STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001713	A. BUILDING: _____ B. WING _____	C 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WEST CHICAGO	201 WEST NORTH AVENUE WEST CHICAGO, IL 60185

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S 000	Initial Comments Facility Reported Incidents of March 24, 2021 IL132211 and IL132208	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3240 a) 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 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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to keep residents safe from physical, mental, and verbal abuse by V19 (Certified Nurse Aide) and V18 (Licensed Practical Nurse - LPN). This resulted in R5 and R6 being physically abused by V19 when R5 and R6 were thrown into bed during transfers instead of using a mechanical lift. R5 was also abused by V19 when V19 applied tooth paste to R5 during incontinent care in place of peri-wash.

This also resulted in R7, R8, R9, and R10 being verbally and mentally abused by V18 (Licensed Practical Nurse). R7, R8, R9, and R10 became fearful due to threats of unit changes to the locked unit when residents refused to follow V18's instructions.

This applies to 6 of 6 (R5, R6, R7, R8, R9, R10) reviewed for abuse from a total sample of 10

The findings include:

1) R6 is a 38-year-old male admitted to facility on 3/12/18 with diagnosis Paraplegia, Osteoarthritis, Schizophrenia, Bipolar, Major Depressive disorder, and Metachromatic Leukodystrophy. R6's MDS showed R6 (3/16/21) to be cognitively intact and Social Service documentation notes R6 has no problem with memory and decision making. In addition, R6 is noted to need extensive assistance with all ADLs (Activities of Daily Living) and is dependent on staff for

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transfers and personal care.

On 3/30/21, interview with V17 (Certified Nursing Aide), noted V17 was assisting V19 (Certified Nursing Aide) putting R6 back to bed. V17 stated, "Due to R6's condition we are to use a mechanical lift on him, but V19 lifted him up under his armpits and threw him into bed." V17 asked V19 "What are you doing", and V19 replied, "Don't worry about it." V17 stated this appeared to be uncomfortable for R6. While repositioning and transferring R6, V19 was always rough. V17 reported this to V2 and V20 3 times over the last few months.

V17 (Certified Nursing Aide) noted during another occasion during incontinent care, V19 (Certified Nursing Aide) was pulling R6's pubic hair, "You could see it was painful on R6's face and I told V19 to stop. (V19) looked at me with an angry look." V17 saw this happen 2 times, and reported this to V2 (DON) a few days later.

On 3/30/21, V14 (Certified Nursing Aide) noticed during meal time "(V19) (Certified Nursing Aide) making fun of R6 and the way he communicates. R6 looked very sad, and after V19 was done assisting him with his meal, I went over to comfort him. I told R6 that I was going to inform V2 and V20 about the inappropriate behavior from V19. The next day I notified both V2 and V20 the above incident."

On 3/30/21, during an interview with R6, he was able to communicate by shaking his head yes/no, and using soft mumble like words. R6 agreed V19 (Certified Nursing Aide) was rough and caused pain while transferring him into the bed. R6 also stated "yes" to the question of being belittled and mocked during dining due to his

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inability to speak. R6 answered "yes" when asked during his incontinent care if V19 would pull his pubic hair intentionally. During this course of time, R6 felt sad, humiliated, and unsafe at the facility. When told V19 was no long going to be working at the facility, he nodded his head "yes" and mumbled the word "good."

2) R5 is a 69-year-old resident totally dependent upon staff for personal care, transfers and hygiene, and has been coded per the MDS (Minimum Data Sets) Assessment of 1/13/21) to be severely cognitively impaired. Face sheet, dated 6/19/20, showed R5 with diagnosis of Metabolic Encephalopathy, Type 2 Diabetes Mellitus, Major Depressive disorder, Dementia, Anxiety disorder, Dysphagia, Hypertension, Protein Malnutrition.

Admission nursing progress note, dated on 6/23/20, noted R5 is alert orientated x2, anxious, disoriented, thumping fist on wall calling for son. Resident was placed on 30 minute safety checks for 24 hours. Initial Social service screening appeared anxious and disoriented, calling out for son, unable to give details about her home life situation.

