STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145261	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Dekalb	1212 South Second Street Dekalb, IL 60115

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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on interview and record review, the facility failed to implement their abuse policy by not removing staff from resident care during an abuse investigation for 1 of 3 residents (R1) reviewed for abuse in the sample of 6. The findings include: On 9/17/24 at 11:27 AM, V6 Certified Nursing Assistant (CNA) said the morning of 9/12/24 she was assigned to the north hall. V6 said she went to the south hall to retrieve a sling. V6 said V2 Social Services Director stopped her on the south hall and asked her to assist R1. V6 said she went into R1's room and assisted him to clean up, get dressed and transferred to a wheelchair. V6 said R1 became rude and agitated that V6 had to leave to continue providing care on her assigned hall. V6 said she did not push or lay her hands on R1 in an aggressive manner. V6 said she left the room and reported to the nurse R1's change in temperament and the need for another staff person to approach him. V6 said she returned to the north hall to continue providing care for the residents for at least an hour before she was called in to a meeting with V2 and the Administrator. At 8:51 AM, V2 confirmed she asked V6 to assist R1 with care the morning of 9/12/24. V2 said V6 was assigned to another hall but was just outside R1's door at the time. V2 said she was later stopped by V3 restorative CNA and asked to see R1 as he was upset. R1 told her that V6 pushed his shoulder and that upset him. V2 said she immediately called V1 Administrator on the phone and was directed to keep V6 on the north hall. V2 said R1 has a history of making false allegations and is not always cognitively intact. At 9:44 AM, V3 restorative CNA said on 9/12/24, V6 exited R1's room and said he was ungrateful and threw her hands up. V3 said she entered R1's room and R1 told her V6 put her hands on him. V3 said she immediately told V2 of R1's allegation. At 9:50 AM, V4 Licensed Practical Nurse (LPN) said on 9/12/24 she worked the north hall with V5 CNA and V6. V4 said there were no issues with V6's job performance and no resident complaints of her care. V4 said V6 continued to provide care to residents on the north hall until about lunchtime when she was sent home. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:58 AM, V5 CNA said on 9/12/24 she worked the north hall with V6. V5 said she had known V6 about [AGE] years and loved working with her. V5 had no concerns with V6's care. V5 said R1's memory is not always there, and he asks for things he knows he can't have and gets mad when he doesn't get it. V5 said on 9/12/24, she and V6 provided care to residents on the north hall until about lunch when V6 was sent home. At 11:00 AM, V1 Administrator confirmed she was notified by phone on 9/12/24 at 8:50 AM of R1's abuse allegation against V6. V1 confirmed V6's 9/12/24 timesheet showed V6 left the facility at 10:52 AM. At 11:52 AM, V2 said it's important to protect residents during an abuse investigation to prevent abuse and make sure the residents are safe. At 11:58 AM, V1 said it's important to protect residents during an abuse investigation to stop and prevent abuse and keep the residents safe from abuse. The facility's 10/24/22 Abuse Prevention and Reporting Policy showed employees of the facility who have been accused of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will be removed from resident contact immediately. V6's time sheet showed on 9/12/24 she worked from 7:26 AM-10:52 AM.