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	IL6008312	A. BUILDING: _____ B. WING _____	C 05/02/2025

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APERION CARE WILMINGTON	555 WEST KAHLER WILMINGTON, IL 60481

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S 000	Initial Comments Investigation of Facility Reported Incident of April 20, 2025/IL191281	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect a cognitively impaired resident who is at risk for abuse (R1)	S9999		

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from being physically and emotionally abused by another resident (R2). The facility also failed to develop interventions to address the potential for abuse for two of three residents (R1, R2) reviewed for abuse in a sample of 4. This failure resulted in R2 physically slapping R1 on the face, scratching R1's upper body, and biting R1's hand, which caused R1 to experience emotional distress.

Findings include:

Final facility incident report documented the following: On 04/20/2025, R1 and his roommate R2 had an alleged resident to resident behavior and were immediately separated and assessed for injuries. Both residents have Dementia. Upon assessment for injuries, none were noted to R2. R1 was noted with superficial scratches to face and right earlobe, and left knee, a discoloration to the upper lip and left had middle finger, which have all healed. R1 was moved to another room. R1 has poor impulse control and lacks social boundaries related to Dementia...

1. R1's face sheet indicated resident admitted to facility on 08/28/2023 and has a past medical history not limited to major depressive disorder, dementia, obsessive-compulsive disorder, anxiety, Alzheimer's Disease, and psychosis.

Review of Minimum Data Set Section C - Cognitive Patterns dated 02/13/2025 showed R1 has severe cognitive impairment.

R1's care plan last reviewed on 02/17/2025 documented a history of sexual abuse as a child and physical and emotional abuse during childhood/adolescence; at risk for abuse/neglect related to dementia, confusion, depression,

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history of abuse, passive personality/minimally communicative, often wander in peers' bedrooms which can be startling/upsetting to peers; 01/28/25-was bitten by peer after wandering into his room (last revised on 02/28/2025); an elopement risk/wanderer related to confusion, disorientation, dementia ...often enter peers' bedrooms due to confusion, disorientation; do not exhibit disruptive behavior when entering peers' bedrooms, though my presence is often startling to peers ...; have impaired cognitive function as evidenced by confusion, disorientation, impaired memory, inattention, care rejection related to dementia, unspecified psychosis, Wernicke's Encephalopathy, mild cognitive impairment.

Review of nurses note dated 04/20/2025 at 10:01 AM reads in part, "resident was noted on the floor together with the other resident. Upon assessment, the following observations noted: scrape on the right cheek and a scratch on the left cheek, a rounded mark was noticeable on his left hand around the middle finger, a scrape on the left earlobe, a purplish discoloration on the upper lip, and a small scrape on left knee ..."

Review of behavior note dated 04/20/2025 at 12:00 PM reads in part, "per staff report, nursing staff was alerted of incident in resident's bedroom by peer; when nurse arrived, she reportedly observed the resident on the floor with one of his roommates [R2]; the resident's finger (R1) was reportedly in [R2's] mouth. Per nursing report, it was unclear what had instigated the incident, though the resident has a pattern of wandering into peers' rooms related to confusion which may startle or upset peers..."

R1's abuse/trauma screening dated 04/21/2025 indicated that resident is at high risk for the

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likelihood of abuse/trauma occurring.

On 05/02/2025 at 10:40 AM, R1 was ambulating in the hallway throughout the locked unit. R1 was not interviewable.

2. R2's face sheet indicated resident admitted to facility on 03/03/2025 and has a past medical history not limited to Parkinson's Disease, Dementia, cerebrovascular accident, major depressive disorder, and anxiety disorder.

Review of Minimum Data Set Section C - Cognitive Patterns dated 03/10/2025 showed R2 has severe cognitive impairment.

R2's aggressive behavior assessment dated 03/10/2025 indicted that resident "has a history or recent episode of aggressive/agitated behavior and/or non-compliance with medications, treatment, regimen, resisting care" and a "history of agitation/aggressive behavior at previous [skilled nursing facility]".

R2's care plan last reviewed on 03/17/2025 documented have the potential for aggressive behavior, per history, related to Dementia, may yell at staff or make loud vocalizations during care provision related to confusion (initiated 03/03/2025); have a behavior problem related to Dementia, occasionally will make hypersexualized comments and may touch staff inappropriately during activities of daily living (ADL) care provisions; am resistive to care (shower/ADL care refusal) related to Dementia and depression (last revised on 04/21/2025).