Nursing 72 hours admission noted R5 unable to bear weight, and is dependent upon staff for all ADL's (Activities of Daily Living) personal hygiene, dressing, toileting, eating, and transfer x2 assist with mechanical lift. R5 started Hospice with Unity Hospice on 9/29/20.

Care plan, dated 7/10/20, noted under Social Service, documented R5 is at risk for abuse/neglect due to Dementia, and has history of abuse from family member.

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During a phone interview on 3/30/21 with V16 (Certified Nursing Aide), "(V19) was extremely rough with (R5)." V16 noted she and V17 (Certified Nurse's Aide) saw V19 (Certified Nurse's Aide) pick R5 up by one hand and one ankle and throw her into her bed. V16 continued to add she asked V19 to stop, and V19 ignored V16. "While I was in the room, (V19) proceeded to do incontinent care on (R5) using toothpaste for instead of peri-wash. When questioned what he was doing, (V19) stated he wanted her to smell fresh. While (V19) was doing the incontinent care on (R5), she said ouch and no for him to stop, but (V19) continued. I did tell (V19) to stop so I could finish (R5's) care, but he refused and finished her care." V16 spoke to V2 (Director of Nursing), V3 (Assistant Director of Nursing), and V20 (Restorative Director) the next day. V16 noted V19 using toothpaste on R5 at least four timea over the last few months during incontinent care.

On 3/30/31 phone interview with V17 (Certified Nurse Aide), noted he was in R5's room straightening up the room when V19 (Certified Nurse Aide) brought R5 back to her room for the night. Instead of using a mechanical lift he lifted her up under her arms and threw her into her bed. "I asked (V19) what are you doing, and told me to leave the room if I didn't like it, I refused and we completed the care together." V17 proceeded to tell V2 (DON), and V20 (Restorative Director) about the way V19 was transferring R5 the day after the incident. V17 noted V19 transferring R5 in the same manner three more times in the past few months.

3) Residents R7, R8, R9 and R10 all voiced complaints about V18's conduct in the facility. V1

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was notified of V18's behavior via anonymous complaint that V18 was abusive to residents. A final abuse investigation was filed with the department on 3-29-2021. V18 was terminated by the facility for failure to follow the facility's abuse policy.

On 4/5/31 10:00am, R7 stated, "(V18) (License Practical Nurse) speaks to me rudely even if I ask her for water. Not too long ago, V18 got so mad at me because I kept asking her for things, she threatened to move me to the 3rd floor if I didn't stop asking the questions. There also have been times when V18 is upset with me, she will totally ignore me when I ask for something. I feel that I can't speak the truth due to the repercussions that might happen."

On 4/5/21 10:30am, R8 stated she has had situations with V18 (Licensed Practical Nurse) where V18 has been "unkind to me by using loud yelling voice when I asked for medication. I don't think she likes me. There have been times she totally ignores me and will not answer my questions or requests for medicine. I feel disrespected from V18."

On 4/5/21 11:00am, R9 stated, "(V18) (Licensed Practical Nurse) and I have gotten into a few disagreements and the last one sent me to the 3rd floor locked unit. I was just telling her what I thought and V18 made such a big deal about it and exaggerated it that's when I was transferred to the 3rd floor. V18 has a loud voice and while I was on the floor she would yell at residents all day long. I feel that if you tell the truth you still get punished, I feel like I can't trust anyone."

On 4/5/21 11:30am, R10 stated, "I remember one time I asked for water from (V18) (Licensed

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Practical Nurse) and she yelled no and wouldn't give it to me. Then all of a sudden she gave me a few cups. I caught her sleeping at the desk, I woke her up because I needed my medication. (V18) told me if I said anything she would transfer me to the 3rd floor. Nurses like V18 make you feel belittled and sad about yourself."

The facility's investigation, dated March 30, 2021, documents V19 was "terminated for providing inappropriate resident care and not following the facility's abuse policy."

On 3/30/21, during an interview with V1 (Administrator), V1 stated she was in the process of terminating the following staff members. V14, V15, V16, V17 V18 and V19, for not notifying the administrated staff of above allegation in a timely manner.

The facility's policy entitled "Abuse Prevention and Reporting", revised January 22, 2019, documents: "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation." The policy defines as "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physician harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that necessary to attain or maintain physical mental and psychosocial well-being. Instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."

(A)