STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peoria Heights	1629 East Gardner Lane Peoria Heights, IL 61616

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30312 Based on observation, interview, and record review the facility failed to ensure a resident had clean clothes, underwear, and socks to wear for one of three residents (R19) reviewed for dignity in a sample of 32. Findings include: R19's Minimum Data Set (MDS) assessment dated [DATE] documents that R19 is moderately visually impaired and requires extensive assistance for dressing and personal hygiene. R19's current care plan states that R19 needs extensive assistance of one person to dress and is visually impaired. On 11/1/21 at 1:30p.m. R19 was seated in R19's room in a wheelchair wearing black sweatpants, a black sweatshirt, a green stocking cap, and a brown coat. R19's fingernails were moderately long with dirt visible under each fingernail on both hands. R19 stated R19 has been wearing the same sweatshirt and sweatpants for at least the last two weeks. R19 stated R19 does not have any clean underwear or socks and feels very uncomfortable in the soiled clothes. At 2:15p.m. V14 (Certified Nurse Aide/CNA) entered R19's room. R19 told V14 that R19's clothes were dirty, and R19 did not have any underwear and socks to wear. V14 looked in R19's closet to see if R19 had any hanging clothes. There was a shirt with another resident's name on it, a shirt with R19's name on it, and no pants. V14 proceeded to look in R19's chest of drawers and found no shirts, pants, socks or underwear. V14 proceeded to assist R19 into the bathroom. When V14 assisted R19 to pull down R19's pants, R19 was not wearing any underwear. R19 stated R19 was uncomfortable wearing sweatpants without underwear. V14 stated she was late leaving her shift for the day and proceeded to leave R19's room. On 11/2/21 at 8:45a.m. R19 was seated on the edge of the bed with the same sweatpants and sweatshirt on that R19 wore the day before. R19 stated that R19 still does not have any clean clothes and needs clean clothes and a shower, because I stink. R19 stated that facility staff have not offered to provide R19 with clean clothes or underwear and socks to wear. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/21 at 1:09p.m. V12 (R19's Family) stated that R19 leaves the facility to visit family about every two weeks. V12 stated that every time R19 visits, R19 is wearing the same dirty clothes over and over. V12 stated that the last time R19 came to visit, R19's family had to immediately go out to buy R19 some new clothing. V12 stated the facility has not notified her that R19 needs new clothing. V12 stated the facility should make sure R19 is wearing clean clothes every day.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Noncompliance resulted in two deficient practice statements. A. Based on observation, interview and record review the facility failed to educate one resident (R16) about R16's diagnosis of HIV (Human Immunodeficiency Virus) and Hepatitis C who was known to proposition sex in exchange for money and/or cigarettes, known to have a criminal history of prostitution and known to have diagnoses of sexually transmitted disease. The facility also failed to develop interventions to protect residents from potentially having unprotected sex with R16. These failures resulted in R16 having access to all 82 residents in the facility from admission (9/14/21) to 10/29/21. These failures resulted in an Immediate Jeopardy being called on 11/23/21 at 1:20pm. While the immediacy was removed on 11/24/21 at 12:05 the facility remains out of compliance at a Severity Level 2, as the facility continues to educate all staff on identifying and protecting residents with sexually transmitted disease and the facility's Abuse policies and procedures. B. Based on interview and record review the facility failed to prevent physical abuse for one of eight residents (R1) reviewed for physical abuse in a sample of 32. A. Findings include: Facility Policy/Abuse prevention and Reporting dated/revised 1/22/19 documents: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. The facility will conduct an investigation and protect the resident from non-consensual sexual relations anytime the facility has reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent. Resident Room Roster dated 10/29/21 indicates 82 residents in the facility. Current Physician Orders indicate R16 was admitted to the facility on [DATE] with diagnoses that include Bipolar Disorder, HIV (Human Immunodeficiency Virus), Viral Hepatitis C and PTSD (Post Traumatic Stress Disorder). Comprehensive assessment dated [DATE] indicates R16 is cognitively intact, understands, is understood and is independently mobile. Per (R16's guidelines) implemented on 10/29/21, R16 had access to the entire facility including the smoking area prior to 10/29/21. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	State Police Record dated 9/14/21 indicates R16 has criminal history of numerous prostitution convictions among other felony charges and convictions. State Criminal History Analysis Report/Identified Offender's Program dated 10/25/21 indicates the facility received the Report Via Facsimile on R16 on that date. Report indicates details whether and to what extent, the identified offender's criminal history necessitates the implementation of security measures within the long-term care facility. Report indicates R16 was identified as a Moderate Risk - the resident requires closer supervision and more frequent observation than standard or may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient. Report indicates the following specific considerations were important in arriving at the above recommendations: (R16) criminal history consisted of convictions for possession of drug paraphernalia. prostitution - several times, criminal trespass to land, possession of stolen vehicles - twice, resisting arrest. Report indicates R16 is diagnosed with both psychiatric and medical disorders. Report further indicates Nursing facility staff stated that R16 has inappropriately fondled a male resident and made several attempts to obtain sexual favors for money with him. In view of R16's inappropriate behavior with a male resident and psychiatric condition, R16 is a moderate risk and supervision status is recommended. Written Statement by V11 (SSD) dated 11/3/21 is documented as follows: (R17) talked to me about (R16) asking for (R17) cigarettes and that (R16) offered (R17) 'sex for cigarettes' I discussed how to decline/stay away from (R16). (R17) expressed (R17) was comfortable telling (R16) 'No.' I provided suggestions to let staff know if (R16) did not stop asking when (R17) said 'No.' (R17) stated R17 was not afraid of (R16) or anyone else. Physician's Progress Note dated 10/27/21 at 1:17pm indicates Reason for visit - (R16) has allegedly been making sexual advances toward other residents. Discussed the importance of not making any sexual advances toward other residents. On 11/8/21 at 9:10 V22 (Licensed Practical Nurse/LPN) stated that she had been told by R17 that R17 had been offered sex by R16, but R17 said No. On 11/4/21 R30 reported R16 would beg for food and cigarettes and offer sex for money to other residents. On 11/4/21 V1(Interim Administrator) acknowledged V11 (SSD) was aware of R16 propositioning R17 sex for money. V1 stated that she asked other staff and they also were aware of R16's behavior. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/4/21 at 3:45pm R4 stated that R4 had been in a consensual relationship with R16, however R16 did not have boundaries and wanted more of a sexual relationship than R4 wanted. R4 stated that R16 did not understand No and would still persist in initiating sex. R4 stated that eventually R16 moved on to R15. No additional monitoring or supervision was identified, implemented or documented related to R16's Identified Offender status, Criminal History Analysis Report or medical diagnoses. No attempts by the facility to counsel, educate or address R16's HIV or Hepatitis C diagnoses were found or presented. No interventions to protect other residents were implemented. On 11/23/21 at 2:00pm V2 (Director of Nurses/DON) stated that the physician and V25 (previous Administrator) discussed R16's sexually transmitted disease status with R16 and stated, I don't know if any of it is documented though. V2 stated that R16 was told to disclose R16's HIV/Hepatitis C diagnosis to R4 and any other potential partner. V2 stated that the facility was without a care plan coordinator for a while and Corporate was doing the care plans. On 11/23/21 at 2:05pm V1 (Administrator) stated that R16's diagnoses (of HIV and Hepatitis C) were on R16's admission records, Corporate could have initiated a care plan from that information and that the nurses were also aware of R16's diagnoses. The facility was aware of R16's offering sex in exchange for money/cigarettes prior to 9/30/21, was aware of R16 fondling a male resident (R17) per State Criminal History Analysis Report dated 10/14/21 and aware of the consensual intimate relationship with R4 who stated that R16 wanted more of a sexual relationship than R4 wanted and that R16 didn't understand No. No additional monitoring or supervision was identified, implemented or documented related to R16's Identified Offender status, Criminal History Analysis Report or medical diagnoses. No attempts by the facility to counsel, educate or address R16's HIV or Hepatitis C diagnoses were found or presented. Adequate interventions to protect other residents were not implemented until 10/29/21. The Immediate Jeopardy was identified to have begun on 9/14/21 when R16 was admitted to the facility with diagnoses of HIV (Human Immunodeficiency Virus) and Hepatitis C, and the facility failed to identify a plan to address these potentially sexually transmitted diseases and protect any potential sexual partners of R16. V1 (Administrator) was notified of the Immediate Jeopardy on 11/23/21 at 1:20pm. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. Corporate Nurse Consultant/RN (Registered Nurse) educated all staff during an in-service after initiation of an extended survey when substandard quality of care was identified. The education included how to recognize sexual abuse and the facility's protocol to prevent abuse of residents - training included indicators of abuse. This training will be ongoing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	All staff hired after 11/5/21 or on leave/vacation were educated by the Human Resources Director on 11/5/21. 2. On 11/5/21 All interviewable residents were interviewed to ensure they were not experiencing sexual abuse. 3. On 10/28/21 R16 was placed into a private room. 4. On 10/29/21 R16 was placed on 15-minute checks when in R16's room and remains on 15-minute checks. R16 was also provided scheduled smoking times/location (which is separate from general smoking area) and staff accompany R16 when out of R16'sroom. 5. On 10/28/21 Social Service Director, Director of Nursing and V1 (Administrator) met with R16 and reviewed written guidelines of smoking times and monitoring by staff when out of R16's room. At that time, R16 signed a written agreement of the guidelines. 6. On 11/23/21 All residents identified as having the potential to be sexually active will be educated on safe sex practices. 7. On 10/27/21 Physician's Assistant educated R16 on R16's diagnoses of HIV and Hepatitis C as well as safe sex practices. Physician Assistant also educated R16 on the importance of responsibly notifying any potential sexual partner of her HIV status. 8. On 10/27/21 R16 was started on a new medication (antidepressant) to decrease R16's sexual urges. This was confirmed through review of the Physician's orders and the Medication Administration Record. 9. R16 was found to be compliant with the anti-viral medication R16 has received for HIV since admission. 10. Social Service Director will discuss and re-educate R16 on safe sex practices on a regular basis. 11. Random audits will be conducted by the Administrator /Designee regarding resident concerns, psychosocial needs. Results of audits will be reviewed by Quality Assurance committee for a minimum of 12 weeks. 12. On 11/24/21 R16 was interviewed and observed to be in a private room and visible from the nurses' station. R16 stated that staff do monitor R16 when out of R16's room. Social Service Director was observed accompanying R16 to a psychosocial group. 