STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145160	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Capitol	555 West Carpenter Springfield, IL 62702

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interview, observation, and record review the facility failed to accommodate smoking needs for 4 of 4 (R14, R47, R61, and R97) residents reviewed for accommodation of needs in the sample of 57. The findings include: 1. R14's care plan documented R14 requires assistance with transfers r/t (related to): Old CVA / MVA (cerebrovascular / motor vehicle accident) with limited use of left side. This plan of care is documented as being initiated on 04/23/2019 with interventions as follow: Teach me to transfer to: -bed -chair -toilet with a sit to stand and 1 staff per his request. R14 care plan also included that has a physical and psychological addiction to nicotine/smoking and smoking routine. Significant extended disruptions in smoking routine may cause physical and psychosocial/ behavioral disturbance. The Date Initiated for this area is 12/03/2020. R14's MDS (minimum data set) completed on 7/5/2024 documented R14 being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, indicating he is cognitively intact. On 7/16/24 at 1:28 PM (V11) CNA, stated R14 broke his wheelchair due to the way he leans, arches backward and slumps to the left side. V11 CNA stated they are waiting on a new wheelchair, but it has to be a special kind to fit his needs. V11 CNA stated that V1 should be working on getting this done. V11 stated R14 has staff come to work with him on positioning and range of motion but he refuses it and only cares about being able to get out and smoke. On 07/17/24 at 9:08 AM R14 seen sitting in a wheelchair right outside the dining room. The wheelchair has one foot rest on the right side so R14 can prop his left foot on top of without sliding off. R14 is on top of two seat cushions. R14 stated he had to stay in bed all day yesterday because they did not get him a new wheelchair. R14 stated it's not good to stay in bed all day and he didn't like it. R14 stated he did not get to smoke at all yesterday either. R14 stated they usually give him three smoke breaks a day for 6 minutes at a time and that is not very much time at all. 40650 (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 07/16/2024 at 10:00 AM, R47 stated that smokes breaks are too short, they are only allowed 1 cigarette and the staff stays out only for 6 minutes. R47 also stated that it makes him feel like he is locked up. R47's MDS, dated [DATE], documented that his cognition was intact. 3. On 07/15/24 at 11:08 AM, R61 stated, We are told we can have 1 cigarette and we have 6 minutes to smoke it and that is all we get. R61 was given 1 cigarette and it was lit by staff. Once R61 completed smoking his cigarette, he asked for another one and was told by an unknown staff member, that he only gets one. R61 stated, See, I told you so. R61's MDS, dated [DATE], documented that his cognition was intact. 4. On 7/16/2024 at 9:45 AM, R97 stated that when he goes outside to smoke, he is allowed 1 cigarette and he has 6 minutes to smoke it. R97 also stated that he would like to be able to smoke more than 1 cigarette when he is allowed to go out. On 7/16/2024 at 11:05 AM, R97 was being taken out to smoke by staff. There were approximately 5 to 6 residents outside to smoke during this time. R47 was allowed 1 cigarette and was taken back inside the facility when he was finished with it. On 7/16/2024 at 3:05 PM, R97 was being taken out to smoke by staff. There were approximately 6 residents outside to smoke. R97, was given 1 cigarette, it was lit by the staff. R47 stated that he would like a 2nd cigarette but was not heard by the staff and the staff took him back inside. On 7/16/2024 at 3:25 PM, V31, Activity Director, stated that the residents are allowed 1 cigarette and that they have 6 minutes to smoke it and that the 20 minutes is documented on the Smoking Times, document. R97's Minimum Data Set, dated dated [DATE], documented his cognition was intact. The Facility's document, Smoking Times, undated, documented, 2nd floor 9:15 AM-9:40 AM, 3rd Floor 9:50-10:10 AM, 2nd Floor 11:00 AM - 11:20 AM, 3rd Floor 11:30 AM - 11:50 AM, 2nd Floor 3:00 PM - 3:20 PM, 3rd Floor 3:30 PM-3:50 PM, 2nd floor 6:00 PM-6:20 PM, 3rd floor 6:30 PM-6:50 PM. On 7/18/24 at 11:50 AM, V1, Administrator, stated the residents are allowed to smoke more than 1 cigarette, but they figured 1 cigarette takes about 6 minutes to smoke. V1 stated, We also can't take everyone out at once and if they smoke more than 1 or 2 cigarettes, and they have to buy their own cigarettes, they would run out before they can get more money to buy more.