

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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  Second Probationary Licensure Survey.  Statement of licensure violations	S 000		
S9999	Final Observations  1 of 5 Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of these checks. b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender. 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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>Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.</p> <p>d) The facility shall comply with all applicable provisions contained in the Uniform Conviction Information Act.</p> <p>j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care.</p> <p>l) If the identified offender is a convicted (see 730 ILCS 150/2) or registered (see 730 ILCS 150/3) sex offender or if the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the Act reveals that the identified offender poses a significant risk of harm to others within the facility, the offender shall be required to have his or her own room within the facility subject to the rights of married residents under Section 2-108(e) of the Act. (Section 2-201.6(d) of the Act)</p> <p>This REQUIREMENT is NOT met as evidenced by: Based on interview and record review, the facility failed to notify the Illinois State Police of an identified sex offender living in the facility, failed to arrange for a fingerprint-based criminal history record within 72 hours of receiving a name-based criminal history check indicating the resident's past offenses, failed to ensure the identified sex offender was placed into a private room and failed to create a care plan regarding the criminal history of the resident for one of 10 recently admitted residents (R108) reviewed for criminal history background checks.</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 2</p> <p>This failure had the potential to affect all 65 residents living in the facility.</p> <p>Findings include:</p> <p>R108's electronic medical record documents R108 was admitted to the facility on 4/28/16.</p> <p>On 7/6/16 at 11:55 a.m., E10, Social Service Director, provided copies of R108's Illinois State Police UCIA (Uniform Conviction Information Act) forms dated 4/28/16 and 6/22/16, which both document R108 has a "hit" result, indicating R108 has a criminal history. These same forms document R108's criminal history to include the following conviction: "Aggravated Criminal Sexual Abuse of a victim less than 13." At this same date and time, E10 stated that the facility was unaware of R108's sex offender status until 6/22/16. E10 stated, "The corporate office never sent (R108's) initial background check to the facility. I was reviewing (R108's) chart on 6/21/16 and noticed there still was no background check, so I contacted the corporate office, and they sent (R108's) UCIA form dated 4/28/16, which had a hit. But since it was more than 30 days old, it was re-ran on 6/22/16."</p> <p>On 7/6/16 at 12:15 p.m., E10, Social Service Director, stated that R108 was not placed into a private room in the facility until 6/22/16. E10 also stated that the facility did not contact the Illinois State Police regarding fingerprinting for R108 until 6/22/16. E10 then stated that since the facility was unaware of R108's sex offender status until 6/22/16, a care plan with goals and interventions addressing R108's sex offender status was not initiated until 6/23/16. E10 also stated that R108 is alert and oriented and able to propel in a wheelchair independently throughout</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 3</p> <p>the building.</p> <p>R108's current electronic care plan documents that a care plan addressing R108's sex offender status was not created until 6/23/16.</p> <p>On 7/6/16 at 2:08 p.m., E7, Care Plan Coordinator, verified that R108's offender status care plan was created on 6/23/16.</p> <p>The facility's Daily Staffing Requirements form dated 7/5/16 documents that 65 residents currently reside at the facility.</p> <p>(AW)</p> <p>2 of 5 Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow accepted infection control practices for three of eight residents (R103,R105,R106 ) on the sample of</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 4</p> <p>eight and ten residents (R109,R111,R112,R113, R114, R115,R116, R117, R118,R119) on the supplemental sample. The facility failed to use clean technique when administering medications and failed to disinfect the blood glucose meter between resident use to prevent the potential spread of infection.