30312 B. Findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An Abuse Prevention and Reporting policy dated as revised 1/22/19 states, Residents have the right to be free of abuse, neglect, misappropriation of resident property, and exploitation. This policy also documents that, Abuse is the willful infliction of injury. R4's current care plan documents that R4 has, the potential to be physically aggressive (related to) Anger, Depression, Poor impulse control. R1's nurse's note dated 10/12/21 and entered by V2 (Director of Nurses) documents, (R1) was hit in head by peer. R1 and R4's abuse investigation dated as initial 10/12/21 and final dated 10/22/21 documents that on 10/12/21 physical abuse occurred when R4 made contact with (R1's) head with (R4's) hand, because R4 became upset with R1 because R1 was calling R4 names. This investigation documents R4 was sent to the emergency room following the incident to have a Psych evaluation. In addition, this investigation documents that when R4 was interviewed R4 stated, I got really upset and I lost my temper, I couldn't handle the names. (R1) poured coffee on the ground by my feet and I hit (R1). This report documents that the local police were notified and came to the facility following the incident. The investigation also documents the responding police officer declined to file an official report but instead instructed R1 and R4 to stay away from each other. The investigation concluded that physical abuse from R4 to R1 was unsubstantiated because R4 didn't intend to hurt R1. On 11/3/21 V1 (Administrator) verified that on 10/12/21 R4 purposefully hit R1 in the head after R4 thought R1 was calling R4 names. V1 stated she did not substantiate the incident as abuse because V1 thought R4 didn't really mean to harm R1.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Based on interview and record review the facility failed to implement their abuse policy related to sexual abuse allegations. This failure has the potential to affect all 82 resident in the facility. Findings include: Resident Room Roster dated 10/29/21 indicates 82 residents in the facility. Facility Policy/Abuse Prevention and Reporting dated/revised 1/22/19 documents: Pre-Admission Screening of Potential Residents: The facility will check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. While the background or fingerprint checks, and/or Identified Offender Report and Recommendations are pending, the facility shall take all steps necessary to ensure the safety of residents. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Protection of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. Internal Investigation: All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or documents. External Reporting/Initial Reporting of Allegations: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When an allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property has occurred, the resident's representative and the State Agency shall be informed by telephone or fax. All allegations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property are to be reported immediately, but not later than two hours after the allegation is made. Informing Law Enforcement: The facility shall also contact local law enforcement authorities in the following situations: Sexual abuse of a resident by a staff member, another resident, or a visitor. Current Physician Orders indicate R16 was admitted to the facility on [DATE] with diagnoses that include Bipolar Disorder, HIV (Human Immunodeficiency Virus), Viral hepatitis C and PTSD (Post Traumatic Stress Disorder). Comprehensive assessment dated [DATE] indicates R16 is cognitively intact, understands, is understood and is independently mobile. Per (R16's guidelines) implemented on 10/29/21, R16 had access to the entire facility including the smoking area prior to 10/29/21. Current Physician Orders indicate R17 was admitted to the facility on [DATE] with diagnoses that include Seizure Disorder, Schizophrenia and Anxiety Disorder. Current Comprehensive Assessment indicates R17 is mildly cognitively impaired. Progress Note dated 9/30/21 indicates R17 was transferred to the hospital on that date and did not return to the facility. State Police Record dated 9/14/21 indicates R16 has criminal history of numerous prostitution convictions among other felony charges and convictions. State Criminal History Analysis Report/Identified Offender's Program dated 10/25/21 indicates the facility received the Report Via Facsimile on R16 on that date. Report indicates details whether and to what extent, the identified offender's criminal history necessitates the implementation of security measures within the long-term care facility. Criminal History Analysis Security Recommendation Report for R16 dated 10/14/21 indicates the analysis and recommendation is based on the review of the following information: Criminal History Analysis Summary Identified Offender Questionnaire Facility Nursing/Medical Administrator Questionnaire Criminal History Background Report Police Report, Victim Impact Statement or Review of Statement of Facts. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report indicates R16 was identified as a Moderate Risk - the resident requires closer supervision and more frequent observation than standard or may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient. Report indicates the following specific considerations were important in arriving at the above recommendations: (R16) criminal history consisted of convictions for possession of drug paraphernalia. prostitution - several times, criminal trespass to land, possession of stolen vehicles - twice, resisting arrest. Report indicates R16 is diagnosed with both psychiatric and medical disorders. Report further indicates Nursing facility staff stated that R16 has inappropriately fondled a male resident and made several attempts to obtain sexual favors for money with him. In view of R16's inappropriate behavior with a male resident and psychiatric condition, R16 is a moderate risk and supervision status is recommended. Written Statement by V11 (SSD) dated 11/3/21 is documented as follows: (R17) talked to me about (R16) asking for (R17) cigarettes and that (R16) offered (R17) 'sex for cigarettes' I discussed how to decline/stay away from (R16). (R17) expressed (R17) was comfortable telling (R16) 'No.' I provided suggestions to let staff know if (R16) did not stop asking when (R17) said 'No.' (R17) stated R17 was not afraid of (R16) or anyone else. On 11/3/21 at 3pm V11 (SSD) stated that she took over the Identified Offender's after the previous administrator left (approximately one month ago). V11 stated she did not recall when the Criminal History Report was received at the facility and didn't know if it was mailed or faxed. V11 stated that when she did see the report, she saw that R16 was a moderate risk, however she acknowledged that she did not read the rest of the report, specifically the paragraph containing the specific considerations for the recommendations. V11 stated that she was present during the interview with the state Identified Offender Investigator (on 9/30/21) but didn't recall providing the information regarding R16's inappropriate sexual behavior that R16 had displayed. On 11/4/21 at 9:45am V11 (SSD) stated that V26 (State Identified Offender Investigator) held a video meeting (on 9/30/21) regarding R16. V11 stated that V26 interviews her then interviews R16 and that no one else participated. V11 stated that she was aware of R16 propositioning other residents - sex for money and that's why she put it on R16's care plan (on 10/4/21). V11 stated - at that time - staff told her about R16's behavior and that it involved R17. V11 stated that she did report R16's behavior to V25 (previous Administrator). On 11/4/21 at 12:51pm V19 (State Identified Offender Program Manager) stated V26 (Investigator) conducted the interview with V11 (SSD) and R16 via a video meeting on 9/30/21. V19 stated no other staff contributed to the meeting or the information - V11 was the only staff who provided information to V19. V19 stated that V11 (SSD) provided information to V26 (Investigator) that R16 had displayed inappropriate sexual behavior, including propositioning male residents with sex in exchange for money since admit to the facility on [DATE]. V19 stated V26 requested the incident reports/investigations from the facility regarding R16's behavior and never received any reports or follow up from V11. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Current Care Plan (date initiated 9/27/21) indicates R16 has a history of criminal behavior and has demonstrated stability during the screening process and does not appear to be a present risk. Care Plan indicates R16 fits the criteria for an Identified Offender. R16's Care Plan was not updated to include the Criminal History Analysis Report Recommendations on 10/25/21. Care Plan (date initiated 10/4/21) indicates R16 has a history of the following: Socially inappropriate behavior related to offering peers sex for money. This is related to R16's history of being homeless and using prostitution as a means to earn money to survive. Care Plan did not include any specific supervision or specific interventions to address R16's behavior. Care Plan (date initiated 10/29/21) indicates R16 had a psychosocial wellbeing problem and that R16 reported feeling lonely which has led R16 to have episodes of socially inappropriate behavior - at times sexual in nature. On 11/8/21 at 9:30am V11 (SSD) stated that it was actually R17 who told her that R16 had been offering R17 sex for money and/or cigarettes - not staff. V11 acknowledged that she updated R17's care plan on 9/19/21 and it may have been due to R17's allegations regarding R16. V11 stated that she updated R16's care plan on 10/4/21 in response to R17's allegations and stated, I just didn't get around to it until then. V11 stated that R17 was mildly cognitively impaired and at increased risk of abuse. V11 stated that R17 may not have an official diagnosis of being intellectually disabled, however seemed like (R17) was by the way (R17) acted and spoke. On 11/8/21 at 9:10 V22 (Licensed Practical Nurse/LPN) stated that she had been told by R17 that R17 had been offered sex by R16, but R17 said No. On 11/4/21 R30 reported R16 would beg for food and cigarettes and offer sex for money to other residents. On 11/4/21 V1 (Administrator) acknowledged V11 (SSD) was aware of R16 propositioning R17 sex for money. V1 stated that she asked other staff and they also were aware of R16's behavior. V1 stated these incidents and behaviors should have been reported and investigated immediately. No additional monitoring or supervision was identified, implemented or documented related to R16's Identified Offender status or Criminal History Analysis Report. No investigation, protection of other residents, reporting to the state agency or law enforcement was done until 10/29/21 involving R16 and R17. 2) Current Physician Orders indicates R15 was admitted to the facility on [DATE] with diagnoses that include Schizophrenia and age-related Osteoporosis. Current Comprehensive Assessment indicates R15 is cognitively intact and make needs known. Abuse Investigation Report dated 10/27/21 indicates on 10/27/21 at approximately 9am, R7 reported to a nurse that R7 saw another resident (R16) in bed with R7's roommate (R15). On 10/29/21 at 2:53pm R7 stated that R16 had been coming into their room for several days and (on 10/26/21) R16 was on top of R15 in R15's bed and R15 was saying No. R7 stated that R7 also saw R16 hold R15 up against the wall, trying to kiss R15. R7 stated that R7 is afraid of R16 and doesn't want R16 in their room. R7 stated that R7 reported the concerns to V16 (Therapist) the next day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peoria Heights	1629 East Gardner Lane Peoria Heights, IL 61616

