STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006399	A. BUILDING: _____ B. WING _____	C 03/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MORTON VILLA	190 EAST QUEENWOOD ROAD MORTON, IL 61550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: #1821426/IL100771 Complaint Investigation: #1821471/IL100818	S 000		
S9999	Final Observations Statement of Licensure Violation: Licensure 1 of 2: 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: A. Based on interview and record review the facility failed to turn a resident using the assist of two staff members while performing cares for one of three residents (R1) reviewed for falls in the sample of three. This failure resulted in R1 falling out of bed and sustaining a right femur fracture which required R1 to be hospitalized and to have surgery.	S9999		

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S9999	Continued From page 2 B. Based on observation, interview, and record review the facility failed to implement fall interventions after a resident fall for one of three residents (R3) reviewed for falls in the sample of three. Findings include: 1. R1's Facesheet documents R1 was admitted to the facility on 11/28/17. This same facesheet also states R1 has a history of falls. R1's Physician Order Sheets (POS) dated 1/1/18-1/31/18 lists diagnoses including but not limited to weakness, stroke, and a LBKA (Left below the knee amputation). This same POS also states, "(Mechanical) lift for all transfers." R1's Activity of Daily Living sheet (not dated) documents R1 requires the assistance of two plus persons for bed mobility and requires total dependence on staff for transfers. R1's Minimum Data Set (MDS), dated 12/10/17, documents R1 is cognitively intact. This same MDS also documents R1 requires extensive assistance for bed mobility. R1's Nurse's Notes on 1/16/18 at 9:00 P.M. states, "Resident (R1) fell out of bed while CNA (Certified Nursing Assistant/V4) was providing care. Skin tear noted on left elbow. Resident complaining of pain 8/10 on hips and chest around ribs. Resident being transported to (local area hospital) for further evaluation..." R1's Report of Incident form to the local state agency on 1/23/18 documents a final report summary, "(V4) was providing evening cares on (R1). (V4) turned (R1) to (R1's) left side while in	S9999		

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S9999	Continued From page 3 bed during cares, and (R1) began sliding out of bed away from (V4)..." R1's "XR (X-Ray) Hip 2 Views Unilateral Right" at local area hospital on 1/17/18 at 12:51 A.M. documents an impression of "Acute mildly displaced intertrochanteric fracture of the right femur." R1's Discharge Summary from local area hospital documents R1 underwent "Right Hip Gamma Nail Insertion" on 1/18/18. On 3/6/18 at 3:00 P.M., V4 (CNA) stated, "I was cleaning (R1) by myself..I had someone help me (mechanically lift) (R1) from the wheelchair to the bed, but then the CNA left the room and I rolled (R1) to (R1's) left side by myself. Normally when we rolled (R1) side to side we would have two (staff members). We are supposed to roll a resident with two people when they are a (mechanical lift)..If we are rolling a resident by ourselves, we should roll the resident towards us. (R1) was turned away from me." V4 also stated that no siderails were in use on R1's bed. On 3/6/18 at 4:10 P.M., V2 (Director of Nursing) stated, "(R1) should have had two CNAs (Certified Nursing Assistants) when being rolled to (R1's) side in bed. (R1) was a (mechanical lift) transfer. All (mechanical lift transfers) are automatically two assist with cares regarding bed mobility and transfers. (R1) was also a left lower extremity amputee, even more of a reason to have two (staff members). There were ten CNAs on the shift the night (R1) fell. There was no reason to have only used one CNA. The use of two CNAs could have prevented this fall...Even if the resident only requires one CNA for cares, the resident should always be turned toward the staff	S9999		

