STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003453	A. BUILDING: _____ B. WING _____	C 10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WEST RIDGE	6450 NORTH RIDGE BLVD CHICAGO, IL 60626

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of October 9, 2022/IL152646	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1220b)3) 300.3210t) 300.3240f) 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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. Section 300.3240 Abuse and Neglect 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. These requirements were not met as evidenced by: Based on observations, interviews and record review, the facility failed to protect the residents' (R1) right to be free from physical abuse from R2 for 3 out of 4 residents (R1, R5 and R6) reviewed for abuse. Failures includes R2, a resident with history of multiple physical aggression towards other residents (R1, R5 and R6) hitting R1 unprovoked resulting to R1 sustaining a deep abrasion requiring stitches to the forehead. Findings include:	S9999		

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S9999	Continued From page 2 Per facility reported incident dated 10/9/2022, R4 came to the Nurse's Station and reported to V2 (Licensed Practical Nurse/LPN) that R1 was sitting on his bed with blood on his face inside the room. R4 was seen on 10/27/2022 at 11:50 AM entering the front door of the facility and agreed to talk inside his room. R4 was alert and able to express his thoughts well. R4 stated that he was the person who reported what happened to R1. R4 stated that he saw what happened between R1 and R2. R4 said, "He (R2) punched him in the eyes. R1 was bleeding from his nose and eye, and blood covered his face." R4's BIMS score dated 9/7/2022 was 14, which means R4's cognition was intact. R2 is 42 years old, with diagnosis of schizophrenia was seen in the facility on 10/27/2022 at 11:57 PM. R2 was seen on the bed inside his room. R2 was alert kept turning his head when being asked a question. R2 did not respond to conversation after multiple question. R1 is 65 years old, with diagnosis of schizophrenia was seen in the facility on 10/27/2022 at 12:29 PM. R1 was in the dining room at the basement, eating lunch. R1 was seen with a dressing on his forehead about 3 to 4 inches in length. R1 said that another resident hit him on the head. R1 did not respond when asked if he felt safe. R1 kept on repeating the word "alright." then did not respond to my question after R2's name was mentioned. A review of R2's progress notes documented that R2, not including current incident, had 2 prior incidents involving other residents being physically aggressive. The following are incidents related to R2 being	S9999		

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S9999	Continued From page 3 physically aggressive to other residents: The first incident happened on 7/2/2022 between R2 and R6. Per Facility Reported Incident dated 7/2/2022 documents that R2 hit R6 on the head while inside the elevator. R6 sustained scratch to the left side of his head. Second incident happened on 7/12/2022 between R2 and R5. Per Facility Reported Incident dated 7/12/2022 documents that on day, V9 (PRSC) stated that he heard a noise outside of the social service office. When he looked outside into the hall R5 was noted crying, stating that R2 hit her in the back. On the same report, documents that R7 was interviewed. R7 stated that he noticed R2 and R5 talking to each other, and shortly after that, R7 noticed R2 ran and hit R5 on the back. R7's BIMS (Brief Interview for Mental Status) score dated 4/5/2022 was 15, which means his cognitive status was intact. The third incident happened on 10/9/2022 between R2 and R1. Per Facility Reported Incident dated 10/9/2022 documents that R2 punched R1 resulting to R1 sustaining a wound to upper right eye. Per V2 (LPN) notes dated 10/9/2022, R1 was sent to the hospital. And per V10 (Licensed Practical Nurse/LPN) notes dated 10/9/2022, R1 returned to facility with abrasion and stitches on his right forehead. On 10/27/2022 at 1:32 PM, V5 (PRSD) said, "Care plan must be done on the same day to address an identified problem. Yes, a behavioral care plan should have been done on 7/2/2022 after the first incident." After showing V5 the history of R2's intervention documenting the same intervention after second and third incident, V5 said, "I see what you mean. I think these	S9999		

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S9999	Continued From page 4	S9999		

interventions do not address R2's behavioral problem. Care plan intervention needs to be modified if it does not work. I agree if there was intervention in place during the first incident on 7/2/2022. And other interventions were put into place. Yes, I agree subsequent incidents may have been prevented."

On 10/27/2022 at 1:52 PM, V7 (Wound Coordinator / Registered Nurse) stated that R1 sustained a deep abrasion with 4 stitches because of the incident that happened between him (R2) and R1. R1's initial wound assessment dated 10/11/2022, documents right forehead traumatic laceration facility acquired measuring 3 by 0.25 by 0.10 centimeters. R2's behavioral symptoms care plan for physically aggressive related to anger was initiated on 7/13/2022. The same care plan was not initiated after first incident, dated 7/2/2022. Review of intervention addressing R2's interventions related to physical aggression documents that identical interventions were placed after repeated physical aggression by R2.

On 10/27/2022 at 2:57 PM, V1 (Assistant Administrator) was asked related to R2's notes by V11 (Licensed Practical Nurse/LPN) and V12 (Licensed Practical Nurse/LPN) dated 10/11/2022 which document R2 was only transferred to the hospital after another behavioral aggression. Although the incident between R1 and R2 occurred on midnight of 10/9/2022, given R2's history of physical aggression, V1 said, "I understand what you mean. Although R2 was transferred to another floor, other residents are still at risk of his aggression. I think you are right, it would be safer for other residents if R2 was transferred to the hospital instead of waiting for another possible incident to happen. I agree that

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S9999	Continued From page 5 it preventive measures should have been placed to avoid similar incidents to happen. Given R2's history, preventive measures should have been in place." Facility policy on Abuse Prevention dated as revised 4/29/2022 in part reads: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting to physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, mental abuse. 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. Under abuse prevention, this facility desires to prevent abuse by establishing a resident sensitive and resident secure environment. Under protection of resident, resident who allegedly abused another resident will be removed from contact with 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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