(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6004147	B. WING		C 01/08/2024	
	PROVIDER OR SUPPLIER	HTS 1629 GAF	DRESS, CITY, S RDNER LANE HEIGHTS, IL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure S Complaint Investiga	urvey ation: 23210014/IL167322				
S9999	Final Observations		S9999			
	Statement of Licens 300.610a) 300.1210a) 300.1210b)4)5) 300.1210d)3)6)	sure Violations I of II:				
	a) The facility shall procedures governifacility. The written be formulated by a Committee consistiadministrator, the amedical advisory conforming and othe policies shall complements the facility and shall	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	Nursing and Person a) Comprehensive with the participation resident's guardian applicable, must de comprehensive carrincludes measurable meet the resident's and psychosocial ne	General Requirements for all Care Resident Care Plan. A facility, of the resident and the or representative, as velop and implement a e plan for each resident that e objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which				

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

Electronically Signed 02/09/24

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		IL6004147	B. WING			8/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APERIO	APERION CARE PEORIA HEIGHTS 1629 GA PEORIA					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	practicable level of provide for discharge restrictive setting be needs. The assess the active participate resident's guardian applicable. (Section b) The facility shall and services to attar practicable physical well-being of the reeach resident's complan. Adequate and care and personal cresident to meet the care needs of the reach resident to meet the care needs of the reach resident to meet the care needs of the reach resident to meet the care needs of the reach resident to meet the care needs of the reach resident to meet the care needs of the reach resident to meet the care needs of the reach resident to meet the care needs of the reach resident to meet the care needs of the reach resident that did the care needs of the reach resident that did	provide the necessary care ain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care ament shall be developed with tion of the resident and the or representative, as a 3-202.2a of the Act) provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with a prehensive resident care I properly supervised nursing care shall be provided to each a total nursing and personal aesident. ersonnel shall assist and as so that a resident's abilities living do not diminish unless are individual's clinical condition aminution was unavoidable. A resident's abilities to bathe, arransfer and ambulate; toilet; h, language, or other ication systems. A resident arry out activities of daily living arvices necessary to maintain arrices and personal hygiene. Dersonnel shall assist and as with ambulation and safe as often as necessary in an aretain or maintain their highest functioning.	S9999			
		section (a), general nursing at a minimum, the following				

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 2 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					С		
		IL6004147	B. WING		01/0	08/2024	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S RDNER LANE	STATE, ZIP CODE =			
APERIO	N CARE PEORIA HEIC	HIS	IEIGHTS, IL				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
S9999	resident's condition emotional changes, determining care re further medical eva made by nursing st resident's medical r 6) All necessa to assure that the re as free of accident nursing personnel s	eed on a 24-hour, basis: servations of changes in a , including mental and , as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the record. ary precautions shall be taken esidents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision	S9999				
		NT is not met as evidenced by:					
	Based on interview and record review the facility failed to implement appropriate fall prevention interventions and failed to investigate a fall with an injury (10/6/23), for two of nine residents (R17 and R38) reviewed for falls, in a sample of 43. These failures resulted in R17 sustaining a second fall from the bed with a fracture on 12/2/23.						
	Findings include:						
	(revised) 11/21/17 of include measures we needs of each residuals and implement interventions to pro and assistive devices.	Fall Prevention Program, dated directs staff, "The program will which determine the individual dent by assessing the risk of tation of appropriate vide necessary supervision es are utilized as necessary. a Program includes the					

