STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

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

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review, the facility failed to ensure timely reporting of potential abuse and neglect allegations, including an injury of unknown origin for 2 (R1 and R4) of 4 residents reviewed for abuse in the sample of 6. Findings include: 1. R1's Face Sheet documented an initial admitted [DATE] with diagnoses that included malignant neoplasm of prostate, unsteadiness of feet, lack of coordination, abnormalities of gait and mobility, adult failure to thrive, and cerebrovascular disease. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, indicating R1 had moderate cognitive impairment. On 8/23/24 at 1:00 PM, R1's right great toenail was black with blood under the nail. R1's feet had greenish yellow bruising to the tops of both feet measuring approximately 3 inches x 3 inches. R1 said he did not know how his feet had been injured. R1's Hospice Visit Note dated 7/26/24 documented R1 did not have any bruising to the feet. R1's Hospice Visit Note dated 7/29/24 documented in part .Rt. (right) foot and leg was swollen and had bruises present, SNF (Skilled Nursing Facility) reported no falls or injuries for (R1) . R1's Hospice Visit Note dated 8/2/24 documented in part . Lt (left) foot has a bruise on the top of foot size of a softball circle with purple/green in color. (Right) leg was swollen around ankle bone and had bruises present on top of the foot and side of ankle with purple/green bruise. SNF reported no falls or injuries . reported these findings to (V2 - Director of Nursing/DON). Pt (patient/R1) is unaware of how or when the bruise occurred . SN (Skilled Nurse) left a message with person answering (facility) work phone for Nurse on staff to give me a call, as SN needs a report of unknown bruise noted as staff nurses had not document [sic] on BLE (Bilateral Lower Extremities) having any bruise. (V7 - Registered Nurse/RN) on staff at SNF was not present during any SNV (Skilled Nurse Visit) and SN was unable to give (V7) report as no staff could find (V7) . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Hospice Visit Note dated 8/5/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V13 - Licensed Practical Nurse/LPN) and (V7) and stated SN needed a incident report since they have no report filled out stating that SNF staff has seen or document pt (R1) having bruises to BLE. Staff is supposed to write up a report stating that bruise are from unknown causes, both (V7) and (V13) voiced understanding . R1's Hospice Visit Note dated 8/9/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V5/LPN) and (V2/DON). SN stated hospice needed a incident report since they have no report filled out stating that the SNF staff has seen or document (R1) having bruises to BLE. (sic) Staff was suppose to write up a report stating that bruise are from unknown causes, both (V7) and (V13) voiced understanding at last SNV and no report can be found or has been filled out per (V5) and (V2). (sic) Per (V2) a report will be filled out and SN can obtain a copy from them next week . R1's Hospice Visit Note dated 8/12/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V3 - Assistant Director of Nursing/ADON) SN stated hospice needed a incident report since they have no report filled out stating that the SNF staff has seen or document (R1) having bruises to BLE. Staff was suppose to write up a report stating that bruise are from unknown causes, report is filled out but is not signed by any of the nurses yet . R1's Hospice Visit Report dated 8/16/24 documented in part .SN received report from (V17- Hospice Certified Nursing Assistant/CNA) that (R1) had bleeding to (right) great toe and bruising noted around toe nail bed. (R1's right) great toe has blood under toe nail bed . with bruising around nail bed noted. SN spoke with (V2) and (V3) and per them 'assessed toe d/t (due to) Hospice aide (V17/CNA) reported findings to (V2) and (V3)' . No reports noted of pt (patient) fall or injury noted per staff records. SN is still unable to get report from SNF of bruised [sic] noted on 8/2/24 as per (V2) and (V3) 'note is not signed yet' . R1's Hospice Visit Note dated 8/20/24 documented in part .brusied [sic] noted to Rt. great toe with dried blood under nail bed. SN reported SN findings to (V7/RN). SN still does not have report from 8/2/24 as it still not signed by RN .MD is aware of SN and CNA reporting SNF to (State Agency). On 8/23/24 at 10:59 AM, V4 (Hospice Registered Nurse/RN) said R1 had bruising found on 8/2/24 to the top of both feet about the size of a softball. V4 said she had reported the bruising to V2 (DON) when V4 found the bruising. V4 said on 8/5/24, V4 returned to the facility and V7 (RN) and V13 (LPN) said they were not aware of R1 having any injuries. V4 said on 8/9/24 she told V2 that V4 would need a report on the bruises because the staff could not tell V4 how R1 was injured and there was no documentation of the bruising in R1's medical record. V4 said that on 8/16/24, R1 was found to have bleeding and a hematoma under the right great toenail with surrounding bruising to the toe. V4 said the facility was not able to explain how R1's right great toe was injured. V4 said she had asked the facility several times for a report on R1's injuries of unknown origin but none had been provided. