STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145857	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE ST ELMO	**221 EAST CUMBERLAND ST ELMO, IL 62458**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint Investigation #1653776 / IL86794 - No deficiencies Validation Survey for Subpart U: Alzheimer Unit The Aperion of St Elmo is in substantial compliance with Subpart U, 77 Illinois Administrative Code 300.7000.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow their policy on reporting allegations of abuse in a timely manner for two of two residents, (R2 and R10), reviewed for abuse in the sample of 10. Findings include: 1. An Incident Report Investigation dated 05/29/16, documents at 5:30 PM, before dinner, E11, (Certified Nurse Aide-CNA), was told by R10 that E12, (CNA), hit him in the mouth. E11 waited until after dinner before reporting this allegation to E10, (Licensed Practical Nurse).	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 2. An Incident Report Investigation, dated 11/12/15 at 7:53 PM, notes that R2 reported that E12 hit her in the mouth. E10 sent E12 home at that time. However, E10 did not notify E1(Administrator) of the incident until the next morning. The facility's Abuse Prevention Program Facility Procedure, (not dated), Page 3 A of 7, section V, Internal Reporting Requirements and Identification of Allegations states; Employees are required to report any incident, allegations or suspicion of potential abuse, neglect or misappropriation of property they observe, hear about or suspect to the administrator or the person in charge of the facility acting on behalf of the administrator, or an immediate supervisor who must then immediately report it to the administrator. The employee orientation materials page 3, Suspected Abuse and Neglect part A ....Report the suspected abuse or neglect to the Executive Director of the facility immediately. During an interview with E1, (Administrator), on 07/13/16 at 12:55 PM, E1 said staff would be inserviced regarding reporting abuse timely.	F 226		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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F 431	Continued From page 2 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to store medications in a safe manner and keep medication under the direct observation of the nurse for 1 resident, (R25), in the supplemental sample reviewed for medication storage. Findings include: On 07/11/16 from 3:55 PM-4:03 PM, during a	F 431		

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F 431	Continued From page 3 continuous observation, the Treatment Cart was observed unattended and unlocked in a small room across from the main floor nurse's station. During this time, no nurse was observed supervising the cart. R25 was seen wandering the area during the observation. E2, (Director of Nurses), stated on 07/12/16 at 3:45 PM, that R25 can wander the halls independently. E2 also stated the cart should have been locked. R25's 05/20/16 Quarterly Minimum Data Set states that R25's Brief Interview for Mental Status cannot be conducted because R25 is rarely/never understood. The computerized medical record states that R25 has a diagnoses of Unspecified Disorder of Psychological Development, Schizophrenia, and Dementia with Bipolar Disorder. The Facility's 01/01/15 Medication Administration Policy states that the medication room, medication cart and treatment cart "must be locked when not in use by authorized personnel."	F 431		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide 80 square feet of space per resident bed for 5 of 5	F 458		

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F 458	Continued From page 4 residents, (R3, R4, R7, R8 and R9), reviewed for the room size waiver in the sample of 10, and 13 residents, (R12 - R24), in the supplemental sample. The findings include: 1. E1, (Administrator), stated on 7/13/16 at 9:30 am that resident rooms 19 - 22 and 23 - 31 are the rooms included in the facility's room size waiver. All of the rooms have been measured and do not provide the required 80 square feet per resident bed. The rooms vary in size but are no smaller than 78 feet squared per resident bed. E1 provided documentation on 7/11/16 that Rooms 19 -22 and room 31 are Medicare and Medicaid certified. The remainder of the wavered rooms 23 - 30 are Medicaid Certified. E1 provided a room roster on 7/11/16 that confirmed R3, R4, R7, R8, R9 and R12 - R24 reside in the undersized rooms. 2. Observation of these rooms throughout the survey from 7/11/16 to 7/14/16 found no issues related to room size. The observation of the rooms found that there was adequate space to meet the medical and personal needs of the residents living in the waivered rooms. Interview with R14 on 7/12/16 at 2:30 pm, during the group meeting, and an individual interview with R12 on 7/13/16 at 11:15 am, whom both reside in waivered rooms found no issues with the room size or personal space.	F 458		