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 01/26/2021

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 Complaint Investigation #2190290/IL130187 #2190355/IL130265 #2190422/IL130334	S 000		
S9999	Final Observations Statement of licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210 d)3) 300.1210 d)6) 300.3240 a) 300.3240 f) Section 300.610 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. This REQUIREMENT is not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interview, and record review, the facility failed to follow their abuse policy and keep a resident free from physical abuse; failed to create and implement patient specific interventions to prevent abuse from occurring; and failed to substantiate that abuse occurred for two of six residents (R4 and R5) reviewed for abuse. The facility failed to provide consistent well-being checks/counseling for two of six resident's (R4 and R5) who are at risk for abuse and behaviors due to mental illness and failed to provide counseling along with updating care plan after abuse occurred. This deficiency resulted in R4 being physically assaulted by R5 and sustaining a laceration to scalp that required staples, multiple bruises and a brain bleed. This failure also resulted in R4's continued behaviors and psychological harms as evidenced by of screaming out and accusing other peers that they are attacking her after returning from the hospital. Findings include: R4 has diagnoses of schizophrenia, her cognition is severely impaired, and she encountered an injury during her stay at facility on 1/17/21. R5 has diagnoses of schizophrenia and her cognition is moderately impaired. Facility initial report sent to state department on 1/17/21 notes at approximately 8:00am, R4 involved in an altercation with roommate (R5) and sustained a wound to her head along with bruises and superficial abrasions to both hands. R4 and R5 were sent to the hospital. V7's Social Service assessment on 1/17/21 at 9:00am (after the incident) notes R4's care plan will be updated. CT of Head on 1/17/21 at 11:10am notes that R4	S9999		

Illinois Department of Public Health

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S9999	Continued From page 3 sustained blunt head trauma and has areas of sub-arachnoid hemorrhage (brain bleed). Facility final investigation dated 1/22/21 notes R4 sustained a wound to head "Traumatic Subarachnoid Hemorrhage/Bleed", along with bruises and superficial abrasions to both hands. R4's scalp lacerations were treated with staples. R4's mental status is alert and oriented to self only. Upon return from the hospital, R4 stated "my roommate...Bam, Bam, Bam". R5 admitted to punching R4 but stated she doesn't know what happened after that. She did not indicate that she used anything other than her hand to strike R4. R5 said she becomes catatonic at times and does not know what she is doing. She woke up with visions of chopped up organs in the room, so she punched the wall. R6 (R4 and R5's roommate) stated that R4 and R5 were arguing, then R5 tackled R4 and she heard a loud noise. R5 indicated she struck R4 due to her delusional thought that R4 had slept with one of her sons. Facility conclusion notes the evidence does not indicate that there was an intent to harm, therefore there was no abuse and abuse cannot be substantiated. Social Service will meet with R4 to maintain a healthy psychosocial well-being and provide her counseling if she verbalized any emotional distress. R4's care plan will be updated. On 1/20/21 at 3:25pm, V6 (Director of Nursing, DON) stated that through interviews with R6, we were able to establish that R4 and R5 first had a verbal altercation, then she heard a boom and R4 asking for help. R5 went to the bathroom to wash her hands. R4, R5 or R6 did not report this but V9 (Environmental Services) found R4 in bed, bleeding from her head about 8:00am when rounding. I encouraged residents to report this	S9999		

