STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145371	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE BLOOMINGTON	1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701

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

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on record review and interview the facility failed to ensure transfer in a safe manner using a full mechanical lift for one of four residents (R19) reviewed for falls on the sample list of 37. Findings include: (Private Company) undated manufacturers full mechanical lift guidance which documents the following: (Page 36-37) Warning, The wheelchair wheel must be in a locked position before lowering the patient into the wheelchair for transport. Use the straps or handles on the side and the back to guide the patients hips as far back as possible into the seat for proper positioning. 4. Position the patient over the seat with their back against the back of the chair. 5. Begin to lower the patient either by opening the control valve or by pressing down button. 6. With one assistant behind the chair and the other operating the patient lift, the assistant behind the chair will pull back on the handle (on select model) or the sides of the sling to seat the patient well into the back of the chair. This will maintain a good center of balance and prevent the chair from tipping forward. R19's Fall - Initial Occurrence Note dated [DATE] at 10:30 am documents the following: Fall Description: Resident (R19) had a witnessed fall 03/02/2020 (at) 10:30 AM Location of Fall: Residents room. This nurse (V3, Assistant Director of Nursing/ADON) was notified by CNA (Certified Nursing Assistant/V7) of fall. Resident observed on the floor partially in wheelchair. Wheelchair was tipped over. Resident was assessed. ROM WNL (Range of motion within normal limits), No c/o (complaint of) pain, and no injuries noted. On 03/02/2020 10:30 AM Resident statement (if applicable): I (R19) was trying to adjust myself. On [DATE] at 1:45pm V6, CNA closed the door in a small empty lounge and V6 reenacted R19's fall [DATE]. V6, CNA stated V6, CNA, V7, CNA and V8, CNA transferred R19 resulting in the a fall [DATE]. V6 stated V7, CNA reported immediately to the V3, ADON. V6, CNA stated V6, V7, and V8 CNA 's transferred R19 from R19's bed to R19's reclined high back wheel chair, using a full mechanical lift. V6, CNA stated once R19 was in the reclined high back wheel chair, V6, and V8 removed the sling loops. V7, CNA moved the mechanical lift away from R19's wheelchair. V7 went to the foot of R19's wheel chair and started to put the foot peddles on. R19 was not straighten out in the wheelchair, the high back of the wheel chair was totally reclined. V6 stated and showed how R19 attempted to adjust R19's position in the wheel chair, when the highback reclined wheel chair tipped completely backwards thrusting R19s head back into the bathroom door and R19's body overflowing the right side of the wheelchair causing it to land on its side. V6 stated V6 was on the left side of the wheelchair and was not able to prevent R19's fall. V6, CNA stated The head of the wheelchair was reclined completely and probably shouldn't have been in that position when R19 tried to adjust by herself. V6 also stated (R19) is a big woman and the wheelchair started to tip backwards towards the bathroom door. V6 stated (V8,CNA) and I (V6, CNA) could have positioned (R19) more upright in her wheelchair once we transferred her (R19) but I'm not sure if the back of the wheelchair was up, the fall could have been prevented. V 6 laid down on the floor to demonstrate how R19's body hung the wheelchair until V3, ADON came into assess R19 after the fall. On [DATE] at 11:05 am V8, CNA reiterated V6,CNA recollection of R19's fall [DATE] full mechanical lift transfer and that the high back wheelchair was reclined to a laying position. On [DATE] at 2:00 pm V1, Administrator confirmed R19's fall [DATE] occurred during mechanical lift transfer from the bed to R19's reclining wheelchair.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (R34) received as needed pain (PRN) medication for one of twenty-five residents reviewed for pain management in the sample list of 37. Findings include: R34's current physician's orders [REDACTED]. R34's Minimum Data Set ((MDS) dated [DATE] documents R34 is cognitively intact. R34's Progress Notes dated 2/10/2020, documents: nurse practitioner to see resident; resident has complaint of pain in bilateral lower extremities (BLE); unable to ambulate; new order for STAT (immediately) bilateral lower extremities venous doppler and bilateral knee x-ray - two views. R34's Medical Diagnostic Services, Incorporated results, have an order from R34's Nurse Practitioner (V13) that documents: looks like she (R34) has OA ([MEDICAL CONDITION]), [MEDICATION NAME] [MED] 1% 2 gram to each knee TID (three times a day) daily for 14 days then change to PRN - may wrap the knee for swelling during the day hours - EM 2/11/20. R34's Medication Administration Record (MAR) dated [DATE] through 3/31/2020, does not document an order for [REDACTED]. On [DATE] at 6:20 AM, R34 stated R34's knees hurt so bad. This information was reported to the nurses, V14 and V15, both Licensed Practical Nurses (LPN), who both stated the medication would be given to R34 after report. R34's MAR for March 2, 2020, does not have any documentation of an order for [REDACTED]. On [DATE] at 10:40 AM, V3 Assistant Director of Nursing (ADON) stated there was no order in the March MAR for [MEDICATION NAME] PRN or wrapping knees for R34, it was not transcribed nts anywhere. V3 also stated as far as V3 knows, the topical pain medication ([MEDICATION NAME]) was never given to R34 after the 14-day routine order and R34's knees were never wrapped. V3 stated the orders should have been written on the March 2020 MAR and it was not, and treatments were not being done. On 3/5/20 at 9:45 AM R34 stated R34's knees hurt so bad at night and the nurses don't put anything on them and they don't ask me about my pain R34 stated R34 has to use R34's wheelchair now because of the pain and R34 wants to use her walker again. -R34 stated the medication helped when they were using it on my knees. The facility's Pain Management Program Policy dated Revised 7/6/2018, documents to establish a program to effectively manage pain to remove adverse physiologic and physiological effects of unrelieved pain and to promote resident comfort; preserve and enhance resident dignity and facilitate involvement; and pain control will be assessed during routine medication passes.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Failures at this level required more than one deficient practice statement. A. Based on record review, observation and interview the facility failed to disinfect resident shared blood glucose monitors on both the two facility wide medication carts. This failure has the potential to affect thirteen residents (R1, R2, R11, R16, R21, R26, R29, R35, R55, R56, R58, R61 and R62) of thirteen residents reviewed for cross contamination during medication administration on the sample list 37. B. Based on record review, observation and interview the facility failed to administer eye drops in a safe sanitary manner to prevent cross contamination for one of one resident (R46) reviewed for infection control during medication administration on the sample list of 37. C. Based on record review, observation and interview the facility failed to remove soiled gloves and perform hand hygiene to prevent cross contamination after providing perineal care and between two resident provision of care. This failure affected two of two residents (R19 and R33) reviewed for infection control on the samples of 37. Findings include: a. R1, R2, R11, R16, R21, R26, R29, R35, R55, R56, R58, R61 and R62's Physician order [REDACTED]. On 03/02/20 at 07:31 am V12, License Practical Nurse (LPN) removed a resident shared glucose (accucheck) monitor (glucometer) from the top drawer of V12's unit medication cart. V12, LPN used a resident shared glucometer to

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) measure R58's blood glucose level, at 217 milligrams per deciliter. V12 returned to V12's unit medication cart and wiped the resident shared glucometer with a one inch by one inch alcohol pad. V12 placed the resident shared glucometer back in the top drawer of V12 unit medication cart without disinfecting (according to facility policy) the monitor. On [DATE] at 7:50 am V12, LPN stated V12 had already measured the other residents blood glucose on V12's units that morning. V12 confirmed the blood glucose monitors in both of the two facility medication carts are shared by all residents (R1, R2, R11, R16, R21, R26, R29, R35, R55, R56, R58, R61 and R62's) in the facility. V12 also stated We don't have bleach wipes to clean the accucheck monitors (blood glucose monitors), we use alcohol wipes here (in the facility). On [DATE] at 9:50 am V2, Director of Nursing (DON) was administering medications from the second and only other medication cart. V2, DON stated all residents had already received blood glucose monitor checks on V2, DON's units that morning. V2, DON also stated We clean our resident shared glucose monitors with an alcohol wipe. We do not have bleach wipes on the carts (medication). On [DATE] at 9:15 am V2, DON submitted a facility wide list of residents (R1, R2, R11, R16, R21, R26, R29, R35, R55, R56, R58, R61 and R62's) who receive blood glucose monitoring from the two facility medication cart, resident shared blood glucose monitors. The facility policy Glucometer Cleaning dated [DATE] documents the following: Purpose: To prevent the growth and spread of microorganisms and bloodborne pathogens. Guidelines: The blood glucose monitor should be cleaned and disinfected between each resident test. Procedure: 