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	IL6015333	A. BUILDING: _____ B. WING _____	C 11/27/2024

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APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

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S 000	Initial Comments Complaint Investigation: 2499573/IL181366 Investigation of Facility Reported Incident of October 2, 2024/IL180393	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210d)6) 300.3210t) 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 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	S9999		

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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 300.3210 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 interview and record review, the facility failed to protect residents from resident to resident physical abuse. This failure affects four of four residents (R1, R2, R3 R4) reviewed for abuse. This failure resulted in R1 getting feces thrown in R1's eye and on R1's body. This physical abuse caused R1 to feel upset, disgusted, abused, and scared R4 would throw more and R4 would try to attack R1.

Findings include:

1.) R1 is an 81-year-old resident admitted to facility on 2/17/2024 with medical diagnoses including but not limited to: major depressive disorder, moderate protein-calorie malnutrition, adult failure to thrive and age-related osteoporosis.

R1 has a Brief Interview for Mental Status (BIMS) score of 9/15 dated 10/30/2024 which suggests moderate cognitive impairment.

Minimum data set (MDS) section GG dated

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10/30/2024, R1 requires substantial/maximal assistance for shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. R1 is dependent on staff for toileting hygiene. R1 needs partial/moderate assistance for oral hygiene. R1 needs supervision or touching assistance for eating.

R1 reported an allegation of abuse on 11/19/2024 that had allegedly happened on 11/17/2024 to the State Survey Agency.

On 11/25/2024, at 09:33 AM, R1 stated, regarding another resident throwing feces/urine at me this happened in R1's old room. R4 was my old roommate. They moved me after that. R4 uses a colostomy bag. Feces got in my eye. The facility did not send me to the doctor. My linens were all a mess, and I was hollering, and the nurse came to my room. The nurse V5 LPN (Licensed Practical Nurse) helped clean me up. The social worker came in and asked me what happened.. I am not sure if the other resident (R4) is still here. I did have eye drops put in my eyes after that which helped. I do not have any other problems other than my complaint.

On 11/25/2024, at 12:31 PM, R1 stated it made me feel awful and scared when R4 threw feces on me. We shared food and stuff before this. I feel safe to stay here now. I don't believe they will allow anyone to come in here and abuse me again.

On 11/26/2024, at 11:05 AM, R1 stated I felt just terrible and awful when R4 threw feces at me. It felt disgusting to have feces all over me. It got in my eye and all over my body. I was scared that R4 might throw more or reach over and try to

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attack me. I called my son right after the nurse (V5) cleaned me up to tell him because I was so upset. My son got upset too. It felt like something was under my eyelid. That was an uneasy feeling.

On 11/25/2024, at 12:23 PM, surveyor asked R4 if she got in an altercation with R1 last week. R4 stated, I am a nice person I did not try to throw anything on R1 I have nervous hands. I am a nice person. R1 don't like me. I'm going to stay in this room. I like it here. I am a nice person; I didn't try to do that.

R1's Progress note dated 11/17/2024 documents: Late Entry:
Narrative: V5 informed by certified nursing assistant that resident roommate bodily fluids made contact with her. V5 immediately intervened, R1 sitting on the own separate bed, close curtains to make sure remain separation. Full head to toe body assessment made and no injuries noted. ADL care performed on R1. V5 remain with resident until certified nursing assistant came and took resident to shower room.

R4 progress note dated 11/18/2024 documents in part: Note Text: Resident's behavior/mood noted at times. Resident's behavior noted as was physically aggressive. Other resident specific behaviors not noted above: Bodily fluids making contact to roommate (R1)

Reportable initial transmission dated 11/25/2024 for this incident that occurred on 11/17/2024 reviewed.

