

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE MARSEILLES	STREET ADDRESS, CITY, STATE, ZIP CODE 578 WEST COMMERCIAL STREET MARSEILLES, IL 61341
--	---

(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 Annual Licensure Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.625a) 300.625c) Section 300.626 Discharge Planning for Identified Offenders a) If, based on the security measures listed in the Identified Offender Report and Recommendation, a facility determines that it cannot manage the identified offender resident safely within the facility, it shall commence involuntary transfer or discharge proceedings pursuant to Section 3-402 of the Act and Section 300.3300 of this Part. (Section 2-201.6(g) of the Act) c) When a resident who is an identified offender is discharged, the discharging facility shall notify the Department. These REQUIREMENTS are not met as evidenced by: Based on observation, interview and record review, the facility failed to notify the (State) Department of Public Health of the discharges for two residents (R178 and R179) of two residents reviewed for Identified Offenders Discharges in a sample of 31. Findings include:	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
07/03/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE MARSEILLES	STREET ADDRESS, CITY, STATE, ZIP CODE 578 WEST COMMERCIAL STREET MARSEILLES, IL 61341
--	---

(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
S9999	<p>Continued From page 1</p> <p>The facility's Admission of Identified Offender-(State) Policy dated 1/24/18 documents: "4. Facility must review screenings and all supporting documentation to determine if the placement is appropriate. 5. Facility must develop a plan of care appropriate to the needs of the offender."</p> <p>The Identified Offenders Program Facility Report dated 6/6/24 documents: "R178 and R179, Identified Offenders- Current Residents."</p> <p>The facility's Electronic Health Record/EHR documents R178 was admitted to the facility on 8/5/21 and discharged on 11/18/21. The facility's EHR documents R179 was admitted to the facility on 11/7/19 and discharged on 6/29/20.</p> <p>There were no EHR documentation to indicate that discharge information was sent to (State) Department of Public Health for R178 and R179.</p> <p>On 6/14/24 at 1:05pm, V5 Social Services Director/SSD stated, "Both of them deceased in the facility on hospice; we know there is nothing found in documentation to show that we notified the State Department of their discharges; could have been that when they deceased, we did not know that we had to notify State."</p> <p>(C)</p>	S9999		