STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peoria Heights	1629 East Gardner Lane Peoria Heights, IL 61616

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on observation, interview, and record review the facility failed to ensure all facility doors were secured and properly alarmed; failed to provide adequate supervision; failed to ensure staff were able to properly identify R1; and failed to thoroughly investigate multiple elopements for one of three residents (R1) reviewed for elopement in the sample of three. These failures resulted in R1, a cognitively moderately impaired resident with the diagnoses of Traumatic Brain Injury, Convulsions, Epilepsy with Seizures, Alcohol Abuse, and Lack of Coordination eloping from the facility on two different occasions, and on the last occasion on 6-11-22 around 10:00 PM being found 3.1 miles from the facility, after dark, scared, and wandering aimlessly on a four-lane highway that runs parallel to the Illinois River. Facility staff were unaware of R1 missing for over an hour and a half before an off-duty staff member (V3 Certified Nursing Assistant) found R1 walking in the road. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 6-17-22 to have started on 4-22-22 when the facility failed to provide adequate supervision and implement elopement interventions after R1 was found outside of the facility and unattended by staff. This resulted in R 1 eloping from the facility a second time on 6-11-22 around 10:00 PM being found 3.1 miles from the facility, after dark, scared, and wandering aimlessly on a four-lane highway that runs parallel to the Illinois River. On 6-17-22 at 6:10 PM V1 (Administrator) and V2 (MDS Coordinator) were notified of the Immediate Jeopardy. While the immediacy was removed on 6-22-22, the facility remains out of compliance at a severity Level II as the facility continues to provide in-servicing to all staff, including new hires, on R1's and all other residents at risk for elopement updated care plan interventions, provide in-servicing of all staff and new hires on identifying residents at risk for elopement and how to provide adequate supervision for those at risk to prevent elopement, along with the facility's elopement drill (code pink), assess all residents quarterly who wander/exit seek and with any changes in behavior, and check door alarms every shift. The facility's IDT (Inter-Disciplinary Team) will review elopement risk assessment quarterly and reviewed elopement plans of action monthly. Findings include: (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Code Pin Missing Resident/Elopement policy dated 11-15-18 documents, Should an employee discover that a resident is missing from the facility, he or she should: a) Immediately report the missing resident to the charge nurse or nursing supervisor. b) Review the physician order to determine if the resident is out on an authorized leave or pass. c) Alert staff by announcing Code Pink over the paging system. d) Inform staff of the name of the missing resident and visualized picture of resident if available. g) The Administrator and Director of Nursing will evaluate the situation and develop a plan of action based on the individual resident. The following steps should occur: 1. A nurse should notify the attending physician. 2. Notify the resident's legal representative/responsible party. 7. Complete incident report and notify the state agency according to reporting guidelines. 8. Documents appropriate notations in the medical record. Upon return to the facility: 2. Contact the attending physician and report finding and condition of the resident. Follow physician's order. Notify the legal guardian/responsible party. 7. Complete the incident report, indicating when resident returned and condition of resident. 8. Make appropriate entries into the resident's medical record. 10. Complete a new Elopement Risk Assessment and updated plan of care as appropriate. 11. Review and update Elopement Risk binder. R1's Face Sheet documents R1 was admitted to the facility on [DATE] with the diagnoses of Type II Diabetes Mellitus, Unspecified Convulsions, Lack of Coordination, Symptomatic Epilepsy and Epileptic Syndromes with Complex Partial Seizures, Alcohol Abuse, Psychoactive Substance Abuse. Tobacco Use, and Personal History of Traumatic Brain Injury. R1's MDS (Minimum Data Set) assessment dated [DATE] documents R1 is cognitively moderately impaired and requires supervision with walking and locomotion on and off the unit. R1's Current Elopement Care Plan documents R1 is to have 15-minute checks. R1's Progress Notes dated 6-12-22 at 4:55 AM and signed by V11 (Registered Nurse/RN) document, (R1) attempted to exit the facility at around 9:40 PM (On 