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(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 - Many	On 11/3/21 at 3pm V16 (Therapist) stated that R7 told her early on 10/27/21 that R16 came into their room last night, got into R15's bed and was trying to hump R15 for 20 minutes while R15 was sleeping. V16 stated that R7 told her R7 was scared. V16 stated that she immediately told R15's nurse. V16 stated that later that day R16 was moved to the other side of the facility. No interview of V16 was found in the investigation report. On 11/4/21 at 4:15pm R30 stated R30 saw R15 and R16 out on the patio smoking. R30 stated that R30 told R16 to leave R15 alone because R16 would try to be inappropriate with R15 and wouldn't leave R15 alone. On 11/4/21 at 3:45pm R4 stated that R4 had been in a consensual relationship with R16, however R16 did not have boundaries and wanted more of a sexual relationship than R4 wanted. R4 stated that R16 did not understand No and would still persist in initiating sex. R4 stated (R16) eventually stopped coming around and moved on to hanging around with (R15). On 11/4/21 at 10:00am V11 (SSD) stated that R15 is very private and very passive and doesn't want to get anyone into trouble. On 11/8/21 at 9:20am V22 (LPN) stated that in the evening of (10/26/21), she received a phone call from R2 who stated that R7 told R2 that R16 said or did something inappropriate with R15 (R7's roommate). V22 stated she interviewed both R15 and R16 at that time - and both denied anything inappropriate - however did not interview R7 who made the allegation and was a witness. V22 did not report R7's concerns about R16 to a supervisor or the administrator and an investigation was not initiated until the next day when R7 again reported R7's concerns to V16 (Therapist.) On 11/5/21 at 10:00am V1 (Administrator) stated V22 (LPN) should have reported the allegations to V2 (Director of Nurses/DON) or to her (on 10/26/21.) 3) On 11/8/21 at 9:15am V22 (LPN) stated that R14 has V23 (CNA's/Certified Nurse Assistant) personal cell phone number and stated (R14) shouldn't have his personal number. He's an employee here and (R14) is a resident. V22 stated V23 works the night shift, only works the other unit but comes over there to see R14 when he's working. V22 stated V23 goes into R14's room and shuts the door for like 15- 20 minutes. V22 stated They're not supposed to be friends. (V23) brings (R14) food and clothes. I told the previous administrator and (V2 DON) - they said they spoke with (V23) and he's not supposed to go into (R14's) room when he's at work, but he still does. I tell him he's not supposed to be in there, but he still does it anyway. This has been going on for about three months. V22 stated that she and R14 are related and has spoken to R14 about V23, and R14 stated that R14 loves V23 and wants to marry him. V22 stated that R14 denies any intimate or sexual relationship and she has never seen them in any type of sexual act But I think it's possible. V22 stated that V25 didn't always take things seriously and tended to blow things off. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/8/21 at 9:30am V2 stated that she was present during a meeting (a few months ago) that V25 had with V23 regarding R14. V2 stated that V23 was told if he wanted to visit R14 he couldn't visit while he was working and when not working has to be identified as any other visitor. V2 stated that she was unaware that V23 was still visiting R14 during working hours. V2 stated that V22 should have reported her concerns about V23 still visiting R14 during working hours. V2 stated If someone would've done an investigation, that would've been V25 - not me. No investigation into the allegations of a sexual relationship between V23 (CNA) and R14 was initiated until 10/29/21. On 11/8/21 at 9:30am V1 stated that the previous administrator should have investigated and reported the allegations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30312 Based on observation, interview, and record review the facility failed to immediately report allegations of sexual abuse to the Abuse Coordinator and to the State Agency. This failure affects four residents (R14, R15, R16, R17) of eight residents reviewed for abuse. The facility also failed to report a final abuse investigation within five working days which affected two of eight residents (R1, R4) reviewed for abuse in a sample of 32. Findings include: Facility Policy/Abuse Prevention and Reporting dated/revised 1/22/19 documents: Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. External Reporting/Initial Reporting of Allegations: When an allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property has occurred, the resident's representative and the State Agency shall be informed by telephone or fax. All allegations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property are to be reported immediately, but not later than two hours after the allegation is made. Informing Law Enforcement: The facility shall also contact local law enforcement authorities in the following situations: Sexual abuse of a resident by a staff member, another resident, or a visitor. Current Physician Orders indicate R16 was admitted to the facility on [DATE] with diagnoses that include Bipolar Disorder, HIV (Human Immunodeficiency Virus), Viral hepatitis C and PTSD (Post Traumatic Stress Disorder). Comprehensive assessment dated [DATE] indicates R16 is cognitively intact, understands and is understood. Current Physician Orders indicate R17 was admitted to the facility on [DATE] with diagnoses that include Seizure Disorder, Schizophrenia and Anxiety Disorder. Current Comprehensive Assessment indicates R17 is mildly cognitively impaired. Progress Note dated 9/30/21 indicates R17 was transferred to the hospital on that date and did not return to the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Criminal History Analysis Report dated 10/25/21 indicates R16 was identified as a Moderate Risk - the resident requires closer supervision and more frequent observation than standard or may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient. Report indicates the following specific considerations were important in arriving at the above recommendations: (R16) criminal history consisted of convictions for possession of drug paraphernalia. prostitution - several times, criminal trespass to land, possession of stolen vehicles - twice, resisting arrest. Report indicates R16 is diagnosed with both psychiatric and medical disorders. Report further indicates Nursing facility staff stated that R16 has inappropriately fondled a male resident and made several attempts to obtain sexual favors for money with him. In view of R16's inappropriate behavior with a male resident and psychiatric condition, R16 is a moderate risk and supervision status is recommended. Written Statement by V11 (SSD) dated 11/3/21 is documented as follows: (R17) talked to me about (R16) asking for (R17) cigarettes and that (R16) offered (R17) 'sex for cigarettes' I discussed how to decline/stay away from (R16). (R17) expressed (R17) was comfortable telling (R16) 'No.' I provided suggestions to let staff know if (R16) did not stop asking when (R17) said 'No.' (R17) stated R17 was not afraid of (R16) or anyone else. On 11/4/21 at 12:51pm V19, State Identified Offender Program Manager stated V26 (Investigator) conducted the interview with V11 (SSD) and R16 via a video meeting on 9/30/21. V19 stated no other staff contributed to the meeting or the information - V11 was the only staff who provided information to V19. V19 stated that V11 (SSD) provided information to V26 (Investigator) that R16 had displayed inappropriate sexual behavior, including propositioning male residents with sex in exchange for money since admit to the facility on [DATE]. V19 stated that V26 requested the incident reports/investigations from the facility regarding R16's behavior and never received any reports or follow up from V11. Care Plan (date initiated 10/29/21) indicates R16 has a psychosocial wellbeing problem and that R16 reported feeling lonely which has led R16 to have episodes of socially inappropriate behavior - at times sexual in nature. On 11/8/21 at 9:30am V11 (SSD) stated that it was actually R17 who told her that R16 had been offering R17 sex for money and/or cigarettes - not staff. V11 acknowledged that she updated R17's care plan on 9/19/21 and it may have been due to R17's allegations regarding R16. V11 stated that she updated R16's care plan on 10/4/21 in response to R17's allegations and stated, I just didn't get around to it until then. V11 stated that R17 was mildly cognitively impaired and at increased risk of abuse. V11 stated that R17 may not have an official diagnosis of being intellectually disabled, however seemed like (R17) was by the way (R17) acted and spoke. On 11/8/21 at 9:10 V22 (LPN/Licensed Practical Nurse) stated that she had been told by R17 that R17 had been offered sex by R16, but R17 said No. On 11/4/21 R30 reported R16 would beg for food and cigarettes and offer sex for money to other residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/21 V1 (Administrator) acknowledged V11 (SSD) was aware of R16 propositioning R17 sex for money. V1 stated that she asked other staff and they also were aware of R16's behavior. V1 stated these allegations and behaviors should have been reported and investigated immediately. No investigation or reporting to the state agency or law enforcement was done until 10/29/21 involving R16 and R17. 2) Current Physician Orders indicates R15 was admitted to the facility on [DATE] with diagnoses that include Schizophrenia and age-related Osteoporosis. Current Comprehensive Assessment indicates R15 is cognitively intact and make needs known. Abuse Investigation Report dated 10/27/21 indicates on 10/27/21 at approximately 9am, R7 reported to a nurse that R7 saw another resident (R16) in bed with R7's roommate (R15). On 10/29/21 at 2:53pm R7 stated that R16 had been coming into their room for several days and (on 10/26/21) R16 was on top of R15 in R15's bed and R15 was saying No. R7 stated that R7 also saw R16 hold R15 up against the wall, trying to kiss R15. R7 stated that R7 is afraid of R16 and doesn't want R16 in their room. R7 stated that R7 reported the concerns to V16 (Therapist) the next day. On 11/3/21 at 3pm V16 (Therapist) stated that R7 told her early on 10/27/21 that the night before R16 came into their room and got into R15's bed and was trying to hump R15 for 20 minutes while R15 was sleeping. V16 stated that R7 told her R7 was scared. V16 stated that she immediately told R15's nurse. V16 stated that later that day R16 was moved to the other side of the facility. On 11/4/21 at 4:15pm R30 stated R30 saw R15 and R16 out on the patio smoking. R30 stated that R30 told R16 to leave R15 alone because R16 would try to be inappropriate with R15 and wouldn't leave R15 alone. On 11/4/21 at 3:45pm R4 stated that R4 had been in a consensual relationship with R16, however R16 did not have boundaries and wanted more of a sexual relationship than R4 wanted. R4 stated that R16 did not understand No and will still persist in initiating sex. R4 stated that eventually R16 moved on to R15. On 11/4/21 at 10:00am V11 (SSD) stated that R15 is very private and very passive and doesn't want to get anyone into trouble. On 11/8/21 at 9:20am V22 (LPN) stated that in the evening of (10/26/21), she received a phone call from R2 who stated that R7 told R2 that R16 said or did something inappropriate with R15 (R7's roommate). V22 stated she interviewed both R15 and R16 at that time - and both denied anything inappropriate. However, did not interview R7 who made the allegation and was a witness. V22 did not report R7's concerns about R16 to a supervisor or the administrator and an internal investigation was not initiated until the next day when R7 again reported R7's concerns to V16 (Therapist.) On 11/5/21 at 10:00am V1 (Administrator) stated V22 (LPN) should have reported the allegations to V2 (Director of Nurses/DON) or to her (on 10/26/21). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 11/8/21 at 9:15am V22 (LPN) stated that R14 has V23 (CNA's/Certified Nurse Assistant) personal cell phone number and stated (R14) shouldn't have his personal number. He's an employee here and (R14) is a resident. V22 stated V23 works the night shift, only works the other unit but comes over here to see R14 when he's working. V22 stated V23 goes into R14's room and shuts the door for like 15- 20 minutes. V22 stated They're not supposed to be friends. (V23) brings R14 food and clothes. I told the previous administrator and (V2 DON) - they said they spoke with (V23) and he's not supposed to go into (R14's) room when he's at work, but he still does. I tell him he's not supposed to be in there, but he still does it anyway. This has been going on for about three months. V22 stated that her and R14 are related and has spoken to R14 about V23, and R14 stated that R14 loves V23 and wants to marry him. V22 stated that R14 denies any intimate or sexual relationship and she has never seen them in any type of sexual act But I think it's possible. V22 stated that V25 didn't always take things seriously and tended to blow things off. On 11/8/21 at 9:30am V2 stated that she was present during a meeting (a few months ago) that V25 had with V23 regarding R14. V2 stated that V23 was told if he wanted to visit R14 he couldn't visit while he was working and when not working has to be identified as any other visitor. V2 stated that she was unaware that V23 was still visiting R14 during working hours. V2 stated that V22 should have reported her concerns to V1. V2 stated If someone would've done an investigation, that would've been V25 - not me. No investigation or reporting to the State Agency of the allegation of a sexual relationship between V23(CNA) and R14 was initiated until 10/29/21. On 11/8/21 at 9:30am V1 stated that the previous administrator should have investigated and reported the allegations. 4) An Abuse Prevention and Reporting policy dated as revised 1/22/19 documents, The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working day of the reported incident. and The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the (State Agency) within five working days of the reported incident. R1 and R4's initial abuse investigation documents that on 10/12/21 an allegation of physical abuse occurred between R4 and R1 which was reported to the State Agency. This investigation also documents that the final written report of the results of the investigation was not sent to the State Agency until 10/22/21, eight working days after the incident. On 11/4/21 at 11:00a.m. V1 (Administrator) verified that an allegation of physical abuse between R4 and R1 was reported, and the initial investigation began on 10/12/21. V1 also verified that the final written report for this abuse investigation was not sent to the State Agency until 10/22/21, which is not within the required five working days.