Illinois Department of Public Health

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S9999	Continued From page 4 next time. R4 or R5 did not say what happened at the time. R4 was sent to the Emergency room and received 7 staples to the left side of her head. A CT scan (Head Scan) showed a brain bleed. R4 was readmitted to facility on 1/19/21. R5 was sent to the hospital for evaluation. On 1/20/21 at 3:56pm, V7 (Social Worker) stated that R4 is alert but doesn't say a lot. R4's care plan and assessment notes she is at risk for abuse related to her aggressive behavior and mental illness. On 11/22/20, a revision from myself states that she became verbally aggressive with her roommate. I cannot remember who it was or what happened and there is not further note or interventions but there should be more information. R4 also had a history of being physically aggressive with a roommate before she was admitted to our facility on 5/18/20. R5's care plan notes she is at risk for abuse related to aggressive behavior, depression and mental illness. The intervention is to report any abuse to administrator immediately. R5 minimized a lot of things and I have seen her agitated at times. On 1/4/21, the doctor note states she identifies as man and I did not know that. It states she also wants to be called "Augustus". I did not know R5 very well. I believed that R4 or R5 would report abuse if it happened. One of the ways we try and prevent abuse is to monitor the resident's for agitated behavior. V7's note on 11/21/20 notes R4 has feelings of depression, trouble sleeping, poor appetite, and had auditory hallucinations on 11/20/20. R4 has verbal and behavioral symptoms directed towards others and is verbally aggressive towards roommate. R4's behavior appears to be worse and refuses medication daily.	S9999		

Illinois Department of Public Health

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S9999	Continued From page 5	S9999		

On 1/25/21 at 10:14am, R4 sat up in bed and pointed to head and stated, "bang, bang". V10 (Licensed Practical Nurse, LPN) reached out to touch R4's hair and staples on the left side of her scalp and R4 winced back. R4's left ear is swollen and has crusted, dried blood to the wound. R4 also has bruises to forehead, right elbow, right and left forearms and multiple areas on both hands. Left hand has a healing cut as well. R4 is childlike in responses and difficult to understand at times.

On 1/25/21 at 10:15am, V10 (LPN) stated that I had taken care of R4, when she was on the other wing, before she was injured. Since she came back from the hospital, she has some PTSD (post-traumatic stress disorder) symptoms. She screams out in her room and when the Certified Nursing Assistants or I go in there, she says that her roommate is trying to get her, but her roommate is asleep in the next bed. She has done this at least once a shift for several days. We talk to her until she calms down. I am not sure who her social worker is. I have told V1 (Administrator) or V6 (Director of Nursing) last week, I think.
On 1/25/21 at 11:00am, R4 walked out of room and down the hallway to a male peer standing in his doorway. R4 walked up to his face, pointed and stated loudly, "it was you; it was you" before staff redirected her back to her room and she closed the door. At 11:14am, R4 screamed in her room, then walked out into the hallway, following several different male peers around closely before staff asked her to go back to her room and close the door.

On 1/25/21 at 12:05pm, V6 (DON) stated that we have been watching her more closely since she

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S9999	Continued From page 6	S9999		

has been back from the hospital and has a new roommate. She will not pull her call light if she needs anything. The nurses and Certified Nursing Assistants are checking in on her and ask her if she is ok? She is not one to readily offer if she needs assistance or anything. I have not had a report that she has had any behaviors since she has returned from the hospital.

On 1/25/21 at 12:15pm, V7 (Social Worker) stated that R4's non-verbal status can put her at risk for abuse as well. When residents come back from the hospital, after an abuse situation, social services will check residents, to make sure they feel safe. I checked on her Friday, 1/22/21 after she returned from the hospital (on 1/19/21) and the nurses are checking on her. I did not get a report from nurses regarding behaviors of screaming or feeling unsafe. The social service assessment on 1/18/21 notes her care plan will be updated but it was not. We constantly monitor residents and address behaviors to prevent abuse. I try to meet with the residents at least twice a month if I can get to them. I met with R5 for well-being checks/counseling on 11/1/20 and 11/24/20, regarding coping skills. I have not seen her for counseling since. We got understaffed and counseling sessions happened sparsely. Prior to the incident on 1/17/21, I saw R4 for well-being checks and counseling for symptom management last on 12/30/20 and sporadically in between.
V10's behavior note dated 1/25/21 at 1:30pm notes that R4 keeps saying my roommate is trying to attack me and screaming. This time, R4 attempted to hit roommate.

