Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008312	A. BUILDING _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WILMINGTON	555 WEST KAHLER WILMINGTON, IL 60481

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S 000	Initial Comments Complaint Investigation: 2379433/IL166611	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3240a) 300.3240b) 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 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) This REQUIREMENT is not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on observation, interview, and record review, the facility failed to ensure a resident (R2) was free from abuse. This failure resulted in R2 being physically abused by V5 (Certified Nursing Assistant/CNA) on 11/2/23; R2 complaining of leg pain and limping on 11/5/23; a new order for morphine sulfate every six hours for pain being placed on 11/6/23; and R2 using a wheelchair for leg pain relief. The findings include: R2's Admission Record, printed by the facility on 11/16/23, showed she had diagnoses including severe dementia, senile degeneration of brain, adult failure to thrive, and weakness. R2's 8/14/23 facility assessment showed R2 had severe cognitive impairment, with hallucinations and delusions. The assessment showed R2 had behaviors of rejection of care and required extensive staff assistance for dressing, toileting, and personal hygiene. R2's care plan initiated on 5/3/23 showed she is resistive to care and will regularly refuse ADL (activities of daily living)/hygiene tasks such as showering, changing soiled clothes and linens related to dementia. The care plan showed R2 may become aggressive/ combative during care related to confusion. Interventions in place included: Encourage as much participation/interaction by the resident as possible during care activities. Give clear explanation of all care activities prior to and as they occur during each contact. Identify and document resident's triggers for resisting care. If resident resists with ADLs, reassure resident,	S9999		

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S9999	Continued From page 2 leave, and return 5-10 minutes later and try again. R2's care plan initiated on 5/6/22 showed she was receiving hospice services related to a diagnosis of failure to thrive and dementia. R2's care plan initiated on 3/5/23 showed she was at risk for abuse and neglect related to cognitive impairment, depression, and dysfunctional behavior (combative behavior, care resistance) related to dementia and senile degeneration of brain. On 11/16/23 at 11:22 AM, V3 (CNA) said she worked a double shift on 11/2/23 from 6:00 AM-10:00 PM. V3 said about 9:00 PM that night she was assisting V4 (CNA) with changing R2's clothes and providing nighttime care. V3 said she asked V4 about using the cream (topical antianxiety cream) for R2 that calms her down before changing. V3 said V4 declined using the cream. V3 said her and V4 took off R2's shirt and R2 was grabbing onto her clothes when they were taking them off. V3 said R2 was not being combative. V3 said V5 was in the room at the time, charting on a computer and V4 asked V5 to help with R2. V3 said V5 grabbed R2's hair and started punching R2 in the chest. V3 said V5 hit R2 in the chest at least 6 times, maybe as much as 12 times. V3 said V5 then kicked R2 in the leg. V3 said her and V4 told V5 to stop several times. V3 said she (V3) backed away and V4 got in between R2 and V5 to block them. V3 said it all happened so fast. V3 said one of the times V5 hit R2 close to the neck and she heard R2 gasp for air. V3 said the incident started in the bathroom doorway and ended up in the corner of the bathroom. V3 said she did not see R2 do anything to make V5 do that. V3 said R2 was not combative prior to V5 hitting her. V3 said of course R2 was combative after V5 started hitting	S9999		

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her. V3 said she did not report the incident until the next morning because she was afraid of retaliation.

On 11/16/23 at 11:58 AM, V4 (CNA) said he worked on 11/2/23 from 4:00 PM-10:00 PM. V4 said he was the CNA assigned to R2 on 11/2/23. V4 said R2 was being a handful so he asked V3 to help him. V4 said he asked V5 to help and hold R2's hands. V4 said he did not know if V5 pulled R2's hair because he was trying to pull R2's pants up. V4 said when he stood up, both V5 and R2's hands were swinging, and he could not tell who was hitting who. V4 said he had to stand between R2 and V5 to make sure no physical contact continued, because they were both hitting each other. V4 said he can get R2 to calm down and de-escalate by playing music. V4 said he did not report the incident. V4 said he was baffled by the situation and did not know what to do. V4 said he had never seen V5 act like that with any other resident.