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to provide timely and complete incontinent care, including hand hygiene, and glove changes, for 4 of 5 residents (R4, R25, R58, R97) reviewed for incontinent care in the sample of 57. 1. R25's Face Sheet, undated, documents R25 was admitted to the facility on [DATE], with diagnosis of Multiple Sclerosis (MS), irritable bowel syndrome with Diarrhea, and Major Depressive Disorder. R25's Care Plan, dated 6/11/24, documents R25 has a bowel/ bladder incontinence related to disease process MS, Impaired Mobility, Physical limitations. Interventions: 12/14/21 Remove peri-wash from bedside table and encourage to call for assistance, apply barrier cream after each incontinent episode, check and change Q (every) 2-3 Hours and PRN (as needed), clean peri-area with each incontinence episode, complete bowel and bladder assessment upon admission, quarterly and as needed, encourage fluids during the day to promote prompted voiding responses, ensure call light is within reach and answer promptly, monitor and document intake and output as per facility policy, monitor skin and report any areas of breakdown, monitor/document for s/sx (signs/symptoms) UTI (Urinary Tract Infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns, toilet before and after meals, upon rising in the AM and before bed at night. R25's Minimum Data Set (MDS), dated [DATE], documents R25 is cognitively intact and is dependent on staff for toileting and all other ADLs (Activities of Daily Living). R25 is frequently incontinent of both bowel and bladder. On 7/15/24 at 11:18 AM, R25 seen lying in bed, stated she's been here for eight years, is incontinent and will let staff know when she's wet/soiled. R25 stated she does get cleaned up, but she usually has to wait between a half hour to an hour before staff will clean her up. On 7/16/24 at 10:15 AM, R25 seen lying in bed, stated she is wet now and has been all morning. R25 stated that no one has checked on her or cleaned her up yet today. R25 stated they don't usually clean her up until right before lunch. R25 stated that is the norm here and she is used to it by now. R25 stated she always feels cold when she is wet and waiting for staff to clean her up. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/24 at 11:05 AM, V11, CNA, and V12, CNA, entered to provide peri-care to R25. V11 tucked R25's saturated brief between her legs, used the same pair of gloves and got a wet washcloth from the basin of water with peri-wash poured into it, wiped under the abdominal fold of R25, then using the same gloves, got a dry washcloth and dried the abdominal fold. V11 used the same soiled gloves and got a wet washcloth out of the clean water basin and wiped R25's right groin, then got a dry washcloth and dried R25's groin. Still using the same gloves, got another wet washcloth from the water basin and wiped R25's left groin, then got a dry cloth and dried it. V11 used same gloves again to get a wet washcloth from water basin and wiped once down the middle of R25's vagina, got dry washcloth and dried it. V11 doffed her gloves, walked to the restroom, and turned the sink water on, then returned to the bedside within five seconds with dry hands. It did not appear that V11 washed her hands. V11 then donned new gloves and obtained a wet cloth from the water basin and wiped R25's left buttocks, got dry cloth and dried her, then using same gloves, V11 got wet cloth from the water basin and wiped between R25's legs from front to back, including the anal area, got dry cloth and dried R25. V11 doffed her gloves and again walked to restroom and returned within seconds with dry hands, donned gloves, and put a clean incontinence pad and clean brief down on the bed. R25 was turned to her left side and V12 removed the soiled linen/brief from under R25. R25's buttocks were slightly reddened. V12 obtained a wet cloth from the water basin, and wiped R25's right buttock, dried it, then applied barrier cream to R25's buttocks, rolled R25 back to her back and applied barrier cream to abdominal fold, and other skin folds. R25 sat in a saturated incontinent brief for extended amount of time prior to CNAs entering to clean her up. Both CNAs failed to change gloves once soiled and failed to do hand hygiene between the glove changes. V11 contaminated the clean water by putting her soiled gloves into the basin multiple times. 