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24 at 11:31 AM, V2 (DON) said V4 had reported to V2 that R1 had injuries to his feet but was not sure of the dates V4 had reported R1's injuries. V2 said she thought R1's injuries had been caused by staff hitting R1's feet on the bar of the mechanical lift. V2 said R1's injuries were not witnessed by any staff to V2's knowledge. V2 verified R1's injuries were injuries of unknown origin. V2 said any injury of unknown origin should be reported to V1 (Administrator). V2 said any injury of unknown origin should be reported to (State Agency). V2 said she was not sure why she did not report R1's injuries of unknown origin to V1. On 8/23/24 at 11:40 AM, V1 said the facility's Electronic Medical Record (EMR) system would flag V1 when an incident was documented. V1 said R1 had an incident documented on 8/10/24 but was documented as injury of known origin. V1 said she had not been made aware of R1 having any injuries of unknown origin by staff. V1 said due to her not being aware of R1's injuries of unknown origin she had not reported them or started an investigation. On 8/23/24 at 2:00 PM, V13 (LPN) said he recalled the hospice nurse reporting something about R1's foot but was unsure what the hospice nurse had reported, or on what date. On 8/23/24 at 12:39 PM, V7 (RN) said the hospice nurse brought R1's bruising to her attention but was not sure of the date. V7 said R1 had bruising to the ankle and the tops of both feet. V7 said when she assessed R1, the bruising did not appear to be fresh due to the color. V7 said R1's bruising was not dark blue or purple, it was more of a greenish color. V7 said she did not report R1's injuries because V2 was aware of them. On 8/29/24 at 11:43 AM, V1 verified there was no skin assessment or progress note documenting R1's injuries on 8/10/24. V1 said V7 should have completed a skin assessment when V7 documented the incident in risk management. V1 said V13 should have completed a skin assessment when hospice notified him on 7/29/24. V1 said V2 should have completed a skin assessment when the hospice nurse notified her on 8/2/24. V1 said no skin assessments were completed for R1. R1's Report to (State Agency) dated 8/28/24 documented in part .Interviews with staff revealed that resident is tall, a maximum assist, dependent with care. Resident is transferred by 2 staff or at times has had to use a (mechanical lift). Staff stated (R1) has bumped feet on (mechanical lift) before. Staff interviews revealed that resident has been observed to also attempt to self transfer, pulls rolling wheelchair toward him . Interview with (R1) revealed that (R1) was unable to tell me what happened but he could tell me he was alright and having no pain in feet . 2. R4's Face Sheet documented an admitted [DATE] with diagnoses that included cognitive communication deficit, schizoaffective disorder, dementia, and lack of coordination. R4's MDS dated [DATE] documented a BIMS score of 2, indicating R4 was severely cognitively impaired. An undated and untitled abuse questionnaire signed by V18 (CNA) on 8/16/24 documented in part . Have you heard any resident say they have been abused? Yes . Do you know of any resident being abused? Yes . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Aperion Care Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated and untitled abuse questionnaire signed by V20 (CNA) on 8/16/24 documented in part . Have you heard any resident say have been abused? Yes . Do you know of any resident being abused? Yes-ish . On 8/28/24 at 9:11 AM, V1 (Administrator) was asked why V18 (CNA) and V20 (CNA) had answered yes to the questions Have you heard any resident say they have been abused? and Do you know of any resident being abused? on R1's injury of unknown origin investigation packet, and V1 replied she was unsure because she found them the previous night. On 8/28/24 at 12:06 PM, V1 sent an email that documented in part .I just spoke with (V18) in person and (V20) by facetime. They answered yes because of an incident that occurred when they were working (specific hall). They reported to work at (6:00 AM) that day and noted that one of the residents was incontinent and