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S9999	Continued From page 4 member, not away from them. (R1) was turned away from (V4)." 2. R3's current care plan includes but is not limited to diagnoses of left sided hemiplegia, muscle weakness, abnormal posture, unsteadiness on feet, and other lack of coordination. R3's Nurse's Notes on 1/1/18 at 6:58 P.M. states, "This nurse was called to the DR (dining room) at approx. (approximately) 6:30 P.M. to observe resident sitting on the floor...See Fall Report for details..." R3's Incident Investigation Worksheet on 1/1/2018 lists a fall intervention of "tilt wheelchair." R3's Report of Incident form to the local state agency on 1/14/18 states "(R3) age 80 had a fall on 1/13/18 at 6:10 P.M. (R3)was sent into the ER (Emergency Room) for further evaluation and treatment." R3's Incident Investigation Worksheet on 1/13/2018 list a fall intervention of (anti-slip mat) to wheelchair." Throughout the days of 3/6/18 and 3/7/18, R3's wheelchair was not tilted and an anti-slip mat was not noted in the seat of R3's wheelchair. On 3/7/18 at 2:10 P.M., V2 (Director of Nursing) verified that there was not an anti-slip mat in R3's wheelchair and that the wheelchair was not tilted. V2 stated, "There should be." On 3/7/18 at 2:20 P.M., V6 (Maintenance	S9999		

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S9999	Continued From page 5 Director) stated "I was never informed that (R3) needed a tilt wheelchair. I am the only one in the building who knows how to tilt the wheelchairs. The wheelchair (R3) is in currently does not tilt. (R3) would need a whole new wheelchair. Had I been notified, the wheelchair could have been changed out right away." (A) Licensure 2 of 2: 300.1230d)1)2) Section 300.1230 Direct Care Staffing d) Each facility shall provide minimum direct care staff by: 1) Determining the amount of direct care staffing needed to meet the needs of its residents; an 2) Meeting the minimum direct care staffing ratios set forth in this Section. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to meet the minimum daily number of direct care staff for eight of 14 days reviewed for staffing. This has the potential to affect all 82 residents in the facility. Findings include: On 3/7/18 at 4:25 P.M. V3 (Assistant Director of Nursing) and V9 (Scheduling Coordinator) verified the Daily Caregiver Assignment Sheets for 2/22/18-3/7/18 were updated with actual working staff.	S9999		

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S9999	Continued From page 6 On 3/8/18 at 10:00 A.M., V2 (Director of Nursing) provided the number of residents requiring skilled or intermediate care for 2/22/18-3/7/18. The dates of 2/22/18-2/25/18 noted there to be 10 skilled residents and 74 intermediate residents in the facility. According to the Staffing Calculator, this requires 21 direct care staff over all three shifts. The Daily Caregiver Assignment Sheets for 2/22/18 document there was 20 direct care staff for all three shifts, 2/23/18 document there was 13 direct care staff for all shifts, 2/24/18 document there was 18 direct care staff for all shifts, 2/25/18 document there was 18 direct care staff for all shifts. The date of 3/2/18 noted there to be 11 skilled residents and 71 intermediate residents in the facility. According to the Staffing Calculator, this requires 21 direct care staff over all three shifts. The Daily Caregiver Assignment Sheets for 3/2/18 document there were 20 direct care staff for all three shifts. The dates of 3/3/18 and 3/4/18 noted there to be nine skilled residents and 71 intermediate residents in the facility. According to the Staffing Calculator, this requires 20 direct care staff over all three shifts. The Daily Caregiver Assignment Sheets for 3/3/18 document there were 18 direct care staff for all three shifts and 3/4/18 documents there were 15 direct care staff for all three shifts. The date of 3/6/18 noted there to be eight skilled residents and 72 intermediate residents in the facility. According to the Staffing Calculator, this requires 20 direct care staff over all three shifts. The Daily Caregiver Assignment Sheets document there was 12 direct care staff over all	S9999		

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S9999	Continued From page 7 three shifts. On 3/8/18 at 10:15 A.M. V2 (Director of Nursing) verified that the facility did not meet the minimum direct care staffing requirements for the eight days in question. V2 stated that the facility has had problems getting CNAs (Certified Nursing Assistants) hired and that the staff does complain that the facility is short staffed. Resident Roster provided by V1 (Administrator) on 3/6/18 at 9:00 A.M. noted 82 residents to be residing in the facility. (AW)	S9999		