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 3 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6004147	B. WING			C 08/2024
	PROVIDER OR SUPPLIER N CARE PEORIA HEIC	HTS 1629 GAI	DDRESS, CITY, S'RDNER LANE	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	following componer Immediate change successful, Care Pleach fall, Interventifall, Preventative m. 1. R17's facility Adn R17 was admitted the following diagnot (Principal Diagnosis history of Falling. R17's Care Plan, da following Focus are included is the following Focus are included is the following resident's call light the resident to use The resident needs requests for assistation where my feet are for Therapy) evaluate a (As needed). R17's (facility) Incidentification (R17's) room in section of	Ints: Assessment time frames, in interventions that were lan incorporates: Addresses ons are changed with each easures." Inission record documents that to the facility on 6/19/23 with oses: Syncope and Collapse is), Unsteadiness on feet, Interventions: Anticipate is within reach and encourage it for assistance as needed. In prompt response to all ance; Bed height to be placed if and treat as ordered or PRN Ident Notes, dated 7/17/23 at ant, "(R17) located in bathroom supine position with knees Moderate amount of blood to d. First aid administered; 11 called for transfer to ED	\$9999			

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 4 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6004147	B. WING		I	C 08/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1629 GAI	RDNER LANE	,		
APERIO	APERION CARE PEORIA HEIGHTS PEORIA			61616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	(urinary catheter) (k down."	ped) bag at night after laying				
	11:02 P.M. docume floor next to (R17's) (R17) is very confushere. No injury note noted to (R17's) (ur facility Incident Repin R17's chart. R17's (facility) Incident R0:00 P.M. docume P.M., (R17) was four right side, next to him rolled out of bed. (R	gress Notes, dated 10/6/23 at ent, "(R17) found sitting on the bed at around 9:30 P.M. sed as usual when (R17) got ed. Small amount of blood inary catheter) tubing." No cort or Investigation was found ent Notes, dated 12/2/23 at ents, "On 12/2/23 at 10:00 and lying on the floor on his is bed. It appears that (R17) R17) said he was lying in bed to lay on his side (R17) rolled ies noted."				
	R17's Nursing Prog 1:27 A.M. documen assessment post-fa (right knee). Deep p Reddish-purple bru noted. Yellow bruisi 2-view x-ray of the R17's Radiology Red documents, "Right	gress Note, dated 12/5/2023 at ht, "(R17) Follow up all. Swelling observed at site burple bruising noted. Green bruising ng noted. Physician ordered a right knee." eport, dated 12/5/23 Knee. Indication: Right knee				
	bruising. Findings: A the anterior knee w lateral border of the the front view. Consum bruise. Small creso aspect of the femur. On 12/12/23 at 11:4	Acute soft tissue swelling of ith cortical irregularity of the medial femoral condyle on sider MRI of the joint for bone entic avulsion fracture medial." 12 A.M., V1 (Administrator)				
	verified there was n R17's 10/6/23 fall.	o facility investigation into				

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 5 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
APERIO	N CARE PEORIA HEIO	HTS	RDNER LANE			
	I	PEORIA I	HEIGHTS, IL	61616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
	Practical Nurse/Car Data Set Coordinat Fall Inter Disciplina When a resident fa fall mats around the didn't add fall mats next to his bed (on prevented the injury 12/2/23)." 2. R38 was admitte of Type 2 Diabetes Morbid Obesity. On 8/29/2023 at 12 "Resident in the din off the toilet onto th (R38's) head. No res	3 A.M., V19 (Licensed re Plan Coordinator/Minimum or) stated, "I am part of the ry Team that reviews all falls. Ils or rolls out of bed, we place eir bed. I don't know why we for R17 after he was found 10/6/23). Maybe it would have y to his knee (from the fall on d on 5/25/18 with diagnoses Mellitus, Schizophrenia and :00 PM, the record noted ing room and stated (R38) slide floor and denies hitting edness or bruising noted. V2 i) and V25 (doctor) notified of				
	"Patient was seen the Patient slipped out (complains of) R (Report noted to Report foot. No breath), chest pain, (headache), N/V/D diarrhea), dysuria (conter complaints. Proceedings of the Procedure of the Proc	5 PM, a Nurses Note noted ferral to ortho doctor) for fracture rt (right)				
		ote noted "Summary of the				

