Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | | | | |
|---|---|---|---|---|-------------------------------|--|--|--|--|--|--|
| | | | | | | | | | | | |
| | | !L6004147 | B. WING | | C 10/11/2023 | | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | | | |
| APERION CARE PEORIA HEIGHTS 1629 GARDNER LANE PEORIA HEIGHTS, IL 61616 | | | | | | | | | | | |
| (X4) ID | | | | | | | | | | | |
| PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY) | D BE COMPLETE | | | | | | |
| S 000 | Initial Comments | | S 000 | | | | | | | | |
| | Complaint Investigation: 2327322/IL163965 | | | | | | | | | | |
| S9999 | Final Observations | | S9999 | | | | | | | | |
| | Statement of Licensure Violations: 300.3210t) | | | | | | | | | | |
| | subjected to physica | ensure that residents are not al, verbal, sexual or e, neglect, exploitation, or | | | | | | | | | |
| | This REQUIREMEN | IT is not met as evidenced by: | ÷ | | | | | | | | |
| | review, the facility fa right (R9) to be free another resident (R0 reviewed for abuse | on, interview and record ailed to protect a resident's from physical abuse by 8) out of four residents in a sample of 14. This 9 sustaining a fractured nose. | | | | | | | | | |
| | Findings include: | | | | | | | | | | |
| | policy revised 10/24. Abuse means any p sexual assault inflict by accidental means Abuse is the willful in unreasonable confin punishment with resmental anguish to a | e Prevention and Reporting" /22 documents "Abuse: hysical or mental injury or ted upon a resident other than is (210 ILCS 45/1-103). infliction of injury, hement, intimidation, or ulting physical harm, pain, or resident (42 CFR 483.5). | | Attachment Attachment Statement of Licensure | | | | | | | |
| linois Department of Public Health ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DA | | | | | | | | | | | |

STATE FORM

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If con inua ion sheet 1 of 4

PRINTED: 12/13/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: _ IL6004147 **B. WING** 10/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1629 GARDNER LANE APERION CARE PEORIA HEIGHTS** PEORIA HEIGHTS, IL 61616 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 1 S9999 The facility's incident report dated 9/28/23 documents "On 9/28/23 at 7:30 PM, (R9) was pushing a resident in a wheelchair to the smoking area when (R8) suddenly punched him in the face. When (R9) fell to the ground then (R8) began to kick (R9) on his arms and chest area. (R9) stated that he did nothing to provoke this attack. (R9) was helped up off the floor and sat in a chair. Writer noted that (R9) was bleeding from his nose. Writer applied a cool towel to (R9)'s face and nose to stop the bleeding. Writer Checked the resident's vitals and called the resident's primary care physician and received telephone orders to send (R9) to the hospital for further evaluation and treatment." R9's hospital medical record dated 9/28/23 documents "Closed fracture of nasal bone due to assault." R8's medical record documents a diagnosis of Schizophrenia. R8's medical records dated 9/18/23 documents "After providing the resident his medication, resident told the nurse that he was hearing voices telling him to harm people. The nurse then relayed this information to MD (Medical Doctor) and DON (Director of Nursing). The nurse then contacted (Psychiatry Service) and spoke with the on-call psychiatrist. Received orders to provide Haloperidol (antipsychotic) 5 milligrams (mg) every six hours as needed for 14 days. Resident then had his smoke break upon

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returning, resident stated that he was feeling

On 10/3/23 at 8:30 AM, V1 (Administrator) stated "(R8) hears voices in his head to hurt people. On 9/28, (R8) was in the dayroom when he started hearing voices, (R9) was walking down the hall,

better. Will continue to monitor."

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| AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | | | | |
|--|---|--|--|-------------------------------|---|--|--|--|--|--|--|
| IL6004147 | | B. WING | | C 10/11/2023 | | | | | | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | | | | | | |
| APERION CARE PEORIA HEIGHTS 1629 GARDNER LANE PEORIA HEIGHTS, IL. 61616 | | | | | | | | | | | |
| | | | | | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL | (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE | | | | | | |
| S9999 | Continued From page 2 | | S9999 | | | | | | | | |
| | face breaking his na happened. (R9) did happened to be the (R8) to the hospital called the police to On 10/3/23 at 11:44 with a faint bruise to bridge of R9's nose R9 stated "I was puwhen (R8) came arblue, just punched if fell on the ground a in the body and hea helped me. She go noticed my nose was the hospital to get of (emergency Room) broken, but there's about it and sent misher to the provoked him before. I always ke | R9) and punched him in the ose. It's pretty cut and dry. It dn't provoke (R8). (R9) just unfortunate victim. We sent for psych evaluation and file an assault report." AM, R9 observed lying in bed the left side of his nose. The was also slanted to the right, shing a resident down the hall ound the corner and out of the me in the face for no reason. Ind then he started kicking me and the off the ground and as bleeding. She sent me to thecked out. The ER doctor said was my nose was really nothing they can do e back here. I don't know. I've never talked to him ep to myself. He just came and POW! Punched me right | | | | | | | | | |
| N. | Assistant) stated "(I | AM, V13 (Certified Nursing R9) never provoked (R8). pices in his head to hurt (R9) rith no warning." | | | | | | | | | |
| | anything to me. I w time. I heard voice: | AM, R8 stated "(R9) didn't do ras not in the right place at the is in my head telling me to hurt ched him in the face and then | | | | | | | | | |
| A. | dayroom, and I saw | PM, R7 stated "I was in the r (R8) come around the corner he face and then he started | | | | | | | | | |

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PRINTED: 12/13/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: _ COMPLETED B. WING **IL6004147** 10/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1629 GARDNER LANE APERION CARE PEORIA HEIGHTS** PEORIA HEIGHTS, IL 61616 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETE ID PREFIX PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 3 S9999 kicking him when he fell. (R9) was pushing (Resident) in his wheelchair minding his own business. I don't know why (R8) punched him. (R9) didn't say anything. He was literally just walking." "A"

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