STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146002	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE CAIRO	**2001 CEDAR STREET CAIRO, IL 62914**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow it's Abuse Prevention and Reporting Policy by not identifying willful intent involving resident to resident altercations for 2 of 4 residents (R3 and R4) reviewed for abuse in the sample of 6. Findings include: According to a Preliminary 24- Hour Abuse Investigation Report completed by V1, Administrator, on 2/21/2020, at approximately 12:17 PM, staff reported an alleged resident to resident physical altercation. This same document identifies the residents involved as R3 with a [DIAGNOSES REDACTED]. The statement Residents assessed with [REDACTED]. A witness statement written and signed by V8, CNA (Certified Nurse's Aid) on 2/21/2020 states, At 12:17 PM, R3 and R4 were sitting in TV (television) area when R3 was trying to take R4's walker. R4 wouldn't let go of his walker and that's when R3 started to elbow him (R4) in his side. V8 verified this statement as accurate as read back to her on 3/12/2020 at 1:30 PM. A witness statement written and signed by, V9, CNA, on 2/21/2020 states, R3 and R4 were sitting in the TV room. R3 was trying to take R4's walker , R4 would not let his walker go, so R3 started hitting R4 in his side with his elbow and trying to take his walker. I and another CNA intervened and took R3 to his room and reported to charge nurse. A Final Abuse Investigation dated 2/27/2020 and completed by V1 states , in part, the following, The definition of abuse includes the requirement that it be willful infliction of harm. The evidence does not include that there was any intent to harm and therefore, there was no abuse or neglect. The facility was unable to find the allegation of willful abuse substantiated. The facility has determined the act of R3 elbowing R4 did occur but due to R3's cognitive status and [DIAGNOSES REDACTED]. The facility feels that R4 was protecting his walker and R3 reacted According to the Abuse Prevention and Reporting Policy with an effective date of 11/28/16, on page 1 under Definitions: Abuse is the willful infliction of injury .with resulting physical harm . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Page 1, next to the last paragraph states Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Page 6 under Internal Investigation, Any incident or allegation involving abuse .will result in an investigation. Page 7 of the same document under Final Investigation Report states, in part, the final investigation report shall contain the following; Conclusion of the investigation based on known facts. On 3/11/2020 at 2:30 PM , V1 verified that he found physical abuse unsubstantiated in this case, believing that R3 was just reacting to the situation.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to conclude willful intent occurred during incidents involving resident to resident altercations for 2 of 4 residents (R3, R4) reviewed for abuse in the sample of 6. Findings include: According to a Preliminary 24- Hour Abuse Investigation Report completed by V1, Administrator, on 2/21/2020, at approximately 12:17 PM, staff reported an alleged resident to resident physical altercation. This same document identifies the residents involved as R3 with a [DIAGNOSES REDACTED]. The statement Residents assessed with [REDACTED]. A witness statement written and signed by V8, CNA (Certified Nurse's Aid) on 2/21/2020 states, At 12:17 PM, R3 and R4 were sitting in TV (television) area when R3 was trying to take R4's walker. R4 wouldn't let go of his walker and that's when R3 started to elbow him (R4) in his side. V8 verified this statement as accurate as read back to her on 3/12/2020 at 1:30 PM. A witness statement written and signed by, V9, CNA, on 2/21/2020 states, R3 and R4 were sitting in the TV room. R3 ws trying to take R4's walker , R4 would not let his walker go, so R3 started hitting R4 in his side with his elbow and trying to take his walker. I and another CNA intervened and took R3 to his room and reported to charge nurse. A Final Abuse Investigation dated 2/27/2020 and completed by V1 states , in part, the following, The definition of abuse includes the requirement that it be willful infliction of harm. The evidence does not include that there was any intent to harm and therefore, there was no abuse or neglect. The facility was unable to find the allegation of willful abuse substantiated. The facility has determined the act of R3 elbowing R4 did occur but due to R3's cognitive status and [DIAGNOSES REDACTED]. The facility feels that R4 was protecting his walker and R3 reacted . . On 3/11/2020 at 2:30 PM , V1 verified that he found physical abuse unsubstantiated in this case, believing that R3 was just reacting to the situation.

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

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.