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Noncompliance resulted in two deficient practice statements. A. Based on interview and record review the facility failed to immediately investigate and protect residents from sexual propositions by R16 for money and cigarettes. Prior to 9/30/21, R17 reported to V11 (Social Service Director) that R16 had offered sex in exchange for money and/or cigarettes. This allegation was not investigated until 10/29/21 allowing R16 to remain unsupervised with full access to all residential areas within the facility. These failures have the potential to affect all 82 residents in the facility. These failures resulted in an Immediate Jeopardy being called on 11/23/21 at 1:20pm. While the immediacy was removed on 11/24/21 at 12:05pm the facility remains out of compliance at Severity Level 2, as the facility continues to educate all staff on identifying, reporting and protection of residents regarding sexual abuse. B. Based on interview and record review the facility failed to conduct a timely investigation of an allegation of sexual abuse by a staff member to a resident for 1of 5 residents (R14) reviewed for sexual abuse of a resident by a staff member. A. Findings include: Facility Policy/Abuse Prevention and Reporting dated/revised 1/22/19 documents: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. The facility will conduct an investigation and protect the resident from non-consensual sexual relations anytime the facility has reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Protection of Residents: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. Internal Investigation: All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or documents. Resident Room Roster dated 10/29/21 indicates 82 residents in the facility. Current Physician Orders indicate R16 was admitted to the facility on [DATE] with diagnoses that include Bipolar Disorder, HIV (Human Immunodeficiency Virus), Viral hepatitis C and PTSD (Post Traumatic Stress Disorder). Comprehensive assessment dated [DATE] indicates R16 is cognitively intact, understands, is understood and is independently mobile. Per (R16's guidelines) implemented on 10/29/21, R16 had access to the entire facility including the smoking area prior to 10/29/21. Current Physician Orders indicate R17 was admitted to the facility on [DATE] with diagnoses that include Seizure Disorder, Schizophrenia and Anxiety Disorder. Current Comprehensive Assessment indicates R17 is mildly cognitively impaired. Progress Note dated 9/30/21 indicates R17 was transferred to the hospital on that date and did not return to the facility. Criminal History Analysis Report dated 10/25/21 indicates R16 was identified as a Moderate Risk - the resident requires closer supervision and more frequent observation than standard or may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient. Report indicates the following specific considerations were important in arriving at the above recommendations: (R16) criminal history consisted of convictions for possession of drug paraphernalia. prostitution - several times, criminal trespass to land, possession of stolen vehicles - twice, resisting arrest. Report indicates R16 is diagnosed with both psychiatric and medical disorders. Report further indicates Nursing facility staff stated that R16 has inappropriately fondled a male resident and made several attempts to obtain sexual favors for money with him. In view of R16's inappropriate behavior with a male resident and psychiatric condition, R16 is a moderate risk and supervision status is recommended. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Written Statement by V11 (SSD) dated 11/3/21 is documented as follows: (R17) talked to me about (R16) asking for (R17) cigarettes and that (R16) offered (R17) 'sex for cigarettes' I discussed how to decline/stay away from (R16). (R17) expressed (R17) was comfortable telling (R16) 'No.' I provided suggestions to let staff know if (R16) did not stop asking when (R17) said 'No.' (R17) stated R17 was not afraid of (R16) or anyone else. On 11/4/21 at 9:45am V11 (SSD) stated that V26 (State Identified Offender Investigator) held a video meeting (on 9/30/21) regarding R16. V11 stated that V26 interviews her then interviews R16 and that no one else participated. V11 stated that she was aware of R16 propositioning other residents - sex for money and that's why she put it on R16's care plan (on 10/4/21). V11 stated - at that time - staff told her about R16's behavior and that it involved R17. V11 stated that she did report R16's behavior to V25 (previous Administrator). On 11/4/21 at 12:51pm V19 (State Identified Offender Program Manager) stated V26 (Investigator) conducted the interview with V11 (SSD) and R16 via a video meeting on 9/30/21. V19 stated no other staff contributed to the meeting or the information - V11 was the only staff who provided information to V19. V19 stated that V11 (SSD) provided information to V26 (Investigator) that R16 had displayed inappropriate sexual behavior, including propositioning male residents with sex in exchange for money since admit to the facility on [DATE]. V19 stated V26 requested the incident reports/investigations from the facility regarding R16's behavior and never received any reports or follow up from V11. On 11/8/21 at 9:30am V11 (SSD) stated that it was actually R17 who told her that R16 had been offering R17 sex for money and/or cigarettes - not staff. V11 acknowledged that she updated R17's care plan on 9/19/21 and it may have been due to R17's allegations regarding R16. V11 stated that she updated R16's care plan on 10/4/21 in response to R17's allegations and stated, I just didn't get around to it until then. V11 stated that R17 was mildly cognitively impaired and at increased risk of abuse. V11 stated that R17 may not have an official diagnosis of being intellectually disabled, however seemed like (R17) was by the way (R17) acted and spoke. On 11/8/21 at 9:10 V22 (Licensed Practical Nurse/LPN) stated that she had been told by R17 that R17 had been offered sex by R16, but R17 said No. On 11/4/21 R30 reported R16 would beg for food and cigarettes and offer sex for money to other residents. No investigation or prevention of further inappropriate sexual behavior by R16 was done until 10/29/21 involving R16 and R17. No documentation of any of the known behaviors by R16 were documented in R16 or R17's medical record. On 10/29/21 at 4:15pm V1 (Administrator) stated that she was unaware of R16's behaviors of propositioning residents with sex for money or any allegations made by R17 until (10/29/21) and that the allegations should have been investigated, including interventions to protect other residents - immediately. (continued on next page)

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	145811	A. Building B. Wing	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peoria Heights	1629 East Gardner Lane Peoria Heights, IL 61616

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Current Medication Administration Record indicates R16 was not placed on hourly checks until 10/28/21 and was not placed on 15-minute checks until 10/29/21. 2) Current Physician Orders indicates R15 was admitted to the facility on [DATE] with diagnoses that include Schizophrenia and age-related Osteoporosis. Current Comprehensive Assessment indicates R15 is cognitively intact and make needs known. Abuse Investigation Report dated 10/27/21 indicates on 10/27/21 at approximately 9am, R7 reported to a nurse that R7 saw another resident (R16) in bed with R7's roommate (R15). On 10/29/21 at 2:53pm R7 stated that R16 had been coming into their room for several days and (on 10/26/21) R16 was on top of R15 in R15's bed and R15 was saying No. R7 stated that R7 also saw R16 hold R15 up against the wall, trying to kiss R15. R7 stated that R7 is afraid of R16 and doesn't want R16 in their room. R7 stated that R7 reported the concerns to V16 (Therapist) the next day. On 11/3/21 at 3pm V16 (Therapist) stated that R7 told her early on 10/27/21 that R16 came into their room last night, got into R15's bed and was trying to hump R15 for 20 minutes while R15 was sleeping. V16 stated that R7 told her R7 was scared. V16 stated that she immediately told R15's nurse. V16 stated that later that day R16 was moved to the other side of the facility. No interview of V16 was found in the investigation report. On 11/4/21 at 4:15pm R30 stated R30 saw R15 and R16 out on the patio smoking. R30 stated that R30 told R16 to leave R15 alone because R16 would try to be inappropriate with R15 and wouldn't leave R15 alone. On 11/4/21 at 3:45pm R4 stated that R4 had been in a consensual relationship with R16, however R16 did not have boundaries and wanted more of a sexual relationship than R4 wanted. R4 stated that R16 did not understand No and would still persist in initiating sex. R4 stated that eventually R16 moved on to R15. On 11/4/21 at 10:00am V11 (SSD) stated that R15 is very private and very passive and doesn't want to get anyone into trouble. On 11/8/21 at 9:20am V22 (LPN) stated that in the evening of (10/26/21), she received a phone call from R2 who stated that R7 told R2 that R16 said or did something inappropriate with R15 (R7's roommate). V22 stated she interviewed both R15 and R16 at that time - and both denied anything inappropriate - however did not interview R7 who made the allegation and was a witness. V22 did not immediately report R7's concerns about R16 to a supervisor or to the administrator and an investigation was not initiated until the next day when R7 again reported R7's concerns to V16 (Therapist.) R16 was not moved to the other side of the building (away from R15) until the afternoon of 10/27/21. On 10/29/21 R15 refused to answer any and all questions regarding R16. At that time V1 (Interim Administrator) stated that R15 also refused to speak to the police and insisted nothing happened and that R16 was her friend. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Current Medication Administration Record indicates R16 was not placed on hourly checks until 10/28/21 and was not placed on 15-minute checks until 10/29/21. The Immediate Jeopardy was identified to have begun on 9/30/21 when R16 was known to have propositioned R17 with sex for money and/or cigarettes, known to have a history of criminal prostitution and known to have diagnoses of HIV (Human Immunodeficiency Virus) and Hepatitis C. The facility failed to initiate an investigation until 10/29/21. V1 (Administrator) was notified of the Immediate Jeopardy on 11/23/21 at 1:20pm. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. Corporate Nurse Consultant/RN (Registered Nurse) educated all staff during an in-service after initiation of an extended survey when substandard quality of care was identified. The education included how to recognize sexual abuse and the facility's protocol to prevent abuse of residents - training included indicators of abuse. This training will be ongoing. All staff hired after 11/5/21 or on leave/vacation were educated by the Human Resources Director on 11/5/21. 2. On 11/5/21 All interviewable residents were interviewed to ensure they were not experiencing sexual abuse. 3. On 10/28/21 R16 was placed into a private room. 4. On 10/29/21 R16 was placed on 15-minute checks when in R16's room and remains on 15-minute checks. R16 was also provided scheduled smoking times/location (which is separate from general smoking area) and staff accompany R16 when out of R16's room. 5. On 10/28/21 Social Service Director, Director of Nursing and V1(Administrator) met with R16 and reviewed written guidelines of smoking times and monitoring by staff when out of R16's room. At that time, R16 signed a written agreement of the guidelines. 6. On 11/23/21 All residents identified as having the potential to be sexually active will be educated on safe sex practices. 7. On 10/27/21 Physician's Assistant educated R16 on R16's diagnoses of HIV and Hepatitis C as well as safe sex practices. Physician Assistant also educated R16 on the importance of responsibly notifying any potential sexual partner of R16's HIV status. 8. On 10/27/21 R16 was started on a new medication (antidepressant) to decrease R16's sexual urges. This was confirmed through review of the Physician's orders and the Medication Administration Record. 9. R16 was found to be compliant with the anti-viral medication R16 has received for HIV since admission. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	10. Social Service Director will discuss and re-educate R16 on safe sex practices on a regular basis. 11. Random audits will be conducted by the Administrator /Designee regarding resident concerns, psychosocial needs. Results of audits will be reviewed by Quality Assurance committee for a minimum of 12 weeks. 12. On 11/24/21 R16 was interviewed and observed to be in a private room and visible from the nurses' station. R16 stated that staff do monitor R16 when out of R16's room. Social Service Director was observed accompanying R16 to a psychosocial group. 