARDNER LANE PEORIA HEIGHTS, IL 61616

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S 000	Initial Comments Complaint Investigation 2420111/IL168395 2420569/IL168983	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610a) 300.1450 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 300.1450 Language Assistance Services A facility shall provide language assistance services in accordance with the Language Assistance Services Act and the Language Assistance Services Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to allow the use of an electronic communication device/tablet for one of three Residents (R2) reviewed for communication in a sample of 21. This failure resulted in (R2) a	S9999		

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deaf and aphasic resident experiencing agitation, crying and without a preferred source of communication.

Findings include:

Facility Resident Rights for People in Long Term Care Facilities, undated, documents: you have the right to dignity and respect; to make your own choices; care for you in a manner that promotes your quality of life; provide equal access to quality care regardless of diagnosis, condition, or payment source. The Facility must provide services to keep your physical and mental health, at their highest practical levels. You should receive the services and/or items included in your plan of care. You have the right to receive and make phone calls in private and access to the use of a telephone where calls can be made without being overheard; and you have the right to use your personal property.

The Facility Abuse Prevention and Reporting Policy, revised 10/24/22, documents: the Facility affirms the right of the Residents to be free from misappropriation of property. Misappropriation of property means the wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent. Resident concerns will be recorded, reviewed, addressed, and responded to using the Facility's grievance procedure. Residents will be informed of the Facility's grievance procedures; an essential element of "customer satisfaction" is timely response back to Resident concerns expressed; and employees are required to report any incident of misappropriation of resident property they observe, hear about, or suspect to the Administrator immediately or to an immediate supervisor who must then immediately report it to

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the Administration. Residents are encouraged to report their concerns or suspected incidents and reports should be documented and a record kept of the documentation.

The Facility Grievance Log, dated 9/1/23 through 1/20/24, does not document R2's concerns of a missing/stolen tablet.

R2's current Care Plan documents that R2 has diagnoses including Impaired Communication related to Hearing Deficit, Hearing Loss/ Deaf, and prefers to communicate by using an electronic tablet, reading lips and sign language.

R2's current Care Plan documents: will maintain current level of communication function by using appropriate gestures, responding to yes/no questions appropriately, using my electronic tablet; ensure able to utilize communication book; will use a communication tablet to communicate with staff and other residents.

R2's Progress Notes, dated 11/1/23 through 1/20/24, do not document concern/grievance investigation/resolution of R2's missing tablet.

On 1/20/24 at 9:08 am, R2 was crying, groaning, grunting, and throwing arms in the air and wrote on a piece of paper that "They took my computer tablet. I cannot talk to anyone." R2 was unable to communicate and continued to grunt, frown, and throw arms in the air. R2 was agitated and was unable to find staff to interpret concerns. R2 walked to V2's (Director of Nursing) office door on R2's hallway and pointed. R2 then proceeded to walk to the opposite side of the Facility and pointed at V3 (Social Service Manager), who was sitting in V3's chair, and pointed. R2 verified that V2 and V3 had R2's computer tablet. R2's

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electronic communication device was not available to R2 and was not in R2's room. R2 verified that R2 had spoken to V2 (Director of Nursing) and V3 (Social Service Manager) and that V2 and V3 had taken R2's tablet and had not given it back.

On 1/20/24 at 9:40 am, V3 (Social Service Department) stated, "(R2) is deaf and cannot talk and uses a tablet, but since (R2) was communicating to the local Police on (R2's) tablet. I believe (R2's) tablet is now locked up in someone's room. I know that (R2) is upset that we took her tablet. We have not given it back to (R2) since she was communicating with the Police. I really do not know much more about it. I do not even know where it is at. I did not file a grievance for the missing tablet either." R2's electronic communication device/tablet was not available to R2 and was not in R2's room.