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 6 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APERIO	N CARE PEORIA HEIC	SHTS	RDNER LANE HEIGHTS, IL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
\$9999	fall: res (resident) s the toilet. Root caus staff assist. Interver res to utilize staff as On 12/10/23 at 1:00 have a boot at beds (the boot) when I ge On 12/10/23 at 1:10 had handrails mour loose, slid side to s The Witnessed Fall 8/29/23 noted "Res (R38) made the sta she/he seen (R38) observed at time of assistance." The W lacked documentati right foot, had an x- right foot fracture no conducted to ensur functioning. The care plan dated documentation of ri safety measures re and/or boot and equ On 12/13/69 at 2:00 stated the facility fa interventions to red	lid off onto floor while using se of fall: res did not utilize ntion and care plan updated: ssist for transfers on/off toilet." O PM, R38 was observed to side and R38 stated "I wear it et up. I broke my foot." O PM, R38's bathroom toilet nted to the toilet although were ide and was unstable. I Investigation Report dated ident was in (R38's) bed when tement. Roommate stated slide off toilet. No injuries incident. Ambulatory without itnessed Fall Investigation ion R38 complained of pain in ray, was ordered a boot for or was an investigation e safety intervention were	\$9999			
	J					
	Statement of Licens	sure Violations II of II:				

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 7 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		IL6004147	B. WING			C 08/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
APERIO	N CARE PEORIA HEIO	SHTS	RDNER LANE			
	T	PEORIA I	HEIGHTS, IL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 7	S9999			
	300.610a) 300.2020 300.2100 Section 300.610 Re a) The facility shall procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall compliments the facility and shall by this committee, or some some state of the	esident Care Policies have written policies and ing all services provided by the policies and procedures shall Resident Care Policy ng of at least the dvisory physician or the pommittee, and representatives in services in the facility. The ly with the Act and this Part. Is shall be followed in operating libe reviewed at least annually documented by written, signed				
	Director of Food Set There shall be suffiner shall be suffiner sonnel employed dietary needs of all facility. Their working meet the total dietard dietary employees' assignments shall be bietary duties and javailable in the diet knowledge and use Section 300.2100 F Every facility shall or rules entitled "Food Adm. Code 750).	Dietary Staff in Addition to ervices cient number of food service d and on duty to meet the persons eating meals in the ng hours shall be scheduled to ry needs of the residents. All time schedules and work be posted in the kitchen. ob procedures shall be ary department for employees'				

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 8 of 19

Illinois Department of Public Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY COMPLETED	
AND FLAIN	OI CONNECTION	IDENTIFICATION NUMBER:	A. BUILDING:		C		
		IL6004147	B. WING			; 8/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
APERIO	N CARE PEORIA HEIG	HTS	DNER LANE				
0(4) 15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES			DNI .	()/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 8	S9999				
	review, the facility fakitchen that include beverage drip trays oven, large contained facility failed to laber refrigerated foods a placed raw meat uningredients and failed proof pans. The facheck the level of Cosanitation buckets. off the floor of the worked freezer. The facility inside the walk-in retaility failed to cooler. The facility silverware so that diserving area of the facility failed to consoler the facility failed to consoler facility failed to consoler facility failed to consoler the facility failed to consoler facility failed	on, interview and record ailed to maintain a clean s ovens, ranges, mixers, grease trays, microwave ers steam table area. The all and date food products for and dry goods. The facility ider ready to eat food or food ed to put raw meat in leak cility failed to consistently duaternary Ammonia in the The facility failed to keep food walk-in refrigerator and walk-in railed to place thermometers efrigerator and walk-in freezer. keep dished up food in the failed to store the dishes and ust/grime could not reach the dishes and silverware. The sistently record steam table and failed to follow/attain in heating foods in a these failures have the 182 residents living in the					
	The findings include	e:					
	AM. V7 (Cook) was "I'm working by mys have a Dietary Man toured. The convecthe top of the applia grease, grime, and the ledge on the ou	tered on 12/10/23 at 10:10 s washing dishes. V7 stated, self. I'm new and we don't ager." The kitchen was tion oven had dust wads on the ager and a buildup of black food particles/crumbs on both tside of the oven and on the					

