STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006829	A. BUILDING: _____ B. WING _____	C 05/16/2023

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APERION CARE HILLSIDE	323 OAKRIDGE AVENUE HILLSIDE, IL 60162

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S 000	Initial Comments Complaint Investigation 2393786/IL159570	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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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S9999	Continued From page 1 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to prevent resident to resident physical abuse. This affected 2 of 5 residents (R2, R3) reviewed for abuse. This failure resulted in R2 being touched in breast area by R3 unsolicited. Using the reasonable person theory R2 would have felt scared, humiliated, violated, and angered by R3's actions. Findings Include: R2 is a 50-year-old with the following diagnosis: Down Syndrome, Alzheimer's disease, cognitive communication deficit, and dementia. R2 admitted to the facility on 4/26/23. R3 is a 64-year-old with the following diagnosis: unspecified dementia with behavioral disturbance. R3 admitted to the facility on 1/11/22. R4 is a 51-year-old with the following diagnosis: absence of the larynx. R4 admitted to the facility on 1/4/23. On 5/9/23 at 1:55PM, R4 is not able to talk due to a missing larynx. R4 communicates through writing, hand gestures, and mouthing words. R4 wrote R3 grabbed R2's left breast while in the dining room on 5/5/23 while they all were sitting at	S9999		

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the same table. R4 wrote that R3 rolled the wheelchair next to R2 and just started groping and squeezing R2's breast. R4 wrote R4 tried to get R3's attention by pounding on the table and shaking R4's head "no," but R3 would not stop. R4 wrote, "it was like R3 was in a trance and I could not snap R3 out of it." R4 mouthed that R4 went to go get the nurses to tell them what was happening, and they immediately went to check on R2 and R3. R4 wrote that when the nurses came to the table R3 was already backed away from R2 and had stopped touching R2. R4 shook R4's head "no" when asked if R2 was able to consent to being touched. R4 wrote that R2 does not talk. R4 mouthed to ask the administrator for the video because staff was talking about seeing R2 being touched by R3 on the cameras.

On 5/9/23 at 2:11PM, R2 was sitting at a table in the dining room. When approached and spoken to, R2 did not respond to any questions or engage in any conversation. R2 did not have any marks on the arms or chest area.

On 5/9/23 at 2:21PM, V3 (CNA) stated, R3 was sitting at the table in the dining room, and R4 was sitting over there too. R3 rolled over to R2, and that's when R4 started banging on the table. R4 can't talk, but he was trying to tell us that R3 was touching R2 on the chest. R4 couldn't say what happened, but R4 was using R4's hands to tell us and pointing. I know the administrator looked at the cameras and confirmed that R3 did touch R2 but I'm not sure exactly what happened. R2 is nonverbal and you can't really have a conversation with R2. R2 doesn't even let you know that R2 understands you so R2 could not have consented to something like this. This would be sexual abuse. R3 was touching R2 inappropriately.

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S9999	Continued From page 3 On 5/9/23 at 2:30PM, V4 (Social Services) stated, R2 is nonverbal and does not have any behaviors. There's no reaction from R2 when you speak to R2. You can't tell if R2 understands you or not or if R2's listening. I understand that there was an incident between R2 and R3. I was told that R3 possibly touched R2. On 5/9/23 at 3:33PM, V2 (DON) stated, suddenly, the resident R4 wrote a note to us to call the police because R4 saw R3 touch R2 on the upper chest. R4 was pointing to where R3 touched R2 with R4's hands. (The DON was motioning with her hands over the breast area) When we asked R3 what happened R3 denied touching her. R2 can't speak. We transferred R3 for inappropriate behavior. This would be sexual abuse because it would be considered inappropriate touching. On 5/11/23 at 1:58PM, R3 remembered going to the hospital but was unable to say when. R3 stated, "they took me away to neverland." R3 was not able to state why R3 was sent to the hospital and only reported they "took lots of blood samples." R3 denied having any relationships with other residents. R3 endorsed knowing R2 but denied talking with R2. R3 denied ever touching R2 and denied ever touching and residents inappropriately. On 5/11/23 at 2:18PM, V1 (Administrator) stated, R2 is nonverbal and cannot consent to anything. R4 sitting at one of the dining rooms tables and R4 saw R3 touch R2 in the chest area. R4 was not able to speak so R4 ran to get the nurse's attention, and when the nurses went back over there, they did not see R3 touching R2. R3 denied ever touching R2. R3 was sent out for a psychiatric evaluation based off what we were	S9999		

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told. I did go back and review the cameras for that as well. The camera footage is very grainy, so it was hard to see. You do see R3 move closer to R2 and touch R2, but you were not able to see where R3 touches R2 at.