3. To clean and disinfect the meter (glucometer), use a pre-moistened wipe/towel of one ml (milliter) or five to six percent sodium hypochlorite solution (household bleach) and nine ml water to achieve a one to ten ratio dilution final concentration of five to six percent sodium hypochlorite. b. R46 Physician order [REDACTED]. On [DATE] at 9:15 am V2, DON entered R46's room carrying a small bottle of Artificial Tears eye drops, an oral medication cup containing pills, a drinking glass containing water and a pair of latex gloves. V2, DON laid R46's Artificial Tears eye drop bottle, an oral medication cup containing pills, a drinking glass containing water and a pair of latex gloves on R46's visibly cluttered bedside table. R46's bedside table was cluttered with R46's denture cup, multiple loose stacks of denture tablets, television remote control, soda can, stacks of loose paper and paper clips. R46's cluttered bedside tables had sticky clear and white substances adhering to the table top in a splattered pattern. After V2 emptied V2's hands by placing the above items on R46's contaminated bedside table, V2 opened a soda from R46's refrigerator and administered R46's oral medication. V2, DON picked the contaminated latex gloves off the contaminated bedside table and tucked them under V2's arm pit. V2, DON walked into the bathroom to wash V2's hands with the contaminated gloves clenched under her arm. V2 washed V2's hands with the latex gloves clenched firmly under her arm pit. V2, DON returned to R46's bedside drying her hands with the contaminated latex gloves under V2's arm pit. V2, DON donned the soiled gloves and administered R46's Artificial Tears eye drop to both of R46's eyes. On [DATE] at 9:50 am V2, DON acknowledged V2 administered R46's eye drops with contaminated gloves and stated I (V2) considered my armpit clean when I tucked in the gloves, because I know my clothes are clean. The gloves probably shouldn't have been directly on the cluttered bedside table. The facility policy Infection Prevention and Control Program dated 11/28/17 documents the following: Guidelines: 14. All facility personnel are required to routinely wash hands and use appropriate barrier precautions to prevent transmission of infections. c. On [DATE]20 at 1:10 pm V5, Certified Nursing Assist (CNA) V6, CNA's used a gait belt to transfer R33 from the wheel chair to the toilet. R33 voided continent of bowel and bladder. V6, CNA performed R33's perineal cleaning care, while V5, CNA maintained R33 in a standing position in the front of the toilet. V6, CNA did not remove V6's soiled gloves, wash V6's hands or use hand sanitizer after V6, CNA performed R33's perineal care. V6, CNA assisted V5, CNA to stabilize R33's by guiding R33 with R33's gait belt to a seated position in R33's wheelchair. V6, CNA continued with the same contaminated gloves and pushed R33's wheelchair into the R33's bedroom. V5, CNA and V6, CNA transferred R33 to bed. V6, CNA took R33's shoes off and assisted R33 to a back lying position in bed. V6, CNA applied a blanket draped over R33's head, wrapped the blanket criss-crossed scarf fashion over R33's neck, shoulders and chest using the same contaminated gloves. V6, CNA exited R33's room without removing V6, CNA's contaminated gloves, washing V6, CNA's hands or using hand sanitizer. At 1:25 pm when V5, CNA and V6, CNA left R33's room, V6, CNA pushed a full mechanical lift down the hall and entered R19's room with the same contaminated gloves used during R33's perineal cleaning. V6, CNA and V5 CNA attached the the full mechanical lift sling loops to the mechanical lift transfer bar. V6, CNA continued with the same contaminated gloves used during R33's perineal cleaning. V5 and V6, CNA's transferred R19 from R19's wheelchair to R19's bed using the full mechanical lift. V6, CNA touched R19's mechanical lift sling, clothing and bed linens with the same contaminated gloves. R19 was repositioned to a side lying position. V6 CNA placed a bed pan under R19's buttocks and repositioned R19 to a back lying position to void bowel and bladder. V6, CNA placed the bed pan without removing the same contaminated gloves used for R33's perineal care. V6, CNA removed the contaminated gloves and left R19's room without washing V6's hands or using hand sanitizer. On [DATE] at 2: 10 pm V6, CNA stated I know better and should have been washing my hands before during and after (R33's) care. I guess I was a little nervous when I (V6, CNA) left (R33's) room with dirty gloves on. I (V6, CNA) definitely should have washed my hands between (R19) and (R33's) care. The facility policy Incontinence Care dated 1/16/18 documents the following: Procedure 2. Perform hand hygiene and put on non-sterile gloves. After the completion of incontinence/perineal care, the same policy documents the following: Remove gloves and perform hand hygiene. (in bold print) Do not touch any clean surfaces while wearing soiled gloves.