STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002059	A. BUILDING: _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE OAK LAWN	9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453

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S 000	Initial Comments Complaint Investigation: 2497046/IL177546	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)3)4) 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 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. 3) All nursing personnel shall assist and encourage residents so that a resident who is	S9999		

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incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to prevent residents from experiencing neglect inflicted by a Certified Nursing Assistant. This failure applied to two (R3, R4) of three residents reviewed for abuse and neglect and resulted in R3 and R4 being knowingly left in soiled incontinence briefs for multiple hours by staff. R3 reported that R3 was having severe

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discomfort due to incontinence causing R3's skin to burn in sites of open skin areas. R4 stated he felt unappreciated, like a stepchild and left in the corner.

Findings include:

R3 is 52 years old and admitted to the facility 8/24/23 with diagnoses that include osteoarthritis, morbid obesity, and chronic respiratory failure. According to the minimum data assessment of 8/5/24, R3 is dependent on staff for activities of daily living including toileting.

On 9/12/24 at 1:15pm R3 was observed to be alert and coherent sitting in bed and described an incident that occurred with a CNA (Certified Nursing Assistant) on 9/1/24. During this interview, R3 said the CNA (V4) failed to answer requests for assistance when R3 activated the call light which prompted R3 to call the front desk from R3's cell phone. R3 said that R3 waited longer and shared this complaint to a family member who also called the facility to ask for assistance on behalf of R3. R3 reported that R3 was having severe discomfort due to incontinence causing R3's skin to burn in sites of open skin areas. R3 said that V4 finally came into the room after 5pm, which is two hours from the start of the evening shift and when V4 came into the room to render care, V4 was confrontational, rude, and rough with care. R3 said, after this interaction, V4 did not return to the room to provide care to R3 or R3's roommate for the entirety of the 3-11 shift. R3 said they called out into the hall to ask for care to be given to R4 (roommate), and R3's calls were ignored. R3 said R3 overheard V4 in the hallway passing the room saying, 'I guess they are going to sit there [in excrement]- I ain't going back in that room'. R3

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said that is when R3 called the manager on call.

R4 is the roommate of R3 and according to Minimum data assessment, is cognitively intact, totally dependent on staff for all activities of daily living and is incontinent of bowel and bladder. On 9/12/24 at 1:50pm, R4 said that R4 witnessed the interaction between R3 and V4 from R4's bed. R4 said after V4 left the room, V4 did not come back into the room and R4 did not receive any incontinence care the entirety of the 3-11pm shift. R4 stated he felt unappreciated, like a stepchild and left in the corner.

Point of Care documentation was reviewed for 9/1/24 and meaning no staff documented providing incontinence care to R3 or R4 during the 3-11pm shift.

On 9/12/24 at 4:04pm V6 (Wound Care Coordinator) said on 9/2/24, V6 received a complaint from R3 via the on-call clinical phone. V6 said that when R3 was explaining the interaction that happened with V4 the previous evening, R3 mentioned that R3 felt "neglected". V6 said as soon as V6 ended the call with R3, V6 reported the concern to the Administrator in Training (V2) who was in the facility at the time.

On 9/16/24 at 10:31am V2 (Administrator in Training) said that V2 was notified of R3's complaint and went to speak with R3 at the bedside. V2 said V2 did not speak with R4 or any other residents to ensure other residents were not feeling or experiencing neglect. V2 said V2 relayed R3's interview and information to V1 (Administrator), and V2 was instructed to complete a concern grievance form for R3.

The grievance form dated 9/1/24 lists the nature

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of the concern as: "conduct and care of staff." The grievance did not elaborate on the concern, nor was there a progress note available to review in the health record. Corrective Actions were taken with V4 on 9/3/24, and included: Inservice of staff member, not assigned to same resident, staff member suspended for poor customer service and lack of response time in providing patient care.

On 9/16/24 at 10:20am, V1 (Administrator) said V1 received a call from V2 on 9/2/24 regarding the incident with R3 and V4 that occurred on 9/1/24. V1 said V4 was suspended 9/2/24 for substantiated concerns of "poor customer service". V1 said that it was not relayed that an allegation of neglect was a concern, and therefore did not investigate.

V4 (CNA) was not available to be interviewed during this investigation.

Facility Abuse prevention and Reporting Policy, revised 10/24/22 states in part, "The 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 will be done by: Identifying concerns of resident' allegation of deprivation of goods and services by staff; Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment and misappropriation of property; Filing accurate and timely investigative reports.

The policy goes on to define Neglect: Neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain or mental anguish. Neglect means a

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facility's treatment, psychiatric rehabilitation, person al care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident including deprivation of goods and services by staff. Neglect may be the result of a pattern of failures or the result of one or more failures involving one resident and one staff person.

Facility Employee handbook updated 1/23 states in part; under "Violations of Conduct Standards That Constitute Grounds for Immediate Dismissal"- Negligent or willful acts of conduct detrimental to customer service or [facility] operations.

"Conduct Toward Residents"- All employees have an ethical and professional responsibility to support and promote the highest standards of conduct. It is the policy of [the facility] to comply with all applicable federal, state and local laws and regulations. Every employee will voluntarily assume the obligations of self-discipline, honor and integrity as set forth by [the facility]. We will not accept conduct which limits, restricts or interferes with our ability to respond to the needs of [the facility's] residents or vendors. [The facility] has a zero-tolerance policy for abuse and neglect. The abuse, neglect, or other mistreatment of residents in the facility is unlawful and prohibited. It is always imperative that every employee commit to maintaining the dignity of each resident.

"B"