</p> <p>Findings include:</p> <p>1. On 7/6/16 at 11:10am E6 RN(Registered Nurse) checked R112's glucose level using a blood glucose meter. E6 didn't clean the blood glucose meter after checking R112's glucose level. On 7/6/16 at 11:12am E6, using the same blood glucose meter, checked R105's glucose level.</p> <p>On 7/6/16 at 11:40am E6 confirmed that she forgot to clean the blood glucose meter after using it for R112 and using it for R105.</p> <p>On 7/6/16 at 2:00pm E2, Director of Nursing, provided a list of residents receiving blood glucose monitoring. The residents affected are as follows:R109, R112, R113, R114, R115 and R116.</p> <p>2 a. On 7/5/16 at 11:38am E3, RN used hand sanitizer, then after handling the medication cart keys, E3 pushed R118's medications out of the package directly into her hand and then into the medication cup.</p> <p>On 7/5/16 at 11:55am E3, RN washed her hands, then after touching the medication cart, E3 pushed R111's medications out of the package directly into her hand and then into the medication cup.</p> <p>On 7/5/16 at 12:00pm E3, RN used hand sanitizer on her hands, then after touching the medication cart, E3 pushed R117's medications out of the package directly into her hand and then into the medication cup.</p> <p>On 7/5/16 at 12:03pm E3, RN used hand sanitizer on her hands, then after touching the medication cart, E3 pushed R119's medications</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>		
(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 5</p> <p>out of the package directly into her hand and then into the medication cup.</p> <p>On 7/5/16 at 12:05pm E3, RN used hand sanitizer, then after handling the medication cart keys, E3 pushed R106's medications out of the package directly into her hand and then into the medication cup.</p> <p>On 7/5/16 at 12:08pm E3, RN used hand sanitizer, then after handling the medication cart keys, E3 pushed R114's medications out of the package directly into her hand and then into the medication cup.</p> <p>b. On 7/5/16 at 2:40pm E4, LPN (Licensed Practical Nurse) used hand sanitizer, then after touching the medication cart, pushed R103's medications out of the package directly into her hand and then into the medication cup.</p> <p>The facility Infection Control Policy dated 1/2014 documents the following: "All facility personnel are required to routinely wash hands and use appropriate barrier precautions to prevent transmission of infections....The facility shall assure the necessary training...to carry out an effective Infection Control Program..."</p> <p>3. On 7/6/16 at 11:25am E6, RN prepared to give R105 Glulisine (insulin) 16 units. E6 was attempting to put on a glove when the glove fell to the floor. E6 picked up the glove on the floor and put it on. With the same glove on E6, holding the syringe of insulin and open alcohol swab package went into R105's room. E6 then administered the insulin injection while still wearing the same glove.</p> <p>The undated facility Maintaining the Blood Glucose Meters policy documents the following: "The blood glucose monitor should be cleaned and disinfected between each resident test..."</p> <p>(AW)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 6</p> <p>3 of 5 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. This REQUIREMENT is NOT met as evidenced</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 7</p> <p>by: Based on observation, interview and record review, the facility failed to create an assistive device, intravenous line and wound care plan for three of eight residents (R104, R105 and R106) reviewed for care plan accuracy in the sample of eight.</p> <p>Findings include: The facility's Care Plan policy (dated 1/1/14) documents the following: "All residents will have comprehensive assessments and an individualized plan of care developed to assist in achieving and maintaining their optimal status... Concerns, problems, needs and/or strengths are listed based on resident's individual needs. Physician's orders and personal care and nursing needs are also listed based upon comprehensive assessments... The Resident Care Coordinator is responsible for coordinating each resident's care plan and for ensuring that the appropriate information is available to all staff..."</p> <p>1. R104's (Enclosed Wheeled Walker) Ambulation Device Assessment Form (dated 8/2/14) documents that R104 uses an enclosed wheeled walker as an assistive device for ambulation.</p> <p>On 7/6/16 at 8:15 AM and 1:30 PM, R104 was ambulating in the facility's hallway using R104's enclosed wheeled walker.</p> <p>R104's current electronic Care Plan (revised 2/10/16) does not document R104's enclosed wheeled walker as a focus area with goals and interventions.