Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ B. WING 12/18/2020 IL6002489 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **555 WEST CARPENTER** APERION CARE CAPITOL SPRINGFIELD, IL 62702 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Final Observations S9999 S9999 Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)3) 300.1220b)3) 300.3240a) 300.3240e) Section 300.610 Resident Care Policies 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 The facility shall provide the necessary b) care and services to attain or maintain the highest Attachment A practicable physical, mental, and psychological Statement of Licensure Violations 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

Illinois Department of Public Health
LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 02/03/2021 FORM APPROVED Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ B. WING 12/18/2020 **1L6002489** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **555 WEST CARPENTER APERION CARE CAPITOL** SPRINGFIELD, IL 62702 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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: Objective observations of changes in a 3) resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services The DON shall supervise and oversee the **b**) nursing services of the facility, including: Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

An owner, licensee, administrator, employee or agent of a facility shall not abuse or Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 12/18/2020 IL6002489 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER **APERION CARE CAPITOL** SPRINGFIELD, IL 62702 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 2 \$9999 neglect a resident. (A, B) (Section 2-107 of the Act) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility. pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents are not sexually abused for one of one resident (R2) reviewed for sexual abuse in the sample of 5. This failure resulted in R2 engaging in an ongoing sexual relationship that included sexual intercourse with a facility employee, V4 (Housekeeper). This failure occurred when V4. Facility Employee. began having sex with R2. R2 is vulnerable for exploitation and abuse related to her diagnoses of bipolar disorder, major depressive disorder. anxiety disorder, and disruptive mood dysregulation. Due to R2's vulnerability for exploitation related to these diagnoses, this failure increased her likelihood for risk of psychosocial harm and potential future abuse.

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| | IL6002489 | | B. WING 12 | | 12/1 | 8/2020 |
| NAME OF F | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
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| APERION | I CARE CAPITOL | | ELD, IL 627 | | | |
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| | Finding includes: | 2 | | | | |
| | Filliang moduces. | | į | | | |
| | On 11/25/2020 at 1 | :12 AM, R2 Nurse's Note | | | | 1 |
| | documented "Resid | dent (R2) was upset, stated | | | | |
| | | eave the facility by one of the | 1 | | | |
| | | have sexual intercourse, she | | | | |
| | | t she would be in trouble, V1, Administrator) was | | | | |
| 0); | informed by the 2n | -10p nurse and that she is not | | | | |
| | in trouble, redirecte | ed her and informed her that | | | 1 | |
| | | e ok and to get some rest. | | | | > |
| | Resident verbalize | d understanding and went to | | | | |
| | | necked on her 30 min later and | | | | |
| | she was sleeping." | • | | | | |
| | On 41/25/20 at 0:3 | 0 AM, V1 documented an | | | | |
| | interview with R2 | The interview documented R2 | 1 | | | |
| | informed V1 that s | he was having an ongoing | | | | |
| | sexual relationship | with V4, Housekeeper that | | | | |
| | included sexual int | ercourse since March, 2020. | | | 1 | |
| | | 45 414 374 decomposito d'in | | | | |
| | On 11/25/20 at 10 | :15 AM, V1 documented in the local police were notified | | | | |
| | of the allegation in | nvestigation notes documented, | | | | |
| | at 10:30 AM. R2 w | as interviewed via telephone by | | | | |
| | the police. | | | | - | |
| | | | | | | |
| | | 17 PM, V6, Nurse Practitioner, | | | | |
| | | rse's notes, R2 stated "She has | | | | |
| | | ual relationship with an icility. She tells me that this | l | | | |
| | relationship has he | een going on since March 2020. | 1 | | | |
| | She tells me that s | she would go to his office and | 1 | | | |
| | have sexual interc | ourse with him. However, she | | | | |
| | is now wanting the | relationship to stop. She is | | | | |
| | very upset and wo | rried that he will get in trouble." | | | | |
| | The second secon | ad again) media agrees abata | | | | |
| | from P2's mobile | ed social media screen shots ohone of messages between | | | | |
| | R2 and V4. Screen | n shot of message between R2 | | | | |

