STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001713	A. BUILDING: _____ B. WING _____	C 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WEST CHICAGO	201 WEST NORTH AVENUE WEST CHICAGO, IL 60185

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S 000	Initial Comments Facility Reported Inident of May 30, 2022 IL148053	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 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 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide one to one supervision to a resident that was involved in prior physical altercations. The facility failed to prevent R1 from attacking R3 and R2 in the third-floor dining room when R1 was under one-to-one supervision for an earlier incident. This failure resulted in R3 requiring emergency medical care and sustaining a fractured nose and laceration to the head that required sutures. This applies to 1 of 4 residents reviewed for supervision and behaviors. The findings include: R1 is a 30-year-old resident, first admitted to the facility on 1/4/22, with diagnosis to include Schizoaffective Disorder, Anxiety, History of Self harm and past substance abuse. R1 did not return to the facility after discharge from the facility to the hospital for psychiatric care post incident of 5/30/22. On 5/29/22, R1 was involved in an incident on the third floor with R5, in which R5 reported R1 was physically aggressive with R5. R1 was placed on safety checks after this incident. R1 was also involved in an incident involving physical aggressive behavior with R6 on 4/19/22.	S9999		

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S9999	Continued From page 2 R1's care plan, initiated 5/29/22, included R1was involved in altercation with peer, and placed on 30-minute safety checks. The same care plan also included R1 has potential to be physically aggressive related to poor impulse control, agitation, SMI (serious mental illness), poor coping skills. The facility reported an incident, dated 5/30/22, to the department regarding R1's behavior on the smoking patio and third floor dining room. R1 and R2 were initially involved in a physical altercation on the outside smoking patio on 5/30/22. R1 and R2 were separated by staff when the verbal disagreement became physical, and R1 was escorted back to the third floor. According to the facility's incident report, R1 ran into the dining area and struck R3 and R4. R3 suffered bleeding from a laceration on her forehead and was transferred to the hospital for care. R3 was re-admitted to the facility the next day with 7 sutures on her forehead and a fractured nose. Facility nurses' station on 3rd floor was observed to be in an enclosed area from the hallway that led to the dining room. The height of this enclosure was greater than 3 feet. On 6/23/22 at 10:31 AM, R3 stated, "I was sitting on a wheelchair in the dining room and [R1] just came into the dining room and just hit me on my forehead and my nose got broken and split my forehead open with her fist. There were 2 staff in the nurses station, but they were just standing there and did not do anything to stop it. There was an altercation earlier that day, and she should have been removed from the facility and wasn't. She has been talking all day in an	S9999		

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S9999	Continued From page 3 antagonistic way towards residents. I was sent out to the hospital." R3's quarterly MDS, dated 6/01/22, showed R3 was cognitively intact. On 6/23/22 at 10:40 AM, R4 stated, "I was sitting in the dining room at the back table and [R1] came in and started yelling and then started to punch [R3]. [V4] was at the nursing station calling ambulance as she [R1] hit [R2] in the smoking area. After she hit [R3], [V4] came to check on [R3] and then went to the nursing station to call somebody. [R1] then started punching me too, and I got hit at the back of my head, and it was painful at first." R4's quarterly MDS, dated 4/20/22, showed R4 was cognitively intact. On 6/23/22 at 11:44 AM, V1 (Administrator) stated the altercation between R1 and R2 occurred on Memorial Day on the patio during smoking break. V1 stated he was not in the facility, but watched a video of the incident, and saw R1 and R2 were separated by behavioral aides. V1 stated R1 was placed on 1:1 monitoring, but staff were sporadic on that day, due to the Memorial Day Holiday. V1 stated V4 (Registered Nurse) on duty that day was supposed to have eye contact with her. V1 stated R1 ran into the dining room and punched another resident, and nurses went in to intervene. V1 stated one staff on one resident is 1:1 monitoring. V1 stated if there is a concern for resident to harm self or others, then the resident should be in the room by self with 1:1 monitoring. On 6/23/22 at 1:52 PM, V5 (Behavioral Aide) stated R1 and R2 were arguing during the last smoking break at the 1st floor patio. V5 stated R1 was threatening R2, and then punched R2. V5 stated he, with the help of his peer V6 (Behavioral	S9999		

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S9999	Continued From page 4	S9999		

Aide), separated both residents. V5 stated he took R1 up the elevator to the 3rd floor, and took her to her room and stayed with her for about 20 minutes, and left as he had to assist V6 to bring the residents up, as they were short staffed that day (related to the holiday). V6 stated V4 was at the nurse's station when he left the floor. V5 stated he heard R1 came out of the room and started attacking again.

On 6/23/22 at around 2:00 PM, V4 (Registered Nurse) stated he worked the 3-11 shift on 5/30/22, and R1 was under his care. V4 stated he was behind the nurses station making a phone call to R1's medical doctor to send her out for psych evaluation following the altercation of R1 to R2. V4 stated R1 was under the supervision of V5 (Behavioral Aide) following this incident, but he had to leave the floor to assist with bringing residents up. V4 stated R1 was within his view, when she went past the nurse's station and went into the dining room and was aggressive towards R3 and then R4. V4 stated R4 was injured and was sent out via 911.