</p> <p>On 7/6/16 at 11:10 AM, E7 (Care Plan Coordinator) verified that R104 uses an enclosed wheeled walker and that R104's enclosed wheeled walker is not care planned as a focus area with goals and interventions.</p> <p>On 7/6/16 at 2:00 PM, E2 (Director of Nursing) verified that R104's enclosed wheeled walker is</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 8</p> <p>not care planned and stated that R104's enclosed wheeled walker should be care planned as a focus area with goals and interventions.</p> <p>2. R105's current electronic Physician's Orders documents an order for Meropenem 1 gram (antibiotic) intravenously every eight hours; Start on 6/20/16.</p> <p>On 7/5/16 at 1:45 PM, R105 was sitting in R105's room. R105 had a central venous catheter (intravenous line) on R105's right chest with a clean, dry dressing covering it.</p> <p>R105's current electronic Care Plan (revised 6/23/16) does not document R105's central venous catheter as a focus area with goals and interventions.</p> <p>On 7/6/16 at 11:10 AM, E7 verified that R105's central venous catheter was not care planned as a focus area with goals and interventions.</p> <p>On 7/6/16 at 2:00 PM, E2 verified that R105's central venous catheter was not care planned and stated that R105's central venous catheter should be care planned as focus area with goals and interventions.</p> <p>3. R106's current clinical record includes the following diagnoses: Cerebral Vascular Accident; Hemiplegia/Hemiparesis and Aphasia.</p> <p>R106's Skin Reports by E9, Wound Nurse, dated 6/17/16, 6/23/16 and 6/30/16 document a friction/shear wound located on R106's coccyx.</p> <p>R106's Skin Report includes coccyx wound measurements of 2.2 centimeters (cm) in length (L) by 0.5 cm wide (W).</p> <p>R106's current Care Plan, dated 6/9/16 did not include a Care Plan addressing R106's coccyx wound.</p> <p>On 7/5/16 at 3:35 p.m., E7, Care Plan Coordinator (CPC) verified that R106's current Care Plan did not include a plan of care addressing R106's current coccyx wound.</p> <p>On 7/6/16 at approximately 10:40 a.m., E9,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 9</p> <p>Wound Nurse stated that R106 has had a coccyx wound which "comes and goes" and re-opened on 6/17/16. E9 stated R106's coccyx wound was currently open and being treated.</p> <p>On 7/6/16 at approximately 10:45 a.m., E9, Wound Nurse performed R106's coccyx wound care. R106's coccyx wound was noted to be open, measuring approximately 2.0 cm (L) by 0.3 cm (W) and less than 0.1 cm in depth.</p> <p>On 7/7/16 at approximately 8:55 a.m., E2, Director of Nursing stated E2 became aware that R106's coccyx area had re-opened on 6/16/16 and no Care Plan was created addressing the wound. E2 stated R106's coccyx area is known to "break down" intermittently and a wound care plan should be in place. E2 verified that R106's coccyx wound had last healed on 4/21/16 per R106's Skin Report and Z1's, (Wound Doctor), Progress Notes of the same date.</p> <p>(B)</p> <p>4 of 5 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. This REQUIREMENT is NOT met as evidenced by: Based on observation, interview and record review, the facility failed to implement fall prevention interventions for one of three residents (R104) reviewed for falls in the sample of eight.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 10</p> <p>Findings include: The facility's Fall Prevention and Management policy (dated 10/22/14) documents the following: "While preventing all resident falls is not possible, it is our policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate as safe of an environment as possible... Nursing staff will initiate any necessary fall prevention precautions at the time of admission and whenever necessary due to a change in condition..."</p> <p>R104's Nursing Progress Notes (dated 4/2016-current) document R104 had falls on the following dates: 4/13/16, 4/22/16 and 6/3/16.</p> <p>R104's electronic Fall Risk Assessment (dated 4/13/16) documents a score of 21 indicating R104 is at risk for falling.</p> <p>R104's Fall Investigation Report (dated 4/15/16) documents that R104 was ambulating without R104's enclosed wheeled walker and fell. This same form documents that the root cause of R104's fall was that R104 was not using R104's enclosed wheeled walker and that the intervention was to ensure that R104's enclosed wheeled walker was near R104 at all times.</p> <p>On 7/5/16 at 9:00 AM and 1:30 PM, R104 was lying in R104's bed. R104's enclosed wheeled walker was located outside R104's room in the hallway not within R104's reach.</p> <p>On 7/6/16 at 10:45 AM, R104 was lying in R104's bed. R104's enclosed wheeled walker was located outside of R104's room in the hallway not within R104's reach.