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PRINTED: 02/03/2021 FORM APPROVED Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING IL6002489 12/18/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **555 WEST CARPENTER** APERION CARE CAPITOL SPRINGFIELD, IL 62702 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 and V4 dated 9/12/20 at 1:36 PM, documented "Love you much more, when u want me to come down." The response from V4 was documented as, "How about tomorrow." R2 responded, "I'll try." On 09/12/20 at 2:31 PM, V4 documented, "Hey sexy." On 09/27/20 at 2:34 PM, the social media pictures documented V4 stated "I love you win [sic] you sick [sic] d***." R2's response was documented as "I know bae, I love it when you put it in. I wish you were here in my room to give me some." V4 then documented the response as "I love you." R2's response was documented as "I love you more." On 12/10/19, a County Court Order documented R2 was an alleged disabled adult and appointed V19, R2's Grandfather, as her legal guardian. The Physician's Order Sheet (POS), dated 12/01/20, documented R2 had the following diagnoses, in part as, Bipolar Disorder, major depressive disorder, anxiety disorder, chlamydia (sexually transmitted disease) and disruptive mood dysregulation. R2's Minimum Data Set (MDS), dated 10/19/20, documented R2 was cognitively intact and required limited assist of one staff for all Activities of Daily Living (ADL's). R2's Care Plan, revision date 04/28/20, documented R2 was "I am sexually active or have been sexually active during my tenure in the facility." Interventions include: "Counsel resident

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concerning safe sex practices (e.g. sexually transmitted diseases...), issues of consensual sexual contact..., educate resident that condoms are available at the nurse's station and social services office and provide information about birth control and contraception." Also, it documented

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STATEMENT OF DEFICIENCIES (X1) PR

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| S9999 | 11/25/20 alleged se and an employee." On 11/01/19, the At | s being "at risk for ed to history of abuse and exual relations between herself buse/Neglect Screening | S9999 | | | | |
| | potential future prol mistreatment. On 1 Screening document under the comment problems/symptom to intellectual disab | is a high risk for the likelihood blems/symptoms related 1/25/20, the Abuse/Neglect inted R2 was a high risk and its section: "High risk of 's related to mistreatment due ilities, Serious Mental Illness f being abused in the past." | <i>y</i> | | | ************************************** | |
| | R2 was alert and or known. V1 stated R activity and not usin stated R2 had a his diseases. V1 stated practices with V4, F | O AM, V1, Administrator stated riented and makes her needs to had a history of sexual ag safe sex precautions. V1 story of sexually transmitted to R2 did not use safe sex Housekeeper. V1 stated that of the standard of conduct sility. | | s 9, | | 25 | |
| | of Operations state and could make he was sexually active sex for money and transmitted disease believe R2 and V4 practices. V3 states | 30 AM, V3, Regional Director d R2 was alert and oriented r needs known. V3 stated R2 and had a history of having contracted sexually es. V3 stated she did not used any type of safe sex d that V4 was in violation of the st expected by the facility. | | | | | |
| • | ongoing sexual rela Housekeeper that i March, 2020. R2 st | 50 PM, R2 stated she had an ationship with V4, ncluded intercourse since ated she kept the relationship he knew it would get V4 in | | | | | |

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 12/18/2020 IL6002489 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER **APERION CARE CAPITOL** SPRINGFIELD, IL 62702 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 6 trouble. R2 stated they had unprotected sex and knew she should have used condoms. R2 stated she told staff about the relationship only because she wanted to stop it and V4 wanted to continue to see her. She further stated she felt nervous about V4 returning to work and wanting to see On 12/09/20 at 9:45 AM, V19, R2's Guardian stated he believed R2 makes poor choices in regards to having sex and therefore must be monitored. V19 stated he became her guardian because she was having sexual encounters for money and because of those poor choices R2 contracted sexually transmitted diseases. The policy titled, "Compliance Program Employee Guide, dated 12/19/18" documented "III. **Employee Conduct: Rules of Conduct: As** members of the team responsible for providing quality care and services to our residents, the Facility expects that each employees' conduct and performance will conform with the highest standards of professionalism and ethical practice; the requirements of his or her job; published and common-sense health and safety rules; and applicable federal, state, and local laws, rules and regulations." It continues "5. Engaging in words or actions that violate the residents' legally protected rights. (Note: This includes, but is not limited to, threatening, intimidating, or abusing residents in any way - physically, mentally, verbally, sexually, etc.)." The policy titled, "Abuse Prevention Policy", dated 12/19/18 documented, "The abuse, neglect, or other mistreatment of residents in (facility), physically, mentally or emotionally, is unlawful and is prohibited." Also, under, "Abuse policy: It is

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the policy of (facility) that each resident will be

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| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| | free from 'abuse'. A mental, sexual, or punishment or involved prohibition applies to residents, staff, volude No abuse of any typesidents and staff protection. (Facility) | abuse can include verbal, ohysical abuse, corporal luntary seclusion. This to (facility) staff, other unteers, families and friends. De will be tolerated, and will be monitored for the will strive to educate staff and ividuals in techniques to | | | | | |
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