Illinois Department of Public Health (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING_ IL6008312 04/20/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

555 WEST KAHLER **APERION CARE WILMINGTON**

| APERION CARE WILMINGTON WILMINGTON, IL 60481 | | | | | |
|--|---|---------------------|---|--------------------------|--|
| (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 | S 000 | | | |
| | Facility Reported Incident IL132419 of 3/30/2021 | | | | |
| S9999 | Final Observations | S9999 | | | |
| | Facility Reported Incident IL 132419 | | | | |
| | STATEMENT OF LICENSURE FINDINGS: | | | | |
| | 300.1210b) 300.1210d)6) | | | | |
| 78 | 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. | | | | |
| | Section 300.1210 General Requirements for Nursing and Personal Care | | | | |
| | 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: | × | | | |
| n Ta | 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 that each resident receives adequate supervision and assistance to prevent accidents. | | Attachment A Statement of Licensure Violations | | |

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|----------------------------|---|-----|-------------------------------|--|
| AND FEAR OF CONTRECTION | | | A. BUILDING: | | | | |
| | | IL6008312 | B. WING | | I . | C 2 0/2021 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | 8: | |
| | | 555 WES1 | Γ KAHLER | | | | |
| APERIO | N CARE WILMINGTO | N WILMING | TON, IL 604 | 81 😘 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C | | | ON SHOULD BE COMPLETE HE APPROPRIATE DATE | | | |
| S9999 | Continued From pa | age 1 | S9999 | | | | |
| | Based on observat review the facility fa a wheelchair in a si medical equipment result R2 sustained use of a long hard. This applies to 1(R accident/incide | 2) of 3 residents reviewed for ijuries. de: ays R1 is 288 pounds and has ent diagnosis: Non- displaced shaft, morbid obesity, r disease, venous insufficiency, | | | | | |
| | on 4/14/2021 at 10 obese with a hard I said she has left hi on 3/30/2021, V8(A pushing me from a inside of the buildin rest on her wheelch under the wheelch v7(Family) was pre R2 said V8 is not a After V7(Family of stopped, but my less chair. R2 said she was yelling in pain, and pushed me bat o my room. V7 pla without notifying the | s of the left hip, lumbago with side and spinal stenosis. 2:21AM, R2 was laying in bed, ong cast to the left leg. R2 p and left leg issues. R2 said williary Technician) was n outside visit with family to ag. R2 said there were no leg hair. My left leg got caught air causing a tibia fracture. Esent and saw what happened. Certified nursing assistant. R2) told V8 to "stop", V7 g was already underneath the could not respond because Then V7 turned me around ackwards into the building and ced me by the bed and exited a nurse. After sitting in pain I door and saw V5(Nurse), told | | | | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--|---|--|----------------------------|--|------------------|--------------------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | | |
| | | | | | С | | |
| IL6008312 | | IL6008312 | B. WING | <u> </u> | 04/20/2021 | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| APERION CARE WILMINGTON 555 WEST KAPWILMINGTON, | | | | 81 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D 8E | (X5) COMPLETE DATE | |
| S9999 | Continued From page 2 | | \$9999 | | | | |
| | leg rest were lost de rooms) because of have had my leg re would not be broke | 3 | | | | | |
| | could not remembe outside of the room complained of foot at R2's foot there w knee cap had a slo her leg got caught of V7 was pushing he V10(Medical Docto | 17PM, V5(Nurse) said she or the time but R2 saw her passing medication and pain. V5 said when she looked was no difference but her left ping mark. V5 said R2 told me underneath the wheelchair as r. V5 said she called r/ Director) and an x- ray was R2 has a tibia fracture from the | | | | | |
| | happened on 3/30/2 yelled at V8 to stop screaming in pain a said her wheelchair it. V7 said at 1PM, discovered that R2 said if R2 had wheel | PM, V7(Family of R2) said it 2021 at 11:50AM. V7 said she because R2 was yelping and as he rolled over her leg. V7 did not have any leg rest on she called the facility and was not treated until 1 PM. V7 elchair leg rests on her would not be broken. | | | | - (m) - (m) | |
| | said he was pushin an outside visit and underneath the who hold her up legs wh confirmed V7 was prest on the wheelch | 10PM, V8(Auxiliary Technician) g R2 back to her room from her foot got caught eelchair.V8 said he told R2 to hile he pushed her. V8 present and there was no legular.V8 confirmed after it ed R2 backwards to her room. | | | | | |
| Ħ | with a long hard leg | 09 AM, R2 was again in bed g cast on the left leg. R2 said to raise her legs as he pushed | | == | | | |

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PRINTED: 04/27/2021 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6008312 04/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **555 WEST KAHLER APERION CARE WILMINGTON** WILMINGTON, IL 60481 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **TAG DEFICIENCY**) S9999 Continued From page 3 S9999 her. R2 said I could not have raised my legs, I have left hip and left leg issues, constant swelling in both legs and I need a hip replacment. R2 said she has to be pushed by someone and she does not remember who pushed her outside for the visit, it was not V8. R2 said V8 pushed her for the first time the day he got her leg caught underneath the wheelchair. Restorative Care Plan dated 4/3/2021 says "Wheelchair to have leg rests on when being pushed by staff. On 4/16/2021 at 8:17AM,V1(Administrator) said V8 is a male with a small frame and it was probably difficult for him to propel R2 who is obese. V1 said R2 did not have leg rest on because she propels herself and leg rest are not indicated for self propelling residents. When asked why was V8 pushing a resident who propels herself, V1 responded I can not answer that." On 4/15/2021 at 5PM, V10(Medical Doctor/Director) said he does not get involved in analysis on the cause or prevention of injuries. V10 said he has 1000's of patients and does not remember R2's medical history," I am a doctor and I prescribe treatment." On 5/16/2021 V12(Medical Doctor) said he has no knowledge of how R2 injured her leg. X- Ray Report dated 3/30/2021 says, "Left Acute spiral distal tibia fracture."

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PRINTED: 04/27/2021

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING IL6008312 04/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **555 WEST KAHLER APERION CARE WILMINGTON** WILMINGTON, IL 60481 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 (B)

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