

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145877	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Dolton		STREET ADDRESS, CITY, STATE, ZIP CODE 14325 South Blackstone Dolton, IL 60419	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>38796</p> <p>Based on interview and record review the facility failed to protect the resident right to free from mental abuse by staff when needing assist. This affected one of three residents (R1) reviewed for abuse. V1 told R1 that she would not fit in the shower chair. This failure results in R1 feeling dehumanized and humiliated.</p> <p>Findings include:</p> <p>1.R1 MDS (Minimum Data Set) dated 3/2/2024 denotes in-part section C BIMS/brief interview for mental status score of 15 (cognitively intact. Section GG for functional abilities and goals denotes shower/ bathing, (02) R1 requires substantial/ maximal assistance, helper does more than half the effort.</p> <p>Facility final report to the department denotes in-part, around 1140hr on 3/21/24, the Administrator interviewed R1. She (R1) alleged that on 3/19/24, V1 (CNA/certified nursing assistant) was her assigned staff; she brought a bowl of wash water and towels for her bed bath and told her to wash up, knowing she needed help. She (R1) stated (V1) did not render assistance to her and was very unprofessional when she asked her for help. Which she didn't do, adding it took an hour for her to return to her. Also, on 3/20/24, V1 placed her breakfast tray where she couldn't reach it. When she (R1) called her back to help, she had an attitude with her. It was her (R1) shower day and during their conversation, V1 told her rudely, 'either you want this shower, or you don't'. While she (R1) was being showered, she reported V1 being very unprofessional and snappy with her. After the shower, she (R1) heard V1 saying she was not going to deal with R1 anymore. V1 was interviewed on 3/21/24. She (V1) stated that on 3/19/24, she handed a pail of water to R1 and asked her to 'wash up' she'll be back to do the rest. She (V1) said it took an hour to convince R1 to do her shower on 3/20/24 and admitted to saying to her either you do, or you don't at this point, referencing the shower. V2 (resident liaison) and V6 (CNA) were two of the staff members that helped V1 transfer R1 to the shower chair on 3/20/24 and they both stated they did not witness the alleged unprofessional acts towards R1, from V1, while they were present there. V3 (restorative aide) was one of the staff that helped render care to R1 on 3/20/24 and she stated she heard V1 in the hallway venting to herself about how she does not want to work with R1 anymore. A complete assessment was immediately performed for R1. There was no findings of bruise or trauma. R1 denies being any pain, discomfort, or being fearful R1 was reassured of her continued safety at the facility. V1 was terminated for unprofessional conducts and poor customer service.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 4/13/24 at 10:21am R1 agreeable to interview. R1 observed alert, orient to person, place, and time. R1 said the incident happened on a Wednesday, her shower day. R1 said V1 came in the room and she (R1) informed V1 that it was her shower day, and V1 said I know and turned and left the room. R1 said around 10:00am she put the call light on and V1 responded and R1 asked about her shower and V1 began to explain to R1 that we have to get you up in the chair, transfer you to the shower room, then transfer you to the shower chair. R1 said V1 left and came back about 11:00am and told her (R1) you won't fit in the shower chair. R1 said she asked V1 to bring the shower chair so that she could see if she could fit. R1 said V1 brought the chair in the room and R1 said she told V1 that my big *** will fit. R1 said V1 then said do you want a shower or not very rudely. R1 said she told V1 yes. R1 said V1 and other staff transferred her to the wheelchair and took her to the shower room. R1 said when she was in the shower room V1 gave her soap and towel and left the shower room. R1 said an aide name V4 (CNA) stayed in there with her. R1 said she washed her upper body as best as she could. R1 said V1 returned at some point, and she asked V1 if she could wash her perineal area and buttocks and V1 responded no one wants to touch the water on you, R1 said V1 did not wash her perineal area or buttocks. R1 said V1 assisted with washing her legs because she could not reach her legs. R1 said the towel was not warm that V1 used to wash her legs with. R1 said while they were in the shower room, V1 said to V4 I'm not working next week, if they put me on the schedule I'm calling off. R1 said V1 was trying to engage V4 in conversation but V4 would not respond to V1's comments. R1 said V1 made the statement multiple times. R1 said I know why V1 said she would call off, its so that she would not have to give me a shower on Wednesday. R1 said V1 was rude towards her. R1 said V1's behavior was not necessary, V1 was rude and unprofessional. R1 said she does not like some of the staff that help.