STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012173	A. BUILDING: _____ B. WING _____	C 12/03/2023

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APERION CARE WESTCHESTER	2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154

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S 000	Initial Comments Complaint Investigation: 2399973/IL167251 & 2399990/IL167291	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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) These requirements were not met as evidenced	S9999		

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S9999	Continued From page 2 by: Based on observations, interviews and record reviews, the facility failed to protect a confused and vulnerable resident (R1) from being physically abused by a staff member and failed to follow their abuse policy by not preventing staff to resident physical abuse. This failure resulted in R1 obtaining facial injuries with noted scratches with active bleeding, swelling, pain and bruising that required the resident to be transferred emergently to a local hospital for further evaluation. Findings include: R1's face sheet indicated that resident admitted to the facility from an acute care hospital on 11/10/2023 and has a past medical history not limited to: Alzheimer's Disease, Seizures, Vascular Dementia, Psychosis, Difficulty in Walking, Lack of Coordination, Weakness, Abnormalities of Gait and Mobility, Malignant Neoplasm of Brain, Atrial Flutter, Cerebral Infarction, and History of Falling. R1's Minimum Data Set Section C dated 11/13/2023 documented a score of BIMS (brief interview for mental status score) of "11" which indicates some cognitive impairment. R1's care plan last reviewed 11/13/2023 reads in part: use antidepressant medication (amitriptyline) related to Depression (11/20/2023); alteration in neurological status related to disease processes of Alzheimer's Disease and Vascular Dementia (11/20/2023); feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by: ineffective coping, low self-esteem, tearfulness, motor agitation, withdrawal from care/activities related to brain	S9999		

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S9999	Continued From page 3 deterioration, dependence, relocation, recent admission to long term care, decline in visits from family, decline in health (12/01/2023); given my poor and compromised health status, cognitive issues, physical decline and need for 24-hour care, the Inter-Disciplinary Team (IDT) recognizes that I am considered a vulnerable adult. Comprehensive assessment reveals a history of suspected abuse, neglect, exploitation and/or additional factors that may increase my susceptibility to abuse/neglect related to diagnosis of Dementia (12/01/2023). R1's active physician orders reads in part: Aripiprazole Oral Tablet 5 milligrams (mg) give 1 tablet by mouth one time a day for Anxiety; Amitriptyline HCl Tablet 75mg give 1 tablet by mouth at bedtime for depression; Apixaban Oral Tablet 2.5mg give 1 tablet by mouth two times a day for prevent blood clots. R1's behavior note dated 11/30/2023 04:43 documented verbal and physical aggression with no documentation of a physical altercation or of any noted injuries. R1's nursing progress note dated 11/30/2023 08:50 indicated resident was sent to local hospital for further evaluation and assessment. Reason for evaluation and assessment was not indicated, no documentation of a physical altercation, any noted injuries, or provided first aid was noted. R1's hospital records dated 11/30 2023 indicated resident was seen for contusion/abrasion of face and documented no fractures were found with hematoma (bruise) to left periorbital (eye) and left mandibular (jaw) soft tissues. R1's facility reported incident report dated 11/30/2023 indicated R1 stated that V5 (Certified	S9999		

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S9999	Continued From page 4 Nursing Assistant) allegedly touched his face who was suspended pending investigation of physical abuse. Police report #23-02658. Fire department report #23-3147. On 12/01/2023, facility provided V5's statement dated 11/30/2023 that reads in part: while approaching R1's bed to try and calm him down, R1 kicked V5 in the stomach. V5 then said she grabbed R1's feet to help put the back into bed when R1 tried to hit her and had punched her breast. V5 added that she was trying to cover herself with her hands to keep space between her and R1 when another staff member came in between her and R1 and took V5 out of the room. Also provided was V7's (Licensed Practical Nurse) statement dated 11/30/2023 which indicated V7 was providing care to R1's roommate with the privacy curtain pulled when she heard R1 start yelling. V7 said she then went around the curtain and saw R1 kicking V5 (Certified Nursing Assistant) and proceeded to take her out of the room. On 12/01/2023 at 11:09 AM, observed three small scratches that were scabbed to the left side of R1's face, near the end of his corner eyebrow area, small light purple colored bruise below scabbed areas, and red scratch to R1's right cheek that was approximately three inches in length. When asked how the facial injuries occurred, R1 said "I got the sh*t kicked out of me by a little girl". R1 continued to state that he didn't recall the date of the incident, but said it happened a few days ago. R1 then said on that night, he was lying in bed when "she" (V5) came over to me and "smacked me on my head with her hand". R1 added that he was struck to the head and face "a few times". R1 then showed surveyor purple colored bruising to his left side/rib	S9999		

