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 05/24/2023

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

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S 000	Initial Comments Complaint Investigation 2384154/IL160018	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were Not Met as evidenced by: Based on observation, interview, and record review, the facility failed to protect a resident from physical abuse. This failure resulted in one resident having a change in condition and requiring emergency medical services. The resident was diagnosed with a concussion syndrome. This failure affects one of three residents (R4) reviewed for physical abuse in a total sample of six residents. Findings include: R4 is a 28-year-old male. R4's diagnoses are but not limited to depression, diabetes, anxiety disorder, and suicidal ideations. R4's BIMS (Brief Interview for Mental Status) dated 05/09/2023, notes R4 is alert. R4's MDS (Minimum Data Set) dated 05/09/2023, notes R4 requires supervision only. R4's care plan notes R4 has the potential to be physical aggressive due to poor impulse control. On 05/17/2023, R4 had a physical altercation with staff that left R4 with a bruise to the right eyebrow.	S9999		

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Progress note dated 05/17/2023, notes R4 had a physical altercation with a staff member (behavioral aide). Noted with swollen right eyebrow, no bleeding noted. R4 was noted to be threatening towards writer demanding for a cigarette. R4 started recording, following, and blocking writer's ability to leave the basement area. As writer attempted to leave the area to another exit, R4 attacked writer. Writer then called for a code yellow to assist with the situation. NOD (Nurse on duty) was made aware of the incident. R4 refused emergency medical services but complained about being dizzy. R4 noted with extreme agitation. Nurse on duty made aware; monitoring will continue. R4 refused to go to the emergency department. R4 educated and advised on the importance to seek further medical attention. R4 verbalized understanding but still refused. R4 responsible for self.

Progress note dated 05/18/2023, R4 sent out to local hospital today due to altercation the previous day. R4 left in stable condition. R4 walked out of the facility. At 9:00PM, R4 returned from local emergency room visit. R4 returned with a diagnosis of post-concussion syndrome. R4 was advised to follow up appointment with R4's primary physician.

On 05/18/2023, at 12:24PM, V1 (Administrator) stated, the staff member was suspended pending investigation. Originally, I was told by V3 (Psychiatric Services Coordinator) that V3 was attacked by a resident. V3 called the police, and a code yellow was called. V3 tried to call later. The nurse called me and told me R4 has an injury, and R4 stated R4 was attacked. Once the police left, I made a preliminary. No one saw anything. This is unwitnessed. Staff did come down afterwards. I did see the video this morning.

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S9999	Continued From page 3 There are cameras in the hallway. This is currently being investigated." On 05/18/2023, at 1:51PM, R4 stated, "Last night they did not call for a smoke break. I made a complaint, and the staff member started acting hostile. The staff member works with social services. My right eye is swollen. This staff member hit me. I don't know the staff member's name. The staff member straight-up assaulted me. I informed the police and the administrator." On 05/18/2023, at 1:54PM, R5 stated, "I saw them both shove each other, I saw a blood clot on R4's right eye and R4 puked many times last night. It was V3. I am new to the facility." During this interview, R4 does have a swollen right eye. R4 also stated R4's head is swollen. On 05/18/2023, at 2:25PM, V3 (Psychiatric Services Coordinator) stated, "I was attempting to leave work. R4 would not let me leave because R4 wanted a cigarette. I said R4 missed the smoke break. R4 stated R4 was going to record me with R4's phone. R4 would not let me leave and was blocking the door. I tried to go another way. I said leave me alone. R4 told me R4 was filming, and I said alright R4 can film me. R4 was coming after me and I was trying to leave. R4 followed me into the stairwell where R4 can't go. R4 pushed me into the stairwell. R4 had me in a choke hold and gauged my eyes. At that point R4 was trying to kill me. I just used CPI (Crisis Prevention Intervention) to get R4 under control and call for help. People came and R4 started yelling and stated how I beat R4 up. I could have gotten killed. I would never strike a patient. I held R4 by R4's upper body where R4 could not grab at my face and control R4's arms. I was able to get my hips on top of R4's hips so R4 could not	S9999		

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keep fighting me. I was able to control R4 there. R4 got a finger in my eye. I had to control R4's arms. I have a bite mark, and we were in a tight space place. This was a matter of trying not to get R4 to kill me. R4 might have fallen against the stairs and hurt himself. I do not know."