On 11/27/2024, at 12:43 PM, V30 (CNA) stated, regarding the incident that involved R1 and R4 about a week ago, I went down the hall and when

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I got to that room R4 was upset about not eating her lunch as it ended up on the floor. Both R1 and R4 were arguing back and forth on how the lunch got on the floor. I went to get her a sandwich, cookies and potato chips. She was thankful for that and R1 and R4 were calm. I went to check on R1 and R4 about an hour later. R4 asked if I could help her empty her colostomy bag. R4 said, I can do it, but her hand was shaking really bad. I put two towels under her breast like R4 asked and R4 pushed the bowel movement out of her colostomy bag into the gradual container. I cleaned the gradual. R4 asked me for the gradual container back so she could empty colostomy later. Both residents were calm when I left the room. Later, I was passing down the hall with my dirty linen cart and R1 and R4's room light was on. R1 stated, R4 got bowel movement on me. I had already done rounds on that room. I went in the room to see what R1 needed and seen bowel movement on R1's arm. R4's gradual container to empty R4's colostomy was laying on R1's arm. R1 was starting to make a phone call. R1 was upset and I went and told the nurse.

On 11/25/2024, at 1:34 PM V6 (Social Worker) stated, I was notified of the incident with R4 throwing feces at R1 on Monday when I returned. That incident happened on a Sunday from my understanding. I asked how the situation escalated. R1 and R4 had already been separated in different rooms. I interviewed each resident to see what went on. R4 did not have much to say except being upset that she could not discharge home. R4's mom can no longer care for her. R4 stated she had been under some stress over this and kind of reacted. R1 explained R4 was having an episode and R1 was asking if R4 was ok. R4 started calling R1 names and everything escalated from there. R1 said she got

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feces in her eye and mouth and R1 was screaming. The nurse (V5) and certified nursing assistant got her into the shower chair and went to clean her up and separated R1 and R4 immediately. I have been doing well being checks on R1 and R4 since that incident.

On 11/25/2024, at 09:56 AM, V5 Licensed Practical Nurse (LPN) stated I am aware of an incident of R4 throwing feces at R1. It happened last week Sunday (11/17/2024). R4 is still here and on this floor. When I came in that morning, I was informed by certified nursing assistant that R4 threw feces on R1. That happened before I got here. I went straight to that room. Both R1 and R4 were in their bed. I cleaned R1 up and stayed with her until certified nursing assistant came and got her up to go to shower. R1 had already notified her son. I did notify V3 (Director of Nursing). R1 said some feces splashed in her eye so I rinsed them out. V31 (Nurse Practitioner) came later in the week to see her. No new orders. R4 is now in a room by herself. That was the only time R4 ever did something like that.

On 11/26/24, at 11:27 AM, V3 Director of Nursing (DON) stated, regarding the situation with R1 and R4, I do recall this was on a Sunday (11/17/2024). The nurse sent me a message that R1 had feces on her. I asked what happened and R1 stated it came from R4 direction. The nurse would get assistance to clean her up. I asked how both residents were. Nurse stated, they were both ok. I told her to ask R4 if she knew how the feces got on R1. R4 initially said, "I don't know". I did delegate to nurse to notify family and physicians. I don't recall hearing about R4's family. I do know the nurse got ahold of R1's son. I was made aware there were no injuries. When they cleaned up R1 the staff removed her from the room while

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we investigated what had happened. I was not made aware that R1 stated she got feces in her eye. I was made aware she had feces in her hair and on left shoulder. Monday morning comes and it is thoroughly investigated, and administration got involved. Monday it was found out that R4 threw feces at R1. R4 did tell a staff member on Monday that her cousins made her do it. R4's cousins were not in the facility at this time. This would be considered abuse. V1 (Administrator) is the abuse coordinator. I did report this to V1 on Sunday (11/17/2024). I do not know when this was reported to the state survey agency. My expectation of staff regarding any type of abuse is to notify V1 the administrator immediately.

On 11/25/24, at 2:16 PM, V2 (Assistant Administrator) stated, regarding R1 and R4 incident where R4 threw feces at R1, R4 was sent out by involuntary petition to a local hospital. The hospital held her for a period of time. This incident was not reported to the state because we did not have all the details until Monday morning when we investigated. The incident happened on a Sunday (11/17/2024). This incident as of 11/25/2024 still has not been reported to the state survey agency.