13. Any residents that R16 may have had intimate/sexual contact with will be offered confidential STD (Sexually Transmitted Disease) testing - initiated on 11/23/21. 14. Any resident that may have had intimate/sexual contact that are no longer residing at the facility will be notified they may have been exposed to HIV and will be offered testing - initiated on 11/23/21. 15. All residents will have abuse/neglect risk screening completed. All high-risk residents will have care plan and interventions updated - initiated on 11/5/21. B) Findings include: On 11/8/21 at 9:15am V22 (LPN) stated that R14 has V23 (CNA's/Certified Nurse Assistant) personal cell phone number and stated (R14) shouldn't have his personal number. He's an employee here and (R14) is a resident. V22 stated V23 works the night shift, only works the other unit but comes over there to see R14 when he's working. V22 stated V23 goes into R14's room and shuts the door for like 15- 20 minutes. V22 stated They're not supposed to be friends. (V23) brings (R14) food and clothes. I told the previous administrator and (V2 DON) - they said they spoke with (V23) and he's not supposed to go into (R14's) room when he's at work, but he still does. I tell him he's not supposed to be in there, but he still does it anyway. This has been going on for about three months. V22 stated that she and R14 are related and has spoken to R14 about V23, and R14 stated that R14 loves V23 and wants to marry him. V22 stated that R14 denies any intimate or sexual relationship and she has never seen them in any type of sexual act But I think it's possible. V22 stated that V25 didn't always take things seriously and tended to blow things off. On 11/8/21 at 9:30am V2 stated that she was present during a meeting (a few months ago) that V25 had with V23 regarding R14. V2 stated that V23 was told if he wanted to visit R14 he couldn't visit while he was working and when not working has to be identified as any other visitor. V2 stated that she was unaware that V23 was still visiting R14 during working hours. V2 stated that V22 should have reported her concerns about V23 still visiting R14 during working hours. V2 stated If someone would've done an investigation, that would've been V25 - not me. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	No investigation into the allegations of a sexual relationship between V23 (CNA) and R14 was initiated until 10/29/21. Prevention of potential further abuse to R14 or other residents was not addressed until 10/29/21 when V23 was suspended. On 11/8/21 at 9:30am V1 (Administrator) stated that the previous administrator should have investigated and reported the allegations, including suspending V23 when the allegations were first reported.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30312 Based on interview and record review the facility failed to provide documentation by a physician with the basis of a resident's involuntary transfer/discharge with indications for why a resident should not return to the facility or what resident needs could not be met at the facility and failed to provide evidence the facility's refusal to readmit a resident was not based on the resident's status at the time of transfer. These failures affected one of three residents (R1) reviewed for involuntary discharge in a sample of 32. Findings include: A Notice of Transfer and Discharge policy dated as revised 8/6/20 states, Prior to discharge or transfer the facility will: Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. The policy also states, Record the reasons for the transfer or discharge in the resident's medical record, and The facility will not transfer or discharge the resident while the appeal is pending, or when a resident exercises his or her right to appeal a transfer or discharge notice from the facility unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The danger that failure to transfer or discharge would pose will be documented in the clinical record. This policy does not include criteria for physician documentation when a resident's involuntary discharge occurs or what documentation should be included when the facility is unable to meet a resident's needs. A Bed Hold and Return to Facility policy dated as revised 9/16/17 gives its purpose as including, conditions for return to facility upon admission and at time of a transfer from the facility. This policy states, The facility's bed-hold policies apply to all residents. In addition, this policy states, Residents whose hospitalization or therapeutic leave exceeds the bed-hold period may return to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services; and (C) The facility is able to meet the needs of the resident. R1's list of current diagnoses include Major Depressive Disorder, Anxiety Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Insomnia. The Facility assessment dated [DATE] documents that the facility can accept residents with diagnoses profiles including Psychiatric/Mood disorders. This same assessment documents under the heading of Psychiatric Mood/ Disorders, We utilize a Psychiatric consultant which sends a (Social Worker) and NP (Nurse Practitioner) who assist the staff and medical director with resident's who have behavioral needs. R1's current care plan documents R1, Is at risk for abuse/neglect (related to) delusional thinking. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Social Services notes documented by V11 (Social Services Director) dated 10/13/21 document that R1 was transferred emergently to the hospital on that date after exhibiting the behaviors of yelling, cursing, threatening, name calling, and delusions. R1's facility progress notes dated 10/2/21 to 10/13/21, from R1's admission to discharge, includes only two physician progress notes, one dated 10/6/21 and the other dated 10/9/21. Neither physician's progress notes document why R1 needed emergent admission to the hospital, what specific needs for R1 that the facility cannot meet, what efforts the facility has made to meet those needs, what specific services are available elsewhere that cannot be met at the facility. R1's hospital Interdisciplinary Team (IDT) meeting notes dated 11/1/21 document that R1's principal problem is Psychosis in Elderly. These same notes document that on 10/25/21, (R1) is ready for discharge; writer will contact (the Facility) as (R1) has not received an involuntary discharge from the facility. R1's IDT notes also document that on 10/28/21 R1 was still at the hospital because, Discharge is pending placement. These same notes document as of 11/1/21, (R1) will be discharged on ce placement is found. On 10/27/21 at 2:24p.m. V7 (Ombudsman) stated that R1 is not being allowed to return to the Facility despite being ready to discharge from the hospital. V7 stated that V1 (Administrator) told V7 she would not readmit R1 back into the facility. V7 stated that if the resident is ready for discharge from the hospital and the Facility will not take R1 back, that is considered an involuntary discharge. V7 stated that the facility would need to provide specific documentation on what measures they attempted and what needs they cannot meet before they can issue an involuntary discharge. V7 stated the facility would need to provide a notice of discharge to R1 and the Ombudsman's office with information on how R1 can appeal the involuntary discharge. V7 stated these measures are in place to protect residents from being inappropriately discharged from long-term care facilities. V7 stated that the Facility has not provided a notice of discharge to the Ombudsman office and has not provided documentation for why the facility can no longer meet R1's needs. On 10/27/21 at 9:30a.m. and at 12:55p.m. V1 stated that R1 cannot return to the facility until R1's mental status is stabilized. V1 stated that the facility does not have the services R1 needs in R1's current condition. V1 stated that V6 (Admissions) sends her regular updates on R1's condition while R1 is admitted to the hospital. V1 stated that based on R1's hospital notes, R1 is not suitable to come back to the facility despite R1's hospital IDT notes recommending discharge back to the facility. V1 stated that neither the facility Medical Director, and no other facility physician or physician's surrogate has reviewed R1's circumstances for being emergently admitted to the hospital, R1's hospital treatment plan, or current condition/ behaviors to determine whether R1 is appropriate to return to the facility. V1 stated the facility has provided the hospital with a referral to another facility that is more suited to R1's psychiatric needs but V1 did not specify R1's needs that can't be met at V1's facility that this other facility can meet. On 11/1/21 at 9:11a.m. V13 (Hospital Social Worker) stated that R1 was involuntarily admitted to the hospital on 10/13/21 because of behavioral problems R1 had on that date. V13 stated that R1's behaviors are now in stable condition and R1 is ready for discharge back to the facility, however, the facility is refusing to take R1 back. V13 stated she has discussed R1's readiness for discharge with the facility several times but the facility has refused R1's readmission each time. V13 stated that if the hospital physician has deemed R1 ready for discharge but the facility will not accept R1 back, that is an involuntary discharge. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/21 at 11:00a.m. V11 (Social Services Director) stated that after R1 was emergently admitted to the hospital on 10/13/21 V11, V1 and V2 (Director of Nurses) had a meeting to discuss R1's situation. V11 stated that during that meeting, V1, V2 and V11 determined that R1 would not be allowed to return to the facility.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 30312 Based on interview and record review the facility failed to provide a written notice of discharge to a facility-initiated hospitalized resident and the Office of State Long-Term Care Ombudsman after refusing to readmit that resident for one of three residents (R1) reviewed for notice of discharge in a sample of 32. Findings include: A Notice of Transfer and Discharge policy dated as revised 8/6/20 states, Prior to discharge or transfer, the facility will: Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. This policy also states, Written notice of transfer or discharge will contain the following: The reason for the transfer; The effective date of transfer or discharge; The location to which the resident is transferred or discharged ; The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. In addition, this policy documents that regarding the timing of the notice, Notice must be made as soon as practicable before transfer or discharge when-The safety of individuals in the facility would be endangered, or The health of the individual s in the facility would be endangered, and An immediate transfer or discharge is required by the resident's urgent medical needs. R1's list of current diagnoses include Major Depressive Disorder, Anxiety Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Insomnia. R1's care plan documents R1, Is at risk for abuse/neglect (related to) delusional thinking. R1's Social Services notes documented by V11 (Social Services Director) dated 10/13/21 document that R1 was transferred emergently to the hospital on that date after exhibiting the behaviors of yelling, cursing, threatening, name calling, and delusions. R1's hospital Interdisciplinary Team (IDT) meeting notes dated 11/1/21 document that R1's principal problem is Psychosis in Elderly. These same notes document that on 10/25/21, (R1) is ready for discharge; writer will contact (the Facility) as (R1) has not received an involuntary discharge from the facility. R1's IDT notes also document that on 10/28/21 R1 was still at the hospital because, Discharge is pending placement. These same notes document as of 11/1/21, (R1) will be discharged on ce placement is found. On 10/27/21 at 2:24p.m. V7 (Ombudsman) stated that R1 is not being allowed to return to the Facility despite being ready to discharge from the hospital. V7 stated the Facility wants R1 to transfer to another facility over 130 miles away. V7 stated that she has not received a notice of involuntary discharge from the facility which would allow R1 to appeal the discharge and return to the facility pending results of the appeal. V7 stated she called the facility to give instructions on how an involuntary discharge should be conducted including sending a written notice of discharge but stated, I didn't get anywhere with that. V7 stated that V1 (Administrator) told V7 she would not readmit R1 back into the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/27/21 at 9:30a.m. and 11/1/21 at 1:00p.m. V1 verified that the facility did not issue R1 or the State Long-Term Care Ombudsman a written notice of discharge. V1 stated that despite refusing the hospital's request for R1's readmission multiple times, V1 doesn't consider R1 officially discharged from the facility yet. V1 also verified that the facility offered the hospital a referral for R1 to transfer to a different long-term care facility over 130 miles away. On 11/1/21 at 9:11a.m. V13 (Hospital Social Worker) stated that R1 was involuntarily admitted to the hospital on 10/13/21 because of behaviors R1 had while at the long-term care facility. V13 stated that R1 is ready for discharge but the facility R1 came from is refusing to take R1 back. V13 stated that the facility did not issue R1 a notice of discharge so that R1 could file an appeal. V13 stated she spoke to the facility and asked them to send her R1's involuntary discharge paperwork. V13 stated the facility did not respond to her request.