appeared that (R4) may have been wet for some time. They felt like the midnight (CNA) did not change (R4) when needed . On 8/28/24 at 1:36 PM, V1 stated that on 8/16/24, V1 had sent V3 (ADON) to complete some staff abuse questionnaires. V18 and V20 reported the (R4) incident to V3 and V3 told V18 and V20 the incident with R4 was not what the abuse questionnaires were pertaining to. V1 stated that V3, V18, and V20 had not reported the incident regarding R4 to V1. V1 said she expected staff to immediately report any concerns with abuse or neglect to V1. V1 said she will be educating all staff on the definitions of abuse and reporting abuse. V1 said she would be starting an investigation immediately. On 8/28/24 at 1:08 PM, V18 (CNA) stated that on 8/16/24 when she arrived in the facility at 6:00 AM, R4 was found to be sitting in a recliner in the dining room. V18 said the recliner and R4's clothing was soaked in urine. V18 said R4's shirt was white and had brown lines of dried urine due to no one assisting R4 with incontinence care for a long time. V18 said she felt like this was possibly neglect and had reported it to the nurse working on 8/16/24. V18 said she could not recall who the nurse was she reported the incident to. V18 said she thought the nurse would report V18's concerns of neglect to management. V18 said she was aware R4 can be combative, but that was no reason to neglect someone. On 8/29/24 at 8:40 AM, V20 (CNA) stated that on 8/16/24 when she arrived at work at 6:00 AM, she found R4 to be sitting in the dining room in a recliner soaked in urine from mid-back to mid-thigh. V20 said R4 had a brown ring of dried urine on both her shirt and pants. V20 said she reported the incident to the nurse. V20 said later that day on 8/16/24 at approximately 4:30 PM, V3 (ADON) had given V20 an abuse questionnaire and V20 had reported the incident to V3. V20 said after reporting the incident to V3, V3 told V20 that was a hygiene problem, not abuse. V20 said she told V3 the incident was abuse because she felt R4 had been neglected. V20 said V3 did not say anything else and walked away. V20 said the night shift of 8/15/24 to 8/16/24 was staffed as usual with 1 licensed nurse and 2 CNA's. V20 said on multiple occasions she has arrived at work and had been told by V21 (CNA) that some residents were not up or had not been assisted with incontinence care because V21 says she is too old to do it. V20 said she has told V21 if V21 is too old to complete her job duties, V21 needs to find a different job that V21 can do. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 11:16 AM, V3 (ADON) stated that on 8/16/24, V1 had asked V3 to go around and ask staff members the questions on the abuse questionnaire. V3 said V18 and V20 had told her they had witnessed abuse but refused to elaborate any details. V3 said V18 and V20 told her V1 could come ask them for further details of their concerns. V3 said when she returned to V1's office, V1 was in a meeting and V3 had slid the abuse questionnaire papers under V1's door. On 8/29/24 at 11:43 AM, V1 said V3 did not slide the 8/16/24 abuse questionnaires under her office door. V1 said on 8/16/24 when V3 had completed the abuse questionnaires, V1 had already left the facility for the day. V1 stated that on 8/19/24, V1's office door was open and V1 was down the hall, and when V1 returned to her office, V3 had placed the abuse questionnaires on her desk. V1 said V3 never reported V18 and V20's abuse allegations. On 8/29/24 at 8:56 AM, V1 said she expected staff to report any concerns with abuse immediately to V1. The facility's revised 10/24/22 Abuse Prevention and Reporting - (State) policy documented in part . Employees are required to report any incident, allegation or suspicion of potential abuse . they observed, hear about, or suspect to the administrator, or to an immediate supervisor who must immediately report it to the administrator . All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential abuse . to the administrator or an immediate supervisor who must then immediately report it to the administrator . Reports should be documented and a record kept of the documentation . Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours . The nursing staff is additionally responsible for reporting on a facility incident report the appearance of suspicious bruises . as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator . Injuries of Unknown Source . For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person other source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury . or the number of the injuries observed at one particular point in time . If classified as an injury of unknow source, . The (State Agency) will be notified. Time frames for reporting and investigation abuse will be followed .