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S9999	Continued From page 5 area and to his left lower back/flank area but said he could not recall how these injuries had occurred. R1 informed surveyor that he has had a few falls while transferring himself since coming to this facility. R1's abuse/neglect screen dated 12/01/2023 12:02 documented a score of "7" which indicated resident is at a "high risk" for abuse (Time stamp indicates assessment was completed during and not prior to this complaint investigation). No other abuse/neglect screening was found in R1's electronic medical record. On 12/01/2023 at 12:05 PM and 12:13 PM, attempted to call V5 (Certified Nursing Assistant) with no answer at either attempt, message left. On 12/02/2023 at 12:43 PM, attempted to call V5 but was unsuccessful. On 12/01/2023 at 12:54 PM, V1 (Administrator) said R1 reported being smacked by a "small lady" then said the alleged incident occurred on third shift, so by the process of elimination from R1's description, V5 was identified as the alleged perpetrator and was suspended pending outcome of the facility's investigation. V1 also added that she has been trying to contact V5 but was unable to reach her, then said that she thinks V5 is scared. On 12/01/2023 at 1:56 PM V8 (Certified Nursing Assistant) said incident happened Wednesday night into Thursday morning (11/29-11/30/23) at approximately 2:30 AM. V8 then said that during rounds, V7 (LPN) asked her and V5 (CNA) for assistance with R1's roommate when R1, who was lying in bed, started to yell out "is there a party in here". V7 added that V5 had left the room to get more supplies while she went to the other	S9999		

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S9999	Continued From page 6 side of room with V7 with the privacy curtain pulled around resident's bed. V8 said she then heard R1 yelling out racial slurs that was coming from the other side of curtain, so she didn't know where V5 was in the room or what she was doing. V8 then said she started hearing a commotion that sounded like an altercation, so she came from behind the curtain and saw R1 sitting on the edge of the bed and V5 was standing in front of him. She added that she saw R1 kicking V5 to her stomach area while V5 was pushing R1's legs away from her with her hands trying to stop R1 from kicking her. V8 added that she saw bleeding to the top of R1's left face, by his eyebrow and a scratch to his cheek on the right side of his face. V8 continued saying that V8 then came around from behind the curtain and told V5 to get out of the room then V7 assessed R1. V8 added that a few minutes later, V7 left out of R1's room and told V5 she had to leave the facility and needed to call 911 and file an incident report. During review of V8's (CNA) statement, she recalled R1 yelling out "stop" multiple times and heard V5 (CNA) who sounded angered saying "stop it, don't put your feet on me". V8 (Certified Nursing Assistant) also said that she did not know how R1 obtained the injuries to his face, doesn't recall if they were present upon entering the room but is certain that R1 was not bleeding when she entered the room, and the injuries were not self-inflicted. V8 added that she has worked with V5 frequently but had never seen anything like "this" before. On 12/01/2023 at 2:40 PM, V7 (Licensed Practical Nurse) said on Thursday (11/30/2023) between 3:00-3:30 AM, she went into R1's room to provide care to R1's roommate with the assistance of V8 (CNA) and the privacy curtain was pulled all the way around the bed. She added that V5 was not in the room initially, she came	S9999		

