STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008312	A. BUILDING: _____ B. WING _____	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WILMINGTON	555 WEST KAHLER 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 Complaint Investigation #2273633/IL146737	S 000		
S9999	Final Observations Complaint Investigation #2273633/IL146737 Statement of Licensure Viiolations: 300.610a) 3001210b) 300.1210d)6) Section 300.610 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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.	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision to prevent a fall. This applies to 1 of 3 residents (R1) reviewed for falls with injuries in a sample of 3. This failure resulted in R1 incurring a nasal bone and right orbital fracture. Findings include: R1's 3/8/2022 Social Service Progress Note documents R1 admitted to the facility on 3/7/2022 from a hospitalization due to worsening mood and increased agitation. R1's diagnoses include dementia with behaviors and psychosis. This note further documents R1 as oriented to person only and with impaired memory and judgement. R1's Fall Initial Occurrence Note dated 3/9/2022 at 1:45 PM documents R1 as trying to get up from the reclining wheelchair and falling forward hitting	S9999		

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S9999	Continued From page 2 her right eye. This report documents R1 with a bump on her forehead and a bruise to her right eye. R1 was sent to the hospital for evaluation and treatment. On 5/10/2022 at 2:29 PM V5 (Former Nurse) stated R1 had been trying to get out of R1 wheelchair all day. V5 stated she and the staff were trying to redirect R1 but it was not working and she required supervision to prevent her from falling out of the chair. V5 stated she left for her lunch break and at that time R1 was in the dining room with staff. V5 stated she instructed the staff to supervise R1 before she left. V5 stated when she returned she was notified R1 had an unwitnessed fall in the hallway and was not in the presence of staff at the time of the fall as instructed by V5. On 5/10/2022 at 3:26 PM V11 (Nursing Assistant) stated she was assigned as R1's Nursing Assistant on 3/9/2022 when R1 fell. V11 stated R1 was a "huge fall risk." V11 stated she put R1 to bed but she was trying to get up so V11 placed R1 in her reclining wheelchair in the hallway so she could be supervised closely. V11 stated she was rounding and in another residents room when another resident yelled out. V11 stated she came out of the room and found R1 on the floor. Per V11 R1 had climbed out of her reclining wheelchair and was laying face down on the floor trying to roll onto her back and the chair was pushed over. V11 stated she required 1:1 supervision and she was doing rounds and was unable to supervise her as she required. 5/11/2022 12:02 PM V13 (Nurse Practitioner) confirmed R1's injury was preventable. V13 stated if V5 instructed staff to supervise R1 and they did not provide that supervision the fall and	S9999		

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S9999	Continued From page 3 subsequent injuries could have been prevented. R1's hospital Cat Scan 3/9/2022 of the Facial Bones Bones documents R1 with nasal bone and right orbital fractures. The facility policy Fall Prevention Program dated 11/21/2017 documents the purpose of the policy is to assure the safety of all residents. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision. This policy further documents it is the responsibility of all assigned nursing personnel to ensure precautions are put in place and consistently maintained. (A)	S9999		