2. R58's Face Sheet, undated, documents R58 was originally admitted to the facility on [DATE], with the diagnosis of Cerebral Infarction with Monoplegia, Dysphagia, Aphasia, Gastrostomy, Chronic Obstructive Pulmonary Disease, Hypertension, Atherosclerotic Heart Disease, Gastro-Esophageal Reflux Disease, and Major Depressive disorder. R58's Care Plan, dated 7/7/24, documents R58 has an ADL (Activities of Daily Living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day related to Hemiplegia, Limited Mobility. Interventions: R58 receives all nutrition per tube feedings. It continues R58 requires tube feeding related to dysphagia. Interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record, R58 is dependent with tube feeding and water flushes. See MD orders for current feeding orders, needs the HOB (head of bed) elevated 45 degrees during and thirty minutes after tube feed, monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of: Aspiration- fever, SOB (shortness of breath), tube dislodged, infection at tube site, self-extubating, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration, provide local care to G-Tube site as ordered and monitor for s/sx of infection, RD (Registered Dietitian) to evaluate quarterly and PRN, monitor caloric intake, estimate needs, make recommendations for changes to tube feeding as needed. R58's Minimum Data Set (MDS), dated [DATE], documents R58 has a severe cognitive impairment and is dependent on staff for all ADLs. R58 is always incontinent of both bowel and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/24 at 9:34 PM, V25, CNA, and V26, CNA, provided peri-care to R58. Supplies at bedside, including a basin of water. V25 got a wet washcloth from basin of water, sprayed it with peri-wash, then wiped once down the middle of R58's vagina, then got another wet washcloth from the basin of water and wiped R58's left groin, which showed feces on the cloth. V25 got another wet washcloth from basin of water and wiped R58's right groin, also showing feces on the cloth. R58 was rolled to her right side and V25 got two wet washcloths from the basin of water and wiped R58's anal area showing feces. V25 used the same gloves and got another wet cloth and washed R58's buttocks, then got a clean pad and brief and put then on bed. R58 was rolled to her left side, while V26 pulled the soiled linen and brief out from under R58 and then R58 was rolled back to her back side, V25 got a towel and dried R58's groins and pubic area, then fastened the brief. R58 was covered with a sheet, and the head of the bed elevated. There was incomplete cleaning of the peri area during this care, along with contaminating the clean water by putting soiled gloves into the water to obtain a wet washcloth. On 7/18/24 at 11:42 AM, V1, Administrator, stated I would expect staff to provide timely and complete incontinent care to the residents. I would expect staff the dry the residents after cleaning and to fold the washcloth/towel to clean areas if using the same cloth to wipe the resident. I would expect the staff to do hand hygiene before, during glove changes, and after resident care. I would expect staff to change their gloves when soiled and going from soiled areas to clean areas. I would expect staff not to touch items in the resident's room while wearing soiled gloves. The facility's Incontinent Care Policy, dated 4/20/21, documents Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. Procedure: 2. Perform hand hygiene and put on non-sterile gloves. 4. Soap one cloth at a time to wash genitalia using a clean part of the cloth for each swipe. In the female, separate labia, wash with strokes from top downward (with gloved hand), each side separately with a clean cloth or clean area of the cloth. Keep labia separated with one hand. 6. Gently pat area dry with a towel from anterior to posterior. 9. Change gloves and perform hand hygiene. The facility's Glove Use-Nursing Policy, dated 1/31/18, documents 5. Gloves used for contact shall be removed and discarded after contact with each person, fluid item, or surface. 7. Hand hygiene will be performed after removing gloves. The facility's Hany Hygiene/Handwashing Policy, dated 1/10/18, documents Examples of when to perform hand hygiene (either alcohol-based hand sanitizer or handwashing): After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. If hands will be moving from a contaminated body site to a clean body site during patient care. After glove removal. 