On 11/25/2024, at 11:47 AM, V1 (Administrator) stated, we investigated the incident with R4 throwing feces at R1. We did a full investigation. I will bring the whole binder on it. We did not report it right away as we were not aware of the feces hit the resident. This should be reported. We were made aware last Monday (11/18/24) that feces did hit the resident We did put in an action plan and a removal plan in place and did education for full house. We did abuse/neglect screenings on everyone. The resident (R4) that threw feces is still in the facility. R4 had never done anything like

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this. R4 has an unrealistic view of discharge and was going through some things. We put R4 in a private room. I do not think R1 went out to hospital. I know she was assessed. This should have been reported to the state survey agency once we found out feces hit R1. The staff handled it well. R1 was cleaned up. In this situation the staff handled the situation well even though we were not 100 percent knowledgeable of extent of the incident. I will bring you the whole binder for this investigation.

R1 Care plan dated 4/8/24 documents:
Focus: ABUSE | NEGLECT | EXPLOITATION | TRAUMA
I am an adult living with chronic health conditions, challenges, and comorbidities.
Based on the comprehensive facility assessment conducted, there is benefit from placement in a skilled care setting and stability has been demonstrated throughout the admission screening process.
Denies having been the perpetrator and/or recipient of mistreatment, abuse, neglect, and/or exploitation.
It is determined that symptomatological factors exist that require monitoring.
Goals: I will be cared for in a safe manner and verbalize to staff any incidences of abuse or neglect through review date.
Interventions: Conduct appropriate screening to determine any history of maltreatment including abuse, neglect, living through trauma or surviving combat/violence. Reach and communicate to the resident that their safety, security and dignified care are the priority.
o Ensure safety if feeling unsafe. [certified nursing assistant (CNA), registered nurse (RN), LPN]
o Focus on PERSON-CENTERED CARE.

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Follow person-centered care models affording the resident as much initiative, control and self-determination as possible. Remind the individual that person-centered care or person-first care is a treatment model based upon honesty, sharing valid concerns, integrity and being forthright with care partners.
o Observe resident in care situations. [LPN,RN]
o Observe resident when in company of peers. [CNA]
o Provide reassurance when negative feelings occur. [CNA,LPN]
o Recognize that the resident is an adult living with chronic, debilitating comorbidities in a skilled care setting and may experience feelings of lack of control and powerless. Work with the resident to overcome these feelings; advocate for expression of resident rights, autonomy and encourage independent decision making.
o Report any verbalization of abuse or neglect to administrator immediately.
[certified nursing assistant (CNA)]

2.) R2 is an 84-year-old resident admitted to facility on 08/07/2024 with medical diagnoses including but not limited to: moderate protein-calorie malnutrition, diabetes mellitus type 2, dementia severe without behavioral disturbance, and adult failure to thrive.

R2 has a Brief Interview for Mental Status (BIMS) score of 6/15 dated 10/01/2024 which suggests severe cognitive impairment.

According to minimum data set (MDS) section GG dated 10/01/2024, R2 requires partial/moderate assistance for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. R2 needs supervision or

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touching assistance for eating and oral hygiene.

R2 Care plan dated 10/3/2024 documents:
Focus: ABUSE | NEGLECT | EXPLOITATION | TRAUMA
I am an adult living with chronic health conditions, challenges, and comorbidities.
MODERATE
Based on the comprehensive facility assessment conducted, there is benefit from placement in a skilled care setting and stability has been demonstrated throughout the admission screening process.
Denies having been the perpetrator and/or recipient of mistreatment, abuse, neglect, and/or exploitation.
It is determined that symptomatological factors exist that require monitoring.
Goals: I will be treated with respect, sensitivity, dignity, and feel safe while I live here in the facility
Interventions: Conduct appropriate screening to determine any history of maltreatment including abuse, neglect, living through trauma or surviving combat/violence. Reach and communicate to the resident that their safety, security and dignified care are the priority.
Focus on PERSON-CENTERED CARE. Follow person-centered care models affording the resident as much initiative, control and self-determination as possible. Remind the individual that person-centered care or person-first care is a treatment model based upon honesty, sharing valid concerns, integrity and being forthright with care partners.
Recognize that the resident is an adult living with chronic, debilitating comorbidities in a skilled care setting and may experience feelings of lack of control and powerless. Work with the resident to overcome these feelings; advocate for expression of resident rights, autonomy and encourage

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independent decision making [social worker (SW)]

R2 Progress note dated 10/2/24 documents in part:
Note Text: Resident's behavior/mood noted at This shift. Resident's behavior noted as none noted. Other resident specific behaviors not noted above:
Behavior triggers: Other resident becoming physically aggressive toward them.

