STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001077	A. BUILDING: ______ B. WING ______	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MIDLOTHIAN	**3249 WEST 147TH STREET MIDLOTHIAN, IL 60445**

(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 Complaint Investigation 2490197/IL168521	S 000		
S9999	Final Observations 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. 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. Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued From page 1	S9999		

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to prevent and protect a resident with a diagnosis of dementia from physical and verbal abuse by facility staff. This affected one of three residents (R2) reviewed for abuse. This failure resulted in R2 being yanked and tugged by V4 (certified nursing aide) and V4 telling R2, "I'm not doing this with you, you're getting on my f****** nerves." Using the reasonable person concept may have resulted in R2 being fearful and displaying anxiety around facility staff.

Findings include:

R2 was admitted to the facility on 12/14/23 with a diagnosis of metabolic encephalopathy, pneumonia, atrial fibrillation, shock, difficulty walking, dysphagia, anemia, unspecified dementia without behavioral disturbances, delirium, restlessness and agitation. R2's brief interview for mental status documents a score of 0 which indicates resident is never/rarely understood.

On 1/9/24 at 12:08 PM, V9 (CNA) said she was assisting R2 back to her room from the dining room with V8 (CNA) and V4 (CNA). R2 has dementia and did not want to get out of the chair. V4 said to R2 "No, you're going to bed." V9 said, V4 (CNA) began to "forcefully yank" R2's clothing off. V9 said V4 told R2, "I'm not doing this with you, you're getting on my f****** nerves!" V9 said

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S9999	Continued From page 2	S9999		

V4 (CNA) was treating R2, "like a ragdoll." V9 said V4 transferred R2 in the bed by giving her "a bear hug and flung her on the bed".

On 1/9/24 at 11:49 AM, V8 (Certified nursing assistant, CNA) said R2 was refusing and yelling and pushing at V4 (CNA). V8 said R2 told V4, "You are not going to do me like that." V8 said V4 stopped for a minute to collect herself but then continued to take off R2's shirt as R2 was resisting. V8 said V4 was pulling and tugging on R2. V8 said V4 (CNA) picked R2 up by grabbing R2's upper arms and threw R2 into the bed. R2 was still refusing when V4 provided incontinence care. V8 said it was abusive and if that was her family member, she would not want them treated in that way.

On 1/9/24 at 1:28 PM, R3 (R2's roommate) who was alert and oriented at time of interview said one staff (V4) will say things to R2 like, "Oh my God" and "You're the hardest one I have to put to bed." R2 is always telling her to "Wait a minute." R3 said V4 is the only staff that seems to have a problem with R2. R3 said no other staff have that problem when they are in the room with R2. R3 said V4 moves too fast and does not have patience with R2.

Facility reportable undated documents: V9 (CNA) was asked to explain what she had witnessed on 1/5/24. V9 stated she witnessed V4 transfer R2 in the bed. V9 began to describe how the R2 was being handled by V4, stating that V4 placed her arms around R2 almost forcefully to put R2 in the bed. V9 was asked if she could come for further interview for her statement. V9 agreed, but resigned later that day.

Facility abuse prevention and reporting policy

Illinois Department of Public Health

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S9999	Continued From page 3 dated 11/28/16 documents: The facility affirms the right of residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. Abuse means any physical or mental injury inflicted in a resident other than by accidental means. Abuse is the willful infliction of injury, intimidation or punishment with resulting pain harm or mental anguish to the resident. Physical abuse is the infliction of injury that occurs other than by accidental means and requires medical attention. physical abuse includes hitting, slapping and controlling behavior through corporal punishment. Verbal abuse may be considered to be a type of mental abuse. Examples include but not limited to: mocking, insulting, ridiculing, yelling or hovering over a resident with the intent to intimidate. (A)	S9999		