40650 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 7/18/2024 at 9:18 AM, V29, CNA and V30, CNA, performed hand hygiene, donned gloves and gowns. V29 removed R4's soiled incontinent brief, cleansed bilateral groins and peri area but did not cleanse R4's thighs nor was the washed areas dried. R4 started to have a bowel movement and was covered up and given a glass of milk while the staff waited for her to finish having a bowel movement. Then at 9:45 AM, V29 and V30, both CNA's continued to perform incontinent care on R4. V29, CNA, washed R4 with no rinse peri wash and a wet wash cloth, cleansed front to back R4's perineum to her rectal area. R4's hips were cleansed, and both were not dried. R4's back of both thighs were not cleansed. V29 then applied peri guard ointment to R4's bottom. R4's Care Plan, dated 6/10/2022, documented, INCONTINENT: Check every 2-3 hours and as needed for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. R4's MDS, dated [DATE], documented R4 was rarely or never understood cognitively, was dependent upon staff for hygiene after toileting and was always incontinent of bowel and bladder. On 7/18/2024 at 10:00 AM, V29 and V30, both CNA's, stated that all areas should be cleansed and dried after incontinent care. On 07/18/24 at 11:50 AM, V1, Administrator, stated she would expect the staff to cleanse all areas while doing incontinent care and drying the resident after using the no rinse peri wash. 4. On 7/17/2024 at 9:40 AM, V17, CNA performed incontinent care on R97 using no rinse soap and wet wash cloths. V17, cleansed down R97's right thigh, right groin, then folded the washcloth and cleansed the left groin and thigh. These areas were dried with a towel and with a new wet wash cloth, V17, then pulled back the foreskin of R97's penis, cleansed the penis tip twice, and down the shaft several times without folding the wash cloth. These areas were dried with a towel. R97 was rolled onto his left side. V17, CNA then cleansed the right hip with a wet wash cloth, and cleansed the rectal area several times because R97 had a bowel movement. V17 did not dry R97's right hip and there were no rinse soap suds visible on R97's right hip. R97 was then rolled on to his right hip and incontinent care was completed. R97's Care Plan, dated 5/5/2023, documented, INCONTINENT: Check every 2-3 hours and as needed for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. R97's MDS, dated [DATE], documented that R97's cognition was intact, that he was always incontinent of his bowel and bladder and was dependent upon staff for hygiene after toileting.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to provide tube feedings according to the facility policy, including the proper labeling of the tube feeding, and the correct positioning of the resident during care for 1 of 2 residents (R58) reviewed for proper tube feeding in the sample of 57. The Findings include: R58's Face Sheet, undated, documents R58 was admitted to the facility on [DATE], with the diagnosis of Cerebral Infarction with Monoplegia, Dysphagia, Aphasia, Gastrostomy, Chronic Obstructive Pulmonary Disease, Hypertension, Atherosclerotic Heart Disease, Gastro-Esophageal Reflux Disease, and Major Depressive disorder. R58's Care Plan, dated 7/7/24, documents R58 has an ADL (Activities of Daily Living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day related to Hemiplegia, Limited Mobility. Interventions: R58 receives all nutrition per tube feedings. R58 requires tube feeding related to dysphagia. Interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record, R58 is dependent with tube feeding and water flushes. See MD orders for current feeding orders, needs the HOB (head of bed) elevated 45 degrees during and thirty minutes after tube feed, monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of: Aspiration- fever, SOB (shortness of breath), tube dislodged, infection at tube site, self-extubating, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration, provide local care to G-Tube site as ordered and monitor for s/sx of infection, RD (Registered Dietitian) to evaluate quarterly and PRN, monitor caloric intake, estimate needs, make recommendations for changes to tube feeding as needed. R58's Minimum Data Set (MDS), dated [DATE], documents R58 has a severe