## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145523	B. WING _		02	C / <b>16/2016</b>	
NAME OF PROVIDER OR SUPPLIER  APERION CARE AMBOY				STREET ADDRESS, CITY, STATE, ZIP COD 15 WEST WASSON ROAD AMBOY, IL 61310		710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	TS .	F 00	00			
F 252 SS=B	( ) ( )		F 25	52		3/1/16	
		melike environment, allowing his or her personal belongings					
	by: Based on observat review, the facility for environment free of This applies to 4 of R7)) interviewed resample of 7. The findings include On February 16, 20 strong smell of urin of the facility. This of 200 and 300 wings facility were dull. The sunken in the middle February 16, 2016 of daughter-R5 is not (housekeeper on the down here yet? The On February 16, 20 odor is very strong some days are real have been bad. As the housekeeping so They need to try an	7 residents (R1, R5, R6 & garding facility odors in the					
ABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	

03/01/2016

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.

Facility ID: IL6005730

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145523	B. WING		0:	C 2/ <b>16/2016</b>	
NAME OF PROVIDER OR SUPPLIER  APERION CARE AMBOY				STREET ADDRESS, CITY, STATE, ZIP CO 15 WEST WASSON ROAD AMBOY, IL 61310		2/10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 252	and daughter buy hereshener a month stop by unannouncher room she is emsaid if she leaves the clothing so does not the facility. On February 16, 2016 at 10:45 A.M. interviewable) said once in a while and main entrance. On A.M., E1 (Business contact person) sai grievances regardinand there is no systomought up by resid 16, 2016 at 1:00 P. there was a common had not been emptioners. Z1 said she commode be emptiseem to be worse or efuses to visit on the facility odors. On Followsekeeper) said wanted housekeeper day, starting in Janifeel she could do a hours. The rest of its since there is no lated On February 16, 20 (Housekeeping) Lauhours a week (per spent in housekeepspent in laundry since the sinc	ge 1  fer at least two cans of air to use in her room. If friends ed and she has not sprayed barrassed by the odors. R1 fe facility she sprays her of go out in public smelling like fruary 16, 2016 at 10:40 A.M., fer is not interviewable) said fare present in the facility feekends. On February 16, for it, Z4 (R7's wife-R7 is not for complains about odors for she notices them near the february 16, 2016 at 11:30  Manager-Administration for there have been no for offensive smells or odors frem to track casual concerns fem to track casual concerns fem to track casual concerns for visitors. On February for it, Z1 (R1's daughter) said for cleaned in over 24 for had to specifically ask that the fed and cleaned. Z1 said odors for the weekends and her son for weekends because of the february 16, 2016 at 10:45 E4 for the old regional director for hours cut to five hours a for user sold she did not for good job cleaning in just five for shift is spent in laundry for staff during the day shift. for an an an an an are for there is no day shift laundry for regional manager cut staff for an		252			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445500					С
		145523	B. WING			02/1	16/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
APERION	N CARE AMBOY				5 WEST WASSON ROAD AMBOY, IL 61310		
	0.0000000000000000000000000000000000000				<u> </u>	. 1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	D BE COMPLÉTION	
F 252	PROVIDER OR SUPPLIER  N CARE AMBOY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F2	252			