

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Morton Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 190 East Queenwood Road Morton, IL 61550	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875</p> <p>Based on interview and record review, the facility failed to prevent abuse for one resident (R2) of three residents reviewed for abuse in a sample of 15. This failure resulted in R2 being sent to the hospital diagnosed with an orbital fracture and suffering psychosocial harm that any reasonable person would after being abused. This past non-compliance, which involved R2, occurred from 3/09/23 to 3/14/23.</p> <p>This failure resulted in an Immediate Jeopardy.</p> <p>Prior to the survey date of 3/29/2024, the facility had taken the following actions to correct the non-compliance:</p> <p>1) Immediate actions taken for those residents identified: On 3/9/24, R2 was assessed and sent to the hospital. On 3/11/24, R2's Abuse screening and Care Plan were reviewed and updated accordingly. On 3/9/24 R1 was assessed and placed on a 1:1 until he was sent to the hospital. On 3/9/24 when R1 returned from the hospital R1 was placed on a 1:1 and remains on 1:1. On 3/11/24 R1's Abuse screening and Care Plan were reviewed and updated accordingly.</p> <p>2) Measures put into place/System changes: On 3/11/24 the Interdisciplinary Team reviewed the Facility's Abuse Prevention Policy with no changes needed at this time. On 3/13/24 V16 (Assistant Director of Nursing) reeducated all staff on the Facility Abuse Prevention Policy. On 3/12/24 the Interdisciplinary Team reviewed and updated all residents current abuse screenings. On 3/13/24 A Quality Assurance and Performance Improvement meeting was held with V12 (Medical Director) to discuss alleged allegation and facility comprehensive follow up. V1 (Administrator), V2 (Director of Nursing), V12 (Medical Director), and V16 (Assistant Director of Nursing) were in attendance. On 3/14/24 the Interdisciplinary Team reviewed and discussed Medical Records of referrals prior to admitting to ensure resident safety and well-being of residents with Dementia. On 3/14/24 the Interdisciplinary Team reviewed and discussed any New Admission's Abuse Screenings and Psychosocial Screenings to ensure resident safety and well-being of residents with Dementia. On 3/13/24 V16 (Assistant Director of Nursing), interviewed all residents to ensure they feel safe and report no similar occurrences.</p> <p>Findings Include:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Abuse Prevention and Reporting policy dated 11/28/16, documents The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used and this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>The Final Abuse Investigation Report sent to (the State Agency) dated 3/9/24, documents that R2 a [AGE] year-old female was physically abused by R1. On 3/9/24, at 1:38 PM, (R1) came out of his room in his wheelchair to use the phone at the nurses station. (R2) was sitting at the nurse's station also. After hanging the phone up (R1) rolled his wheelchair backwards. (R2) moved her chair backward to get out of (R1's) way. When (R1) got turned around (R1) noticed (R2) sitting in her wheelchair. (R1) then moved toward (R2) ultimately making contact. Staff immediately ran to separate the two residents. (R1) then fell out of his wheelchair onto the floor. R2 had an abrasion to the bridge of her nose.</p> <p>On 3/29/24 at 2:40 PM, the video was observed of the incident between R1 and R2. R2 was sitting in the hall near the nurse's desk. R1 wheeled past R2 and went to the nurse's desk to use the phone. When R1 hung the phone up he was backing up in his wheelchair. R2 was backing up to move out of R1's way. R1 turned his wheelchair around and looked like R1 was going to go past R2. Suddenly R1 raised his fist towards R2. R2 put her hands up in front of her face. Quickly R1 grabbed R2's shirt with his left hand at her right shoulder so R2 could not move away from R1. R1 leaned forward in his wheelchair, fully extended his right arm hitting R2 in the face at full force with his fist. R1 hit R2 several times with at least a couple of the hits connecting with R2's face. R1 was trying to stand from his wheelchair as he was hitting R2 and R1 fell to the floor. When R1 fell to the floor R2's wheelchair rolled back and R2's face was out of camera view.