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 30312 Based on interview and record review the facility failed to issue a notice of bed hold at the time of a resident transfer for one of three residents (R1) reviewed for notice of bed-hold in a sample of 32. Findings include: A Bed Hold and Return to Facility policy dated as revised 9/16/17 gives as its purpose, To ensure that residents and/or resident representatives are notified of the facility bed-hold policy and conditions for return to facility upon admission and at the time of a transfer from the facility. This policy also documents, The facility's bed-hold policies apply to all residents, and In cases of emergency transfer, notice 'at the time of transfer' means that the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. R1's Social Services notes documented by V11 (Social Services Director) dated 10/13/21 document that R1 was transferred emergently to the hospital on that date after exhibiting the behaviors of yelling, cursing, threatening, name calling, and delusions. R1's electronic medical record does not document R1 or R1's representative was provided the Facility's bed-hold policy at the time of transfer or within 24 hours. On 11/1/21 at 1:00p.m. V1(Administrator) stated that not all residents who transfer to the hospital receive bed-hold information because of their payor source. V1 (Administrator) stated that because of R1's payor source, R1 was not given a bed-hold policy at the time of transfer or within 24 hours of R1's emergent hospital admission as is specified in the Facility bed-hold policy.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peoria Heights	1629 East Gardner Lane Peoria Heights, IL 61616

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 30312 Based on observation, interview, and record review the facility failed to allow a hospitalized resident to return to the facility after physician's recommendation for discharge for one of three residents (R1) reviewed for readmissions in a sample of 32. Findings include: A Bed Hold and Return to Facility policy dated as revised 9/16/17 gives its purpose as including, conditions for return to facility upon admission and at time of a transfer from the facility. This policy states, The facility's bed-hold policies apply to all residents. In addition, this policy states, Residents whose hospitalization or therapeutic leave exceeds the bed-hold period may return to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services; and (C) The facility is able to meet the needs of the resident. R1's list of current diagnoses include Major Depressive Disorder, Anxiety Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Insomnia. R1's care plan documents R1, Is at risk for abuse/neglect (related to) delusional thinking. R1's Social Services notes documented by V11 (Social Services Director) dated 10/13/21 document that R1 was transferred emergently to the hospital on that date after exhibiting the behaviors of yelling, cursing, threatening, name calling, and delusions. R1's hospital Interdisciplinary Team (IDT) meeting notes dated 11/1/21 document that R1's principal problem is Psychosis in Elderly. These same notes document that on 10/25/21, (R1) is ready for discharge; writer will contact (the Facility) as (R1) has not received an involuntary discharge from the facility. R1's IDT notes also document that on 10/28/21 R1 was still at the hospital because, Discharge is pending placement. These same notes document as of 11/1/21, (R1) will be discharged on ce placement is found. On 10/27/21 at 2:24p.m. V7 (Ombudsman) stated that R1 is not being allowed to return to the Facility despite being ready to discharge from the hospital. V7 stated that V1 (Administrator) told V7 she would not readmit R1 back into the facility. V7 stated that if the resident is ready for discharge from the hospital and the Facility will not take R1 back, that is considered an involuntary discharge. V7 stated that the facility would need to provide specific documentation on what measures they attempted and what needs they cannot meet before they can issue an involuntary discharge. V7 stated the facility would need to provide a notice of discharge to R1 and the Ombudsman's office with information on how R1 can appeal the involuntary discharge. V7 stated these measures are in place to protect residents from being inappropriately discharged from long-term care facilities. V7 stated that the Facility has not provided a notice of discharge to herself or to R1 and has not provided documentation for why the facility can no longer meet R1's needs. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/27/21 at 9:30a.m. and at 12:55p.m. V1 (Administrator) stated that R1 cannot return to the facility until R1's mental status is stabilized. V1 stated that the facility does not have the services R1 needs in R1's current condition. V1 stated that V6 (Admissions) sends her regular updates on R1's condition while R1 is admitted to the hospital. V1 stated that based on R1's hospital notes, R1 is not suitable to come back to the facility despite R1's hospital IDT notes, which includes a physician's documentation, recommending discharge back to the facility. V1 stated that neither the facility Medical Director, and no other facility physician or physician's surrogate has reviewed R1's circumstances for being emergently admitted to the hospital, R1's hospital treatment plan, or current condition/ behaviors to determine whether R1 is appropriate to return to the facility. V1 stated the facility has provided the hospital with a referral to another facility that is more suited to R1's psychiatric needs but V1 did not specify R1's needs that can't be met at V1's facility that this other facility can meet. On 11/1/21 at 9:11a.m. V13 (Hospital Social Worker) stated that R1 was involuntarily admitted to the hospital on 10/13/21 because of behavioral problems R1 had on that date. V13 stated that R1's behaviors are now in stable condition and R1 is ready for discharge back to the facility, however, the facility is refusing to take R1 back. V13 stated she has discussed R1's readiness for discharge with the facility several times but the facility has refused R1's readmission each time. V13 stated that if the hospital physician has deemed R1 ready for discharge but the facility will not accept R1 back, that is an involuntary discharge. On 11/1/21 at 11:00a.m. V11 (Social Services Director) stated that after R1 was emergently admitted to the hospital on 10/13/21 V11, V1 and V2 (Director of Nurses) had a meeting to discuss R1's situation. V11 stated that during that meeting, V1, V2 and V11 determined that R1 would not be allowed to return to the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30312 Based on observation, interview, and record review the facility failed to ensure residents were provided with two showers per week for three of four residents (R18, R19, R22) reviewed for showers in a sample of 32. Findings include: A Bathing-Shower and Tub Bath policy dated 11/28/12 gives as its purpose, To ensure resident's cleanliness to maintain proper hygiene and dignity. This policy also states, A shower, tub bath or bed/sponge bath will be offered according to resident's preference two times per week or according to the resident' preferred frequency and as needed or requested. 1. R19's list of current Diagnoses includes Ataxia, Radiculopathy of Lumbar Region, Lack of Coordination, Vascular Dementia, Unsteadiness on Feet. R19's Physician's Orders Sheet dated 2/7/21 documents that R19 requires 24-hour nursing care. R19's Minimum Data Set (MDS) assessment dated [DATE] documents that R19 requires extensive assistance for personal hygiene and that R19 did not receive a shower during the seven day look back period for this assessment. R19's current care plan states that R19 needs assistance to complete Activities of Daily Living including personal hygiene and bathing. R19's Bathing documentation dated 10/2/21 to 10/31/21 documents that during the last 30 days R19 has received only two showers which occurred on 10/11/21 and 10/16/21. On 11/1/21 at 10:30a.m. V14 (Certified Nurse Aide/CNA) was seated at the nursing desk. V14 stated that R19 was scheduled to receive a shower on that day. V14 stated she was planning to give R19's shower after lunch. On 11/1/21 at 1:30p.m. R19 was seated in R19's room in a wheelchair wearing black sweatpants, a black sweatshirt, a green stocking cap, and a brown coat. R19's fingernails were moderately long with dirt visible under each fingernail on both hands. R19 stated R19 is supposed to receive two showers per week which is also when R19 receives nail care. R19 stated that R19 rarely gets a shower and when R19 does it is only one time per week. R19 stated R19 has not been offered or received a shower in at least two weeks. On 11/1/21 at 2:15p.m. V14 stated she had not given R19 a shower because she ran out of time. V14 stated she would tell the evening CNA to give R19 a shower. V14 stated she believes, It's probably true, that R19 has not received a shower in at least two weeks. On 11/2/21 at 8:45a.m. R19 was seated on the edge of R19's bed with the same sweatpants and sweatshirt on that R19 wore the day before. R19 stated that R19 did not receive a shower yesterday, 11/1/21, by the day, evening or night shift CNA. R19 stated, I need a shower because I stink. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/21 at 1:09p.m. V12 (R19's Family) stated that R19 leaves the facility to visit family about every two weeks. V12 stated that every time R19 visits, R19 is dirty and has not received a shower. V12 stated R19's hair is frequently dirty too. R12 stated that R19's fingernails are not clipped regularly, and the fingernails are always dirty. V12 stated that R19's family spends each of R19's home visits bathing and grooming R19. 2. R18's list of current Diagnoses includes Wernicke's Encephalopathy, Chronic Fatigue, Lack of Coordination, Amnestic Disorder Due to Unknown Physiological Condition. R18's Physician's Orders Sheet dated 10/23/20 documents that R18 requires 24-hour nursing care. R18's Minimum Data Set (MDS) assessment dated [DATE] documents that R18 is severely cognitively impaired, requires supervision and set up for personal hygiene and bathing. R18's current care plan states that R18 needs assistance to complete Activities of Daily Living including personal hygiene and bathing. R18's bathing documentation dated 10/2/21 to 10/31/21 documents that during the last 30 days R18 has received only four showers which occurred on 10/8/21, 10/16/21, 10/22/21, and 10/19/21. On 11/1/21 at 1:09p.m. V12 (R18's Family) stated that R18 leaves the facility to visit family about every two weeks. V12 stated that every time R18 visits, R18 is dirty and has not received a shower. V12 stated that although R18 is more independent than R18's relative, R19, R18 is confused and needs to be instructed to take a shower and needs assistance with that shower. V12 stated that R18's family spends each of R18's home visits bathing and grooming R18. 3. R22's list of current Diagnoses includes Lack of Coordination, Cognitive Communication Deficit, Rhabdomyolysis. R22's Physician's Orders Sheet dated 9/28/21 documents that R22 requires Skilled Nursing Care. R22's Minimum Data Set (MDS) assessment dated [DATE] documents that R22 requires extensive assistance of one person for personal hygiene and that R22 did not receive a shower during the seven day look back period for this assessment. R22's current care plan states that R22 has an Activities of Daily Living self-care performance deficit and requires assistance for bathing/showering including ensuring R22's nails are trimmed and cleaned on bath day and as necessary. R22's Bathing documentation dated 10/2/21 to 10/31/21 documents that during the last 30 days R22 has received only two showers which occurred on 10/18/21 and 10/28/21. On 11/1/21 at 11:00a.m. R22 was seated in a high-backed specialized wheelchair in R22's room. R22's feet had wound dressings in place and were enclosed in pressure relief boots. R22's fingernails were visibly dirty underneath. R22 stated R22 prefers two showers per week and the facility is supposed to offer two showers per week. R22 stated that R22 is usually only offered one shower per week and sometimes is not offered a shower at all. R22 stated R22 could not remember when R22 was given a shower.