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S9999	Continued From page 7 into the room later. V7 then said they started to hear R1 yelling out something about is this a party, then started yelling out profanities and racial slurs and when she came around the curtain, R1 was sitting on the edge of the bed facing the door and told V7 that he "kicked and slapped her", then said that "she slapped me back". V7 added that she saw some bleeding near the corner of R1's left eye above the eyebrow and a red mark on his right upper cheek so she started to assess R1 and tried to stop the bleeding but R1 was resistive. She said after a few minutes, she had stepped out of R1's room, headed down the hall and told V5 that she had to leave the building. V7 then said she informed the physician of R1's bleeding and wanted to send resident out to the hospital because he is on blood thinners, but he was refusing to go. During review of V7's (LPN) statement, she then said the bleeding was to the opposite eye, and the scratch was to the opposite side of R1's face then previously stated. V7 then said at no time did she see any physical contact (which is a contradiction of her previous statement made on 11/30/2023), and the bleeding looked like "old blood because it was dark". On 12/02/2023 at 12:08 PM, V1 (Administrator) said she wasn't sure if abuse screens were to be completed upon admission, but she knows they are done quarterly. At 12:11 PM, V1 said she believes the abuse screens are done upon admission but will have to check with social services. At 12:28 PM, V1 said the screenings are done quarterly with no start date given and as needed with a new diagnosis or data. V1 then said the facility was not fully aware of R1's medial/behavioral/trauma history until recently being informed by resident's family. V1 provided pre-admission behavior notes dated 11/02 and	S9999		

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S9999	Continued From page 8 11/03/2023 for surveyor to review. On 12/02/2023 at 12:16 PM, R1 said regarding the incident with V5 that he was lying in bed when she came into his room, started saying "nasty stuff and cursing" to him, came to his bedside then "smacked the left side of my face" (R1 pointed to injuries to corner of left eye previously observed by surveyor). R1 said he then sat up on the side of the bed when V5 started to come near him again and stated that he had kicked V5 to her chest area. R1 said that V5 then hit him to his left jaw area (displayed facial grimacing while touching area of contact). R1 added that "she got me good" then said he had pain and swelling to the area after it happened. Mild swelling was observed to R1's left jaw area but unable to visualize any bruising due to the presence of a thick beard. On 12/02/2023 at 12:56 PM, V1 (Administrator) and V2 (Director of Nursing) were both present and stated that the nurse who assessed R1 post fall on 11/29 at 10:10 did not fully assess or document post fall injuries/findings then said R1 was sent to the emergency room for further evaluation of the bruising he sustained from the fall. V2 then said injuries could appear on a resident days later after falling. R1's physician note created by V9 (Medical Doctor) on 12/2/2023 14:11:45 that was time stamped for 11/30/2023 14:11 reads in part, "I was contacted by [registered nurse] overnight about [patient] having skin lesion to side of eye, and patient was refusing to go to [emergency room] for eval. Etiology of injury was vague. This AM, I came to eval [patient], he has mild skin abrasions on right and left side of eye, and upon further inspection with [registered nurse] at	S9999		

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S9999	Continued From page 9 bedside, he has bruising on his wrist and torso. Per [registered nurse] management, [patient] had a fall overnight. [Patient] also did report he had some sort of altercation with a staff member, although recollection is vague given his sundowning. I instructed [registered nurse] management to send [patient] to [emergency room] for further evaluation and investigate the patient's claims. Facility provided fall documentation dated 11/29/2023 which indicated no injuries. Facility provided conflicting witness statements dated 11/29/2023 from three staff members with two statements indicating noted bruising post fall to R1's back, and one statement that indicated scratches to R1's face. No other documentation from direct care staff indicating R1 sustained any injuries, no documentation noted indicating staff were monitoring R1's bruising and/or facial injuries until 48 status post fall. Abuse Prevention and Reporting policy last revised 10/24/2022 reads in part: Guidelines: 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. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.	S9999		

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S9999	Continued From page 10 This will be done by: Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment (page 1). Definitions: 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 (page 2). Resident Assessment: As part of the resident's life history on the admission statement, comprehensive care plans, and Material Data Set (MDS) assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers, and behaviors that might lead to conflict (page 7). (B)	S9999		