Illinois Department of Public Health

oven were opaque with a layers of buildup

STATE FORM PBDB11 If continuation sheet 9 of 19

Illinois D	epartment of Public	Health				
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		11 6004447	B. WING		1	
		IL6004147			1 01/0	8/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1629 GAR	DNER LANE			
APERIO	N CARE PEORIA HEIC	SHTS PEORIA H	IEIGHTS, IL	61616		
()(4) ID	CLIMMA DV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
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				DEFICIENCY)		
S9999	Continued From pa	0 an	S9999			
00000	-		00000			
		behind the convection oven				
		bwebs. The range has dried				
	•	e burners and on the back				
		pan on the side of the range				
		some older layers that smelled				
		y located under the burners				
		ed splashes, unknown food				
		rease, and dust. The range				
		food particles and grease				
		om inside of the oven. The				
		appliances had splashes of				
		The food preparation table				
		nge has plates stored on a				
		at are not upside down to				
		sed to dust/contaminants. hen utensils do not have a				
		prevent contamination. The				
		sitting in a pan uncovered.				
		nd personal drink container				
		he pan. The area above the				
		der the shelf to the dining				
		ried food splashes. The				
	handwashing sinks					
		One handwashing sink did not				
		pap dispenser, another				
		did not have paper towels in				
		chine. The electrical boxes				
		e ceiling have a layer of				
		ood preparation table and by				
		Another personal drink				
		g on the beverage table. A				
		ays of fruit cocktail was sitting				
		refrigerator. V7 did not know				
		en sitting out and stated, "It				
		n Friday night (12/08/23)."				
		rator had five crates of milk				
		ce concentrate sitting on the				
		shelf held four ten-pound				
		urger, unopened and one tube				
		opened with 50 % used, no				

Illinois Department of Public Health

STATE FORM 6899 If continuation sheet 10 of 19 PBDB11

IIIINOIS D	epartment of Public	Health				
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		11 000 44 47	B. WING		01/08/2024	
		IL6004147	B. W		01/0	8/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1629 GAR	DNER LANE	:		
APERIO	N CARE PEORIA HEIC	HTS	IEIGHTS, IL			
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(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
1710		,	.,	DEFICIENCY)		
S9999	Continued From pa	ge 10	S9999			
	onen date/lahel an	d a ten-pound opened box of				
		bel or date, all sitting directly				
		a leak-proof pan under them				
		f, located over two cases of				
		-pound bag of hash browns.				
		ere were two five pound bags				
		75 % empty, no label/open				
		iced American Cheese, no				
	label/open date; two pounds of American Cheese,					
	opened, no date/label; a half shallow pan of					
	lettuce leaves, no date/label; an opened jar of					
		used - no label/open date;				
		ontainers of unknown liquid, no				
		oologna sandwiches (8 total),				
	no label/date). The					
		walk-in cooler. The freezer				
		itting directly on the floor, four				
		e concentrate, one box				
		o boxes of biscuits, two cases				
		case of bread, one case of				
		re was no inside thermometer				
	in the freezer. The	large can opener had black				
	debris on the blade	and a large amount of black				
		own substance on the can				
	opener base. The l	large stand mixer's top				
	underneath area ar	nd protective steel guard had a				
	large amount of old	dried food splashes. The				
	microwave oven ha	d old, dried food splashes on				
	the inside ceiling. 1	The juice appliances on the				
	beverage table had	dark, sticky liquid in the drip				
		ır odor. The dry goods stock				
		containers which held, flour,				
	brown sugar, sugar	(no label on the sugar				
		aÌ, breadcrumbs, and rice				
	containers were soi					
		e top and outside of the				
		vere two five-pound bags of				
		ımbs, 75 % gone, no				
		nere was a container of rice				
		d no label/date. During the				