On 6/24/22 at 11:37AM, V10 (Registered Nurse) stated she was the nurse on duty during the incident of R1 and R5 on 5/29/22. V10 stated R1 had pushed R5 down as she used her bathroom, and the Psychiatric doctor said just to separate them, which was done immediately. V10 stated during such resident-resident altercations, the facility protocol is to separate and then do 1:1 monitoring for every shift which is entered in the EMR.

R7 and R8, who were witnesses to the resident-to-resident incident of R1 to R3 and R4, were also interviewed.

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S9999	Continued From page 5 On 6/23/22 at 11:06 AM, R7 stated he was standing before the desk (nurses' station) during the time of the incident between R1 to R3 and R4. R7 stated, "I saw R1 punch R3 in the dining room and she was all bleeding. There was no staff in the dining room. V4 at the desk went to assist and told her [R1] to stay there but she went and started to punch another girl [R4] by the window." R7's Annual MDS, dated 4/23/22, showed R7 was cognitively intact. On 6/23/22 at 10:56 AM, R8 stated he was in the dining room during the incident between R1 to R3 and R4. R8 stated R1 hit R3, and she fell to the ground and was bleeding. R8 stated there was a couple of staff at the nurse's station during the time of the incident, which was "at night around 7:00-8:00 PM." R8's Quarterly MDS, dated 4/18/22, showed R8 was mildly impaired in cognition. On 6/23/22 at 2:44 PM and on 6/24/22 at 9:38 AM, V3 (Social Service Director) stated R1 had an history of serving time in prison due to aggression with a police officer, and was at a mental health institute prior to being admitted to the facility. V3 stated the incident of R1to R2 happened on the last smoking break at 7:30 PM on 5/30/22. V3 stated R1 has had 2 prior incidents of resident-to-resident altercation with peers, one on 4/19/22 with R6, and another one on 5/29/22 with R5. V3 stated on 5/29/22, R1 had pushed R5 down as she used her bathroom, and was placed on 1:1 safety check for every 30 minutes for 72 hours. V3 stated =this safety check task is embedded in the EMR. Review of the BEHAVIOR-safety checks every 30 minutes physical alteration of 5/29/22 showed that checks were done every 30 minutes on 5/29/22, starting 1815 (6:15 PM) until 2245 (10:45 PM). No further	S9999		

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S9999	Continued From page 6 checks were recorded after that. V3 verified the safety check monitoring was overlooked after last recorded check through 5/30/22, until the time R1 was discharged to the hospital. On 6/24/22 at 10:15 AM, R2 stated, "She [R1] has not been nice. She is a bitch. She busted my roommate's [R3] face and has pushed older people to the floor. I don't want to talk about it." R2's quarterly MDS (Minimum Data Set), dated 4/01/22, showed R2 was cognitively intact. On 6/24/22 at 11:11 AM, V7 (Licensed Practical Nurse) stated he was the facility psychotropic nurse and he verifies and follows up with orders from the psychiatrist. V7 stated he was not in the facility on 5/29/22 and 5/30/22 during the resident-to-resident altercations of R1 towards multiple residents. V7 stated 1:1 is an intervention the social services put in effect for safety of the patient and other residents around her. V7 stated the social services and medical doctor/psychiatrist determine how long the monitoring is needed. V7 stated during the time between the incident/altercation and sending the resident out to the hospital, there has to be direct 1:1 supervision, as the resident is in a heightened state. On 6/27/22 at 9:10 AM, V8 (Psychiatrist) stated she is on call for R1's Psychiatrist. V8 stated R1 had a history of presenting anxiety and irritability and was on parole. V8 stated R1 was seen on 5/18/22 with Quetiapine Furamate[antipsychotic] 25 mg/milligrams added for increased anxiety. V8 stated the office was notified of the incident of 5/30/22 [R1 to R2], and orders were given to send R1 out to the hospital for evaluation by calling 911. V8 stated R1 should have direct 1:1 supervision between the time of incident and the	S9999		

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S9999	Continued From page 7 ambulance arrival. V8 also stated the facility will have to follow their protocol for supervision for high-risk patients. Facility Policy and Procedure titled "Behavior Crisis" (effective 11/28/22) included as follows: Purpose: To initiate appropriate measures to control and secure the environment when a resident has a behavior crisis or catastrophic reaction. Definition: A behavior crisis is defined as a situation in which a resident is considered to be significant danger to self and others. The crisis may or may not have been exhibited in the past, however, is not an ongoing (day-day) observed behavior. Guidelines: 1. Implement measures to provide safety. 2. Summon additional staff as needed. 4. Assess need for additional intervention as indicated, including implementing Code Yellow Procedure. Remove resident from situation. Place resident in a safe environment. Remove offending stimuli from resident. Remove onlookers from area. Facility Policy and Procedure titled "Abuse Prevention and Reporting-Illinois" (revised 4/29/22) included as follows: Protection of Residents: Residents who allegedly abused another resident will be removed from contact with the other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. (B)	S9999		

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