FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C B. WING IL6014617 08/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 SOUTH WESTERN AVE** APERION CARE INTERNATIONAL CHICAGO, IL 60609 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint 2285831/IL149409 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 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 The facility shall provide the necessary care and services to attain or maintain the highest

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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

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_\_\_\_\_ B. WING\_ IL6014617 08/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 SOUTH WESTERN AVE APERION CARE INTERNATIONAL** 

APERIO	N CARE INTERNATIONAL CHICAGO	), IL 60609		
(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
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	care needs of the resident.			
	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)			
i	These requirments are not met as evidenced by:		2020	
	Based on observations, interviews, and records review the facility failed to follow thier abuse policy for 1 resident (R60) being free from physical abuse by 1 resident (R102) out of 3 residents reviewed for abuse. R102 hit R60 on the head. The facility also failed to ensure 1 resident (R53) was free from verbal abuse by V5 (Certified Nursing Assistant). These failures resulted in R60 verbalizing feeling scared and unsafe due to physical assault by R102; and R53 verbalizing feeling scared of staff treating her badly and staff retaliation.			
	Findings include:			
	R60 is a 59 years old, observed with bilateral below the knee amputation. Per R60's minimum data set assessment dated 5/18/2022 on brief interview on mental status (BIMS). R60 scored 12, that means his (R60) cognition was borderline between no impairment to moderate impairment. Due to bilateral leg amputation R60 uses his wheelchair for locomotion and does not ambulate.	3	-3 0	
	R102 is 72 years old, with medical diagnosis of violent behavior. Per R102 minimum data set dated 6/25/2022, R102 on brief interview of mental status (BIMS) scored 10; which means moderate impairment in his cognition.			

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED С B. WING IL6014617 08/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 SOUTH WESTERN AVE **APERION CARE INTERNATIONAL** CHICAGO, IL 60609 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 On 07/31/2022 at 11:22 AM, R60 was seen in a wheelchair, with bilateral below the knee amputation (BKA). R60 was using his wheelchair to wheel himself from Nurse's Station to the Dining Room. R60 asked for help since he cannot move fast wheeling himself. R60 was alert and able to express his thoughts well. R60 said, "He (R102) punched me on the ear (pointing at his right ear). I don't know why he did that. It was that hallway (pointing at the hallway outside of the dining room where we passed by.) He (R102) was aggressive to me before, verbally aggressive, shouting at me. After he (R102) punched me, I just went to the office and told the Social Worker. I don't remember the name of the Social Worker. I think R102 went to the hospital after he punched me. They took him out and sent him to the hospital. I don't know where he is right now. But after he (R102) punched me. I feel scared because as I said he (R102) was verbally aggressive towards me. He(R102) also goes to my room even if I don't want him to. R102 was always in my room. I said, "What are you doing in my room? But R102 just ignored me. Also, I told him that I don't like him to go inside my room, but he always goes inside my room. I told staff about it, Social Worker, and nurses. Nobody followed up after the incident. Nobody talked to me, I guess they don't care. My wife came and visited after the incident. She is in another facility. She told me why did I not fight back? I told her that I will be in trouble if I fight back. Staff here, they don't do nothing about it." On 07/31/2022 at 12:12 PM. R102 was seen laying on his bed. R102 was alert and able to express his thoughts within topic. R102 said, "Yes, I know R60. The man with no legs? Right? I

tapped him at the back of his head. I was going to lunch, and he was in my way. He (R60) did not

