STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002059	A. BUILDING: _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE OAK LAWN	9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453

(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 Facility Reported Incident of 1/11/21 IL130097	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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Section 300.1210d)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.

Section 300.3240a)

An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

There regulations were not met as evidenced by:

Based on interview and record review the facility failed to follow their Abuse Prevention Policy and failed to keep a resident safe from sexual abuse by a staff member for 1 of 3 residents (R5) reviewed for abuse in a total sample of 14. This failure resulted in R5 being assaulted during care causing the resident to receive counseling services to cope and treat recurring nightmares related to the sexual assault.

Findings Include:

The Incident Report dated 11/18/20 documents that R5 had informed staff of being sexually assaulted by V7 (CNA) during a bath. A full investigation was completed and IDPH and the Police were notified immediately. V7 admitted to assaulting the resident and was arrested at the facility.

The Nurse's Notes dated 11/18/20 documents that a full body assessment was done on R5 and there were no injuries and no signs of trauma

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S9999	Continued From page 2 noted to the resident. The Social Service Notes dated 11/23 and 11/24/20 documents that R5 is receiving counseling services from a therapist. R5 has been given art supplies, a journal, and is being treated with music therapy. R5 has complaints of nightmares and also has 1:1 sessions to develop coping mechanisms. On 1/13/21 at 11:10am V1 (Administrator) stated "The allegation of sexual assault was substantiated. V7 (CNA) was sticking fingers inside of R5 during a bath. This was done without the resident's consent and may have occurred a couple of times but R5 was unsure of the time frames. We investigated everything, we called the Police and V7 was arrested. We gave testimony to the Attorney General as well. V7 came in and admitted to assaulting R5. V7 was seen on the cameras taking R5 for a shower and was noted to be in the room for an hour. Our interviews of other staff revealed that showers with R5 usually takes about 30 minutes. All staff and all residents in the building were interviewed and there were no other concerns with abuse noted. IDPH was notified." On 1/13/21 at 1:05pm V6 (Social Service Director) stated "R5 is receiving in house therapy and is being seen twice per month. R5 was also given art supplies for art therapy and journaling. R5 has 1:1 sessions with a staff member that is certified in sexual assault. R5 had some nightmares after the assault and was introduced to music and medications were prescribed to help manage the nightmares and trauma. The nightmares have decreased. R5 could not remember how many times the assault had taken place but did say it happened a few times. A	S9999		

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definitive number was not given. R5 did wait a few days before telling me about the incident and reported feelings of being scared. I reassured the resident of the safety measures in place."

On 1/13/21 at 1:10pm V2 (DON) stated "I completed the body assessment. R5 had no signs of external trauma. We did complete sexual abuse in-servicing with all of the staff and talked about reporting behaviors immediately. V7 was arrested and charged. A criminal background check was done prior to V7 being hired and it came back clean."

On 1/13/21 at 2:30pm R5 was observed sitting in the chair. R5 stated "V7 was supposed to be putting me back in bed and V7 touched me inappropriately in my private area by putting fingers inside of me. This happened more than once. I did tell staff at one point and they handled it. I had to talk to the Police and that staff member was fired. I still have nightmares about what happened to me. I have to see a therapist to help with that."

The Abuse Prevention Policy documents that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse. Sexual abuse is the non-consensual sexual contact of any type with a resident. It includes unwanted intimate touching, all types of sexual assault of battery. Any forced, coerced or extorted sexual activity with a resident is considered to be sexual abuse.

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