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34048 Based on observation, interview, and record review the facility failed to complete wound care as ordered for two of three residents (R2, R20) reviewed for pressure ulcers in a sample of 32. Findings include: R2's (Braden) Pressure Ulcer Risk Assessment, dated 8/9/21, documents a score of 11, indicating the R2 is a high risk for pressure ulcers. R2's Wound Evaluation and Management Summary, dated 11/1/21, documents R2's right posterior lower thigh, full thickness wound measuring 4cm (Centimeter) by 7.5cm by 0.3cm. R2's wound to the left posterior thigh measures 1.1cm by 0.5cm by 0.3cm. R2's diabetic wound of the right posterior heel measures 0.2cm by 0.2cm, unable to determine depth. R2's TAR (Treatment Administration Record) dated 9/1/21 through 9/31/21, documents to cleanse left buttock, left lateral knee, left lower posterior thigh, left posterior thigh, right calf, right posterior thigh, with wound cleanser, apply calcium alginate and cover with a bordered dressing every day. This form does not have documentation that R2's wound care was done on 9/11/21, 9/12/21, 9/13/21, 9/22/21 and 9/28/21. R2's TAR (Treatment Administration Record), dated 10/1/21 through 10/31/2021, documents to cleanse the left lower thigh, left posterior thigh, left buttock, right posterior thigh MASD (Moisture Associated Skin Damage) with wound cleanser, pat dry, apply calcium alginate (medicated dressing), and cover with a dry dressing every day. Cleanse right posterior heel with wound cleanser, pat dry, apply triple antibiotic ointment and cover with a dry dressing, every day. This form has no documentation that R's wound care was completed on 10/2/21, 10/8/21, 10/16/21 and 10/17/21. On 11/2/21 at 10:30am, V9 (Wound Care Registered Nurse) assisted R2 to a standing position, R2 had no dressings on her posterior thigh wounds or buttocks, V9 verified that the floor nurse should have been notified after care, so R2's dressings could be replaced. V9 stated that R2 is incontinent at times, and the dressings help protect the wounds. R2's posterior thighs and buttocks were red with sheering like wounds observed. V9 stated that if the treatment is not signed out on the TAR, then the treatment is considered as not being done as ordered. V9 stated that both R2 and R20 are being seen by the wound specialist every week. R20's Braden Pressure Ulcer Risk Assessment, dated 10/11/21, documents a score of 10, indicating that R20 is a high risk for pressure ulcers. R20's Wound Evaluation and Management Summary, dated 10/18/21, documents that R20 has a wound to the right lateral calf, full thickness wound measuring 6cm (centimeters) by 4cm by 0.3cm depth. R20 also has a wound on the right posterior, lateral thigh, full thickness measuring 4cm by 2.5cm by 0.2cm. R20's wound to the left upper medial shin, partial thickness measures 2.8cm by 3.7cm and unable to determine the depth. The right upper medial shin, full thickness wound measures 2.5cm by 1.1cm by 0.3cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's TAR, dated 9/1/21 through 10/27/21, documents to cleanse R20's right calf, right lateral abdomen, right posterior thigh MASD wounds, with wound cleanser, pat dry, apply calcium alginate (medicated dressing), apply an antifungal cream to the peri wound, then cover with a non-bordered foam, daily. Apply a skin protectant to R20's bilateral lower extremities, daily. This form documents that R20's wound care was not signed out as being completed on 9/1/21, 9/6/21, 9/26/21, 10/9/21, and 10/23/21.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30312 Based on interview and record review the facility failed to provide behavioral health care and services and develop individualized interventions to address a residents behavior associated with Schizophrenia, PTSD (Post Traumatic Stress Disorder), and Major Depressive Disorder for one of one resident (R1) reviewed for behavioral health services in a sample of 32. These failures resulted in R1 developing a sudden escalation in behaviors resulting in R1's emergent admission to the hospital. Findings include: R1's hospital physician's progress notes and recapitulation of R1's hospital stay dated 9/24/21, from prior to R1's admission to the facility and obtained from R1's medical records at the facility, documents that R1 has diagnoses to include Anxiety, Bipolar 1 disorder, Depression, Insomnia, PTSD (post-traumatic stress disorder). This progress note documents that R1 was homeless, not taking any medications for his psychiatric conditions, and would, Need to establish Psych care after discharge. This note further documents R1, Will only do what (R1) wants to do. Can be argumentative, and had Disorganized thought processes. A Facility assessment dated [DATE] documents that the facility can accept residents with diagnoses profiles including Psychiatric/Mood disorders. This same assessment documents under the heading of Psychiatric Mood/ Disorders, We utilize a Psychiatric consultant which sends a (Social Worker) and NP (Nurse Practitioner) who assist the staff and medical director with resident's who have behavioral needs. In addition, the Facility Assessment states under section 1.9 that the facility's process to make admission or continuing care decisions for persons that have diagnoses or conditions that the facility is less familiar with or have not previously supported as, Administrator and Director of Nursing would consult the (facility's) contracted vendors if needed. Pharmacy, (Medical Supply Resources), Medical Director, Lab resources. The Administrator and D.O.N. (Director of Nurses) would discuss what services or resources were needed to care for patient and how to come about those resources when needed. Work with Medical Director and VP (Vice President) of Clinical Services to determine facility is capable to meet needs. Equipment and in-services completed prior to admission. This assessment indicates there are at least eight other residents who have Behavioral Health Needs residing in the facility. The assessment documents that specific care of practices provided for residents' Mental Health or Behavior includes, Contract with social work services group, manage medical conditions and medication related issues causing symptoms and behavior. Identify and implement interventions to help support anxiety, cognitive impairment, depression. Further, this assessment documents a list of employed staff, contracted staff, consultants, and ancillary staff providing care or services to residents which includes a Psychiatric Rehabilitation Service Coordinator, Behavior aides, a Psychologist, and a Psychiatrist. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 10/27/21 V6 (Admissions) stated he evaluated R1 prior to accepting R1 as a resident at the facility. V6 stated that he did not assess R1 in person but rather read through R1's hospital records to determine if the facility could meet R1's needs. V6 stated he is not a licensed nurse or medical practitioner. V6 stated that R1's hospital record did not show that R1 had any behaviors. V6 stated that R1 did have some mental health diagnoses which did not warrant any concern. V6 stated he did not think R1's medical record documented that R1 had any mental instability. R1 said that after R1 had to be emergently admitted to the hospital on 10/13/21 for behaviors, the facility did not want R1 to return unless R1 had a psych eval. R1's facility list of current diagnoses includes Major Depressive Disorder, Anxiety Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Insomnia. R1's physicians' orders from the time of R1's admission until R1 was emergently discharged dated 10/1/21 to 10/13/21 do not indicate R1 was prescribed any psychiatric care, treatments or medications to treat R1's psychiatric/mood disorders. R1's orders do not include any referrals for psychiatric or mood order specialists to address R1's diagnoses or lack of treatments. R1's Minimum Data Set (MDS) assessment dated [DATE] documents that R1 is cognitively intact but has verbal behavioral symptoms directed at others four to six days per week, displays behaviors that significantly disrupt care or living environment, rejects care four to six days per week. R1's MDS documents that R1 has a psychiatric history including psychotic symptoms and possible misinterpretation of events and the intentions of others, demonstrates denial and/or evasiveness: when discussing mental health issues, minimizing significance of mental health/psychosocial issues, has diagnosis of depression and/or history of depressive illness: Presents with signs and symptoms of depression/mood distress, low self-esteem, isolation and withdrawn behavior, and complains of chronic pain, illness, fatigue and/or persistent anger, fear and/ or anxiety. This MDS also documents that R1 has a history and presence of dysfunctional behavior such as provoking, aggressive, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention-seeking, and/or otherwise abrasive, /inappropriate behavior including wandering into peer's rooms/ personal space. This MDS concludes based on these indicators that R1 is at high risk for a history of previous/recent mistreatment and/or potential future problems/ symptoms related to mistreatment. R1's care plan does not address R1's behavioral symptoms or R1's diagnoses of PTSD, Schizophrenia, and Major Depressive Disorder except for adding R1, Is at risk for abuse/neglect (related to) delusional thinking. R1's medical record does not include documentation that R1 was receiving behavior monitoring. R1's Social Services notes documented by V11 (Social Services Director) dated 10/13/21 document that R1 was transferred emergently to the hospital on that date after exhibiting the behaviors of yelling, cursing, threatening, name calling, and delusions. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 11/1/21 at 11:00a.m. V11 stated that R1 had been displaying delusions of grandeur and talking continuously to no one in particular using vulgar or inappropriate language since the time of R1's admission. V11 stated the only interventions that were put into place were, The usual things like redirection. V11 could not describe any interventions that were implemented to address R1's specific psychological and mood disorders or symptoms. V11 stated that on 10/13/21 R1 was yelling, cursing, and threatening. V11 stated that R1 was brought into her office to calm down. V11 stated that the more she talked to R1 the worse R1 became so she told R1 she would stop talking if that would help. V11 stated that when no attempt at calming R1 down worked. The facility called for an ambulance to take R1 to the hospital for a psychiatric evaluation. R1's facility progress notes from the time of admission to discharge date d 10/2/21 to 10/13/21 includes only two physician progress notes, one dated 10/6/21 and the other dated 10/9/21. Neither physician's progress notes indicate that R1 has resident needs that cannot be met at the facility or that the facility does not offer services to meet R1's needs. These two physician's progress notes do not address R1's psychiatric/mood disorders or recommend any treatments. There are no progress notes indicating R1 was referred to or evaluated by a Psychiatrist, a Psychologist, a Psychiatric Rehabilitation Service Coordinator, or Behavior aides. R1's hospital Interdisciplinary Team (IDT) meeting notes dated 11/1/21 document that R1's principal problem is Psychosis in Elderly. These same notes document that on 10/25/21, (R1) is ready for discharge; writer will contact (the Facility) as (R1) has not received an involuntary discharge from the facility. R1's IDT notes also document that on 10/28/21 R1 was still at the hospital because, Discharge is pending placement. These same notes document as of 11/1/21, (R1) will be discharged on ce placement is found. On 10/27/21 at 9:30a.m., at 12:55p.m. and on 11/1/21 at 1:00p.m. V1 stated that R1 cannot return to the facility until R1's mental status is stabilized. V1 stated that the facility does not have the services R1 needs in R1's current condition. V1 stated that V6 (Admissions) sends her regular updates on R1's condition while R1 is admitted to the hospital. V1 stated that based on R1's hospital notes, R1 is not suitable to come back to the facility despite R1's hospital IDT notes recommending discharge back to the facility. V1 also stated that no facility physician including the Medical Director, any other facility physician or physician's surrogate has reviewed R1's circumstances for being emergently admitted to the hospital, R1's hospital treatment plan, or current condition/ behaviors to determine whether R1 is appropriate to return to the facility. V1 verified that the Facility Assessment documents that the facility is supposed to be able to care for residents with behaviors and a psychiatric diagnosis, however, V1 stated she didn't accept R1 as a resident in the facility. V1 stated R1 was accepted by the previous Administrator who no longer works at the facility. V1 stated she does not know what type of behaviors R1 had prior to being admitted to the facility. On 11/1/21 at 9:11a.m. V13 (Hospital Social Worker) stated that R1 was involuntarily admitted to the hospital on 10/13/21 because of behavioral problems R1 had on that date. V13 stated that R1 was evaluated by psychiatric specialists who prescribed psychoactive medications and interventions to treat and address R1's symptoms after R1 was admitted to the hospital. V13 stated that R1's behaviors are now in stable condition and R1 is ready for discharge back to the facility, however, the facility is refusing to take R1 back.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. Building B. Wing	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Peoria Heights	1629 East Gardner Lane Peoria Heights, IL 61616