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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			00000	**		
	to 4 times to move	im on his head. I asked him 3 Yeah, I always go in his room.				
	Sometimes he is the	ere, sometimes he is not.				
	like to check on him	and to see what he was	<u> </u>			
	doing. I can walk be	ut I used that wheelchair				
	(pointing at the whe	elchair on the wall fronting the				
	a big deal about it."	d). It was the nurse who made				
	a big deal about it.	İ				
	On 08/01/2022 at 10	0:36 AM. V6 (Assistant		1		
	Administrator) state	d that there could have been		i e		
	additional issues be	tween R60 and R102. We				
	an issue hetween th	e was verbal aggression or em (R60 and R102) before		1		1 1
	the incident. V6 furth	ner stated that R60 has a				1
	history of being dish	onest. But a resident				1
	smacking the head	of another resident is				1
	considered as abuse	e. After R102 hit the head of				1 1
	am not saving that I	aliate to R102. V6 said, "I based my investigation on				1
	R60 being dishonest	on the past but if someone				1 1
	hit my face, I will fee	I bad. Yes, it is abuse to hit				1
	any person on the he	ead."				
	00 00/01/2022 01 44	40 414 1/47 (0 1 1 0				
	Director) stated that	:10 AM, V17 (Social Service R60 was pushed by R102.		k.		
	And R60 is a doubtfu	Il character. V17 was asked				
	if she read the invest	igation report done by				
	facility, that it was de	scribed as a smack not a				
	push on the head of	R60. V17 did not answer the	3			A D
	the head I will consi	'If someone smacked me on der it as abuse. Any person	Ĭ.			
	smacked another per	rson on the head is				
	considered abuse."	The state of the s				
						4
	On 08/01/2022 at 11:	38 AM, V4 (Registered	1			
	incident that basesse	e directly witnessed the				
	preparing medication	ed. V4 said, "While I was to give to R60 near the				4
	Nurse's Station. He (I	R60) was on my side.				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6014617 08/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 SOUTH WESTERN AVE **APERION CARE INTERNATIONAL** CHICAGO, IL 60609 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 Suddenly, R102 came near R60 and yelled, 'Move out of my way!' I told R102 that you don't talk to people that way. Then R102 without warning slapped R60, hitting on the side of his face (pointing to her right ear). His (R102) hands were open. Then I told R102 you don't treat people like that. R102 did not give us a chance to move. I consider slapping the head abuse. I would really feel bad if someone slapped me on the face." Facility Resident Abuse Investigation Form documents the following: Under Summary of Interview with the person reporting the incident. V4 was giving medication to R60 near nurse's station close to the dining room. R102 came down in the hallway in his wheelchair and said, "Get out of the way! R102 began to argue with me (V4) and smacked R60 on the side of his head hitting his ear. We separated the residents immediately, called Social Services, and reported the incident to Administration." Under Summary of Interview with the witnesses: V16 (Licensed Practical Nurse) was working at the nurse's station at the time the incident took place. "I saw R60 talking to the nurse (V4). R102 was yelling at him, telling him to get out of his way. Then I heard him smacked to the side of his head. I heard the nurse (V4) tell him not to act like that. The residents were separated right awav." Progress notes by V3 (Registered Nurse) dated 7/19/2022 documents: She (V3) was passing medications when other staff nurse informed her that resident hit the other

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6014617 B. WING 08/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 SOUTH WESTERN AVE APERION CARE INTERNATIONAL** CHICAGO, IL 60609 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 5 S9999 the way in the dining room. She (V3) asked R102 what happened. And he (R102) stated "I did not hit him." But R102 showed her how he struck resident's (R60's) head. Progress notes by V7 (Social Service) dated 7/19/2022 documents: She (V7) made aware by staff R102 being physically aggressive towards other residents. Social Services along with nurses met with R102 regarding behavior. R102 stated, "I did not hit him, I just tapped him on the side of the head lightly so he could move." R102 was educated regarding safety and keeping hands to himself. However, resident found it to be funny and stated it was not that serious. R102 also being racist towards staff calling them racial slurs and taunting resident calling them a "cry baby." Progress notes by V28 (Wound Nurse) dated 1/3/2022 documents: That R102 had argument with roommate today and started to fight each other. On 08/01/2022 at 02:50 PM. V28 (Registered Nurse) confirmed that R102 has a fight with another resident who was his roommate. But unable to recall the name of R102's roommate. V28 stated that he did not witness physical contact but seen residents attempted to make physical contact. V28 further stated that R102 stopped his roommate to get out of the room that made his roommate upset. R102 most recent complete care plan documents that R102 has history of criminal behavior. R60 most recent complete care plan documents that R60 has limited physical mobility related to general weakness.

Both R60 and R102 Care Plans does not include

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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	abuse as an identifi						
	R53 is 87 years old, includes hemiplegia cerebral infarction a Per R53 minimum of 5/13/2022 on brief in (BIMS), R53 scored cognition was borde to moderate impairm as her mobility device On 07/31/22 10:42 Aroom, sitting on her speak english during calm and pleasant of On 08/01/2022 at 10 Administrator) stated conversation betwee (V40) trying to transl Assistant). It was a roos not know how the was saying no, no, no	with medical diagnosis that and hemiparesis following iffecting right dominant side. Itata set assessment dated interview on mental status 12; that means his (R53) writine between no impairment ment. R53 uses a wheelchair ite.  AM. R53 was seen inside her wheelchair. R53 does not gronversation and was seen					
	Nursing Assistant) st shift. R53 was ready time, we could not co upset and kept sayin daughter. So, I asked When I spoke to her "Do you have probler V37 (Certified Nursin the time, R53 and V4 phone. I think V40 ov roommate, telling tha minute I will change y	:52 AM. V5 (Certified ated, "It was Friday 3-11 or to go to bed. During that ommunicate. So R53 became g, daughter, daughter, daughter (V40) she asked, m with my mom?" I asked g Assistant) to help. During to was speaking on the rerheard me talking to R53's to roommate give me a vou. I think my response was more aggressive towards					

