STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE PEORIA HEIGHTS	**1629 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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** Based on interview, and record review, the facility failed to notify the physician of finding prescription medications and drug paraphernalia in a resident room for one of two residents (R2) reviewed for death and of a change in resident condition for one of three residents (R1) reviewed for change in condition in the sample of 19. Findings include: The Facility's Physician-Family Notification-Change in Condition policy, dated 11/13/18 states, Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner. The Facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner, and if known, notify the resident's legal representative or an interested family member when there is: A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; B) A significant change in the resident's physical, mental, or psychosocial status; C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); D) A decision to transfer or discharge the resident from the facility. 1. R2's Nurses Notes dated 1/7/20 at 12:02 p.m., state Prescription medication that was not prescribed to (R2), a syringe (needle), and a pipe were found in (R2's) room. R2's Behavior Management Contract, signed by R2 on 3/5/19 (according to R2's Care Plan), states The following are inappropriate and unacceptable behaviors and will result in immediate pass suspension: 5. Using non-prescribed drugs and alcohol, this includes illegal substances. 1. I (R2) will remain drug and alcohol free. I will not return to the community under the influence of drugs, nor will I bring drugs into the community. If I test positive for any illicit substances at any time, my doctor will be notified, and I may be subject to involuntary discharge. 3. My person and belongings are subject to be searched if there is a reason to suspect a violation of this contract. The following items are considered contraband and are not allowed in resident's rooms: medication of any type, any sharp or dangerous objects (such as knives, razors, needles, letter openers, box cutters, pins, tacks, etc.) cleaning agents, aerosol cans, rubbing alcohol, any cosmetic item with alcohol content, weapons, candles, glass containers, drug paraphernalia, lighter/matches, metal silverware, Irons, and any cooking materials. R2's Care Plan dated 11/26/19, states I (R2) was read, educated on, understood, and voluntarily signed the behavioral management policy of this facility on 3/5/19. I understand the consequences of violating this policy contract may include drug drops, loss of community pass, medications held per doctor's order, and a safe involuntary discharge. On 8/12/20, V10 (R2's Physician) stated the facility did not notify him that R2 had prescription medications, needle/syringe, and a pipe were found in R2's room on 1/7/20. V10 stated I should have been notified that those items were found in (R2's) room. When incidents like this happen, I talk to the facility about the issue so we can make a plan for that specific individual. I might have ordered a drug screen, and possibly held certain medications on (R2). In certain instances, I send residents to the hospital. Each case is unique which is why it's so important that I'm made aware immediately. On 8/12/20 at 1:35 p.m., V2 (Director of Nursing) stated R2's medical record does not contain documentation that V10 was notified that R2 had prescription medications and drug paraphernalia found in his room on 1/7/20. 2. R1's Progress Notes dated 7/27/2020 at 1:49 AM, state Respiratory Section: Difficulty breathing noted, respirations shallow. Noted shortness of breath while flat, shortness of breath while sitting, and shortness of breath with activity. Abdominal breathing noted. Noted increasing respiratory distress. Currently on respiratory antibiotics: yes. On 8/12/2020 at 2:30 PM V4/LP(Licensed Practical Nurse) stated, I worked the night of 7/27/2020 when (R1) was having a lot of problems breathing. (R1) was getting worse, I could not keep (R1's) oxygen on (R1). (R1) was using (R1's) abdominal muscles to breath, so I knew it was harder for (R1) to breath. (R1) definitely had a change in condition. I did not call the doctor because I knew (R1) was on an antibiotic and using oxygen. On 8/12/2020 at 10:30 AM V2/DON (Director of Nurses) stated, I do expect the nurses to notify the physician when there is a change in a resident's condition. But, in (R1's) case, there was not a change in condition. The nurse just documented incorrectly. You can't have respirations of 20 and be tachypenic. On 8/12/2020 at 11:45 AM V3/PA (R1's Physician's Assistant) stated, I absolutely would expect to be called when a resident has a change in condition. I do not recall being called for (R1).
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview the facility failed to maintain the facility environment in good repair. This failure has the potential to effect all 90 residents residing in the facility. Findings include: On 8/10/20 at 10:00 a.m., there was a piece of tile missing at the riverside doors and the entrance of the dining room. On 8/10/20 at 10:40 a.m., the floor in room [ROOM NUMBER] was soiled due to a liquid spill. On 8/10/20 at 1:10 p.m., the floor was still soiled with the liquid noted at 10:40 a.m., but it had dried and was sticky. On 8/11/20 at 10:00 a.m., room [ROOM NUMBER] had a funnel taped to the sink drain that was then taped to the pipes below it. There was a bath basin on the floor under the sink that had approximately two inches of discolored water in it from the leaking plumbing. room [ROOM NUMBER]'s bathroom had a rotten wall behind the toilet that had been covered up with an approximate 3 foot by 4 foot piece of wall covering screwed to the existing wall. room [ROOM NUMBER]'s floor tile had liquid come up through the cracks when stepped on. room [ROOM NUMBER]'s toilet had black electrical tape on the plumbing to the right of the toilet handle. On 8/11/20 at 10:40 a.m., room [ROOM NUMBER] had a rotten wall, missing baseboard, and loose baseboard. On 8/11/20 at 10:55 a.m., Hillside hallway had loose/missing baseboard. On 8/11/20 at 11:00 a.m., R42 had a piece of baseboard loose and sticking out creating a potential tripping hazard just to the right of the door entrance. On 8/10/20 at 11:00 a.m., All hallways of the facility had chipped and scrapped paint and walls that needed repaired and painted. On 8/11/20 at 11:35 a.m., R16 stated the facility is in horrible condition. R16 stated there are baseboards falling off all over the facility and rotten walls, stained toilets, and leaking pipes. R16 stated My wife and I are ashamed of this place. On 8/11/20 at 9:45 a.m., R17 stated, This facility is a mess. No one in management seems to care that we live in a dilapidated building that is crumbling down. They never paint anything and there are scratches and chipped paint throughout the entire building. I have a wall in my room that is rotten from leaking pipes. I also have a spot on my wall that was patched at some point and then maintenance never came back to sand it or paint the wall. It's ridiculous that we are expected to live in this mess. My husband and I are trying to find another place to live. On 8/11/20 at 10:00 a.m., R14 stated This facility is disgusting and (management) does not

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) care. The place is literally rotting and they do nothing about it. My room is a mess and if someone does come to fix something, they only put a temporary fix on it and then never come back. The conditions are unsanitary. No one here deserves to live like we do. On 8/11/20 at 11:55 a.m., R15 stated My furniture is even in horrible repair. I can't use my dresser because it's in bad condition. I only use my closet. On 8/11/20 at 11:05 a.m., V21 (Maintenance Director) stated I don't have a written maintenance schedule. I just complete any jobs reported through work orders or word of mouth. On 8/13/20 at 2:15 p.m., V1 (Administrator) stated that she has not been making building/room rounds for the last five to six months due to Covid, so maintenance and repairs have gotten behind. V1 stated that the poor condition of the building has not been a part of their Quality Assurance plan The Facility's Centers for Medicare and Medicaid Services Roster Matrix dated 8/10/20, documents 90 residents reside in the facility.