On 1/20/24 at 11:15 am, V11 (Police Officer) stated, "I have been dealing with this Facility for quite some time now. I am very familiar with (R2). (R2) is deaf and unable to speak. (R2) has an electronic tablet that interprets (R2's) sign language and allows (R2) to communicate. (R2) would communicate with the Police Department often and was very, very distraught and has a history of behaviors, but I believe it is because (R2) is unable to communicate (R2's) needs. I also think that the Facility took (R2's) tablet from (R2) because (R2) was communicating with the Police Department, and now (R2) has no way to communicate. (R2) told me that they took the tablet and are not giving it back. I have witnessed the staff with her, and they are unable to communicate with her through sign language. (R2) does have paper and pen to communicate, but (R2) prefers the electronic tablet and the

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tablet is easier, and it also allows (R2) to make phone calls. I have been at this Facility a lot, and I have witnessed the staff be belligerent to Residents and it is very disturbing." R2's electronic communication device/tablet was not available to R2 and was not in R2's room.

On 1/20/24 at 9:55 am, V2 (Director of Nursing) stated, "(R2) has a tablet that she communicates with and can make phone calls. I have no clue where she got it and I have no contact person that you can call to ask anything about it either. We took (R2's) tablet from (R2) because she was misusing it and kept calling the police. As of right now, I cannot tell you where the tablet is at." R2's electronic communication device/tablet was not available to R2 and was not in R2's room.

On 1/20/24 at 9:45 am, V1 (Administrator in Training) stated, "I started working here two weeks ago. I do not have any information for you. I do not even know where (R2's) tablet is at."

On 1/23/24 at 11:30 am, V1 stated, "I cannot find a personal inventory sheet or any documentation for (R2's) tablet.

On 1/23/24 at 1:15 pm, V2 (Director of Nursing) stated, "(R2's) tablet is locked up in the Medication Storage room at the Nurses Station. (R2) does not need her tablet, it is not hers, she does not own it. She can ask for it when she needs it."

"C"

Statement of Licensure Violations II of II:
300.610a)
300.1210a)

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S9999	Continued From page 5 300.1210b) 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 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	S9999		

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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.

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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide adequate supervision for 1 of 14 residents (R4) reviewed for elopement risk in the sample of 21. This failure resulted in a cognitively impaired resident (R4) exiting the facility without staff knowledge and being found at a local bus station approximately three miles away from the facility, in 34-degree Fahrenheit temperature and requiring Police transport back to the Facility.

Findings include:

R4's Minimum Data Set/MDS, dated 11/30/23, documents R4's Brief Interview for Mental

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Status/BIMS score (10/15) as moderate cognitive impairment and Functional Abilities as partial/moderate assistance with Activities of Daily Living/ADLs.

R4's Nursing Progress Note, dated 1/5/24 through 1/20/24, document R4's diagnoses including End Stage Renal Disease dependent on Renal Dialysis, History of Transient Ischemic Attack/TIA and Cerebral Infarct/CVA.

R4's current Care Plan, undated, documents: R4 has communication deficit and speech is not clear, with word choice and usage limited. R4 is living with chronic health conditions and co-morbidities that require the support, services and structures of this care setting to maintain stability and highest practicable level of functioning; recognized that living with chronic medical/psychiatric illness, physical decline, the pandemic and requiring long term care. R4 has an alteration in mood state and psychosocial wellbeing secondary to Anxiety. R4 has an ADL self-care/mobility performance deficit related to Chronic Obstructive Pulmonary Disease, End Stage Renal Disease, Renal Dialysis, and history of Transient Ischemic Attack/TIA; poor impulse control; at risk for falls; arrange transportation as needed/as ordered and assist R4 in/out of transport van as allows. R4 is at risk for abuse/neglect related to poor memory and depression. R4 requires support of a long-care facility secondary to compromised medical status.

R4's Facility Elopement Risk and Community Survival Skills Assessment, dated 1/18/24, (not completed in entirety) documents that R4 is not capable of outside independent pass privilege.

