STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002547	A. BUILDING: _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

(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 1-8-21/IL130787	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) 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 300.1210 General Requirements for Nursing and Personal Care b) 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	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002547	A. BUILDING: _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

(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
S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002547	A. BUILDING: _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

(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
S9999	Continued From page 2	S9999		

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to provide a plan of monitoring and/or supervision interventions for a resident with a known history of wandering and inappropriate social behavior for 1 of 9 residents (R5) reviewed for supervision. This failure resulted in R5 being found naked in bed with R6, a severely cognitively impaired resident. This failure has the potential to cause negative emotional and psychosocial harm to a reasonable person in the same situation.

Findings include:

R6 has the diagnosis of cerebral infarction. R6's Brief Interview for Mental Status (BIMS) dated 11/20/20 documents a score of six, which indicates severe cognitive impairment.

R5 was admitted on 12/22/2020 with the diagnoses including Alzheimer's Disease and unsteadiness on feet. R5's BIMS dated 12/29/2020 documents a score of ten, which indicates moderate impairment. Progress note dated 1/8/2021 documents V15 (Nurse) was made aware by V14 (Certified Nursing Assistant/CNA) that R5 was in R6's bed. R5 was sent to the hospital for altered mental status change.

On 2/9/2021 at 1:01pm, V14 (CNA) stated, "R5 would wander the hallway naked. R5 walked with an unsteady gait. I noticed R5 was not his room. R5 was observed in R6's bed naked. R6's gown was up by her navel. R6 did not have on an adult {incontinence brief}. R6 was confused. I looked at R6's hands, thighs and did not notice anything. I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002547	A. BUILDING: _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

(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
S9999	Continued From page 3	S9999		

was not sure what to look for in R6's vaginal area. Residents don't wear {incontinence briefs} overnight. There was water on R5's floor. There was a puddle with a streak leading away from the puddle as if R5 slid in the water. R6's bed sheets were wet. R5's left side of the body was wet. R5 had a fall."

On 2/9/21 at 1:30pm, V2 (Social Service) stated, "We sent R5 to the hospital for being naked in the bed with R6. R5 was a constant wanderer. R5's cognition was off. We discharged R5 because R5 was not appropriate for this facility. R5 needed constant supervision. R5 wandered into R6's room."

On 2/10/21 at 9:30 am, R6 was pleasantly confused. R6 was unable to report what happened on 1/8/21.

On 2/10/21 at 10:03am, V14 (CNA) stated, "R6 had barrier cream/white paste in between her thighs on her vaginal area and on her buttock. R5 had white paste on his fingertips."

On 2/10/21 at 10:05am, V15 (Nurse) stated, "I could not rule out or confirm whether R6 had vaginal penetration. R6 was sent to the hospital for a medical evaluation."

On 2/11/21 at 2:48pm, V2 (Social Service) stated, "R5 was severely impaired, very confused and wandered aimlessly."

On 2/11/21 at 2:55pm, V20 (Nurse) stated, "R5 was aggressive, refused medication, could not be redirected and required constant supervision for safety."

R5's social service aggressive behavior dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002547	A. BUILDING: _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

(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
S9999	Continued From page 4 12/22/20 documents R5 had moderate problems with self-destructive statements/behavior and threats. R5 has a diagnosis of severe mental illness and a history of recent aggressive/agitated behavior which was scored as substantial/significant problems. Admission/Re-Admission Observation dated 12/23/2020 documents R5 has wandering behaviors that occurred one to three days. R5 has socially inappropriate behavior. R5's care plan dated 12/23/2020 documents R5 is a wanderer. Goals include R5's safety will be maintained. Interventions include to distract R5 from wandering, identify patterns of wandering, and intervene as appropriate. R5's fall occurrence dated 1/8/2020 documents R5 had an unwitnessed fall. R5 was found by staff in room. R5 did not know what happened. R5's section G functional status dated 12/29/2020 documents R5 needed limited assistance with one person physical assist with transfers, walking in room/corridor and locomotion on/off the unit. The hospital paperwork dated 1/8/21 documents R6 was confused, found in bed with a male resident (R5) from the facility who was unclothed. R6 was reported to not have been wearing any briefs. R5 was a confused demented patient. Final Abuse Investigation Report dated 1/15/21 documents V14 (CNA) was passing trays and observed R5 in the bed with R6. R5 had a history of dis-robing and wandering. V14 said she immediately helped R5 out of R6's bed. V14 noticed R5's knee bleeding and R5 was naked. V14 said R6's gown was pushed upward and did not have a brief on. R5 will be discharged to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002547	A. BUILDING: _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

(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
S9999	Continued From page 5 another facility that has a locked unit for wandering. Behavior Management Policy dated 11/28/12 documents "Implementing appropriate intervention consistent with the individualized plan of care and to ensure each resident received appropriate treatment and services to attain the highest practicable mental and psychosocial well-being." (B)	S9999		