Illinois Department of Public Health

STATE FORM 6899 If continuation sheet 11 of 19 PBDB11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		IL6004147	B. WING		1	8/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
APERION CARE PEORIA HEIGHTS			RDNER LANE IEIGHTS, IL				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	nge 11	S9999				
	morning, V7 was o	bserved leaving the kitchen but washing hands and putting would change gloves without					
	alone in the kitcher the dish machine. myself again. I've and have worked the myself or with one Certified Nursing A this morning to help out. If they hadn't leads the continuous of the continuous of the leads the	15 AM, V7 (Cook) was working in, currently washing dishes in V7 stated, "I'm working by only been here for seven days ne majority of the days by other person. A couple of ssistants came into the kitchen of me cook and get breakfast nelped me, I don't know when I the breakfast ready."					
		sment, last reviewed on etary: Food Service Staff - kers per day."					
	that for the first 10 staffed. One day w	chedule for December, shows days, only one day was fully with only two staff; four days f; two days with only four staff; five staff.					
	Nursing) and V20 (kitchen to assist V7 washing her hands dishwasher. V20 whandling soiled dist dirty side of the dishwasher to pans and then hand them on a cart to p V20's hands and properties.	30 AM, V2 (Director of Wound Nurse) came into the 7. V20 put gloves on without and began running the vas observed going from hes and pots and pans on the h machine to pulling racks out that had clean dishes, pots and dling these items and putting ut away, all without washing utting clean gloves on. V20 nois Food Handlers Sanitation					

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 12 of 19

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND I EAR OF COMMECTION		IDENTIFICATION NOWIBER.	A. BUILDING:		COM	LETED	
		IL6004147	B. WING			C 08/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ADEDIO		1629 GAF	RDNER LANE	<u> </u>			
APERIO	N CARE PEORIA HEI	PEORIA I	HEIGHTS, IL	61616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	nge 12	S9999				
	Certificate.						
	Certificate.						
	Nursing), entered the hands or don g Walk-In Refrigerate the food items. Aft of the walk-in and sham." When V2 fo food preparation ta foil, wrapped the haconvection oven.	45 AM, V2 (Director of the kitchen and did not wash loves. V2 went inside of the or where V2 rummaged among er a few minutes, V2 came out stated, "I'm looking for the und the ham sitting out on the ble, V2 got a large roll of tin am, and placed it into the /2 stated, "The kitchen is short t I can to help them out."					
	went around the kit issues. When V1 w Quaternary Ammor looked around and used the strips to che had been in the she had not seen a bucket since she had not seen a bucket since she had is ince she had not seen a bucket since she had not seen a bucket since she had not seen a bucket since she had is ince she had not seen a bucket since she had in the residents that We spent a lot of m in the kitchen just mand the kitchen. It was diffinew floor. The manusable arm and had the new maintenant another three week on 11/20/23. Other helping. My wife ar weekend. The new tomorrow. My I'm in the strips weekend. The new tomorrow. My I'm in the strips weekend.	administrator) at 10:45 AM, inchen. V1 confirmed these was asked to check the level of hia in the Sanitation bucket, V1 stated that he had not seen or heck the sanitation level since kitchen. V7 also stated that any test strips for the sanitation ad started working at the "I've only been here for seven oncerned with the nursing care in how clean the kitchen is. In how clean the kitchen is. In oney on getting the new floor ecently. We didn't have time roughly clean the whole cult moving appliances for the intenance man had just one is since left our employment. Ince guy won't be starting until its. Our Dietary Manager left or staff (not dietary) have been and I worked the kitchen last widietary manager starts more concerned about a have a wound than the					