On 11/17/23 at 9:51 AM, V9 (Registered Nurse/RN) said V3 reported to her before 7:00 AM on 11/3/23, that she (V3), V4 and V5 were changing R2's clothes on the PM shift on 11/2/23 and V5 started punching R2's chest and pulling R2's hair. V9 said V3 told her that at one point during the incident V5 hit R2 by the throat and R2 gasped for air. V9 said V3 told her that V5 kicked R2's leg. V9 said V3 told her that V5 started hitting R2 in R2's room and continued into R2's bathroom. V9 said she assessed R2 after V3 reported the allegation to her. V9 said as she was palpating R2's upper chest area, R2 said "Some people can be nasty." V9 said she asked R2 if anyone hit her, R2 hesitated, then said no. V9 said she thinks it was Sunday (11/5/23) that staff noticed R2 limping. V9 said R2 was

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assessed and when her leg was squeezed, she would move her leg and had pain. V9 said Hospice was updated, X-rays were completed and were negative. V9 said she thinks R2's leg pain was a result of the incident on 11/2/23. V9 said the gel was discontinued and morphine was ordered for the pain. V9 said R2 uses the wheelchair for comfort, to reduce her leg pain. V9 said R2 did not use the wheelchair prior to the incident on 11/2/23.

On 11/17/23 at 2:03 PM, V5 (CNA) said V4 and V3 were taking care of R2 on 11/2/23. V5 said V4 asked her to help with R2. V5 said she went over to help them and R2 hauled off and kicked her (V5) in her knee. V5 denied hitting or kicking R2. V5 said she put her arm out and put her hand on R2's forehead, on her hairline, to stop R2 from kicking her. V5 said V4 got between them and took R2 out of the bathroom.

On 11/17/23 at 10:32 AM, V7 (CNA) said R2 could be calmed down by having the nurse apply the cream, by playing music, telling R2 a story, listening to her, leaving her alone and approach later.

On 11/17/23 at 10:55 AM, V8 (CNA) said R2 could be calmed down by music and with the cream that calms her down.

On 11/16/23 at 1:57 PM, V1 (Administrator) said R2 tends to be aggressive with care. V1 said she was notified of a potential situation related to V5 being aggressive towards R2. V1 said she investigated the allegation. V1 said V3 told her that she did not see everything, but she thought she saw V5 kick R2. V1 said V5 denied this. V1 said when she took V4's statement, he said that R2 kicked V5, and V5 pushed R2 away from her,

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S9999	Continued From page 5 then R2 lunged at V5. V1 said V4 said when R2 lunged out, V5 reflexively responded and made contact with R2's chest. V1 said V4 told him that he stepped between them to separate them. V1 said V5 said she did not strike out but put her hand on top of R2's head to calm her. V1 was asked why V5 was terminated, yet the allegation was not substantiated by the facility. V1 said she terminated V5 because there was inappropriate behavior, but not abusive behavior. V5 should be trained enough to know to walk away from a combative resident. V1 said that was not the correct way to handle the situation. V1 said something physical happened, but it was a reflex reaction, and a physical response was not an appropriate response. V1 said while interviewing V4 he did not tell her that he witnessed V5 hitting R2, and she (V1) can only go by what she is told during the interviews. On 11/16/23, R2 was observed in her room on the dementia unit, lying in a low bed at 10:32 AM. R2 was not able to be interviewed. R2 was also observed sitting in a wheelchair in the dining/activity room holding a stuffed animal on 11/16/23 at 2:00 PM. R2 was confused and not able to be interviewed. The facility's Preliminary 24-hour Abuse Investigation Report, dated 11/3/23, showed an allegation of physical abuse to R2 by an employee was reported on 11/3/23 at 6:37 AM. The report showed V5 was removed from the schedule and suspended pending the investigation. R2's doctor, the police, R2's guardian, and the Ombudsman were all notified. The facility's timecard document from October 23-11/5/23 showed V5's last date and time of work at the facility was 11/2/23 at 10:00 PM.	S9999		

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S9999	Continued From page 6 R2's Progress note dated 11/5/23 showed "Writer was informed by the CNA that the resident is limping on her right leg...Resident was grimacing when the posterior side of the leg was touched." R2's Order Recap Report, printed by the facility on 11/17/23, showed a new order on 11/6/23 for morphine sulfate solution 20 mg (milligrams) per ml (milliliter). Give 0.25 ml by mouth every 6 hours as needed for pain. The report also showed an order placed on 11/6/23 for X-ray of right hip, right femur, right knee, right tibia, right fibula, right ankle, right foot, right toes STAT for pain and limping. The X-ray results dated 11/7/23 showed no fractures or dislocations to any of these areas. V5's employee file was reviewed. The 11/6/23 facility document titled Human Resources Notice of Corrective Action showed R2 was terminated on 11/6/23 due to inappropriate physical behavior towards a resident on 11/2/23. The facility's policy and procedure titled Abuse Prevention and Reporting-Illinois, with a revision date of 10/24/22 showed "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents...Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention...Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment..." "A"	S9999		

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