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43088

Based on observation, interview, and record review, the facility failed to initiate and complete a timely and thorough investigation of an injury of unknown origin for 1 (R1) of 3 residents reviewed for abuse/neglect investigations in the sample of 6.

Findings include:

R1's Face Sheet documented an initial admitted [DATE] with diagnoses that included malignant neoplasm of prostate, unsteadiness of feet, lack of coordination, abnormalities of gait and mobility, adult failure to thrive, and cerebrovascular disease.

R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, indicating R1 had moderate cognitive impairment.

On 8/23/24 at 1:00 PM, R1's right great toenail was black with blood under the nail. R1's feet had greenish yellow bruising to the tops of both feet measuring approximately 3 inches x 3 inches. R1 said he did not know how his feet had been injured.

R1's Hospice Visit Note dated 7/26/24 documented R1 did not have any bruising to the feet.

R1's Hospice Visit Note dated 7/29/24 documented in part .Rt. (right) foot and leg was swollen and had bruises present, SNF (Skilled Nursing Facility) reported no falls or injuries for (R1) .

R1's Hospice Visit Note dated 8/2/24 documented in part . Lt (left) foot has a bruise on the top of foot size of a softball circle with purple/green in color. (Right) leg was swollen around ankle bone and had bruises present on top of the foot and side of ankle with purple/green bruise. SNF reported no falls or injuries . reported these findings to (V2 - Director of Nursing/DON). Pt (patient/R1) is unaware of how or when the bruise occurred . SN (Skilled Nurse) left a message with person answering (facility) work phone for Nurse on staff to give me a call, as SN needs a report of unknown bruise noted as staff nurses had not document on BLE (Bilateral Lower Extremities) having any bruise. (V7 - Registered Nurse/RN) on staff at SNF was not present during any SNV (Skilled Nurse Visit) and SN was unable to give (V7) report as no staff could find (V7) .

R1's Hospice Visit Note dated 8/5/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V13 - Licensed Practical Nurse/LPN) and (V7) and stated SN needed a incident report since they have no report filled out stating that SNF staff has seen or document pt (R1) having bruises to BLE. Staff is supposed to write up a report stating that bruise are from unknown causes, both (V7) and (V13) voiced understanding .

