Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: ____ B. WING ____	C 11/03/2022

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 Investigation of Facility Reported Incident of September 27, 2022/IL152005	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)3)6) 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. 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.	S9999	Attachment A Statement of Licensure Violations	

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

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This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to monitor and supervise a resident that is known to respond to internal stimuli to prevent an avoidable accident. This affected 2 of 3 residents (R2, R3) reviewed for supervision, accident, and incidents. This failure resulted in R3 spontaneously throwing a chair resulting in R2 being hit in the face with the chair sustaining a laceration which required 4 sutures.

Findings Include:

R2's diagnosis: schizoaffective disorder and auditory hallucinations. R2 admitted to the facility 2/17/22.

R3's diagnosis: schizophrenia, bipolar disorder, and psychosis. R3 admitted to the facility on 4/22/22.

A Behavior note dated 9/27/22 at 7:24AM documents R2 was hit by a chair on the forehead in the day room by another resident. Bleeding to forehead was noted with a deep laceration. 911 was called for immediate transfer to the hospital. R2 is alert oriented times 3 and conscious to the situation. No distress was noted.

A Nursing note dated 9/27/22 at 10:32 AM documents R2 returned to the facility from the hospital with 4 sutures to the forehead.

An IDT note dated 9/28/22 documents the summary of the IDT meeting is that R2 was injured as a result of R3's non-targeted outburst. R2 was struck by a chair. R2 will be assisted by intervening when R2 is observed in the vicinity of

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peers responding to internal stimuli.

The Hospital Records dated 9/27/22 document R2 presented to the emergency room with a facial laceration. R2 reported being struck by a chair this morning when another resident threw the chair. R2 denied loss of consciousness, syncope, pain, or uncontrolled bleeding. R2 was seen for a laceration repair and was sent back to the facility.

The Final Incident Report of all dated 10/1/22 documents R2 was accidentally hit by a chair while sitting in the TV room. An open area to the forehead was noted. Four sutures were noted to the forehead upon return from the hospital. R3 was placed on behavior management skills program. No abuse was identified as this was a non-targeted outburst from R3.

On 10/28/22 at 12:22PM, R2 had a laceration to the left upper forehead about 3 inches long. The laceration was glued and is healing. When asked what happened to R2's head, R2 stated, "R3 hit me with a chair one morning. R3 just picked up the chair and threw it across the room. We were in the TV room. It was an accident. R3 didn't act mad before the threw it. R3 was just sitting down then R3 stood up and threw the chair. R3 was strong enough to throw it far enough to hit me. R3 didn't say anything to me. I never talked to R3 before. R3 is usually very quiet. I know R3 has some problems with R3's brain. No one was in the TV room that was staff. It was only 3 or 4 residents in the TV room early that morning."

During this investigation, no staff were noted supervising the residents in the TV room. The number of residents ranged from 2 - 10 people at one time. Staff would look into the TV room as they walked down the hall, but no staff ever

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entered the TV room to check on the residents.

On 10/30/22 at 11:33AM, When asked about the incident when R3 threw the chair at R2, R2 stated, "Yes, I threw it. I don't remember who got hit. I didn't mean to hit anyone. I don't remember why I threw it. I don't have any problems with anyone here." R3 had a very flat affect and would not respond to most questions.

On 10/30/22 at 12:51PM, V11 (Nurse) stated, "I didn't see this happen, but they were both in the TV room when staff started calling for me to come down there. R2's head was bleeding. It was not gushing but R2 did have blood dripping down R2's head. I called 911 right away and got R2 sent out to the hospital. I was told that R3 hit R2 in the head with a chair in the TV room. No, there was no one (staff) in the TV room when R3 did that. I don't know who was supposed to be in there but when this happened it was just the residents. When I asked R2 what happened R2 said that R2 was in the TV room and R3 was in there with R3 and just picked up the chair and threw it. R2 said R3 didn't say anything before R3 threw it. R3 didn't even talk to R2. R3 just picked up the chair and threw it across the room."

On 10/30/22 at 2:18PM, V1 (Administrator) stated, "That incident R3 was responding to some internal stimuli while R3 was in the TV room. R3 picked up the chair and threw it across the room which ended up hitting R2. There was no screaming or any other behaviors before R3 picked up the chair and through it. He never really has aggressive behaviors. I know the maintenance man was walking down the hall and heard a chair fall over, so he went into the TV room to see what was going on and saw that the chair was on the ground next to R2 and R2's

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head was bleeding."