On 05/23/2023, at 10:30AM, V1 stated, "post-concussion syndrome was listed as the diagnosis after R4 was sent out to the hospital on 05/18/2023. The facility does not share camera footage. V3 was CPI (Crisis Prevention Intervention) trained. V4 (CPI trainer) trains and provides education to the staff. Staff had several trainings in January. Staff was in serviced last week and one coming today. I spoke to the Ombudsman today and did a presentation for staff. There have been several abuse trainings, and some people do not act as trained. V3 acted inappropriately on many levels and V3 is being terminated. I expect the staff to give the resident what they want within reason. V3 failed to deescalate the situation. It could have been deescalated before things happened. Or V3 could have been nice to R4. Focus on customer service. V3 could have gotten help much sooner than V3 did if V3 acted appropriately. If a resident misses a smoke break, V3 could have taken R4 out. R4 did send me the video. If staff is being attacked by resident, there is appropriate use of CPI to be used."

V4 could not be contacted during this investigation.

On 05/23/2023, at 12:29PM, V5 stated, "I responded to the code yellow that was called. When I got there, I saw R4 being restrained by V3. Another aide joined me, and we asked what transpired. V3 said R4 would not let V3 go home.

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R4 stopped V3 from going. V3 tried to explain to R4 that V3 was not in charge in cigarette breaks. That is what caused the trouble. I was able to calm R4 down. I saw that R4's right eye was swollen and administered aide. I did not see the altercation. CPI is crisis intervention. This is used to try to make the residents calm. There are strategies to do that. Staff should never hit a resident. There are other ways to deescalate a situation."

On 05/23/2023, at 12:39PM, V6 (Certified Nursing Assistant/CNA) stated, "I was not involved in the situation. I heard someone screaming. I thought it was in a room, but it was in the stairway. I went to the stairway. A nurse from the 1st floor was already there with V3 and R4. The nurse told us to take R4 back to the second floor. There was swelling by R4's eye and it was blood from V3, I believe."
R4 showed the surveyor R4's video. R4's phone video shows R4 and V3 men having an argument. V3 tries to walk away and states R4 is trying to assault V3. V3 tries to go in the stairwell and then the video goes dark. This is where R4 states V3 hit R4.

CPI document titled, CPI Nonviolent Crisis Intervention Training, undated, notes CPI training is safe, nonharmful behavior management system designed to help professionals in any setting provide the best possible care, welfare, safety, and security, of individuals presenting a range of crisis behaviors. V3 was CPI trained on 1/24/2023.

R4's medical records dated 05/18/2023, notes police report notes R4 was attacked by social worker physically. R4's medical records document R4 had soft tissue swelling and

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S9999	Continued From page 6 bruising on the right eye. R4 at the hospital for evaluation after assault/ trauma last night at the nursing home. Possible loss of consciousness. R4 has been nauseous and vomiting since then. R4 complains of pain on the back of R4's scalp with bruising over the right eye. R4 has vision changes and difficulty coordinating R4's movements. R4 was diagnosed with post-concussion syndrome. Facility final investigation dated 05/23/2023, notes it was determined that V3 failed to de-escalate the situation numerous times, acting in an unprofessional manner, using language that was inconsistent with the facilities values. V3 failed to call a code yellow properly and used CPI inappropriately. Facility policy titled, Abuse Prevention and Reporting, dated 12/17/2021, notes this facility affirms the right of our residents to be free from abuse. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and requires medical attention. Physical abuse includes slapping, hitting, pinching, and kicking. (B)	S9999		