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Hospice Visit Note dated 8/9/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V5/LPN) and (V2/DON). SN stated hospice needed a incident report since they have no report filled out stating that the SNF staff has seen or document (R1) having bruises to BLE. (sic) Staff was suppose to write up a report stating that bruise are from unknown causes, both (V7) and (V13) voiced understanding at last SNV and no report can be found or has been filled out per (V5) and (V2). (sic) Per (V2) a report will be filled out and SN can obtain a copy from them next week . R1's Hospice Visit Note dated 8/12/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V3 - Assistant Director of Nursing/ADON) SN stated hospice needed a incident report since they have no report filled out stating that the SNF staff has seen or document (R1) having bruises to BLE. Staff was suppose to write up a report stating that bruise are from unknown causes, report is filled out but is not signed by any of the nurses yet . R1's Hospice Visit Report dated 8/16/24 documented in part .SN received report from (V17- Hospice Certified Nursing Assistant/CNA) that (R1) had bleeding to (right) great toe and bruising noted around toe nail bed. (R1's right) great toe has blood under toe nail bed . with bruising around nail bed noted. SN spoke with (V2) and (V3) and per them 'assessed toe d/t (due to) Hospice aide (V17/CNA) reported findings to (V2) and (V3)' . No reports noted of pt (patient) fall or injury noted per staff records. SN is still unable to get report from SNF of bruised noted on 8/2/24 as per (V2) and (V3) 'note is not signed yet' . R1's Hospice Visit Note dated 8/20/24 documented in part .brusied noted to Rt. great toe with dried blood under nail bed. SN reported SN findings to (V7/RN). SN still does not have report from 8/2/24 as it still not signed by RN .MD is aware of SN and CNA reporting SNF to (State Agency). R1's Report to (State Agency) dated 8/28/24 documented in part .Interviews with staff revealed that resident is tall, a maximum assist, dependent with care. Resident is transferred by 2 staff or at times has had to use a (mechanical lift). Staff stated (R1) has bumped feet on (mechanical lift) before. Staff interviews revealed that resident has been observed to also attempt to self transfer, pulls rolling wheelchair toward him . Interview with (R1) revealed that (R1) was unable to tell me what happened but he could tell me he was alright and having no pain in feet . On 8/23/24 at 10:59 AM, V4 (Hospice RN) said R1 had bruising found on 8/2/24 to the top of both feet about the size of a softball. V4 said she had reported the bruising to V2 (DON) when V4 found the bruising. V4 said that on 8/5/24, V4 returned to the facility and V7 (RN) and V13 (LPN) said they were not aware of R1 having any injuries. V4 said that on 8/9/24, she told V2 that V4 would need a report on the bruises because the staff could not tell V4 how R1 was injured and there was no documentation of the bruising in R1's medical record. V4 said that on 8/16/24, R1 was found to have bleeding and a hematoma under the right great toenail with surrounding bruising to the toe. V4 said the facility was not able to explain how R1's right great toe was injured. V4 said she had asked the facility several times for a report on R1's injuries of unknown origin but none had been provided. On 8/23/24 at 12:39 PM, V7 (RN) said the hospice nurse brought R1's bruising to her attention but was not sure of the date. V7 said R1 had bruising to the ankle and the tops of both feet. V7 said when she assessed R1, the bruising did not appear to be fresh due to the color. V7 said R1's bruising was not dark blue or purple, it was more of a greenish color. V7 said she did not report R1's injuries because V2 was aware of them. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24 at 11:31 AM, V2 (DON) said V4 had reported R1's bruising to her but was unsure of the date. V2 said she thought V4 may have reported R1's bruising on 8/13/24. V2 said she thought R1 had probably hit his feet on the mechanical lift during a transfer. V2 said she was not sure when R1's injuries had appeared. V2 said there was an incident in risk management (a tracking system for any incidents in the facility) on 8/10/24 by V7 noting bruising to R1's feet and was documented as a known injury. V2 verified R1's injuries were of unknown origin. V2 said any injury of unknown origin should be reported to V1 (Administrator) so an investigation can be started. V2 said she was not sure why she did not report R1's injuries of unknown origin to V1. On 8/23/24 at 11:40 AM, V1 said V2 had told her something about R1 having a small cut or something on his toe possibly on 8/10/24. V1 said there was an incident documented in risk management on 8/10/24 by V7 documenting a known injury to R1's foot. V1 said she had not been made aware R1 had any injuries of unknown origin to open an investigation on. V1 said she had not started an investigation on R1's injuries but had asked residents and staff if they had witnessed abuse on 8/16/24. On 8/29/24 at 11:43 AM, V1 verified there was no skin assessment or progress note documenting R1's injuries on 8/10/24. V1 said V7 should have completed a skin assessment when V7 documented the incident in risk management. V1 said V13 should have completed a skin assessment when hospice notified him on 7/29/24. V1 said V2 should have completed a skin assessment when the hospice nurse notified her on 8/2/24. V1 said no skin assessments were completed for R1. On 8/29/24 at 11:16 AM, V3 (ADON) said if V1 was not in the facility to begin an investigation when any allegation of abuse was made, V2 would be next in the chain of command to start an investigation. V3 said V1 would be notified but it would be V2's responsibility to begin an investigation. On 8/29/24 at 11:43 AM, V1 said V2 is the second in the chain of command. V1 said V2 can start an investigation and has access to the portal to complete and send an initial report. On 8/29/24 at 8:56 AM, V1 said she expected