STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146000	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Fairfield	305 N.W. 11th Street Fairfield, IL 62837

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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 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** 43088 Based on observation, interview, and record review the facility failed to supervise a known elopement risk resident and complete wander guard tests to ensure a wander guard was working for 1 of 5 residents (R1) reviewed for supervision in a sample of 5. This failure resulted in R1 eloping from the facility, falling down three steps onto asphalt in R1's wheelchair, and sustaining a laceration to the head requiring sutures. The Immediate Jeopardy began on 6/18/24 at approximately 2:00 AM when R1 was unable to be located by facility staff and was found to have eloped from the facility and had fallen down three steps in R1's wheelchair. V1 (Administrator), V7 (Regional Clinical Director), and V8 (Vice President of Operations) were notified of the Immediate Jeopardy on 7/31/24 at 2:40 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, on 6/20/24, prior to the start of the survey and was therefore past noncompliance. Findings include: 1. R1's face sheet documented an admitted [DATE] with diagnoses including: dementia, hypertension, atherosclerotic heart disease, type 2 diabetes mellitus, hyperlipidemia, presence of cardiac pacemaker. R1's 7/8/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. R1's care plan documented an initiated 8/30/23 focus area documenting in part . I am an elopement risk/ wanderer due to exit seeking, Resident wanders aimlessly . and an initiated 7/6/21 focus area documenting in part . I am at risk for fall/ injury (related to) wandering and poor safety awareness . R1's Order Summary Report documented an 8/6/23 order for Wanderguard (elopement alert device) check function on dayshift every Sunday. (continued on next page)

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.

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	On 7/26/24 at 1:04 PM, V5 (Certified Nursing Assistant/ CNA) said she was caring for R1 during the night of 6/17/24 to 6/18/24. V5 said the facility was short staffed on the night of 6/17/24 to 6/18/24 and V5 and V4 (Licensed Practical Nurse/ LPN) were the only two staff working on R1's unit. V5 said R1 had been in R1's wheelchair ambulating around the facility. V5 said V6 (CNA) arrived at the facility at 2:00 AM. V5 said she was giving V6 report when V6 asked where R1 was in the facility. V5 said after looking around V4, V5, and V6 started a facility wide search. V5 said at approximately 2:36 AM, R1 was found lying in the parking lot in a pool of blood with R1's wheelchair on top of R1. V5 said R1 had fallen down three concrete steps in R1's wheelchair. V5 said the doors leading to the loading dock, where R1 fell , were usually locked but the locking mechanism was not working. V5 said there was no wanderguard alarm sounding and there was no other alarm on the loading dock doors. V5 said prior to the 6/18/24 incident R1 had exit seeking behaviors but R1 had never managed to get out of the facility. On 7/30/24 at 9:11 AM, V4 (LPN) said she was the nurse caring for R1 on the night shift from 6/17/24 to 6/18/24. V4 said she was sitting at the nurse's station charting at approximately 2:30 AM when V5 (CNA) and V6 (CNA) alerted her R1 was missing. V4 said she assisted V5 and V6 with a facility wide search for R1. V4 said at approximately 2:36 AM, V4 was called to the loading dock doors by V5 and found R1 to have fallen down three concrete steps in her wheelchair and was lying in a pool of blood with R1's wheelchair on top of R1. V5 said she could not recall if R1 was lying on R1's back or side but R1's head was busted and bleeding quite a bit. V5 said she immediately called Emergency Medical Services (EMS) to transfer R1 to the hospital for further evaluation. V5 said she was not sure if R1 had a wanderguard on 6/18/24 at the time of this incident but was sure the wanderguard alarm was not sounding. V5 said the door to the loading dock had malfunctioned at the time of the incident on 6/18/24. V5 said when exiting the building a button was pushed to unlock the door and a code had to be entered to unlock the door from the outside but during this incident she and other staff had went out of and back in the door without having to push any buttons