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30312 Based on interview and record review the facility failed to provide a newly admitted resident with behavioral services and care as described in the Facility Assessment for one of three residents (R1) reviewed for Facility Assessment in a sample of 32. This failure resulted in R1 being hospitalized for an escalating behavioral episode. Findings include: A Facility assessment dated [DATE] documents that the facility can accept residents with diagnoses profiles including Psychiatric/Mood disorders. This same assessment documents under the heading of Psychiatric Mood/ Disorders, We utilize a Psychiatric consultant which sends a (Social Worker) and NP (Nurse Practitioner) who assist the staff and medical director with resident's who have behavioral needs. In addition, the Facility Assessment states under section 1.9 that the facility's process to make admission or continuing care decisions for persons that have diagnoses or conditions that the facility is less familiar with or have not previously supported as, Administrator and Director of Nursing would consult the (facility's) contracted vendors if needed. Pharmacy, (Medical Supply Resources), Medical Director, Lab resources. The Administrator and D.O.N. (Director of Nurses) would discuss what services or resources were needed to care for patient and how to come about those resources when needed. Work with Medical Director and VP (Vice President) of Clinical Services to determine facility is capable to meet needs. Equipment and in-services completed prior to admission. This assessment indicates there are at least eight other residents who have Behavioral Health Needs residing in the facility. The assessment documents that specific care of practices provided for residents' Mental Health or Behavior includes, Contract with social work services group, manage medical conditions and medication related issues causing symptoms and behavior. Identify and implement interventions to help support anxiety, cognitive impairment, depression. Further, this assessment documents a list of employed staff, contracted staff, consultants, and ancillary staff providing care or services to residents which includes a Psychiatric Rehabilitation Service Coordinator, Behavior aides, a Psychologist, and a Psychiatrist. R1's hospital physician's progress notes and recapitulation of R1's hospital stay dated 9/24/21, from prior to R1's admission to the facility and obtained from R1's medical records at the facility, documents that R1 had diagnoses to include Anxiety, Bipolar 1 disorder, Depression, Insomnia, PTSD (post-traumatic stress disorder). This progress note documents that R1 was homeless, not taking any medications for his psychiatric conditions, and would, Need to establish Psych care after discharge. This note further documents R1, Will only do what (R1) wants to do. Can be argumentative, and had Disorganized thought processes. R1's list of current diagnoses include Major Depressive Disorder, Anxiety Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Insomnia. R1's physicians' orders from the date of admission until R1's transfer to the hospital dated 10/1/21 to 10/13/21 do not indicate R1 was prescribed any psychiatric care, medications or other interventions to treat R1's psychiatric/mood disorders. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan documents R1, Is at risk for abuse/neglect (related to) delusional thinking. R1's Social Services notes documented by V11 (Social Services Director) dated 10/13/21 document that R1 was transferred emergently to the hospital on that date after exhibiting the behaviors of yelling, cursing, threatening, name calling, and delusions. R1's facility progress notes dated 10/2/21 to 10/13/21 includes only two physician progress notes, one dated 10/6/21 and the other dated 10/9/21. Neither physician's progress notes indicate that R1 has resident needs that cannot be met at the facility or that the facility does not offer services to meet R1's needs. These two physician's progress notes do not address R1's psychiatric/mood disorders or recommend any treatments. There are no progress notes indicating R1 was evaluated by a Psychiatrist, a Psychologist, a Psychiatric Rehabilitation Service Coordinator, or Behavior aides. R1's hospital Interdisciplinary Team (IDT) meeting notes dated 11/1/21 document that R1's principal problem is Psychosis in Elderly. These same notes document that on 10/25/21, (R1) is ready for discharge; writer will contact (the Facility) as (R1) has not received an involuntary discharge from the facility. R1's IDT notes also document that on 10/28/21 R1 was still at the hospital because, Discharge is pending placement. These same notes document as of 11/1/21, (R1) will be discharged on ce placement is found. On 10/27/21 at 9:30a.m. and at 12:55p.m. V1 stated that R1 cannot return to the facility until R1's mental status is stabilized. V1 stated that the facility does not have the services R1 needs in R1's current condition. V1 stated that based on R1's hospital notes, R1 is not suitable to come back to the facility despite R1's hospital IDT notes recommending discharge back to the facility. V1 also stated the facility Medical Director, and no other facility physician or physician's surrogate has reviewed R1's circumstances for being emergently admitted to the hospital, R1's hospital treatment plan, or current condition/ behaviors to determine whether R1 is appropriate to return to the facility. V1 verified that the Facility Assessment documents that the facility is supposed to be able to care for residents with behaviors and a psychiatric diagnosis, however, V1 stated she didn't accept R1. V1 stated R1 was accepted by the previous Administrator who no longer works at the facility. On 10/27/21 V6 (Admissions) stated he evaluated R1 prior to accepting R1 as a resident at the facility. V6 stated that he did not assess R1 in person but rather read through R1's hospital records to determine if the facility could meet R1's needs. V6 stated that R1's hospital record did not show that R1 had any behaviors. V6 stated that R1 did have some mental health diagnoses which did not warrant any concern. V6 stated he did not think R1's medical record documented that R1 had any mental instability. R1 said that after R1 had to be emergently admitted to the hospital on 10/13/21 for behaviors, the facility did not want R1 to return unless R1 had a psych eval. On 11/1/21 at 9:11a.m. V13 (Hospital Social Worker) stated that R1's behaviors are now in stable condition because of psychiatric treatments and services R1 was provided at the hospital by psychiatric specialists.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 30312 Based on observation, interview, and record review the facility failed to maintain an effective pest control program which has the potential to affect all 82 residents in the facility. Findings include: A Pest Control policy dated as revised 2/14/18 gives as its purpose, To prevent or control insects from spreading disease. This policy states, Employees are instructed to promptly report all observations of pests to their department heads, and Garbage and trash containers shall be emptied when full and cleaned prior to returning to the appropriate area. On 11/1/21 at 10:00a.m. R2 was sitting in R2's room on the side of the bed. R2 had a tray with an empty plate and bowl with dried food on them, from dinner the previous day. There was also an ice cream cup with melted ice cream in it. R2 stated that this always happens, then it attracts flies and gnats. At 10:30a.m. another resident's room had four empty plastic cups on the floor and gloves that were inside out on the floor next to the garbage can. On 10/27/21 at 10:15a.m. V3 (Housekeeper) was standing in the residents' hall about halfway down the hallway. V3 stated that she frequently sees cockroaches and mice in the facility. V3 stated she sees cockroaches everywhere within the facility but usually sees them in residents' rooms. V3 stated that some of the residents' furniture is old and cracked which provides a good place for cockroaches to hide. During this conversation, V3 pointed to a narrow brown bug which was approximately one-half inch in length and was crawling on the floor in the hall in front of a resident's room, and stated, There's a cockroach. V3 proceeded to use a paper towel to kill the bug. On 10/27/21 from 10:15a.m. to 2:30p.m., during general observations of the facility, there were multiple flies observed flying down each of the four residents' halls, in and out of residents' rooms, and in the kitchen. There was a squished brown bug, which was identical to the one pointed out by V3 as a cockroach, on the telephone receiver in the room across from the nurse's station. That same room had a trash can which was overflowing with food containers and soda cans. There were multiple residents' rooms with trash cans overflowing with trash and garbage. On 10/27/21 at 10:15am, R3 was sitting in the wheelchair in R3's room. R3 had an open wound on the left forearm. There were three flies crawling on the open wound on R3's left forearm. R3 kept shooing the flies away with R3's right hand. R3 stated that there are always flies in the room. R3 looked towards the bed, there were six flies crawling on R3's incontinence pad which appeared to be soiled with dried urine. At the same time V8 (Certified Nursing Assistant) entered the room. V8 stated that the flies are horrible in the building. V8 stated that she has seen cockroaches in the main dining area and on the opposite hall. On 10/27/21 at 10:35a.m. R7 was in R7's room seated on the side of the bed. R7 stated that the facility has a problem with cockroaches and mice. R7 stated R7 has seen cockroaches in R7's room and out in the hall. R7 stated that over the last few days staff had placed a mouse trap in the room then removed it after it caught a mouse. States the last time R7 saw a mouse running around R7's room was 10/25/21. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/27/21 at 10:50a.m. R5 stated R5 has seen insects crawling on the floor of R5's room. R5 stated R5 was not sure if these insects were cockroaches. R5 stated R5 thinks the bugs are attracted to the water which is always on the floor around the bathroom toilet. On 10/27/21 at 11:00a.m. R4 stated cockroaches have been a problem in the facility. R4 stated R4's family brought a trap for cockroaches which was placed behind R4's nightstand. R4 stated when the trap was full a staff member threw it away. R4 proceeded to pull the nightstand away from the wall exposing a pink material which was stuck to the wall near the baseboard. R4 stated R4 thinks the pink material is part of the cockroach trap. R4 then proceeded to point up to the ceiling above R4's head where two pieces of black tape were stuck in a crisscross pattern. R4 stated that flies have also been a problem in the facility. R4 stated that until this past weekend, R4 had a fly trap hanging above the bed. R4 stated that facility staff removed the fly trap when it became so full that it fell off the ceiling. On 10/27/21 at 11:30a.m. R12 was seated in R12's room rolling cigarettes. R12 stated that cockroaches have been a problem in the facility. R12 stated R12 has seen cockroaches crawling on R12's nightstand. R12 stated the last time R12 saw a cockroach on his nightstand was yesterday, 10/26/21. On 10/27/21 at 11:42a.m. R13 was standing in R13's room. A fly was noted flying in and out of R13's room. R13 stated R13 has seen a lot of flies in the facility lately. R13 also stated there have been mice scurrying around on the floor across from the nurses' station too. On 10/27/21 at 11:45a.m. V5 (Licensed Practical Nurse/LPN) stated that she worked 10/22/21- 10/25/21 and saw cockroaches crawling around the facility each of those days. V5 stated the facility has been having a problem with mice too. V5 stated she hasn't told any supervisors about the mice and cockroaches because, The facility knows these are all problems and have been told but after a while it becomes the norm. Facility pest control invoices dated 7/1/21 to 10/19/21 documents that the most recent pest control service was provided on 10/19/21 for general pests and other crawling insects in the kitchen, office, and common areas of the facility. On 10/27/21 V1 (Administrator) verified the facility has had a problem with pest control. A Resident Census and Conditions of Residents report dated 11/3/21 and signed by V1 documents that at the time of the survey 82 residents resided in the facility.