any staff to immediately report any injury on unknown origin to V1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's revised 10/24/22 Abuse Prevention and Reporting - (State) policy documented in part . Employees are required to report any incident, allegation or suspicion of potential abuse . they observed, hear about, or suspect to the administrator, or to an immediate supervisor who must immediately report it to the administrator . All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential abuse . to the administrator or an immediate supervisor who must then immediately report it to the administrator . Reports should be documented and a record kept of the documentation . Upon learning of the report, the administrator . shall initiate an incident investigation . Injuries of Unknown Source . For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person other source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury . or the number of the injuries observed at one particular point in time . If classified as an injury of unknow source, the person gathering the facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party . Time frames for reporting and investigating will be followed. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on interview and record review, the facility failed to provide timely incontinence care to 2 (R1 and R4) of 3 residents reviewed for Activities of Daily Living (ADL) care in the sample of 6. Findings include: R1's Face Sheet documented an initial admitted [DATE] with diagnoses that included malignant neoplasm of prostate, unsteadiness of feet, lack of coordination, abnormalities of gait and mobility, adult failure to thrive, cerebrovascular disease. R1's 8/6/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, indicating R1 had moderate cognitive impairment. R1's Order Summary Sheet printed 8/26/24 documented a 7/16/24 order admit to (Hospice Company) for end of life. On 8/23/24 at 10:59 AM, V4 (Hospice Registered Nurse/RN) stated that on one occasion, she had found R1's urinary catheter to be leaking. V4 said R1's bed was saturated with urine, with a brown ring around it. V4 said R1 had to be wet for a long time to form a brown ring. On 8/28/24 at 2:23 PM, V17 (Hospice Certified Nursing Assistant/CNA) said on one occasion, she had found R1 lying in bed soiled with dried feces and brown rings on the incontinence pads. V17 said she showed this to a (facility) nurse and told them this was unacceptable. V17 said she had spoken with V19 (Certified Nursing Assistant/ CNA) and was told V19 had not been in to care for R1 in a long time. V17 said on another occasion R1 was found lying in bed with R1's pants soiled with dried feces on them around his ankles. V17 said she had told V2 (Director of Nursing/DON) and V3 (Assistant Director of Nursing/ADON) this was unacceptable. V17 said she felt like the facility was not taking care of R1 and hospice was making extra visits to make sure R1 was getting cared for. On 8/23/24 at 12:30 PM, V8 (CNA) said the facility was short staffed regularly. V8 said when the facility is short staffed it was hard to get all the tasks completed. R1's Hospice Visit Note dated 8/12/24 documented in part .SN (Skilled Nurse) assessed pt (patient/R1) bed as it was soaked in urine SN found a CNA and had her obtained new set of sheets, upon further looking SN noted seen sediment into urine, slime mucous attached to in between pt legs with catheter leaking . R1's Hospice Visit Note dated 8/16/24 documented in part . Upon arrival, pt. (R1) was lying in bed, resting, he was up to getting a bath .noted that his pants were still on, with a soiled dry BM (Bowel Movement), noted that the area on scrotum was red as well as the area on his left upper buttocks .did talk to (V2) . and (V3), at facility about pt's (R1) condition . 2. R4's Face Sheet documented an admitted [DATE] with diagnoses that included cognitive communication deficit, schizoaffective disorder, dementia, lack of coordination. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's MDS dated [DATE] documented a BIMS score of 2, indicating R4 was severely cognitively impaired. On 8/28/24 at 1:08 PM, V18 (CNA) said that on 8/16/24 when she arrived in the facility at 6:00 AM, R4 was found to be sitting in a recliner in the dining room. V18 said the recliner and R4's clothing was soaked in urine. V18 said R4's shirt was white and had brown lines of dried urine due to no one assisting R4 with incontinence care for a long time. V18 said she felt like this was possibly neglect and had reported it to the nurse working on 8/16/24. V18 said she could not recall who the nurse was she reported the incident to. V18 said she thought the nurse would report V18's concerns for neglect to management. V18 said she was aware that R4 can be combative but that was no reason to neglect someone. On 8/29/24 at 8:40 AM, V20 (CNA) said that on 8/16/24 when she arrived at work at 6:00 AM she found R4 to be sitting in the dining room in a recliner soaked in urine from mid-back to mid-thigh. V20 said R4 had a brown ring of dried urine on both her shirt and pants. V20 said she reported the incident to the nurse. V20 said later that day on 8/16/24 at approximately 4:30 PM, V3 (ADON) had given V20 an abuse questionnaire and V20 had reported the incident to V3. V20 said after reporting the incident to V3, V3 told V20 that was a hygiene problem, not abuse. V20 said she told V3 the incident was abuse because she felt R4 had been neglected. V20 said V3 did not say anything else and walked away. V20 said the night shift of 8/15/24 to 8/16/24 was staffed as usual with 1 licensed nurse and 2 CNA's. V20 said on multiple occasions she has arrived at work and been told by V21 (CNA) that some residents were not up or had not been assisted with incontinence care because V21 says she is too old to do it. V20 said she has told V21 if V21 is too old to complete her job duties, V21 needs to find a different job that V21 can do. On 8/29/24 at 11:16 AM, V3 (ADON) said she expected all residents to be assisted with incontinence care in a timely fashion.