R3 Progress note dated 10/2/2024 documents:
Note Text: Resident's behavior/mood noted at This shift. Resident's behavior noted as was physically aggressive.

On 11/25/2024, at 10:04 AM, R2 stated, I have not gotten in a fight with anyone. No one has hit me. I have not hit anyone. I do not know anyone by that name. I have not had any problems with anyone that I know of. If I need help, I will use call light, but I don't need help right now. I have not had any injuries. The staff comes to help me to the restroom. I like it here. I don't have any issues here. I am not neglected. I broke my glasses; I have to talk to my daughter when she comes maybe tomorrow. They come and take care of my hip. Resident sitting up in wheelchair watching television. Resident is clean and well groomed. Resident is thin. No foul odors noted.

On 11/25/2024, at 10:24 AM, R3 stated, I have not gotten in a fight with anyone here. I have not hit anyone, and no one has hit me. No physical abuse or neglect has happened. Staff comes to help me when I hit the call light. I have not had any falls or hurt myself. Resident in bed resting. Resident clean and well groomed. No foul odors noted.

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R2/R3 Investigation 10/2/24 notes in investigation packet document:
R3 - He tried to hit me, but he did not hit me. I did not hit him. I am not happy about the lights being on and the tv being too loud.
R2 - He lightly slapped me on the left side/cheek of my face. I did not hit him back. Family notified. Immediately seperated. Room change R3.

Statement from V7 Registered Nurse (RN) in investigation packet for incident on 10/2/2024 between R2 and R3 documents:
I was informed by a V8 (CNA) that R3 and R2 was arguing about the television. R3 stated that he wants to sleep but R2 won't turn off the lights and doesn't want to lessen the volume of the television. We immediately separated the R2 and R3 and did room change. R3 stated that he slapped R2 because R2 didn't listen to R3. body assessment done, no injuries. Vital signs checked, within normal limits. Both residents didn't complain of pain. (DON), management, (NP) and family notified.

Statement from V8 (CNA) in investigation packet for incident on 10/2/2024 between R3 and R2 documents:
I heard R2 and R3 yelling at each other about the lights being on and the TV being too loud. R3 wanted R2 to turn his TV down and turn the lights off. I heard R2 say that if R3 hits him again he will hit him back. I separated the residents and informed the nurse who then reached out to the (DON) and administrator.

On 11/26/24, at 11:27 AM, V3 Director of Nursing (DON) stated, regarding R2 and R3, I know we separated the residents due to a disagreement over TV volume. R2 and R3 were having a

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disagreement and R2 stated, R3 became physical with him. That is why we initiated separation. Staff did not witness the physical altercation. During investigation it was found to be that R3 slapped/hit R2 on his cheek. I was called on this incident and I notified V1 (Administrator) but my nurse (V7) also notified the abuse coordinator. R3 got sent out for a psychiatric evaluation and returned within 24 hours. I do not recall if R2 was sent out to the hospital. Normally we send the aggressor to the hospital in a situation like this and assess the other resident to see if there is a need to be sent out to hospital. R2 did not have any injuries upon assessment. Family was notified for both R2 and R3. I did not speak to families, but the nurse (V7) did as it is part of our protocol.

On 11/25/24, at 2:16 PM, V2 (Assistant Administrator) stated regarding R2/R3 incident R2 stated he was hit by resident R3, and it made slight contact with his cheek. We did not send out R2 because during the investigation it seemed like the aggressor would have been R3. Our investigation results were that R2 was hit by R3. R3 denied allegations.

