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	IL6008064	A. BUILDING: _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 300.1210 c) 300.1210 d)3)6) 300.3210 t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: I. Based on observations, interviews, and record reviews the facility failed to prevent abuse by not following the plan of care for one resident (R130). R130 had an incident with another resident causing R130 to sustain a fall requiring emergency transfer to a local hospital. R130 was diagnosed with right arm fracture and needed 9 sutures to the right side of the forehead. The facility failed to prevent one resident (R119) from	S9999		

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S9999	Continued From page 2	S9999		

attacking another resident (R90) after R119 showed signs of physical and verbal aggression. This failure resulted in R90 to be transfer to a local hospital for emergency services and receiving 4-5 sutures to the left eyebrow. These failures affected three residents: (R90, R119, and R130) in a total sample of 35 reviewed for abuse and had the potential to affect 170 residents currently at the facility.

II. Based on observation, interview and record review, the facility failed to provide adequate supervision for a resident (R130) who was assessed and known to have a wandering behavior; a resident (R128) who moved self into a different room after having an altercation with another resident in the facility without staff investigating the reason for the room move; and a resident (R119) who has known history of aggressive behavior that was exhibiting increased in agitation and aggressive behaviors prior to attacking another resident (R90). These failures resulted in R130 and R90 sustaining serious injuries that required a transfer for emergency services to a local hospital. R130 sustained a fracture to the arm and sutures to the face. R90 sustained an open wound that needed suturing. This failure affected 4 residents out of 35 reviewed for supervision with a potential to affect 170 residents residing currently at the facility.

Findings include:

A. R130 diagnoses include Dementia with Behavioral Disturbance, Paranoid Schizophrenia, Delusional Disorders, and Schizoaffective Disorder. R130 who was originally admitted into the facility 7/29/14.

On 1/25/22 at 10:44 AM R130 was lying in R130's

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S9999	Continued From page 3 bed with the right arm wrapped and in a brace. Sutures on the right side of R130's forehead was observed V6 (Licensed Practical Nurse) said R130 had an incident with another resident that led to R130's arm and head being injured. V6 stated "I was not present in the facility when the incident occurred. It was reported to me that R130 became confused and wandered into another resident's room. When the resident asked R130 to leave their room, R130 refused resulting in R130 being shoved by the other resident. R130 lost R130 balance after R130 was shoved and fell breaking R130's right arm. R130 also has sutures on the right side of the forehead from the incident." On 1/26/22 at 1:36PM V1 (Administrator) said, an altercation resulted when R130 went into another resident's room. The other resident wanted R130 to leave their room resulting in R130 being pushed. The incident occurred 1/21/22. On 1/26/22 at 3:24PM V2 (Director of Nursing) said she was not aware of R130 having a habit of roaming in and out of other residents' rooms. On 1/26/22 at 3:53PM V3 (Assistant Director of Nursing) said, R130 does not have a history of going into other resident's rooms or roaming/wandering the facility however, she would at times visit with other residents which had not caused any issue in the past. Review of R130's current care plan initiated 5/14/20 reads: R130 wanders and R130 displays poor boundaries. Interventions include counseling R130 individually about the risks of displaying poor boundaries and redirecting R130 to display healthy boundaries.	S9999		

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S9999	Continued From page 4 Facility Reported incident report dated 1/21/22 documents it was reported that another resident pushed R130 on the evening of 1/21/22. R130 had a physical altercation with another resident and fell to the floor, sustained a laceration to the right forehead area and was guarding R130's right arm. R130 was sent out to the hospital and returned to the facility with diagnosis of right arm fracture with a soft cast in place and 9 sutures to the right lateral forehead. R130 has a history of poor social boundary and went into another resident's room uninvited and unwelcomed. Another resident push R130 out of their room causing R130 to fall in the process. On 1/26/22 at 4:48 PM V1 (Administrator) was not able to provide information, investigation as to how abuse towards R130 specifically could have been prevented. B. R119 was admitted to the facility on 7/10/20 with the diagnosis of Unspecified Schizophrenia. R119 is alert and oriented and based on Minimum Data Set (MDS) R119 was assessed for Brief Interview for Mental Status (BIMS) with score of 15, cognitively intact (12/07/2021). 01/24/22 12:10 PM the surveyor observed R119 displaying verbal aggression towards staff during lunch time. R119 had already been served a plate of food and was eating in the bedroom doorway. R119 began yelling expletives to staff threw the plate onto the floor and charged towards the food cart requesting additional lunch portions and options. V7 (Certified Nurse Assistant) informed R119 that all of the residents would have to be served first before giving R119 extra portions. After V7 confirmed all of the residents ate, V7 removed an extra plate off of	S9999		