cognitive impairment and is dependent on staff for all ADLs. R58 is always incontinent of both bowel and bladder. R58's Physician Order (PO), dated 6/6/24, documents, Enteral Feed, every shift for Nutritional Supplement Jevity 1.2 at 55 ML hour continuously. R58's PO, dated 2/6/24, documents, Enteral Feed, five times a day 150 ML water flush 5x daily. R58's PO, dated 1/16/24, documents, Enteral Feed, every shift Enteral - Elevate Head of bed at least 30 Degrees during feeding, any medication administration, and for 30 minutes after feeding. R58's PO, dated 1/16/24, documents, Change intermittent administration set every 24 hours. Every night shift. R58's PO, dated 1/16/24, documents, Enteral Feed, every shift Enteral - Check Tube Placement before Feeding, Flush and Meds. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24 at 11:28 AM, R58 was lying in bed with tube feeding seen infusing at 55 ML (milliliter)/hour. Tube feeding bottle was labeled with R58's name and is dated 7/14/24 at 11:00 AM. There is a new bottle spiked with new tubing hanging besides that bottle but is not started. This new bottle does not have a label with name, room number, or a date written on it. It does have a rate of 65 ML/hour written on it, which is not what R58's is supposed to be running at. On 7/15/24 at 3:20 PM, R58 still has same bottle of tube feeding infusing at 55 ml/hr. The bottle appears empty with the last of the tube feeding in the tubing going into pump. The same full bottle was seen hanging next to the old bottle, and is still unlabeled, with no name or date and has not been started. On 7/16/24 at 9:20 AM, R58's tube feeding was seen infusing at 55 ML/hour with the same spiked unlabeled bottle that was hanging all day on 7/15/24. This bottle was not labeled with a name, or date, with 65 ML/hour written on it. This bottle was started during evening or night shift on 7/15/24. On 7/17/24 at 9:00 AM, R58 lying in bed with tube feeding infusing at 55 ML/hour, appears to have a new bottle hanging that is labeled with R58's name, date of today 7/17/24 at 7:00 AM, with approximately 900 ML left in bottle. On 7/17/24 at 9:05 AM, V10, Licensed Practical Nurse (LPN), stated, When I changed the bottle this morning, the one that was hanging was not labeled and was empty. I hung a new bottle this morning and flushed the tube. If I ever found a spiked bottle of tube feeding without a label indicating when it was spiked, I would throw it out because I would not know when it was spiked or how long it was hanging there. We have to put the resident's name, date and time it was spiked, and the rate it is infusing. On 7/18/24 at 9:34 AM, V25, Certified Nursing Assistant (CNA), and V26, CNA, provided peri-care to R58. R58 had tube feeding infusing at 55 ML/Hour during care. R58's head of bed (HOB) was lowered for care, and R58 was turned to left and right side, and then the HOB was raised after care was completed. The tube feeding was not stopped during care. On 7/18/24 at 9:40 AM, V26, CNA, stated, We don't touch the tube feeding machine, the nurses have to take care of it. We told (V1, Administrator) that we were going to do R58's peri-care, and no one came to shut it off. We didn't know that we have to shut the pump off while we lower the HOB and do resident care. On 7/18/24 at 9:45 AM, V28, LPN, stated, I did not know that the CNAs were going in to do peri-care on (R58). If they would have told me, I would have shut off the tube feeding. They know better. On 7/18/24 at 9:20 AM, V2, Director of Nursing (DON), stated, The nurses are required to put the date and time the tube feeding bottle was spiked, along with the resident information. If there was a bottle that was spiked and did not have a label indicating when it was spiked, that bottle should be discarded and not used. On 7/18/24 at 11:43 AM, V1, Administrator, stated, The CNAs should let the nurse know before they are going to do care on any resident on tube feeding so the pump can be shut off. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Gastrostomy Tube-Feeding and Care Policy, dated 8/3/20, documents Procedure: 3. Label container with resident's name, flow rate, date and time. 5. Position resident on his/her back with head elevated to minimal 30 degrees and preferable 45 degrees. Storage and Handling of Formula: Record date/time formula is opened. Cover opened, unused formula in refrigerator. Discard opened, unused ready-to-feed formula after 48 hours (record date and time of opening). Discard unused reconstituted formula after 24 hours (record date and time of mixing). Hang Time: A. Closed system: a. Formulas in closed systems can safely hang for 24-48 hours. Follow manufacturer's recommendations and instructions for use. b. Record date/time container is hung.