or enter any codes. On 7/30/24 at 11:09 AM, V7 (Maintenance Director) said he hadn't received any work orders pertaining to the loading dock doors locking mechanism or the wanderguard system not functioning at the loading dock doors. V7 said prior to R1's 6/18/24 incident the facility did not have any logs of checking the wanderguard alarming system at points of exit in the facility. V7 said he did not have any logs of checking door locking mechanisms and was unsure how often the locking mechanisms were to be checked. V7 said he was not sure who was responsible for checking door locking mechanisms. On 7/30/24 at 11:25 AM, V7 measured the height from the top of the loading dock platform to the asphalt pavement, where R1 fell , to be 24.5 inches. On 7/31/24 at 2:29 PM, V9 (Physician) said he was familiar with R1. V9 said prior to R1 being moved to the locked unit in the facility it was possible R1 was an elopement risk. V9 said he expected the facility to follow their policy for checking wanderguards. V9 said he expected the facility would have a system in place to keep residents from eloping and the facility should follow their protocol. (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 6/18/24 hospital record documented in part . EMS states: (R1) eloped out the back door of (skilled nursing facility) and fell down 3 stairs causing trauma to the right side of (R1's) head Significant swelling noted to (right) eye. Multiple abrasions to right side of face with one deep laceration/ avulsion to the right forehead that is still bleeding a light amount. Moderate amount of clotted blood present in hair/ on wounds. Unknown if (R1) lost consciousness or not. According to EMS (R1's) cognition is at baseline . wound repair of 6 (centimeter) . subcutaneous laceration to face. Irregularly shaped Skin closed with 16 4-0 Ethilon using simple sutures . R1's 6/18/24 reportable incident investigation folder contained 3 written statements by V4 (LPN), V5 (CNA), and V6 (CNA). V5's (CNA) 6/18/24 statement documented in part .Around midnight (R1) was sitting on the side of the bed. I know she is a fall risk, so I asked her if she wanted to get up and she did. I placed her in her (wheelchair). She was moving about and I redirected her from other hallway and brought her back to sit by the birdcage. I last seen her sitting at the birdcage. I gave report and went and answered a call light. (V6) asked where (R1) was. We did not immediately see her so we began to search the building. I heard a voice out the dock doors as I was down that way looking. (V6) and I opened the door and (R1) was on the parking lot face down with her (wheelchair) on top of her. We called for help. Nurse came. EMS came. That was about 2:36 AM when we seen the resident . V6's (CNA) 6/18/24 statement documented in part . I arrived to work at 2 AM. I received report from (V5). I then heard a call light going off. So (V5) and I went to assist that resident. As I was walking back up the hall I looked toward (R1's) room and noticed she was not in there. (V5) and I immediately began to search the building for her. After 2 passes we informed the nurse (V4) that there was a missing resident. (V5) was down the back hall near the dining room and she thought she faintly could hear something outside. We pushed the door open and seen (R1) down the 3 stairs onto the parking lot in a pool of blood. I opened the door back up and got the nurse to come. (R1) was face down with her (wheelchair) on top of her . Did the door open when you pushed the buttons to get in and out? No all I had to do was open door several times. No code needed . V4's (LPN) 6/18/24 statement documented in part .at about 2:30 AM I was at the computer charting. The 2 CNA's informed me that they could not find (R1) after looking for her in the building. I immediately got up to help with the search. I went down the halls toward therapy (department) and started to walk back up toward the nurse station when I noticed the CNA down the other hall by the dining room waving her arms for me to come. I seen resident lying on stomach and noticed a head injury. I immediately assessed resident. Splinted head (and) neck with a blanket to limit movement and called 911. EMS transported resident next door to hospital . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's revised 9/13/19 Elopement Device policy documented in part . Purpose: To establish procedures for ensuring personal elopement devices are used in accordance with identified risk, physician orders and to ensure the security system is inspected to identify malfunctions should they occur . Procedure: 1. Elopement alert devices will be used as an interventional tool to prevent resident elopements . 3. The elopement alert exit door device will be inspected for proper working and documented by nursing . 5. The ankle or bracelet device will be inspected by nursing personnel at least once each day by: a. Inspecting the location of the device on the arm or leg. b. Placing the transmitter tester near the anklet or bracelet to test the battery for proper working order. 6. In the event the test reveals a malfunctioning personal elopement device, the device will be removed and replaced . The facility's undated Preventive Maintenance and Inspection policy documented in part . In order to provide a safe environment for residents, employees, and visitors, a preventative maintenance program has been implemented to promote the maintenance of fixtures and equipment in a state of good repair and condition . The following are recommended guidelines and may be revised or adjusted as indicated by the individual needs of the facility or according to facility policy . Inspections checklists are developed for at least . the building . exterior inspection will be conducted and documented weekly . interior inspections will be conducted and documented weekly . building inspection includes at a minimum . electronic doors . alarms are calendared on the routine inspection checklists on a weekly basis. Alarms are inspected to verify that they are in working order and are calendared for inspection in accordance with manufacturer's specifications . The Immediate Jeopardy that began on 6/18/24 was removed prior to the survey date on 6/20/24 when the facility took the following actions to remove the immediacy and correct the deficient practice as confirmed through observation, interview, and record review: 1) Immediate actions taken for those residents identified: 1. R1 was moved to the locked Dementia unit (Completed by Interdisciplinary Team (IDT) 06/18/2024). 2. R1 was immediately placed on 15-minute checks until New Wander guard device implementation (Completed by Nursing Staff and IDT Completed 06/18/2024). 3. R1 Elopement assessment and care plan were reviewed and updated accordingly. (Minimum Data Set/ Care Plan (MDS/CP) Coordinator 06/20/2024). 4. R1 's Fall Assessment and Care Plan has been reviewed and updated accordingly. (Director of Nursing (DON), Assistant Director of Nursing (ADON) Completed 06/20/2024). 2) Measures put into place/ System changes: 1. The Facility's Code Pink Policy has been reviewed by the IDT with no changes needed at this time, (Completed IDT 06/19/2024). 2. The Facility's Elopement Policy has been reviewed by the IDT with no changes needed at this time. (Completed IDT 06/19/2024). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. All Staff have been educated on the Facility's Elopement Policy (Completed by Administrator (ADM) 6/19//2024). 4. All Staff have been educated on the Facility's Code Pink Guidelines (Completed by ADON 6/19/2024). 5. All Residents at Risk for Elopement have been placed on 15 minute checks until New Wander guard devices implemented. (Completed by Nursing Staff and IDT 06/18/2024) 6. Affected Door was secured with 1:1 until new alarm was placed. (Completed by Nursing & Activities 06/19/2024). 7. New Wander guard devices implemented as per assessment (Completed by IDT 06/19/2024). 8. All Resident's Elopement Assessments have been reviewed and updated accordingly. (Completed by Social Services Director (SSD), MDS/CP Coordinator, DON, ADON 06/19/2024). 9. All Residents at Risk Plan of Care's has been reviewed and updated accordingly based off the individual Elopement Assessment. (Completed MDS Care Plan Coordinator, SSD, DON, ADON 6/20/2024). 10. An Elopement Drill has been completed on all shifts (ADM 06/19/2024). 11. Functionality of all Door Alarms have been checked. (Completed by ADM, Maintenance Director 06/18/2024). 12. New Door Alarms placed as needed on Exit Doors (Completed by Maintenance 06/19/2024). 13. Maintenance has been educated on the Preventative Maintenance and Inspections Policy. (Completed by ADM 06/20/2024). 14. A QAPI Meeting was held with the Medical Director to discuss R1's incident including interventions and Plan of Care. (Completed 06/19/2024 ADM). 