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R4's Nursing Progress Note, dated 1/18/24 at 6:03 pm, documents R4 was "noted to have followed someone (V15 Dietary Manager) out the front door, (R4) went to the bus station where Police located him, and he was returned to the Facility." The Progress Note also documents that R4 was alert, R4 had no issues and R4 was placed on one-on-one observation.

R4's Police Report, dated 1/18/24, documents on the 1/18/24, V19 (Police Officer) responded to the Facility for a Missing Male (R4), that had been missing since 4:11 pm. The Report documents that V19 recognized the name of (R4) from (R4) previous Elopements wherein R4 "went missing and was found on the (bus station) V19 then transported R4 back to the Facility. Upon arrival V1 (AIT/Administrator in Training) advised that the Facility waited to call Police for over an hour because they did not know R4 was missing.

R4's Nursing Progress Note, dated 1/18/24 at 6:30 pm, documents R4 returned to the Facility at approximately 6:11 pm. with no injuries. The Progress Note also documents that "Officers stated that (R4) was combative" and that R4 was "currently sitting by the fireplace in the front, watching the front door." R4 was placed on one-on-one observation.

R4's Nursing Progress Note, dated 1/18/24 at 7:38 pm, documents that R4 was lying in bed and is "currently still a one-on-one observation."

R4's Nursing Progress Notes, dated 1/18/24 at 7:39 pm through 1/20/24 at 10:54 am, do not document R4's one-on-one observations.

Facility Nursing Daily Assignment and Nurse

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Group Assignment, dated 1/20/24, do not document a staff member assignment for R4's one-on-ones.

On 1/20/24 at 9:10 am, 9:50 am, 9:49 am, 9:50 am and 10:28 am, 1/23/24 at 12:09 pm and 12:56 pm R4 was lying in bed in R4's room, and no staff were present for one-on-one observations.

On 1/20/24 at 12:09 pm, R4 was unable to respond to or recall the events of the 1/18/24 Elopement and was non-conversive.

On 1/23/24 at 12:35 pm, V2 (Director of Nursing) could not identify the staff that were assigned to perform R4's one-on-ones (dated 1/18/24 through 1/20/24). V2 also stated, "We have an elopement book, there are fifteen residents in there, but I do not see (R4's) information in there."

On 1/20/24 at 9:45 am, V12 (CNA/Certified Nursing Assistant), "I was working on Thursday night (1/18/24) when (R4) got out of the building. (R4) was last seen around 4:00 pm. We discovered (R4) missing at the beginning of the dinner time service and medication pass. We could not find (R4), and we searched the entire building inside and out and could not find (R4). I had remembered that a couple of months ago, (R4) was found at the bus station after (R4) went missing from a dialysis appointment. So, I went to the bus station and found (R4) sitting there. I could not get (R4) into my car because (R4) was combative, but there was a Police Officer (V19) already there, so the Police Officer brought him back to the building. Come to find out, (R4) followed (V15 Dietary Manager) out of the front door that night."

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S9999	Continued From page 10 On 1/20/24 at 10:43 am, V1 (AIT/Administrator in Training) stated, "I started working here two weeks ago, I do not have any information for you. All I know is that (R4) got out of the building behind a staff member and was found at the bus station downtown. We think he got onto the bus down the road from the facility and rode the bus to the bus station, but we are not sure. The Police brought him back to the Facility. (R4) was last seen by staff around 4:00 pm on 1/18/24." On 1/20/24 at 10:43 am, V1 stated, "(R4) was approved to be in the community, so I did not consider this an Elopement, so I did not investigate it." On 1/21/24 at 9:15 am, V16 (R4's Brother) stated, "I was out in the Facility around lunch that day (1/18/24), seeing my brother to give him food and money. Then around 5:00 pm, I get a phone call from someone, not sure who, and asked me if my brother was with me and I said no, and they hung up real quick. Then a couple hours later, probably around 7:00 pm or 8:00 pm, I get a phone call from someone at the Facility again. They told me that they found my brother (R4) down at the city bus station. It was freezing out that day and I am not even sure he had a coat on at that time. The thing that makes me mad, is that he followed an employee, someone who works there, that is supposed to be protecting my brother." On 1/23/24 at 11:00 am, V1 (Administrator in Training) stated, "I do not have an investigation. (R4) had left dialysis before and also was found at the same bus station, so I figured that he was okay to do that. We just updated the Elopement Binder today with (R4's) information."	S9999		