On 11/26/24, at 09:40 AM, V1 (Administrator) stated, regarding R2 and R3 staff overheard the argument and got the nurse (V7) and separated the R2 and R3. R3 hit R2 so we sent R3 out for psychiatric evaluation. R3 came back stable. We put them in separate rooms. This was the first time R3 had hit anyone. It is hard to gauge intensity, but from what we could tell it was minor but there was contact.

On 11/25/2024, at 2:23 PM, V7 RN (Registered Nurse) stated, regarding R2 and R3, I remember V8 (CNA) told me that they were arguing because

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	IL6015333	A. BUILDING: _____ B. WING _____	C 11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

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R3 he wanted to sleep around that time, and he wanted to turn off the lights but R2 wanted to watch TV and leave the lights on. V8 went in because they were arguing, and she heard loud voices. As far as I remember it was just a verbal altercation. When I went in there, I immediately separated R2 and R3 to prevent further incident. I informed V3 (DON) right away and V1 (Administrator). I told them that we could change the room of the one resident. R3 was more aggressive. When I got in the room, they were both in the middle of the room. R2 was sitting in w/c watching the TV. R3 was telling R2 to lessen the volume of the TV because R3 couldn't sleep. I do not think it had progressed to anyone putting hands on the other.

On 11/26/2024, at 2:11 PM V8 (CNA) stated, I do recall the incident between R2 and R3. I was next door from their room and was doing my care for the resident there. I heard R2 and R3 talking back and forth. At first, I thought it was the television. It was getting louder. Then I stopped what I was doing and went next door to See what was going on. R2 and R3 were talking at the same time. R2 and R3 were arguing about the television. R2 said, R3 hit him on his face. He told this to me. I did not tell anyone other than my nurse (V7). I talked to R3 and guided him out of the room. R2 was in his bed. I then told the V7 (nurse) when I was in the hallway talking to R3. I don't remember exactly. V7 may have been at the nurse's station because R2 and R3's room was right by the nurses station. V7 talked to R2 and R3 and we decided to change rooms. I did not hear or witness any hits or slaps or sounds like that. Our abuse coordinator is V1 the administrator. This is an allegation of abuse. Our policy states we are to report any abuse to the administrator(V1). I did not call the V1 because I had reported it to the V7

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(registered nurse) so I thought V7 would do it. It didn't dawn on me to report it. I remember V7 texting V1 (administrator) at that time. The last time we had an abuse in-service was last week sometime. V2 (Assistant Administrator) is the one that did the in-service and he did go over that we are all to report to V1 (administrator). I am just used to the nurse reporting it.

On 11/26/2024, at 12:16 PM, V9 (Social Worker) stated, regarding R3 and R2, I was made aware there was a situation over the TV being too loud. I was told by staff that nobody seen it, but R2 told me that R3 hit him on the cheek. I assessed both residents and followed up with both residents. I moved R3 to a room with a resident that he can better cohabitate with. I gave R2 another roommate that fits well with him. R2 had also told V8 (CNA) that he was hit by R3. Our abuse coordinator I think is V3 (DON). Typically, we go through the DON as well as V22 (Social Worker Director). I was not there when it happened. I did not report to the abuse coordinator. I usually report to my director and my director usually reports to the abuse coordinator from what I know. I know we had abuse training recently; I do not know the exact date but it was about a couple weeks ago.

Abuse Prevention and Reporting - Illinois Policy dated 11/28/2016 and with last review dated of 12/17/2021 documents (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

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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.
This will be done by:
Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, and misappropriation of property:

Resident-to-Resident Abuse (Any type):
Resident -to-resident altercations that include any willful action that results in physical injury, mental anguish or pain must be reported in accordance with regulations.

Internal Reporting Requirements and Identification of Allegations:
Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.
External Reporting
Initial Reporting of Allegations:
When any allegation of abuse, exploitation, neglect, mistreatment, or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property has been reported and is being

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S9999	Continued From page 16 investigated. Five-day Final Investigation Report: Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. (B)	S9999		