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

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F 0689 Level of Harm - Actual harm 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 identify and evaluate potential hazards/risks and implement interventions to ensure safe transfers via mechanical lifts for 1 (R1) of 3 residents reviewed for accident hazards and injuries of unknown origin in the sample of 6. This failure resulted in R1 sustaining injuries of bruising to the tops of both feet and a hematoma under the nail of the right great toe. Findings include: R1's Face Sheet documented an initial admitted [DATE] with diagnoses that included unsteadiness of feet, lack of coordination, abnormalities of gait and mobility, adult failure to thrive, and cerebrovascular disease. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, indicating R1 had moderate cognitive impairment. On 8/23/24 at 1:00 PM, R1's right great toenail was black with blood under the nail. R1's feet had greenish yellow bruising to the tops of both feet measuring approximately 3 inches x 3 inches. R1 stated he did not know how his feet had been injured. R1's Hospice Visit Note dated 7/26/24 documented R1 did not have any bruising to the feet. R1's Hospice Visit Note dated 7/29/24 documented in part .Rt. (right) foot and leg was swollen and had bruises present, SNF (Skilled Nursing Facility) reported no falls or injuries for (R1) . R1's Hospice Visit Note dated 8/2/24 documented in part . Lt (left) foot has a bruise on the top of foot size of a softball circle with purple/green in color. (Right) leg was swollen around ankle bone and had bruises present on top of the foot and side of ankle with purple/green bruise. SNF reported no falls or injuries . reported these findings to (V2 - Director of Nursing/DON). Pt (patient/R1) is unaware of how or when the bruise occurred . SN (Skilled Nurse) left a message with person answering (facility) work phone for Nurse on staff to give me a call, as SN needs a report of unknown bruise noted as staff nurses had not document on BLE (Bilateral Lower Extremities) having any bruise. (V7 - Registered Nurse/RN) on staff at SNF was not present during any SNV (Skilled Nurse Visit) and SN was unable to give (V7) report as no staff could find (V7) . R1's Hospice Visit Note dated 8/5/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V13 - Licensed Practical Nurse/LPN) and (V7) and stated SN needed a incident report since they have no report filled out stating that SNF staff has seen or document pt (R1) having bruises to BLE. Staff is supposed to write up a report stating that bruise are from unknown causes, both (V7) and (V13) voiced understanding . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Hospice Visit Note dated 8/9/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V5/LPN) and (V2/DON). SN stated hospice needed a incident report since they have no report filled out stating that the SNF staff has seen or document (R1) having bruises to BLE. Staff was suppose to write up a report stating that bruise are from unknown causes, both (V7) and (V13) voiced understanding at last SNV and no report can be found or has been filled out per (V5) and (V2). (sic) Per (V2) a report will be filled out and SN can obtain a copy from them next week . R1's Hospice Visit Note dated 8/12/24 documented in part .Lt and Rt. feet bruises have improved no new bruises noted. SN spoke with (V3 - Assistant Director of Nursing/ADON) SN stated hospice needed a incident report since they have no report filled out stating that the SNF staff has seen or document (R1) having bruises to BLE. Staff was suppose to write up a report stating that bruise are from unknown causes, report is filled out but is not signed by any of the nurses yet . R1's Hospice Visit Report dated 8/16/24 documented in part .SN received report from (V17- Hospice Certified Nursing Assistant/CNA) that (R1) had bleeding to (right) great toe and bruising noted around toe nail bed. (R1's right) great toe has blood under toe nail bed . with bruising around nail bed noted. SN spoke with (V2) and (V3) and per them 'assessed toe d/t (due to) Hospice aide (V17/CNA) reported findings to (V2) and (V3)' . No reports noted of pt (patient) fall or injury noted per staff records. SN is still unable to get report from SNF of bruise noted on 8/2/24 as per (V2) and (V3) 'note is not signed yet' . R1's Hospice Visit Note dated 8/20/24 documented in part .brusied [sic] noted to Rt. great toe with dried blood under nail bed. SN reported SN findings to (V7/RN). SN still does not have report from 8/2/24 as it still not signed by RN .MD is aware of SN and CNA reporting SNF to (State Agency). R1's Electronic Medical Record (EMR) documented two progress notes on 8/11/24 that had been struck out citing incorrect documentation: R1's struck out progress note dated 8/11/24 at 1:58 AM documented in part Note Text: (R17) Follow up assessment completed. Bruising to top of left, right foot .reddish purple bruising noted . The note documents Strike Out Reason: Incorrect Documentation and Strike Out date: 8/14/24 09:05 (am). R1's struck out progress note dated 8/11/24 at 9:25 AM documented in part Note Text (R17) Follow up assessment completed. Bruising to top left of right foot .No skin issues noted. No Bruising noted. No s/s (signs/symptoms) of infection noted to site. No swelling noted. The note documents Strike Out Reason: Incorrect Documentation and Strike Out date: 8/14/24 09:05 (am). On 8/23/24 at 10:59 AM, V4 (Hospice RN) stated R1 had bruising found on 8/2/24 to the top of both feet about the size of a softball. V4 said she had reported the bruising to V2 (DON) when V4 found the bruising. V4 said that on 8/5/24, V4 had returned to the facility and V7 (RN) and V13 (LPN) said they were not aware of R1 having any injuries. V4 stated that on 8/9/24, she told V2 that V4 would need a report on the bruises because the staff could not tell V4 how R1 was injured and there was no documentation of the bruising in R1's medical record. V4 then stated that on 8/16/24, R1 was found to have bleeding and a hematoma under the right great toenail with surrounding bruising to the toe. V4 said the facility was not able to explain how R1's right great toe was injured. V4 said she had asked the facility several times for a report on R1's injuries of unknown origin but none had been provided. (continued on next page)