Review of V7's social service notes show there were no social service well-being checks/counseling from 11/8/20-11/18/20. V7's

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S9999	Continued From page 7 note on 11/21/20 notes R4 has feelings of depression, trouble sleeping, poor appetite, and had auditory hallucinations on 11/20/20. R4 has verbal, behavioral symptoms directed towards others and is verbally aggressive towards roommate. R4's behavior appears to be worse and refuses medication daily. There are no well-being checks/counseling notes from 11/22-11/27/20. On 12/3/20, V7's note stated he will continue to provide R4 with counseling and supportive services necessary to benefit her ability to maintain a healthy state of mind, however there were no well-being checks/counseling from 12/3/20 through 12/20/20, or 12/31/20 to 1/17/2, until R5 attacked R4. V7's next note on 1/22/21 at 6:27pm, read, he conducted a well-being check and R4 had no issues or concerns at this time and that staff will continue to monitor and document. V7 did put a late entry note in on 1/25/21 that stated he saw R4 on 1/20/21 (after return from the hospital) despite him stating to surveyor that he did not see her until 1/22/21. R4's care plan notes that, she is at risk for abuse related to aggressive behavior, mental illness. On 11/22/20, I became verbally aggressive with my roommate. Interventions, at this time was to observe resident in care situations and report any verbalization of abuse or neglect to the administrator immediately. Further care plans, revised on 11/23/20, also note that I have the potential to be physically aggressive related to schizophrenia, with interventions that include, to analyze triggers and document them; I have been diagnosed with paranoid schizophrenia and may benefit from skills training. The goal is to engage in skills training addressing triggers 2 X per week;	S9999		

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S9999	Continued From page 8 I have a history of being verbally aggressive to staff due to ineffective coping skills. Interventions include to encourage resident to attend group and provide her with individual counseling on how to manage her impulse/anger. R5's care plan, started on 8/24/20 notes that she is at risk for abuse related to aggressive behaviors, depression and mental illness, I hear voices telling me to leave or defend myself against others, have delusions that people are trying to contain or destroy me, so I have to defend myself. The only intervention listed on abuse care plan is to report any verbalization of abuse to administrator immediately. Further care plans note that I hear voices telling me to leave or defend myself against others, have delusions that people are trying to contain or destroy me so I have to defend myself. Interventions include to anticipate care needs and provide them before I becomes overly stressed and provide psychological services as ordered by physician; I have a diagnosis and a history of severe mental illness as manifested by delusions-paranoia, hallucinations. Interventions are to discuss benefits of group or individual counseling sessions and encourage R5 to follow mental health treatment plans. Review of social service notes show that R5 had well-being check/counseling sessions on 11/1/20 and 11/24/20 and none from social service since this date. V7's note on 11/24/2020 at 2:14pm states, Plan: This writer along with the social service staff will continue to provide resident with the counseling and supportive services necessary to benefit resident's ability to maintain a healthy mood. R5's physician orders note R5 may attend group or 1 to 1 psychological service.	S9999		

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S9999	Continued From page 9	S9999		

R5's Physician order dated 1/17/21 notes that R5 may transfer to hospital with petition for physician aggression.

On 1/25/21 at 2:00pm, V1 (Administrator) stated that upon R4 returning from the hospital, I asked social service to check on R4 for any psychosocial concerns or distress from the incident and to update the care plan. The interventions would depend on what she verbalizes and if she had any other ill effects (from being physically assaulted). I would expect social service to initiate a well-being check 24 to 72 hours after being readmitted to see what she would need or sooner if she needed it. I did get report from V10 (LPN) that R4 was screaming one day last week, but no description was given. Behaviors should be reported in morning meeting so social service is made aware. We are moving R4's roommate to a new room just to be sure that she feels safe, there was an incident just a few minutes ago where R4 was upset.

On 1/26/21 at 4:00pm, V1 (Administrator) stated that staff stopped R4, before she struck roommate.

Facility Abuse policy notes that a resident has the right to be free from abuse. Abuse is the willful infliction of injury, resulting in physical harm. Instances of abuse of all resident's, regardless of any mental or physical condition, cause physical harm or mental anguish. 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. The facility desires to prevent abuse by establishing a resident secure environment. This will be accomplished by staff identifying residents with increased vulnerability for abuse or who have

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S9999	Continued From page 10 needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of abuse. (A)	S9999		