

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Wilmington		STREET ADDRESS, CITY, STATE, ZIP CODE 555 West Kahler Wilmington, IL 60481	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>25071</p> <p>Based on observation, record review and interview the facility failed to timely complete a physician order for an X-Ray for 1 of 4 residents (R1) reviewed for change in condition.</p> <p>Findings include:</p> <p>On 04/26/2024 at 11:45 AM R1 was in bed with a cast on her right foot.</p> <p>The Progress Note dated 04/13/2024 10:00 PM documents R1 had a witnessed fall 04/13/2024 at 8:00 PM in the bathroom. R1 stated, I'm alright, my knee just give up, I am not in pain. After an hour R1 complained of pain and swelling to her right ankle. The physician was contacted, and an x ray was ordered to be completed by the on-call X-Ray service.</p> <p>The Radiology Results Report dated 04/17/2024 at 12:00 AM documents R1 with an Oblique fracture of the distal fibula and a distal tip fracture of the medial malleolus with ongoing healing.</p> <p>On 04/26/2024 at 10:40 AM V12 (Quality Assurance Nurse) stated I should have been calling the X-ray company to see why there was the delay in them coming out. I realized (04/16/2024) after needing them for another resident that (R1's) X-ray still wasn't done.</p> <p>The Facility Agreement with the portable X-Ray company documents Provider shall provide Services within 24 business hours or schedule a time for the service. The Provider will promptly notify the Facility if Services time is unable to be met.</p>

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.

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