STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006399	A. BUILDING: _____ B. WING _____	C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MORTON VILLA	190 EAST QUEENWOOD ROAD MORTON, IL 61550

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S 000	Initial Comments Complaint Survey: 23210750/IL168170	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policie 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	S9999		

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care needs of the resident.

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 Requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure physical abuse did not occur for one (R2) of ten residents reviewed for abuse in the sample of 25. These failures resulted in R1 hitting R2 in the right shoulder and punching R2 in the nose twice resulting in R2 bleeding from (R2's) nose and complaining of right shoulder pain.

Findings include:

The facility's Abuse Prevention and Reporting policy and procedure, revised 4/29/22, documents: "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation." This policy defines: "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish... Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish." "The facility shall also contact local law enforcement authorities (i.e., telephoning 911 where available) in the following situations: ... 2. Physical abuse involving physical injury inflicted on a resident by another resident except in situations where the behaviors is associated with

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dementia or developmental disability."

The Abuse Investigation regarding R1 and R2, dated 12/17/23, documents "Summary of investigators findings: Investigation findings noted the (R1) approached (R2) when (R2) wouldn't turn down his TV (television), after repeatedly asked to do so. (R1) made contact in attempt to get (R2's) attention to turn his TV down as his previous attempts to get his attention didn't work as the TV was so loud. Staff witnessed the incident and immediately removed (R1) from the room. (R2) was assessed with no redness or bruising noted. (R2) states he was fine and stated yes when asked if he feels safe in his environment." "(R1) was moved into a different room." This investigation does not indicate law enforcement was notified.

The Progress Note for R1, dated 12/17/23, written by V13 LPN/Licensed Practical Nurse, documents "I walked past residents' room, noted (R1) standing over roommates wheelchair. Observed (R1) strike roommate with closed fist twice. I yelled to stop, when he stopped and said that roommate would not turn down tv. No injuries noted to (R1). He was then moved to another room."

The quarterly MDS (Minimum Data Set) assessment for R1, dated 12/6/23, documents R1 with moderately impaired cognition with no behaviors.

The current Care Plan for R1, documents (R1) is at risk for abuse/neglect and has the potential to be physically and verbally aggressive r/t (related to) Dementia. Interventions include "When (R1) becomes agitated: Intervene before agitation escalates; Guide away from source of distress;

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Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later" and "Observe (R1) when in company of peers."

The Progress Note for R1, dated 12/17/23, written by V13 LPN, documents "I observed (R2) in his room. (R1) was standing over (R2) and struck (R2) with closed fist in face two times. I yelled to stop. (R1) did stop, (R1) stated that (R2) would not turn down tv (television). (R1) was moved to another room. (R2) had bloody nose which was cleaned up. No other open areas noted, (R2) did complain of right shoulder pain."

The quarterly MDS assessment for R2, dated 11/16/23, documents R2 with moderately impaired cognition without behaviors.

The current Care Plan for R2, documents (R2) is at risk for abuse/neglect, has potential to be verbally aggressive r/t poor impulse control, prefers to keep to self, has limited range of motion in right upper and lower extremities related to CVA (stroke) resulting in hemiparesis (partial paralysis and weakness) and some left sided weakness, and has impaired communication.

On 1/3/24, 1/4/24, and 1/5/24 between 8:20 am and 4:00 pm, R1 was sitting in a wheelchair and propelling himself in and out of his room, to and from the dining room and the television area independently. While sitting in the television area there were other residents in the vicinity at times with no staff present. No behaviors were noted.

On 1/3/24, 1/4/24, and 1/5/24 between 9:38 am and 4:00 pm, R2 was sitting in a wheelchair or lying in bed in his room with no behaviors.

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On 1/4/24 at 8:20 am, R1 stated he has not had any problems with anyone at the facility. does not and has not had issues with any of the residents in the facility. When R1 was asked if he had any problems with his prior roommate R1 smiled and stated "I don't know anything about that. I'm not a violent person at all."

On 1/3/24 at 10:20 am, R2 stated he was watching television and R1 came up to him and punched (held up closed fist) him in the right shoulder and in the nose two times (held up two fingers) causing his nose to bleed and pain in his shoulder. R2 stated R1 was moved out of his room.

On 1/3/23 V1 Administrator stated she is the Abuse Coordinator for the facility, and she was notified on 12/17/23 of an altercation between R1 and R2, R1 asking R2 to turn his television down and not doing it, and R1 hitting R2 in the nose causing his nose to bleed a little. V1 Administrator stated the residents were separated, R1 was moved to a different room and an investigation was completed. V1 stated she did not call the police or substantiate the resident-to-resident abuse allegation because R2 said he was fine, R1 apologized and doesn't remember anything, both residents are cognitively impaired and R1 did not intend to harm just to get R2's attention.

On 1/4/24 at 9:08 am, V13 LPN/Licensed Practical Nurse stated she was walking past R1 and R2's room and saw that "(R1) had (R2) backed up into a corner in their room and (R1) was standing in front of (R2). (R1) raised his closed fist and punched (R2) in the nose twice." V13 LPN stated she screamed out for R1 to stop

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S9999	Continued From page 5 and "(R2) was bleeding from his nose." V13 LPN stated when she asked R1 why he was hitting R2, R1 was fumbling for words and making excuses and said "He, He, I told him." V13 LPN stated she didn't see R1 hit R2's shoulder but R2 said R1 did and R2 was complaining of his right shoulder hurting and did not know why R1 hit him. V13 LPN stated evidently R1 was upset because he asked R2 to turn his television down and R2 did not do it. V13 LPN stated she cleaned R2 up and reported the altercation to R2's Physician, family and Administrator and moved R1 to another room on the other side of the facility. V13 LPN stated R1 will attempt to propel himself towards his old room and staff redirect him back to the other side of the facility. V13 LPN stated she believes that R1 "Absolutely 100 percent knows what he is doing." (B)	S9999		