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	146000	A. Building B. Wing	08/29/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/23/24 at 11:31 AM, V2 (DON) said staff would use the mechanical lift to transfer R1 when R1 was not feeling strong enough to stand for transfers. V2 said she thought the injuries to R1's feet had been caused by staff hitting R1's feet on the bar of the mechanical lift. On 8/27/24 at 11:00 AM, V16 (CNA) stated that the facility had several agency staff who don't care, and will hit resident's feet on the bar of the mechanical lift when transferring them. At the same time of this interview with V16, this surveyor observed a dark red substance that appeared to be dried blood on the center bar and central cross bar of the mechanical lift. On 8/27/24 at 11:11 AM, V1 (Administrator) verified the dark red substance found on the mechanical lift looked like blood. R1's Report to (State Agency) dated 8/28/24 documented in part .Interviews with staff revealed that resident is tall, a maximum assist, dependent with care. Resident is transferred by 2 staff or at times has had to use a (mechanical lift). Staff stated (R1) has bumped feet on (mechanical lift) before. Staff interviews revealed that resident has been observed to also attempt to self transfer, pulls rolling wheelchair toward him .Interview with (R1) revealed that (R1) was unable to tell me what happened but he could tell me he was alright and having no pain in feet . The facility's revised 10/24/22 Abuse Prevention and Reporting - (State) policy documented in part . Employees are required to report any incident, allegation or suspicion of potential abuse . they observed, hear about, or suspect to the administrator, or to an immediate supervisor who must immediately report it to the administrator .Upon learning of the report, the administrator .shall initiate an incident investigation . Injuries of Unknown Source .For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person orther source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury .or the number of the injuries observed at one particular point in time .If classified as an injury of unknow source, the person gathering the facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party .