R2's behavior note dated 04/20/2025 at 11:30 AM reads in part, "per staff report, nursing staff was

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alerted of incident in resident's bedroom by peer; when nurse arrived, she reportedly observed the resident on the floor with one of his roommates [R1]; peer's finger was reportedly in the resident's (R2) mouth. Per nursing report, it was unclear what had instigated the incident, though [R1] has a pattern of wandering into peers' personal space related to confusion which may startle or upset peer ..."

R2's active physician orders as of 05/02/2025 revealed orders for haloperidol lactate concentrate 2 milligram/milliliter (MG/ML) give 0.5 mg by mouth every 6 hours as needed for agitation, start on 04/18/2025; hydroxyzine hcl oral Tablet 50 MG by mouth in the evening for agitation, start on 04/04/2025; lorazepam oral tablet 0.5 MG give 1 tablet by mouth every 6 hours as needed for Anxiety, start on 04/18/2025.

On 05/02/2025 at 10:45 AM, R2 was observed in locked unit activity room seated at a table. Regarding incident, R2 said he was in his room and fell. R2 added that "nothing happened with my roommate", then added that he did not get into a "fist fight with anyone or touch anyone". R2 indicated that he feels safe at the facility.

On 05/02/2025 at 12:18 PM, V5 (Certified Nursing Assistant/CNA) indicated at time of incident, she was off the locked unit assisting with a resident transfer, and when she returned to the unit, a resident told her that, "two people are on the floor". When V5 entered the room, she saw R1 and R2 lying on the floor and R2 had R1's right ring and middle fingers in his (R2) mouth and was biting down on them. V5 said she called out for help then ran towards R1 and R2. V5 added that when she attempted to separate the residents, R2 had let go of R1's hand but then

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slapped him (R1) on his left cheek with an opened hand. V5 (CNA) added that R1 was crying and was trying to push R2 away from him and that R1 "looked scared". V5 indicated that R1 and R2 were roommates at the time of incident and R1 walks over to R2's side of the room to stare out the window, stares at R2, then R1 walks away. V5 then said after they were separated, the nurse (V7) came in and she took R1 into the shower room with V6 (CNA). V5 said she saw R1 had a scratch mark behind his ear that was bleeding, a light scratch to his chest, a scrape to his left knee, and a bite mark on his right hand. V5 said R1 was still crying at this time and looked upset. V5 also said that R2 had gotten angry at R1 that morning before breakfast because R1 had walked near R2 to look out the window in the dining room. V5 said that R2 "stood up and started yelling at [R1]" and R2 was trying to get to R1 who was just standing there and staring at him (R2).

On 05/02/2025 at 01:22 PM, attempted to call V7 (Registered Nurse) regarding the incident with R1 & R2. No answer, and a detailed message was left. V7 did not return call upon exiting complaint survey.

On 05/02/2025 at 01:29 PM, V6 (CNA) said regarding incident with R1 & R2, she heard V5 (CNA) yelling for help saying R1 and R2 were, "fighting are the floor". V6 said when she entered the room, she saw R1 and R2 both on the floor and she saw "R2 smack R1 on the face" prior to being separated by staff and R2 was saying that R1 "deserved it" and R2 was laughing at R1. V6 added that R1 was crying, and she could see bite marks to his fingers, his ear was bleeding, and visible redness to R1's back. V6 added that it looked as if R2 had pushed R1 down to the floor

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because R1 had hand marks to his shoulders. V6 said that R2 would "always be mean to R1, would try to kick [R1] out of the room" and that R2 "always seems to be saying stuff to [R1]". V6 indicated that R1 and R2 "kind of have a history" then said that R2 was the aggressor during this incident and R1 was the victim. V6 said after R1 and R2 were separated, she and V5 (CNA) took R1 to the shower room. R1 was still very emotional at this time.

On 05/02/2025 at 1:51 PM, V1 (Administrator) said regarding the findings from her investigation, R1 and R2 were both on the ground, and staff were unable to determine if both residents fell. V1 added that R2 was upset at R1 for looking at him but could not determine who the aggressor was. V1 (Administrator) added that she was not made aware of the incident that occurred in the dining between R1 and R2 on the morning of incident.

Abuse policy last reviewed 10/24/2022 reads in part: 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. This will be done by ...establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, identifying occurrences and patterns of mistreatment

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S9999	Continued From page 7 ...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. "B"	S9999		