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43847 Based on record review and interview the facility failed to administer medications according to physicians' orders for one of 3 (R263) residents reviewed for medications in the sample of 57. Findings include: R263's face sheet dated 7/18/2024 documents admitted [DATE]. R263 has diagnosis of intracerebral bleed, Alzheimer's, and Atrial fibrillation. R263's physicians admitting orders from hospital dated 7/5/2024 documents Seroquel 25mg half tab every day and Seroquel 25mg daily at bedtime. R263's admitting orders at facility dated 7/5/2024 document Seroquel 25mg half tab daily at bedtime for depression. Start Date 07/05/2024 at 8pm, D/C (discontinue) Date 07/11/2024, and Seroquel 25mg tab daily at bedtime dated 7/5/2024. R263's medication administration record dated 7/2024 documents that Seroquel 25mg half tab was administered at 8pm along with Seroquel 25mg at 8pm on the dates of 7/6/2024, 7/7/2024, 7/8/2024, 7/9/2024 and 7/10/2024. On 7/17/2024 at 10:00am V7 (Assistant Director of Nursing) stated she had noticed when she was doing the consents that the orders on R7's Seroquel were not right. V7 stated she thought the doses had been switched and she corrected medication administration times for the doses. V7 stated she was not aware R7 had received a total of 37.5mg at Seroquel at bedtime and that would be a medication error. V7 stated, I will follow the process for medication errors now. V7 stated that according to the medication administration record that R7 received 37.5 mg of Seroquel for the dates of 7/6/2024, 7/7/2024, 7/8/2024, 7/9/2024 and 7/10/2024 instead of the doctor ordered 25mg. V7 stated on 7/11/2024 the order was corrected so R7 started receiving the Seroquel 12.5mg at 0800 and the Seroquel 25mg at 8pm. On 7/17/2024 at 10:10am V2 (Director of Nursing) stated R7 receiving 37.5mg of Seroquel at 8pm instead of the doctor ordered 25mg at bedtime was considered a med error and the facility will follow the policy for med errors. The facility provided a not dated policy titled, Medication Administration General Guidelines which documents medications are to be administered per doctor's order.

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	145160	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Capitol	555 West Carpenter Springfield, IL 62702

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40650 Based on observation, interview and record review, the facility failed to properly store, label and date raw poultry and food, and failed to properly sanitize dishware, cups and silverware. This failure has the potential to affect all 109 residents residing in the facility. Findings include: On 07/15/24 at 9:45 AM, in the 1st refrigerator reviewed, on the top shelf was a zip lock bag with thawed out chicken not dripping on to other foods but there were cups of juices underneath the top shelf. There was also a sandwich that was dated 7/5/24. In the 2nd refrigerator, there was a tray, with fruit in bowls, covered but not dated and there were cups of red, jelled like substance covered but not dated. On 7/15/2024 at 9:55 AM, the dish machine was checked. A staff member was asked to check the chlorine and it was. The Chlorine test strip was reading zero after the 10 sec contact time. The dishwasher was leaking water all over the floor, the temperature gauze, glass was broken, and it read 120F even during a rinse cycle. On 07/17/2024 at 1:55 PM, the thawed out chicken and sandwich that was dated 7/5/24 that was in the 1st refrigerator on 7/15/24 was still there. V15, Dietary Consultant, was made aware and stated that she would take care of it. V15 was also made aware of the undated fruit and Jello that was in the 2nd refrigerator on 7/15/24. V15 stated that yes, she saw that when she came in on Monday, an hour after it was found, and she corrected it at that time. V15 also stated that as far as the dishwasher not registering the chlorine, the chlorine was not pulling to the dish machine so that is why when the chlorine was checked on Monday, it was reading zero. V15 stated that she does not know for how long the chlorine dispenser was not working. Starting today (7/17/2024), they were using the manual ware washing which is they are running the dirty dishes through the dishwasher, then they are soaking it in the quintenary sanitizer and then letting the dishes air dry. V15 stated she was unaware of when the issues started with the dish washing machine. V15 stated that there should not had been thawed out chicken sitting on the top rack of the refrigerator and that they (the staff) know better than that. On 7/17/2024 at 3:00 pm, V15 stated that the facility does not have a policy for Manual dishware washing but in 2 weeks a new policy will go into effect. On 7/18/24 at 11:50 AM, V1, Administrator, stated that the thawed out chicken should have been dated and not on the top shelf. V1 stated that all food should be labeled and dated. V1 stated she was not sure when the chlorine dispenser for the dishwasher stopped working but they came in and fixed the dishwasher and it was working last night. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy, Food Storage (Dry, Refrigerated, and Frozen), undated, documented, A. all food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed or discarded. It continues, C. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration. It continues, E. Store raw animal foods such as eggs, meat, poultry, and fish separately from cooked and ready to eat food. If they cannot be stored separately, place raw meat, poultry and fish items on shelves beneath cooked and ready to eat items. If multiple shelves are available, the raw animal food with the highest final cooking temperatures should be stored on the lowest level, i.e., poultry and stuffed foods. F. Raw animal foods such as eggs, meat, poultry and fish should be stored in drip proof containers. wrap food properly. Never leave any food item uncovered and not labeled. The facility's policy, Dishwashing: Machine Operation, undated, documented, 4. If the machine is found to be out of the acceptable range for either final rinse temperature or proper chemical sanitizing concentration, do not proceed to wash dishes. Empty dishwashing machine, check nozzles and empty bottom screen and restart the dishwashing machine. 5. After trouble shooting, if the dishwashing machine is not functioning, the employee should contact the Dining Services Manager or maintenance or outside vendor per facility per facility guidelines to coordinate repair. The dishwashing machine should be labeled out of service and not utilized until the dishwashing machine is repaired. 6. If the dishwashing machine cannot be repaired in a timely manner, the facility will utilize the manual dishwashing procedure (see Dishwashing: Manual Guidelines in this section). Paper goods may be used as a temporary measure until the dishwashing machine is repaired. The facility's Centers for Medicare/Medicaid application, dated 7/15/2024, documented that there were 109 residents residing in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on interview and record review, the facility failed to A. follow its policy in order to prevent the potential water borne illness. B. don Personal Protective Equipment when providing direct patient care for (R58) residents reviewed for Enhanced Barrier precautions. This failure has the potential to affect all 109 residents residing in the facility. Findings include: A. On 7/17/2024 at 12:45 PM, V20, Maintenance Director, stated there are unoccupied rooms on the 1st and 4th floor of the Facility. V20 stated he lets the water run once a month to flush the pipes. V20 stated he does not document this procedure and stated, I just have to do it. On 7/18/2024 at 9:52 AM, V1, Administrator stated there is construction taking place on the 4th floor of the Facility, changing out plumbing and knows V20 has been flushing the pipes. V1 stated, Maybe he needs to develop a log to document the procedure is being completed. The Facility's Policy Water Management Program for Prevention of Legionella Growth dated 6/30/2017 documents, Purpose: To identify and reduce the risk of Legionella growth and spread. Guidelines: Definition: Legionella is found naturally in [NAME] environments, like lakes and streams, but generally the low amounts in [NAME] do not lead to disease. Legionella can become a health problem in building water systems. To pose a health risk, Legionella first has to grow (increase in numbers). Then it has to be aerosolized so people can breathe in small, contaminated water droplets. It continues to document areas of potential