3) How the corrective actions will be monitored: 1. ADM/Maintenance will complete random 5 observations a week of the door alarms to ensure they are functioning properly for 12 weeks. 2. Maintenance will continue to complete weekly checks of the door alarms to ensure they are functioning properly. 3. ADM/Designee will complete 5 interviews a week with Residents at risk for Elopement to ensure their well-being for 12 weeks. 4. ADM/Designee will complete Elopement Drills bi-weekly on alternating shifts for 12 weeks. 5. DON/Designee will complete 5 Residents Medical Records a week for 12 weeks to ensure appropriate Fall Interventions have been implemented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The results of these interviews will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on interview and record review the facility failed to provide enough staff to supervise residents ensuring residents do not elope for 1 (R1) of 5 residents reviewed for supervision out of a sample of 5. Findings include: 1. R1's face sheet documented an admitted [DATE] with diagnoses including: dementia, hypertension, atherosclerotic heart disease, type 2 diabetes mellitus, hyperlipidemia, presence of cardiac pacemaker. R1's 7/8/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. R1's care plan documented an initiated 8/30/23 focus area documenting in part . I am an elopement risk/ wanderer due to exit seeking, Resident wanders aimlessly . and an initiated 7/6/21 focus area documenting in part . I am at risk for fall/ injury (related to) wandering and poor safety awareness . R1's Order Summary Report documented an 8/6/23 order for Wanderguard (elopement alert device) check function on dayshift every Sunday. On 7/29/24 at 1:04 PM, V5 (Certified Nursing Assistant/ CNA) said she was caring for R1 on the night shift from 6/17/24 to 6/18/24 when R1 eloped from the facility and was injured. V5 said she usually does not work night shift but had agreed due to the facility being short staffed. V5 said on 6/18/24 from 12:00 AM to 2:00 AM V5 was the only CNA working on the nonlocked unit with V4 (Licensed Practical Nurse/ LPN). V5 said when there is only one nurse and one CNA working the nonlocked unit they could not supervise all the residents. V5 said due to V5 not usually working night shift she was unsure how often the night shift was short staffed. On 7/30/24 at 12:48 PM, V3 (Assistant Director of Nursing/ ADON) said she was working in the facility on 6/18/24 until almost 2:00 AM. V3 said while she was working on 6/18/24, she was in her office completing paperwork. V3 said the night shift should be staffed with 4 CNAs and 2 Nurses, 1 nurse and 2 CNAs for the locked unit and 1 nurse and 2 CNA for the nonlocked unit. On 7/30/24 at 12:21 PM, V2 (Director of Nursing/ DON) said night shift should be staffed with 4 to 5 CNA and 2 Nurses. V2 said to meet all the resident needs during the night shift would require 4 to 5 CNA and 2 Nurses. V2 said she was not sure how often the night shift is short staffed. On 8/1/24 at 2:35 PM, V1 (Administrator) verified V4 (LPN) and V5 (CNA) were the only two staff working on the nonlocked unit on 6/18/24 from 12:00 AM to 2:00 AM. V1 said V12 (CNA), V13 (CNA), and V11 (LPN) were working on the locked unit on the night shift of 6/17/24 to 6/18/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 6/18/24 Daily Census documented V4 (LPN) and V5 (CNA) were responsible for supervising and providing care to 41 residents. The facility's Semi-Monthly Time Schedule from 6/9/24 through 6/22/24 documented V4 (LPN) and V11 (Registered Nurse/ RN) were working on 6/17/24 to 6/18/24 from 6:00 PM to 6:00 AM and that the facility only had 5 full time night CNA's. V5's (CNA) Copy of Time Card Report documented V5 clocked in on 6/17/24 at 5:51 PM and clocked out on 6/18/24 at 5:55 AM. V14's (CNA) Copy of Time Card Report documented V14 clocked in on 6/17/24 at 5:54 PM and clocked out on 6/18/24 at 12:02 AM. V6's (CNA) Copy of Time Card Report documented V6 clocked in on 6/18/24 at 2:03 AM, clocked out on 6/18/24 at 10:15 AM, clocked in on 6/18/24 at 10:44 AM, and clocked out on 6/18/24 at 2:03 PM. V12's (CNA) Copy of Time Card Report documented V12 clocked in on 6/17/24 at 6:02 PM and clocked out on 6/18/24 at 6:14 AM. V13's (CNA) Copy of Time Card Report documented V13 clocked in on 6/17/24 at 6:02 PM and clocked out on 6/18/24 at 6:20 AM. On 8/2/24 at 9:40 AM, V8 (Vice President of Operations) said the facility did not have a staffing policy. V8 said the facility is to follow the regulations.