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help to have a translator, and that residents need to be taken care because they are dependent

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED IL6014617 B. WING 08/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 SOUTH WESTERN AVE APERION CARE INTERNATIONAL** CHICAGO, IL 60609 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 8 S9999 with her help." Facility Resident Abuse Investigation Form dated 7/22/2022 documents the following: Summary of Interview with the person reporting the incident: V39 (Licensed Practical Nurse/LPN) stated, "R53 was on her cellphone with her daughter (V40) at the time of incident. V5(CNA) had difficulty understanding the resident because she does not speak Spanish. V5 asked the resident (R53) to contact her daughter (V40) to translate to her. V5 became frustrated and stated to R53's daughter. I do not speak Spanish and raised her voice. I asked another CNA (V37) to come into the room and assist R53 because V37 spoke Spanish and R53 was more comfortable with V37. I told V5 that it is unacceptable to speak to a resident that way." 08/02/2022 at 11:57 AM, V39 (LPN) confirmed her statement on record but stated that she cannot remember what V5 said to R53 when she stated, "It is unacceptable to speak to a resident that way." Facility's Resident Abuse Investigation Form documents: V37 stated, "When I walked into the room, V5 (CNA) was yelling at the resident (R53) and using the wrong size diaper on her (R53). The resident (R53) told me in Spanish that she was being too rough with her and didn't want to help her move her leg when she was trying to get into bed. I have worked with R53 before and never had any behaviors or complaints from her at all." This was confirmed by V37 during interview.

Facility's Resident Abuse Investigation Form

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during interview with stated, "I went into I I changed her diaper couldn't understand not speak Spanish. The because she ket asked her to call her for me. I told her that I was telling R53 that me transfer her to be this resident (R53) of have a problem. She me. The resident's conditional asked me if I was morn. I am not sure came into the room Assistant), V37 ended bed."  Facility's Resident Aldocuments: R53 was translator. R53 state (V5) kept telling me to She (V5) didn't want only speak Spanish adaughter (V40). I kep she put the wrong signot to touch her hand too late. I told V5 I cashe (V5) told me that had an attitude with refused in the right way. If (V5) yelling at me where (V40)."	artified Nursing Assistant) h V6 (Assistant Administrator) her room to get ready for bed, er and followed her lead. I what she said because I do I think she was irritated with ept saying, "No, no, no." I r daughter (V40) to translate at I did not speak Spanish and at she is capable of helping ed. I have only worked with one other time and did not e (R53) didn't want to help daughter (V40) became upset as having a problem with her what went wrong. The nurse with V37 (Certified Nursing ed up getting R53 ready for  buse Investigation Form s interviewed with a d, "V5 was mean to me. She that I can transfer on my own. to help me. I told her that I and that is why we called my of saying no, no, no because de dand was putting me to bed annot move, and I need help. I I don't speak Spanish and me. The other Certified 37) knows how to take care My daughter (V40) heard her en I was on the phone with	\$9999				

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	free from abuse, ne resident property, convoluntary seclusion prohibits mistreatmer residents, and has a resident sensitive an environment. The property of assure that the facility control to prevent of neglect, or abuse of this facility is commore residents from abuse limited to, facility state consultants, volunte providing services to members or legal goindividuals. This facility individuals who have neglecting, or mistreed to accidental means infliction of injury, un intimidation, or punisharm, pain, or mentathe deprivation by an caretaker, of goods conecessary to attain a mental, and psychosassumes that all insteeven those in a comapain or anguish.	glect, misappropriation of orporal punishment, and in. This facility therefore ent, neglect, or abuse of its attempted to establish a ind resident secure surpose of this policy is to ity is doing all that is within its ocurrences of mistreatment, our residents.  Initial to protecting our e by anyone including, but not off, other residents, ers, staff from other agencies of the individuals, family uardians, friends, or any other lity will not knowingly employ been convicted of abusing, rating individuals.  In a facility. Abuse is a willful reasonable confinement, the ment with resulting physical anguish. This also includes individual, including a per services that are ind/or maintain physical, ocial well-being. This ances of abuse of residents, a, cause physical harm or des hitting, slapping, discontrolling behavior	S9999	DEFICIENCY)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_\_\_ COMPLETED C IL6014617 B. WING 08/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 SOUTH WESTERN AVE** APERION CARE INTERNATIONAL CHICAGO, IL 60609 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 11 S9999 gestured language that willfully includes disparaging and derogatory terms to residents or family members, or within their hearing distance, regardless of their age, ability to comprehend, or disability. (B)

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