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S9999	Continued From page 5 the food cart and gave to R119. R119 then took the food into the bedroom. No further redirection was given. The nurse nor any other staff were not informed of the behavior at the time of the event. R119 has a care plan for physical aggression initiated 8/26/20 which was last updated 1/25/22 after R119 had a physical altercation with another Resident (R90). R119 also has a care plan for refusing medication that was initiated 3/27/21 and updated 12/28/21. Medication Administration Record notes that R119 has a history of refusing psychiatric medication and refused medications 13 out of 25 days in January 22. R119's Progress note written 1/25/22 read, R119 requested to switch room due to "paranoia". Writer attempted to explain to resident that R119's paranoia will be present in any room R119 moves to. Writer offered resident a PRN (medication) but resident declined. Writer spoke with V2 (Director of Nursing) and Mental Health Tech supervisor about possible room change for resident. Mental Health Tech supervisor advised to keep resident in the same room under observation. Writer will monitor the situation and make changes as needed. A note written on 1/25/22 reads, Writer counseled resident after R119 attempted to become physically aggressive towards peer. Writer asked resident what happened, and resident stated "Paranoia" Resident would not elaborate instead began jumping from subject-to-subject verbalizing delusional thought about the food and wanting a liquid diet. Writer encouraged resident to take R119's medication and states R119 does not need medicine.	S9999		

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S9999	Continued From page 6 On 1/25/22 at 9:11PM a Nurse notes reads Writer made aware of resident's physical aggression toward female peer. Resident noted with auditory hallucination, hostile and threatening toward self and peers. R119 is non-compliant with medication. MD notified, order received to transfer resident to (local hospital) for psych evaluation and treatment. On 1/25/22 at 11:52 PM R119 was transferred to the hospital and admitted for aggressive behavior. R90 was admitted to the facility 5/10/18 with diagnoses that include and are not limited to Schizophrenia. The minimum data set (MDS) with a Brief Interview for Mental Status (BIMS) results reads: score 10, indicating moderate cognitive impairment. On 01/25/22, R90 was physically abuse by another Resident (R119) and sustained a laceration that resulted in R90 going to the local hospital for emergency services to getting sutures to the left eyebrow. On 1/26/22 at 12:02 PM, R90 was observed in the hallway wearing a white t-shirt with stains that appeared to look like dried blood. R90 was alert and ambulating and was not able to be re-directed when surveyor asked to speak. At 1:30 pm, surveyor went to see R90 again, and R90 was seen wearing a clean white shirt. Black sutures are seen to the left eyebrow. R90 said, I got into a fight with another resident last night and I had to go to the hospital to get some stitches in my face. I'm not hurting anywhere else, and I'm okay now. On 1/26/22 at 4:30PM, V1 (Administrator) said, I" wasn't aware that R119 had been expressing some aggressive behaviors prior to the	S9999		