</p> <p>On 7/6/16 at 10:45 AM, E8 (Certified Nursing Assistant) verified that R104's enclosed wheeled walker was located outside of R104's room not within R104's reach. E8 stated that R104's wheeled walker is usually located outside of R104's room.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 11</p> <p>On 7/6/16 at 10:50 AM, E2 (Director of Nursing) stated that the intervention for R104's 4/13/16 fall was to keep R104's enclosed wheeled walker within R104's reach. E2 verified that R104's enclosed wheeled walker was located outside of R104's room not within R104's reach and stated that the enclosed wheeled walker should be located in R104's room within R104's reach. (B)</p> <p>5 of 5 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer medications as ordered by the Physician for one of eight residents (R105), on the sample of eight and three residents (R109, R110,R111) on the supplemental sample. The facility had 5 medication errors out of 30 opportunities for error. Findings include: 1. On 7/5/16 at 11:10am E3, RN (Registered Nurse) gave R109 Gabapentin (pain/anti-seizure) 100mg (milligrams) one capsule. The Physician's Order dated 5/6/16 documents an order for Gabapentin 200mg three times daily. On 7/5/16 at 1:35pm E3 confirmed she gave R109 only one Gabapentin (100mg) capsule instead of two Gabapentin (200mg) as ordered by the Physician. 2. On 7/5/16 at 11:40am E3 gave R110</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 12</p> <p>Gabapentin 100mg two capsules (200mg). The pharmacy label on the package of Gabapentin dated 3/16/16 documents the medication was dispensed on 3/16/16. The label documents instructions for medication administration as follows: Gabapentin capsule 100mg, two capsules (200mg) three times a day. The Physician's Order dated 5/19/16 documents an order for Gabapentin 300mg one capsule three times a day. The Electronic Medication Administration Record (EMAR) dated 7/1-7/31/16 documents Gabapentin 300mg one capsule three times a day.</p> <p>On 7/5/16 at 1:45pm E3 confirmed she only gave R110 two capsules (200mg) of Gabapentin. E3 stated she gave R110 the Gabapentin as labeled by the pharmacy on the package. E3 confirmed the EMAR dated 7/1-7/31/16 documents Gabapentin 300mg to be given, not 200 mg as she gave to R109.</p> <p>3. On 7/5/16 at 11:55am E3 gave R111 Clonazepam 0.5mg, 1/2 tablet (0.25mg). The Physician's Order dated 4/16/16 documents an order for Clonazepam (sedative) 0.5mg three times a day. The EMAR dated 7/1-7/31/16 documents Clonazepam 0.5mg three times a day. The pharmacy label dated 6/21/16 documents that R111's Clonazepam was dispensed on 6/21/16. The label documents instructions for medication administration as follows: Clonazepam 0.5mg 1/2 tablet (o.25mg) three times a day.</p> <p>On 7/5/16 at 1:55pm E3 confirmed she gave R111 Clonazepam 0.25mg, instead of Clonazepam 0.5mg as ordered. E3 stated she gave R111's Clonazepam according to the pharmacy label, not the EMAR.</p> <p>4. On 7/5/16 at 4:10pm E5, RN gave R105</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE TOLUCA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 EAST VIA GHIGLIERI TOLUCA, IL 61369</b>
--	---

(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 13</p> <p>Meropenem (antibiotic) 1 gram IV (intravenously) through his central venous catheter (IV line). E5 flushed the port of R105's central venous catheter with five to six cc (cubic centimeter) of Normal Saline and then hung the Meropenem. The Physician's Order dated 6/10/16 documents an order to use 10cc of Sodium Chloride 0.9% (Normal Saline) IV every eight hours and as needed. The order documents to Flush line (central venous catheter) prior to and after administration of Meropenem. On 7/5/16 at 4:10pm E5 confirmed she flushed R105's IV line (catheter) with five to six cc of Normal Saline.</p> <p>5. On 7/6/16 at 11:25am E6, RN administered Meropenem one gram IV to R105. The Physician's Order dated 6/20/16 documents an order for Meropenem one gram IV every eight hours. The EMAR dated 7/1-7/31/16 documents the Meropenem is scheduled to be given at 1:00am, 8:00am and 4:00pm. On 7/6/16 at 11:25am E6 stated that R105's Meropenem can be given anytime in the morning. On 7/7/16 at 10:00am E2, Director of Nursing stated giving R105's Meropenem three hours late is not acceptable. The undated facility Medications Administration Oral policy documents: "Always adhere to the five rights of medication administration, right drug,.....right dose, right time...Medications are to be given within one hour of ordered time...." (B)</p>	S9999		