6-11-22). CNA (V3) on hillside noticed the attempt and brought back (R1) safely to the facility. (R1) is not on 15-minute checks. (R1) stayed in room and slept through the night. R1's Medical Record dated 4-1-22 through 6-12-22 does not include any documentation of R1's responsible party or R1's Physician (V13) being notified of R1's elopements in April 2022 and on 6-11-22. R1's Community Survival Skills Assessments dated 9-4-21 and 5-27-22 document, (R1) is sufficiently alert, orientated, and knowledgeable allowing him to be considered for independent outside pass privileges: No. Recommendations: The resident does not appear to be capable of unsupervised outside pass privileges at this time. R1's Elopement/Unauthorized Leave Risk Reviews dated 12-27-21, 2-23-22, and 6-14-22 document, Is there a history of wandering/elopement and/or does (R1) verbalized a strong desire to leave? Yes. Reported/documented episodes of elopement and/or attempts to elope? Yes. Signs of compromised decisional capacity and substantially impaired judgement and/or physical status limitation that would place (R1) at risk in the community: Yes. Elopement Risk Decision: At risk to elope and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. On 6-17-22 at 3:30 PM from 4:00 PM R1 was outside in the designated smoking area. At 4:05 PM R1 walked back into the facility and down the hallway. No staff checked on R1's location during this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6-17-22 at 4:10 PM R1 was standing in the hallway across from the nurse's station on the hallway that R1 resides on. R1 was confused to time and place. When asked where R1 was and what date it was R1 replied, I am in Decatur Illinois. Hell, no I don't know what day it is! On 6-17-22 at 4:50 PM this surveyor and V4 (Maintenance Director) opened the exit gait (where R1 exited on 6-11-22) to the smoking area patio that is located off of the dining room of the facility. When (V4) opened the gait, the alarm did not alert/function. On 6-17-22 at 3:45 PM V9 (Social Service Director/SSD) stated, (R1) is very confused and always wants to go to Decatur Illinois. (R1) is not safe to be in the community unattended and is assessed as a high risk for elopement. I was told on Monday that a CNA found (R1) up the road at night around 10:00 PM clear up by the bridge (three miles away). I am unsure if he exited that back or front door. We decided to put (R1) on 15-minute visual checks. On 6-17-22 at 3:50 PM V10 (LPN/Licensed Practical Nurse) stated, (R1) is confused at times. I did not know (R1) left the building unattended. I am not aware of (R1) being on 15-minute checks. On 6-17-22 at 3:55 PM V5 (CNA) stated, I was working the night (R1) left the building (6-11-22). I was orientating with another CNA and did not know (R1). I am one of the CNA's taking care of (R1) tonight. I do not think that (R1) is no. any checks or supervision. On 6-17-22 at 4:00 PM V6 (LPN) stated, I am new to this job. I do not even know who (R1) is. On 6-17-22 at 4:05 PM V7 (Agency CNA) stated, I have only worked here for two nights. I am (R1's) CNA tonight. I know (R1) is on 15-minute checks, but I have not had time to do them because we have been taking care of other residents. On 6-17-22 at 4:25 PM V12 (Staffing Coordinator) stated, I know a few months ago (R1) got out of the facility unattended. (R1) has always been an elopement risk and tries to get out a lot. (R1) needs to be watched extra close. On 6-17-22 at 4:25 PM V2 (MDS/Minimum Data Set Coordinator) stated, (R1) has always been an elopement risk and should not leave the facility unattended. (R1) has tried to leave the facility before. On Monday (6-13-22) I read the twenty-four-hour report and saw that (R1) had left the building over the weekend. That was the first time I had found out that (R1) left the building. All department heads were in a meeting on Monday (6-13-22) including (V1 and V9/Social Service Director). In the meeting we all discussed that (R1) had left the building unattended on Saturday (6-11-22) and (R1) was found down [NAME] Road by (chain restaurant). (V1) knew (R1) was found by (chain restaurant). We decided to initiate 15-minute visual checks for the staff to monitor (R1). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6-17-22 at 4:35 PM V11 (Registered Nurse) stated, On (6-11-22) I worked 6 PM to 6 AM. I was (R1's) nurse that night. The last time I had saw (R1) that night was sometime around 8:30 PM in the hallway. Next thing I knew a little after 10:00 PM (V3 CNA) had called the facility and said that she had found (R1) way up the road. I was not sure of (R1's) exact location of where he was found but was told it was over a mile away. I called (V1) and told (V1) that (R1) was found over a mile away, unattended by staff. I also told (V1) that no alarms were sounding. Staff did not know (R1) was missing from the facility. (V1) did not give me any instructions on what to do. I brought (R1) back into the building. (R1) is not capable of making his own decisions and should not leave the building without someone with him. (R1) has left the building unattended before. I do not know the exact day. I assessed (R1) when he got back and he was not hurt, just a little scared. On 6-17-22 at 4:55 PM V4 (Maintenance Director) stated, Someone must have de-activated the alarm to the smoking area gait. The alarm on the door that goes into the facility's dining room should alarm when the gait is opened. It should have worked. I check one or two door alarms to the facility exits weekly. I am not aware of the facility having an official policy on how often the door alarms are to be checked. (V1) did not tell me to check the door alarm to the smoking area until Monday (6-13-22) when I found that (V1) had saw on the cameras that (R1) had left the facility through that gait. On 6-17-22 at 4:40 PM V1 (Administrator) stated, I have not completed an investigation of (R1) leaving the facility or reported it to IDPH (Illinois Department of Public Health). I was told (R1) was just found in the parking lot of the facility. I was not told (R1) was found farther down the road until Monday (6-13-22). I have not confirmed that with the staff that supposedly found (R1). I am trying to figure out everything now. Everything I have found out so far is written down in chicken scratches. The elopement book resident pictures definitely need updated. You cannot even see (R1's) face in the book. I watched the cameras and (R1) left the building through the back smoking area gait on 6-11-22 at 8:38 PM. No staff were present when (R1) left the building. The nurse (V11) told me that no door alarms had went off the night (R1) left the building. (R1) is supposed to have 15-minute visual checks since Monday 6-13-22. I am not aware of (R1) ever leaving the premises before. On 6-17-22 at 5:00 PM V3 (CNA) stated, I have worked for four years at this facility. On Saturday (6-11-22) I left the facility at 9:53 PM. I was driving down the road after dark and saw a male who resembled (R1) walking in the road. It was dark and I could not tell if it was (R1) for sure. I called the facility and asked the staff if (R1) was there. No one could find (R1). (V11/RN) said no alarms were going off in the facility. I immediately stopped my car in the middle of [NAME] Road and went up to the man. It was (R1). (R1) was scared. There were no sidewalks beside the road, so (R1) had walked in the road and had gotten clear up to (Chain Restaurant located 3.1 miles from the facility). I could not believe (R1) had walked that far away from the building. The Illinois River is right beside that road. It would have been awful if (R1) would have drowned in the river. I took him back to the facility and made sure (R1) went back into the facility. I also notified (R1's) nurse (V11/RN). About two months ago in April around 4:00 PM, I was outside of the building smoking and saw (R1) walking around the next-door apartment buildings located off of the facility's grounds. (R1) was lost and the staff did not know (R1) was lost. I brought (R1) into the facility and immediately told (V1) that I had found (R1) at wandering outside, lost, and at the next-door apartments. (V1) did not ask me anything about finding (R1) down the road on 6-11-22 until yesterday. I told (V1) that I found (R1) in the road and down by (Chain Restaurant). I have never heard the alarm work or go off that is on the door going to the designated smoking area (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Progress Notes/Medical Record dated 1-1-22 through 5-31-22 do not include any documentation of V3 finding R1 off of the facility grounds, unattended by staff, and at the apartments next door to the facility. The Google Maps website dated 6-17-22 documents the (chain restaurant) that R1 was found in front of on 6-11-22 was located 3.1 miles away from the facility at 3503 North-East [NAME] Street Peoria, Illinois 61603. On 6-17-22 at 4:20 PM a binder containing picture and descriptions of residents at risk for elopement was located on the desk of the front lobby. R1's picture in this book was printed on a piece of 8.5 inch by 11-inch white paper. The picture was completely covered in black ink and R1's picture was unrecognizable. On 6-21-22 at 12:40 PM V16 (Chief Clinical Officer) stated, (R1's) medical record does not document anything about when (R1) left the facility premises in April (2022). After investigating (R1's) elopement in April the best date that we could come up with of when (R1) was found off the premises was 4-22-22. On 4-22-22 was the day that all staff (V3, V12, and V28/Human Resources) had worked together and were aware of (R1) leaving the premises and being found at the apartments next door. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. An investigation of both of R1's elopements was completed on 6-20-22 by V1 and sent to IDPH (Illinois Department of Public Health). 2. V1 was educated by V14 (Regional Nurse Consultant) on 6-20-22 on proper investigation of elopements and the facility's policy and procedure for reporting and completing an investigation. 3. All staff were educated by V1, V2, and V14 on all residents who are at risk for elopement along with their elopement interventions, behavioral sign and symptoms of elopement including wandering between units, hanging out around facility exits and verbalizing serious intent to leave facility. Staff were also educated on who has the physical ability to leave facility, who engages in this behavior, and who responds poorly to staff re-direction when wandering. Education of all staff took place between 6-17-22 and 6-22-22. 4. All staff were educated by V1, V2, and V14 on R1's elopement interventions as follows: increased monitoring/safety checks (1:1 or 15-minute checks), check door alarms for functioning and report any problems, keep resident occupied and in critical areas, notify administrator immediately if resident is exhibiting exit seeking behaviors or actual elopement of the resident occurs. Education of all staff took place between 6-17-22 and 6-22-22. 5. All staff were educated by V1, V2, and V14 to ensure all residents are provided adequate supervision to prevent any further elopements, and to ensure all staff were aware of who R1 and all other elopement risk residents are. Staff were also educated on identifying residents at risk for elopement and the policy and procedure for reporting to leadership to ensure proper interventions/care plans are initiated timely. Education of all staff took place between 6-17-22 and 6-22-22. 6. R1's care plan was updated with new elopement interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. All resident's elopement risk assessments were updated to ensure accurate assessment, and to implement interventions as needed along with updating those resident's care plans. 8. The Elopement Risk binder was updated with current, identifiable pictures of all residents who are elopement risks. 9. All exit doors were checked every shift for alarm function and to ensure alarms were in working order. All alarms were in working order and alarmed when checked by this surveyor on 6-21-22. 10. Code Pink (Elopement-missing person) drills were performed on 6-13-2022, and 6-18-22 through 6-22-22 by V1, V3, and V14. 11. V13 (Medical Director) was notified of R1's elopement on 6-12-2022 in the facility by V1. On 6-21-22 between 8:40 AM and 1:00 PM V24 (Physical Therapy Assistant), V25 (LPN), V26 (LPN), and V27 (CNA) stated that they had not received any in-services or training on who R1 is and what R1's elopement interventions are, residents who are at high risk for elopement and what their interventions are, notifying V1 on any resident who make elopement attempts, or providing increased supervision and activities to residents who are high elopement risks. V24, V25, V26, and V27 also confirmed that they had not received a Code Pink drill. Based on observation, interview, and record reviews conducted on 6-22-22 the facility completed all measures of the facility's abatement plan including the in-servicing regarding elopement procedures and Code Pink drills to all staff. Removal plan completion date 6-22-22.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 31682 Based on record review and interview the facility failed to provide 7 Certified Nurse Assistants with 12 hours of annual training including dementia management training and abuse training. This failure has the potential to affect all 72 residents within the facility. Findings include: The CMS (Centers for Medicare & Medicaid Services) Form 672 dated 6-17-22 documents 72 residents reside within the facility. The Facility's current CNA (Certified Nurse Assistant) Listing documents the following CNAs (V3, V19, V20, V29, V30, V31, V32) have worked for the facility for over one year. These same CNAs employee files do not contain evidence that these CNAs have had the required annual twelve hours of training or the required annual abuse and dementia management training. On 6-21-22 at 12:30 PM V16 (Chief Clinical Officer) stated that V3, V19, V20, V29, V30, V31, V32 have not received the annual twelve hours of training or the required annual abuse and dementia management training.