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S9999	Continued From page 7 altercation with R90. We sometimes have residents who refuse medications and treatment, and we do the best to re-direct them if we can. But ultimately, we cannot force the residents to take medications or do anything else. I expect the nursing and Mental Health Team to take the appropriate measures to address behavioral concerns that a resident may exhibit right away for the safety of the other residents and staff." R90's medical record review reads on 1/25/2022 at 6:24PM the nurse was made aware of physical aggression received by R90 from male peer. R90 was noted with a laceration to the left side of face. The nurse called 911, R90 was transferred to a local hospital for medical evaluation and treatment. R90 returned to the facility on 1/26/22 at 1:11 AM with 4-5 sutures to the left eyebrow and no further injuries confirmed. R90's medical record has an Abuse Risk Assessment (dated 1/26/22) with score of 6 which indicates R90 was at a high risk of abuse. Facility did not provide Abuse Risk Assessment for R119 upon request. Facility did not provide incident report for R119 and R90 upon request. On 1/27/22 12:44 PM V17 (Mental Health Tech Supervisor) said, the Mental Health Techs (MHTs) are scheduled to be in the building during all three shifts. They are trained to use CPI (Crisis Prevention Institute) measures to de-escalate and prevent behavioral situations. The MHTs have a communication report sheet that they are required to document anything pertaining to significant events in the facility during their shift. We don't have a written policy, but within their responsibilities they are required to round on all of the residents and do room checks every two	S9999		

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S9999	Continued From page 8 hours. Utilizing a check system, they go around room to room and use the census to check if residents are in the room. They use the census on one sheet and mark initials on another. The sheet that is initialed does not have the resident's name on it, just the room number. It does not indicate how many residents are in the room, or who is in the room. If the MHT is unfamiliar with the residents they wouldn't know who they are, because sometimes the residents walk around the facility. The MHTs also may not have noticed R128 was not in the assigned room because there have been a lot of room changes recently with relocating the residents on and off of the Covid-19 unit. The facility's Abuse policy reads: "The resident has the right to be free from abuse." "Staff Supervision: Supervisors will monitor the ability of the staff to meet the needs of the residents, including that assigned staff have knowledge of individual resident care needs." C. R128 was admitted to the facility 3/22/12 with diagnoses that include Disorganized Schizophrenia, and major Depressive Disorder with Psychotic Symptoms, based on Minimum Data Set (MDS) R128 was assessed for Brief Interview for Mental Status (BIMS) with score of 8, (12/28/2021) which indicates moderate cognitive impairment. On 1/24/22 at 11:30AM, R128 was observed sitting in a room on a bed closest to the door that was not assigned to any Resident according the facility provided census. R128 had a linear dark reddened mark on the nose and under the left eye. R128 had the right pant leg pulled over the	S9999		

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S9999	Continued From page 9 knee and some red abrasions were seen on the lower leg. R128's name was not on the door of the room and the bed was listed as Empty on the Resident Numerical Census. On 1/24/2022 at 1:18PM V1 (Administrator) said, it appears that R128 moved to a different room without notifying the staff sometime yesterday evening (1/23/22.) The staff did not report this. It is not unusual for residents to go lay in empty beds as most of the residents are high functioning. The staff did not report any allegations of abuse or any altercations by any residents on this day. It is reasonable to believe that R128 would have moved to a different room because the previous room felt unsafe. The nursing staff and the MHTs are expected to round every 2 hours on the residents. According to R128's Progress notes, R128 was not medically evaluated during the course of this investigation. No progress notes were provided by the facility for the date of 1/23/22. Nursing incident report was not provided upon request. On 1/27/22 at 3:05 PM, V28 (Psychotropic Nurse) presented: Skin Condition Report dated 1/27/2022 at 2:28PM for R128 that noted bruising to the right palm, a scratch to the back of the right hand, a scratch to the left eye, left periorbital bruising, a bruising to the right lower leg, bruising to the left shin, and bruising to the left patella. Comments on the assessment read: R128 in incident with peer. The Final Investigation of this incident was not completed or submitted by the facility by the close of this Survey. Facility Abuse policy updated 12/17/21 states in	S9999		

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S9999	Continued From page 10 part; "the nursing staff is additionally responsible for reporting on a facility incident report the appearance of suspicious bruises, laceration, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or the person designated to act on behalf of the administrator in the administrator's absence. The facility did not provide a rounding policy or a policy regarding providing Resident Supervision upon several requests. "B"	S9999		