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 13 of 19

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
74101 2741	or correction.	BENTH TO THE TOTAL BETTE	A. BUILDING:			
IL6004147		B. WING		C 01/08/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APERIO	N CARE PEORIA HEIG	SHTS	DNER LANE			
			IEIGHTS, IL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 13	S9999			
	(to help prevent wo prevent foodborne i V1. V1 stated, "I st	importance of a balanced diet unds) and sanitation (to llness) was emphasized to arted out as a Certified so that side of nursing care is oncerned."				
	The document, Daily Data Sheet, used to record the sanitation bucket sanitation level three times daily, were reviewed for the past 30 days. Only eleven sheets for the sanitation buckets were dated and filled in during that time; four sheets were blank, two sheets had been logged for breakfast; three sheets had been logged for breakfast and lunch; two sheets had been logged for breakfast, lunch, and dinner.					
	when she would be food temperatures. that I had to take te take the food temperatures sit table, she said, "Ho (Cook for evenings) ham should be 165 When asked what the food could be when "165 degrees F." What the danger zon tell the lowest tersteam table (135 dedanger zone temperature) to V7, and record the temperature.	30 PM, V7 (Cook) was asked ready do take the steam table V7 stated, "No one told me mperatures!" V7 began to eratures. When asked what hould be for food on the steam nestly, I don't know." V8 came over and stated, "The degrees Fahrenheit (F). he lowest temperature that in the steam table, V8 stated, then V7 and V8 were asked ne temperature is, V8 stated, F. Neither V7 nor V8 were able egrees F) or the correct rature (which is 41 to 135 ietary Aide) got a book out and d stated, "This is where you tures after you take them."				

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 14 of 19

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6004147	B. WING			C 08/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ADEDIO	N CARE PEORIA HEIO	1629 GAR	DNER LANE	·		
APERIO	N CARE PEORIA NEIC	PEORIA F	IEIGHTS, IL	61616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
\$9999	only eleven sheets logged: 20 days the sheets; two days not for any meal, but th days breakfast and logged; two days te logged; and only two were logged for all to the control of the con	had meal temperatures ere were no temperature to temperatures were logged e sheets were provided; four luncheon temperatures were mperatures were partially o days the meal temperatures	S9999			
	discarded. Keep poor of the temperature	date by which it should be otentially hazardous food out danger zone (41 degrees to nheit). Refrigerated storage				

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 15 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
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		IL6004147	B. WING		01/0	8/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APERIO	N CARE PEORIA HEI	HTS	DNER LANE			
040.15	CLIMMA DV CTA		IEIGHTS, IL		DNI .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 15	S9999			
	in the warmest part the air temperature animal food such a separately from coor they cannot be stor poultry, and fish iter cooked and ready-foods should be stor Wrap foods proper uncovered and not. The document, Prouse, dated 2020, so hands upon entering location, after all broad Gloves are change would be required. They are removed, as	owed: Place a thermometer of the refrigerator to monitor in the refrigerator. Store raw seggs, meat, poultry, and fish oked and ready-to-eat food. If ed separately, place raw meat, ms on shelves beneath co-eat items. Raw animal ored in drip proof containers. by. Never leave any food item labeled." per Hand Washing and Glove tates, "All employees will wash g the kitchen from any other eaks, and between all tasks. It is dany time hand washing when gloves are changed, and hand washing is required. Ilaced on dirty hands."				
	Service Areas, date Services Staff will uschedule will be po The document, Sar Solutions, dated 20	nitation of Dining and Food ed 2020, states, "Dietary aphold sanitation. A cleaning sted for all cleaning tasks." nitizing and Disinfectant 20, states, "The employee will plution in accordance with				
	The document, Sto Equipment, dated 2 sanitized dishes, ut stored in a clean ar keeps them from co or other means."	ring Dishes tableware and 2020, states, "Clean and ensils and equipment will be ad dry location in a way that contamination by splash, dust aning Rotation, dated 2020,				