On 11/1/22 at 9:11AM, V16 (Nurse) stated, "The other resident (R2) that was hit said that R3 just stood up from the chair R3 was sitting in and picked it up and threw it. R2's head was bleeding, and we could not get it to stop so R2 had to be sent out for sutures. No other staff saw it. No one was monitoring the TV room at the time this happened. Someone should be monitoring this area, but I don't know where they were at. When I asked the tech what was happening, she said she was busy doing something else. I told her that someone always needs to be monitoring them."

On 11/1/22 at 9:57AM, V18 (Nurse) stated, "I later found out that morning that R3 threw a chair. R3 must have just been responding to some stimuli that let R3 to have that behavior. I was not here so I do not know if anyone is monitoring the TV room. I don't know who monitors the TV room."

On 11/1/22 at 1:13PM, V5 (Maintenance Director) stated, "It was maybe around 6:30 in the morning, I was walking down the hallway and I heard a chair fall over in the TV room. I went into the TV room and saw a resident (R2) who had blood coming from R2's head and the chair was on the floor next to R2. I tried asking what happened, but no one was answering me at first. I came back down, and another resident was telling me that R3 threw the chair. I know R2 had a laceration on R2's head but I don't know about anything else. R2 did have some blood coming down R2's forehead but it wasn't spraying out or anything. There was no screaming or yelling or anything before I heard the chair fall. The only thing that made me go look in the TV room was the sound of the chair hitting the ground. There was no staff in the TV room when this happened. It was only

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S9999	Continued From page 5 the residents. I think there was 3 or 4 of them in there. I don't know who is supposed to be watching the room." The Psychosocial Assessment dated 9/27/22 documents R2 is injured as a result of R3's non-targeted outburst. R2 reported being hit by a chair thrown by R3. R2 has not had any prior negative interactions with R3. R2 was not interacting with R3 at the time of the incident. R2 was observed to be calm immediately following the incident and did not express being in much pain. The Care Plan dated 7/12/22 documents R2 is at a potentially moderate risk for abuse/neglect related to depression and mental illness. On 9/27/22, R2 was injured due to a peers non-targeted outburst. A Nursing note dated 9/27/22 documents it was reported R3 had a physical altercation with R2. R3 refused to give account of the incident. Both residents were separated and 1:1 monitoring was implemented. Education was provided to R3 to keep R3's hands to self and report issues or concerns to staff. A doctor's order was given to send R3 to the hospital for psychiatric evaluation. R3 left the facility in a calm and cooperative demeanor. An IDT note 9/28/22 documents R3 displayed a non-targeted outburst resulting in an injury to R2. R3 reported R3 had no intention of harming R2. R3 was responding to internal stimuli. R3 was counseled to seek staff to utilize the sensory room when feeling negative urges. There is no other documentation of R3 having any physical altercations or aggressive outbursts with other residents since R3 was admitted.	S9999		

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S9999	Continued From page 6 The Behavior/Mood Charting dated 9/27/22 documents R3 was physically aggressive as shown by throwing a chair across the room that hit another resident. R3 had no triggers to this behavior. R3 was educated during 1:1 monitoring. The Psychosocial Assessment dated 9/27/22 documents R3 displayed a non-targeted outburst resulting in R2 being injured. R3 reported feeling angry and had an urge to act on it. R3 threw a chair blindly that hit R2 by mistake. R3 has partial recollection and awareness of the event. R3 was observed to be somewhat remorseful as mentioned R3 was responding to internal stimuli and had no intention of harming R2. R3 has no indicated triggers that would set off a physical altercation. R3 is known to respond to internal stimuli. The Care Plan dated 4/27/22 documents R3 has a potential to be verbally and physically aggressive related to history of aggressive behavior. On 9/27/22, R3 displayed a non-targeted outburst resulting in a female peer's (R2) injury. Interventions include the educating and counseling R3 to develop insight into aggressive behavior. R3 was encouraged to seek staff to utilize the sensory room when feeling negative urges. The Minimum Data Set Section E dated 10/3/22 documents R3 experiences hallucinations and delusions. There is no documentation of R3 having any physically aggressive behaviors. "B"	S9999		