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On 1/23/24 at 11:30 am, V15 (Dietary Manager) stated, "I have worked here about a month and a half. On 1/28/24 around 4:00 pm, I was leaving the Facility to go home. I exited through the front door and (R4) was sitting in the chair in the reception area. I saw (R4) get up and stand at the exit door, but the door had closed, so I proceeded to my car. I am thinking that the alarm had not reset and that (R4) got out right behind me. I never thought to look back at the door and check to see if (R4) got out. Then I heard that (R4) had gotten out right behind me and I feel so bad. I should have stayed and made sure the door was alarmed or gotten someone to help get him. I do not think (R4) had a coat on."

On 1/23/24 at 12:35 pm, the Facility Elopement Binder documents that (R2, R9 through R20) are Elopement Risks. The Elopement Binder does not document R4's information as an identified Elopement Risk.

On 1/23/24, at 12:35 pm, V2 (Director of Nursing) confirmed that R4's information was not documented in the Elopement Binder.

On 1/23/24 at 1:05 pm, V1 confirmed that R4 had diagnoses and cognitive deficit that should not allow (R4) out in the community alone and that "I probably should have investigated this once I saw the Facility Policy."

On 1/24/24 at 1:00 pm, V1 stated, "I just assumed that it was okay for (R4) to go out in the community on (R4's own). But I do see now on (R4's) Community Assessment for Elopement that (R4) was not approved to be in the community and was not allowed to be out of the Facility alone. (R4) was placed on one-on-ones,

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when (R4) returned to the Facility, and remained on those until Sunday (1/21/24). Then (R4) has been on fifteen-minute checks since 1/23/24, when the local State Agency was talking to me about this being considered an Elopement, and now I am thinking that (R4) will remain on those for five days. I cannot find the documentation for the one-on-ones. We just put (R4's) Elopement information into the Elopement Binder yesterday. I am not even sure at this point what the interventions are going to be for (R4). I am thinking probably trying to arrange more family visits since it seems like every time he gets out, he goes to the bus station and tries to go see them."

Facility Missing Resident/Elopement Policy, reviewed 11/15/2018, documents: all personnel are responsible for reporting a cognitively resident attempting to leave the premises, or suspected of missing, to the Charge Nurse as soon as practical; this includes any Resident that did not sign out on pass and/or did not notify a staff member of his/her leaving; should an employee observe a cognitively impaired Resident leaving the premises or attempting to exit the premises, he/she should attempt to prevent the departure without use of force, obtain assistance from other staff, notify the attending Physician, contact the legal representative/responsible party, make appropriate notations in the Resident's medical record, complete a new Elopement Risk Assessment and update the plan of care with appropriate interventions; example interventions such as (Electronic Monitoring Bracelet), increased monitoring (15 minute visual checks or one-on-one supervision); evaluate for secured unit and review and update the Elopement Risk binder; the Administrator and Director of Nursing will evaluate the situation and develop a plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004147	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PEORIA HEIGHTS	1629 GARDNER LANE PEORIA HEIGHTS, IL 61616

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S9999	Continued From page 13 action based on the individual resident; notify the sheriff and/or local police department and file a missing person report, complete incident report and notify the State Agency according to reporting guidelines; document appropriate notations in the medical record; and complete the incident report, indicating when Resident returned and condition of the Resident. "B"	S9999		