A Nursing note dated 5/5/23 documents the nurse did a head-to-toe assessment on R2 with no abnormal skin findings, no bruising, and no scratches. No new orders were given.

A Social Service note dated 5/5/23 documents R2's family member was notified about the situation that happened between R2 and R3 where R3 inappropriately touched R2.

A Nursing note dated 5/5/23 documents the physician was notified of R3 inappropriately touching R2. A new order to petition R3 to the hospital for a psych eval was given.

A Nursing note dated 5/6/23 documents R3 was admitted to the hospital with a diagnosis of dementia with psychiatric features.

The Police Report dated 5/5/23 documents the police were called to the facility for a report of sexual misconduct between two residents. R2 and R3 were involved in the interaction. The incident had been observed by R4. R4 reported R2 was sitting in the dining room, when R3 rolled up next to R2, and proceeded to pull down a portion of R2's gown and massage R2's breast with R3's hand. R4 then alerted a nurse and as the nurse approached R3 ceased activity. R4 and V1's version of the events described to the police were accurate. Security footage was reviewed with V1. In summary, a subject identified as R2 at the table and a subject identified as R3 rolled up in a wheelchair to R2's left side. R3 then appears

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to be reaching out and touching R2 in the left shoulder or breast area. A subject identified as R4 then gets up and rushes off to the nurses and shortly afterwards two nurses come over and surround R2 and R3.

The Petition for Involuntary/Judicial Admission dated 5/5/23 documents R3 need an involuntary inpatient mission due to being a harm to other residents. R3 inappropriately touched a female resident. R3 has a diagnosis of dementia with behavioral disturbances.

The Nursing Home Transfer Form dated 5/5/23 documents R3 is being transferred to the hospital for inappropriately touching a female resident.

The Resident Abuse Investigation Form dated 5/12/23 documents R2 reported sitting at the dining room table when R4 turned around and saw R3 touching R2 inappropriately in the chest area. R3 denied touching R2 inappropriately. R2 was unable to verbalize anything due to cognition and continues normal activities of daily living. Staff were interviewed and did not see R3 touch R2 inappropriately. R3 received outpatient psych evaluation without concern related to sexual behaviors noted in the evaluation.

The Minimum Data Set (MDS) Section B dated 4/29/23 documents R2 has no speech, R2 rarely/never make self- understood nor can understand others. Section C of the MDS documents the Brief Interview for Mental Status score as a 0 (severe cognitive impairment).

The Abuse and Neglect Screening dated 5/5/23 documents a score of 3, indicating R2 is at a moderate risk for abuse, due to vulnerability, psychiatric history, and/or mental health,

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S9999	Continued From page 6 diagnosis, and diagnosis of depression, and/or history of depressive illness. The Care Plan dated 4/28/23 documents R2 has a chronic/progressive decline in intellectual functioning, characterized by memory deficit, judgment, decision-making, and thought process related to down syndrome, Alzheimer's disease, and dementia. The Care Plan dated 5/4/23 documents R2 has impaired, cognitive function/dementia or impaired thought process related to dementia and being developmentally delayed. The Minimum Data Set (MDS) Section B dated 4/17/23 documents R3 can make self-understood and can understands with clear comprehension. Section C of the MDS documents a Brief Mental Status Score as a 10 (moderate cognitive impairment). The Care Plan dated 12/21/22 documents R3 has a behavior problem/inappropriate behavior where R3 expresses having a girlfriend relationship with another resident. The residents hold hand and kiss each other in front of others. The Minimum Data Set dated 5/3/23 documents a Brief Interview for Mental Status score as 15 (no cognitive impairment). The policy titled, "Abuse Prevention and Reporting - Illinois," dated 10/24/22 documents, "Guidelines: This facility affirmed the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or miss treatment. This facility, therefore, prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.	S9999		

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S9999	Continued From page 7 Generally, sexual contact is non-consensual, if the resident either colon appears to want to contact to occur but lacks a cognitive ability to consent; or does not want the contact to occur during the course of the investigation of an allegation of resident sexual abuse the facility shall assess and make a determination of whether the sexual activity was consensual on the part of the resident." (B)	S9999		