risk include water heaters, shower heads, pipes, valves, fittings, and infrequently used equipment, including eyewash stations. It continues to document, Preventative maintenance will be performed as applicable: The following will be verified and documented at least once weekly: The domestic how water boiler/storage tanks verified to be set between 140-160 degrees F (Fahrenheit). Thermostat indicating the temper of water entering the circulating system at the mixing valve is 120 F or above. Eye wash stations will be inspected and flushed weekly. The Facility's Water System Assessment for Legionella Risk dated 8/17/2023 documents, in part, Risk Activities: Any areas not in use due to construction/remodeling? If yes, list specific areas & interventions: Yes, first floor and 4th floor are not i[n] use. It continues to document, Comments: Any areas of risk identified such as potential stagnation dead legs, etc? If yes, please describe below: Eye wash stations-Potential stagnation due to infrequent use- Intervention: Flush weekly x (times) 5 minutes. It further documents there are 4 eye wash stations and ice machines on the 2nd floor and kitchen. The Facility's CMS (Center for Medicare and Medicaid Services) form dated 7/15/2024 documents there are 109 residents residing in the Facility. B. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R58's Face Sheet, undated, documents R58 was originally admitted to the facility on [DATE], with the diagnosis of Cerebral Infarction with Monoplegia, Dysphagia, Aphasia, Gastrostomy, Chronic Obstructive Pulmonary Disease, Hypertension, Atherosclerotic Heart Disease, Gastro-Esophageal Reflux Disease, and Major Depressive disorder. R58's Care Plan, dated 7/7/24, documents R58 has an ADL (Activities of Daily Living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day related to Hemiplegia, Limited Mobility. Interventions: R58 receives all nutrition per tube feedings. It continues R58 requires tube feeding related to dysphagia. Interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record, R58 is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders, needs the HOB (head of bed) elevated 45 degrees during and thirty minutes after tube feed, monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of: Aspiration- fever, SOB (shortness of breath), tube dislodged, infection at tube site, self-extubating, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration, provide local care to G-Tube site as ordered and monitor for s/sx of infection, RD (Registered Dietitian) to evaluate quarterly and PRN, monitor caloric intake, estimate needs, make recommendations for changes to tube feeding as needed. R58's Minimum Data Set (MDS), dated [DATE], documents R58 has a severe cognitive impairment and is dependent on staff for all ADLs. R58 is always incontinent of both bowel and bladder. On 7/18/24 at 9:34 PM, V25, Certified Nursing Assistant (CNA), and V26, CNA, provided peri-care to R58. Both CNAs entered R58's room without proper PPE on. There is a sign posted on the door indicating that R58 is on Enhanced Barrier Precautions (EBP). Peri-care was performed by both CNAs with no Personal Protective Equipment (PPE) on. On 7/18/24 at 9:42 AM, V25, CNA, stated (R58) is on Enhanced Barrier Precautions to protect her from infections. I guess we were supposed to put a gown on, but we forgot. On 7/18/24 at 9:45 AM, V28, Licensed Practical Nurse (LPN), stated I did not know that the CNAs were going in to do peri-care on (R58). (R58) is also on EBP and the CNAs should have put PPE on when going in the room to do care on her. On 7/18/24 at 11:40 AM, V1, Administrator, stated I would expect all staff going into a resident room who is on EBP, to wear appropriate PPE (Personal Protective Equipment), including gown and gloves, when doing resident care. The facility's Enhanced Barrier Precautions sign documents Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, changing briefs or assisting with toileting, Device care or use: Central line, urinary catheter, feeding tube, tracheostomy, Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Enhanced Barrier Precaution Policy, dated 4/8/24, documents Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Indwelling medical device examples include: Feeding Tubes, Central Lines, Urinary Catheters, Tracheostomies. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities, especially when care is being handled: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care.