6899

Illinois Department of Public Health STATE FORM

states, "Items cleaned and sanitized after every

PBDB11 If continuation sheet 16 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6004147	B. WING		C 01/08/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
ADEDIO	N CARE PEORIA HEIO	1629 GAF	RDNER LANE	Ē		
APERIO	N CARE PEORIA NEIC	PEORIA I	HEIGHTS, IL	61616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 16	S9999			
	use: Can Opener, Counters. Items cle Microwave Oven; H Large Appliances.	Mixer, Worktables and eaned daily: Stove Top, Grill land Washing Sink; Exterior of Monthly clean: Refrigerators n and Sanitize Ingredient Bins.				
	The document, Daily Cleaning Schedule, dated 2020, states, "Wash and sanitize the can opener; wash and sanitize mixer; Wash and sanitize beverage table; Clean Stovetop/Grill; Clean Microwave Oven; Clean Handwashing sink; Clean Food Carts." The document, Weekly Cleaning Schedule, dated 2020 states, "Clean shelves, clean ovens." The document, Dining Services Opening and Closing Checklist, dated 2020, states, "Opening Duties: Prepare sanitation solution and test for proper concentration, log concentration. Closing Duties: Complete Daily Cleaning Schedule; Label, date, store all ingredients used."					
	Cold Food, dated 2 served at the follow safe and appetizing minimum serving to required temperature cooking, or cooling serving/holding temperatures should degrees Fahrenheit temperatures of hor	ving Temperatures for Hot and 020, states, "Foods will be ing temperatures to ensure a dining experience. The emperatures do not reflect the res needed for preparation, of foods. These are minimum peratures. Hot food d range from 135 to 170 to the took will take tood items using approved prior to each meal service."				
	Temperatures, unki	ly Data Sheet, Food nown date of publication, sis, states, "Temperature				

Illinois Department of Public Health

STATE FORM PBDB11 If continuation sheet 17 of 19

Illinois D	Illinois Department of Public Health						
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SI COMPLE		
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
APERIO	N CARE PEORIA HEIC	GHTS	RDNER LANE HEIGHTS, IL				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 17	S9999				
	Danger Zone 40 degrees to 140 degrees Fahrenheit. * Do not serve foods at inappropriate Temperature." *Note this is not the correct temperature range for the State of Illinois Sanitation requirements.						
	procedure for Micro Oven use recomme	able to provide a policy and owave use. The Microwave endations of the United States culture (USDA), Food Safety					
	and Inspection Servine "Microwaves do not out. Microwaves pe	vice, dated 8/08/13, states, t cook food from the inside enetrate the food to a depth of					
	microwaves don't re would cook by cond	hicker pieces of food, the each the center. That area duction of heat from the outer					
	destroyed during mother types of oven	to the middle. Bacteria will be icrowave cooking just as in s, so food is safe cooked in a					
	less evenly than in Microwave cooking	owever, the food can cook a conventional oven. can be uneven just as with					
	to use a food therm	For that reason, it is important nometer and test food in e sure it has reached the					
	recommended temperand other pathogen	perature to destroy bacteria ns that could cause foodborne uniform cooking, arrange food					
	items evenly in a colliquid if needed. Co	overed dish and add some over the dish with a lid or					
	food and the top of	enough space between the the dish so that plastic wrap food. Loosen or vent the lid or					
	wrap to allow steam is created will help	n to vent. The moist heat that destroy harmful bacteria and					
	provide safe, even	oking. Cooking bags also cooking. Stir, rotate, or turn (where possible) midway					
	through the microw	vaving time to even the cooking spots where harmful bacteria					

Illinois Department of Public Health

STATE FORM 6899 If continuation sheet 18 of 19 PBDB11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		C		
		IL6004147	B. WING			8/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APERIO	N CARE PEORIA HEI	HIS	RDNER LANE IEIGHTS, IL			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETE DATE
S9999	Continued From pa	ige 18	S9999			
\$9999	can survive. Even it turntable, it's still he to bottom. Observe continues and is continues and is continues and is continues and is continued in turntable, for a longer time in turkey or beef roas breads, small vege time, the temperatus everal degrees. For advise to let a food	f the microwave oven has a elpful to stir and turn food top the "standing time." Cooking empleted during standing time. It is obliow the manufacturer's waves cause water, fat, and vibrate 2.5 million times per heat. After the oven is off or om the oven, the molecules the heat as they come to a tional cooking after is called "carryover cooking," or "standing time." It occurs dense foods such as a whole than in less-dense foods like tables, and fruits. During this are of a food can increases or that reason, directions may "rest" for a few minutes after a or removing food from the	S9999			

6899

Illinois Department of Public Health STATE FORM

PBDB11 If continuation sheet 19 of 19