</p> <p>R1's Face Sheet documents R1 was admitted to the facility on [DATE] with a diagnosis of Unspecified Dementia, Unspecified Severity, with Agitation, Paranoid Schizophrenia, Schizoaffective Disorder, Bipolar Type, Mixed Hyperlipidemia, Type 2 Diabetes Mellitus without Complications, Other Specified Chronic Obstructive Pulmonary Disease, Other Abnormalities of Gait and Mobility, Hemiplegia and Hemiparesis following Non Traumatic Intracerebral Hemorrhage Affecting Left Non Dominant Side, and Dysphagia, Oral Phase.</p> <p>R1's MDS (Minimum Data Set) dated 2/23/24 documents a BIMS (Brief Interview for Mental Status) Score of 4/15, indicating (severe impairment).</p> <p>R2's Face Sheet documents R2 was admitted to the facility on [DATE] with a diagnosis of Dementia in Other Diseases Classified Elsewhere, Moderate, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Familial Hypercholesterolemia, Other Lack of Coordination, Repeated Falls, Essential (Primary) Hypertension, Other Symptoms and Signs Involving the Musculoskeletal System, and Unilateral Primary Osteoarthritis, Right Knee</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R2's MDS (Minimum Data Set) dated 2/21/24 documents a BIMS (Brief Interview for Mental Status) could not be conducted due to resident is rarely/never understood. R2's primary language is Vietnamese. R2 has Long Term and Short Term Memory Problems.</p> <p>R2's Care Plan documents that R2 has impaired communication: R/T (related to) a language barrier. Date Initiated: 1/29/2021. R2 has an orbital fracture putting her at risk to experience Pain or related discomfort. Date Initiated: 3/11/2024.</p> <p>On 3/29/24 at 1:03 PM, V1 (Administrator) stated that she got a call from V2 (Director of Nursing) that there was an incident between R1 and R2. V1 got on her phone to watch the video of what happened. V1 stated It was disturbing. R1 came out of his room and went to the nurse's station to use the phone. R2 was sitting behind R1 in her wheelchair. R1 started to back up so R2 was backing up also. R1 then turned around and hit R2. The first punch went to R2's face. R2 blocked the second punch, and third punch was in the face also. I have never seen anything like it. R1 fell out of his wheelchair on the third punch. V10 (Agency Licensed Practical Nurse) jumped over R1 to get to R2. The staff got an ice pack and was trying to keep R2 calm. The police were called and 911 was called to take R2 to the hospital.</p> <p>On 3/29/24 at 11:44 AM, V4 (Laundry Assistant) stated that she was going down the hall and saw R1 going towards R2. R1 reached out to grab R2's wheelchair and hit R2 in the face. R1 hit R2 at least twice. R2 does not speak English. It was so fast R2 did not have time to protect herself. R2's glasses pushed into her nose and put a cut on the bridge of her nose.</p> <p>On 3/29/24 at 12:00 PM, V5 (Certified Nursing Assistant) stated that R1 was on the phone at the nurse's station and R2 was behind R1 so she could use the phone next. V5 went into another resident's room and heard a loud commotion in the hall. V5 came out and R1 was on the floor and V6 (CNA) had a towel holding on R2's face. R2 wears safety glasses and sustained cuts on R2's face.</p> <p>On 3/29/24 at 12:16 PM, V6 (Certified Nursing Assistant) stated that she was coming down the hall and heard R2 screaming and saw R1 raised up in his chair with his fist raised towards R2. R1 had already hit R2 and R1 kept hitting R2, R1 only stopped because he fell out of his wheelchair. R1 did not say why he hit R2. R2 does not speak English and did nothing to provoke R1 to hit her.</p> <p>On 3/29/24 at 2:01 PM, V9 (R2's Power of Attorney) (in broken English) stated that a guy punched R2 in the face and R2 got a fracture.</p> <p>On 3/29/24 at 3:04 PM, V10 (agency Licensed Practical Nurse) stated that she was charting and R1 and R2 were both close to the nurse's station. V10 walked to the med room and as V10 was coming back out R1 was attacking R2. R1 was hitting R2 in the face with his fist. R1 fell while he was hitting R2. V4 (Laundry Assistant) was close by R2 and V4 got in front of R2 to protect R2. R2 was pointing at R1, tears were coming from her eyes, and blood was coming from R2's nose. R2 was shocked and afraid. R2 was bleeding from a laceration that R1 caused. When V10 questioned R1, R1 said I didn't do that (R2) did it to herself. The B**** deserved it.</p> <p>On 3/29/24 at 12:27 PM, R1 was asked if he has ever hit anyone at the facility. R1 stated Some Vietnamese woman (R1 laughed). I hit her in the head. R1 was asked why he hit R2, and he stated that R2 talked to him bad in the war. (Unable to confirm if R1 was in the war.)</p> <p>(continued on next page)</p>		

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