</p> <p>On 4/12/24 at 12:00pm V2 (liaison) said on 3/21/24 she was going to talk to R1 about her care plan meeting and R1 mentioned to V1 that V1 was nasty toward her yesterday. V2 said R1 mentioned that she heard the aide say she was going to call off next Wednesday and she knows it's so that she doesn't have to give R1 a shower.</p> <p>On 4/13/24 at 2:10pm V3 (restorative aide) said she assisted V1 with repositioning R1 when R1 was in the shower chair. V3 said V1 was upset that she had to give R1 a shower on 3/20/24. V3 said V1 said she didn't want to give R1 a shower because she had already washed R1 up. V3 said V1 had an attitude about giving R1 a shower. V3 said after assisting with repositioning R1 in the shower chair, she left the shower room. V3 said V1 was in the hallway, and as she was passing V1, she heard V1 saying to herself that she wasn't happy working on that unit and that she should have taken a mental health day. V3 said she responded by saying take a deep breath and pray. V3 said she walked away.</p> <p>On 4/14/24 at 11:09am V4 (CNA) said she did assist V1 with transferring R1 from the bed to the wheelchair and to the shower chair. V4 said after the shower she assisted V1 with transferring R1 back to bed. V4 said she is aware that R1 and V1 had some issues, she knows this because news travels around that facility very quickly.</p> <p>On 4/13/24 at 9:59pm V5 (Administrator) said she was made aware of R1's allegation on 3/21/24 and she responded quickly. V5 said she concluded her investigation and determined that V1's behavior was not professional and V1 was terminated. V5 said she in-serviced her staff on abuse prevention. V5 said V1's behavior is not acceptable, and it does not align with the culture of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The facility policy Titled Abuse Prevention and Reporting- Illinois with last revision date 10/24/2022 denotes in-part the 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 will be done by establishing an environment that promotes resident sensitivity resident security and prevention of mistreatment. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury unreasonable confinement intimidation or punishment with resulting physical harm pain or mental anguish to a resident. This also includes the deprivation by an individual including a caretaker of goods or services that are necessary to attain and or maintain physical mental psychosocial well-being. This assumes that all instances of abuse of residents even those in a coma cause physical harm or pain or mental anguish. The term willful in the definition of abuse means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Mental abuse is the use of verbal or nonverbal conduct which causes or has a potential to cause the resident to experience humiliation intimidation fear shame agitation or degradation. Verbal abuse may be considered a type of mental abuse verbal abuse includes the use of oral written or gestured communication or sounds to a resident within hearing distance regardless of age ability to comprehend or disability.</p> <p>Facility policy titled dignity with last review/revision date of 4/23/18 denotes in part the facility shall promote care for residents in a manner and in an environment that maintains or enhance the resident's dignity and respect and full recognition of his or her individuality. The facility shall consider a resident lifestyle and personal choices identified through the assessment processes to obtain a picture of his or her individual needs and preferences. Staff shall carry out activities in a manner which assists the resident to maintain and enhance his or her self-esteem and self-worth.</p> <p>The facility policy titled Dignity with last review date of 4/23/2018 denotes in -part residents have the right to a dignified existence self-determination and communication with and access to persons and services inside and outside the facility resident has the right to exercise their right as a resident in the facility and as a citizen for resident in the United States. Residents have a right to be free from sexual abuse physical abuse mental abuse corporal punishment neglect and involuntary seclusion. Residents have the right to be free from verbal abuse.</p>		