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 ______	R-C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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 First Certification Revisit Investigation of Facility Reported Incident of September 3, 2022/IL151126 Investigation of Facility Reported Incident of September 3, 2022/IL151634	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.3210t) 300.3240e) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

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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. 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. 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 e) 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: Based on observation, interview, and record review, the facility failed to protect a resident from physical and mental abuse. This failure applied to two (R36 and R37) of twelve residents	S9999		

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reviewed for abuse in a sample of 38 and resulted in R36 verbalizing fear and feeling unsafe in the facility after alleging that he was abused by R37; the facility also failed to act immediately to prevent any potential further abuse between (R36 and R37) after being made aware of an injury of unknown origin.

Findings include:

R36's diagnoses include in part with schizophrenia, major depressive disorder, muscle wasting and atrophy.

R36's MDS (Minimum Data Set) dated 4/3/2023 documents a BIMS (brief interview for mental status) score of 15 out of 15 (indicates that resident is cognitively intact).

Review of R36's MDS Section E Behavioral Symptoms dated 4/5/2023 related to physical symptoms such as hitting or scratching self. Documentation does not include that R36 exhibits any behaviors.

R36's care plan indicates potential moderate risk for abuse dated 4/2/23. There is no care plan in the record noted to document that R36 has any self-harm behaviors.

4/19/23 at 12:15 PM, R36 was observed standing in line in the main dining room area awaiting lunch. R36 was noted to have a large dark colored bruise beneath his right eye.

4/19/23 at 1:22 PM, V15 (Certified Nurse Assistant/CNA) was interviewed regarding R36's bruise to the right eye. V15 stated, "R36 was in bed when I did my rounds this morning. I didn't see him at breakfast. His roommate is R37."

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4/19/23 at 1:26 PM, V12 (Licensed Practical Nurse/LPN) was interviewed regarding R36's bruise to the right eye. At this time, V12 initially stated that she did see R36 and gave him meds but didn't see anything new. V12 then recanted and stated that she had noticed his eye (the new bruise in question) but wasn't sure when he got it. V12 said she then asked V18 (Assistant Director of Nursing/ADON) and was directed to V9 (Director of Behavioral Health) because V9 had already taken care of it. V12 added that R37 is R36's roommate and that she assessed R36 this morning and he didn't tell her that anything happened.

Review of R36's medical record documented that V3 (Psychiatric Services Rehabilitation Director/ PSRD) held a one-to-one social service group with R36 on 4/19/23 at 10:30 AM.

On 4/19/23 at 1:42 PM, V3 was interviewed and asked if they made any observations during one to one with R36 that morning. V3 stated, "I didn't see nothing on his face. I usually meet with him once a week."

4/19/23 at 12:57 PM, two surveyors met with R36 in his room. R36 was behind a closed and darkened room where R36 was lying in bed with his bed sheets drawn up to his neck. R36 had visible bruising and black color under his right eye. Observed a peri orbital hematoma to the right eye, blacked in color with a crescent shape that extended from the right interior to the exterior of the eye measuring approximately two centimeters in size. R36's left eye was noted with a small fading yellowish bruise. Surveyor asked what happened to him. R36 became visibly shaken and hesitated to speak with surveyors.

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After assuring R36 that he was safe to speak with surveyors, R36 stated, "It happened a couple of days ago. Someone from the dining room asked me. It happened in this room. He's done this to me before." Surveyor asked who gave him the black eye and R36 pointed to the bed next to him and stated, "It was my roommate." Surveyor asked how he felt, R36 began shaking and crying and stated, "It makes me afraid. I don't feel safe. It hurt. I didn't tell anyone." Surveyor asked whether this was the first time this happened to him with his roommate (R37) and R36 stated, "No, this is the second time."

Records reviewed on 4/19/23 at 2:00 PM, showed no reports or incidents of abuse involving R36. As of this date/time, there are no progress notes regarding R36's bruised right eye.

Efforts were made to speak with R37 throughout the afternoon of 4/19/23 but facility staff informed surveyor that R37 was out of the building at a day program. Upon return to the facility on 4/19/23 at 2:57 PM, V1 (Administrator) confirmed to the survey team that R37 refused to speak with the survey team regarding the incident. V1 stated, "R37 is refusing to talk to anyone. V9 (Director of Behavioral Health Director) did a psychosocial assessment on R36 and stated that a peer saw R36 hit himself."

R37's diagnoses include in part as unspecified Psychosis, Schizoaffective Disorder, Delusional Disorders, Auditory Hallucinations, Homicidal Ideations and Suicidal Ideations. R37 is the roommate of R36.

R37'S care plan indicates 2/1/23 I (R37) have auditory hallucinations. I (R37) am at risk for suicidal/homicidal issues AEB: voicing thoughts

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and/or intentions. I (R37) have the potential to become delusional and have false beliefs due to my hallucinations and diagnosis of delusional disorder 2/1/23.

A review of progress notes showed on 3/22/23, V22 (Social Worker) wrote, "Resident (R37) was noted to have aggressive behavior when playing games. Writer counseled resident about his aggressive behavior and resident understands."

4/19/23 at approximately 12:17 PM, V20 (Assistant Administrator) was interviewed regarding the bruise noted on R36's right eye. V20 stated, I'm not sure what happened, let me find out.

4/19/23 at approximately 12:19 PM, V9 (Director of Behavioral Health) approached surveyor and stated that she believed that R36 had an old bruise but would find out. At this time, surveyor asked V9 to provide any documentation for any incident reports and/or supporting documentation related to the bruise observed on R36's right eye.

4/19/23 at 3:20 PM, V9 returned to speak with surveyor, along with V1 (Administrator). V9 stated, I talked to R38 yesterday and he said that guy and pointed to R36. R38 was cycling. He was having psychotic behavior and was delusional. At the time, R36 didn't have a bruise. I noticed the bruise today when the surveyor asked me about it then I went and told V1. V9 was then asked if she took R38's statement about R36 hitting himself and investigated it further or if the statement was considered credible, given that R38 was actively having psychotic behaviors and being delusional. V9 responded by stating that she had asked R38 something else and he was able to answer it

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clearly.

4/19/23 at 3:23 PM, V1 (Administrator) was asked about what had been reported to him regarding R36. V1 stated, I am the abuse coordinator. I went to talk with R36 (today), and he just told me to go (expletive) myself. No staff were aware that anyone struck R36. I spoke with V9 again and concluded that R36 hit himself based on the interview that R38 had provided in passing to V9 yesterday. The consultant looked at R36's past care plan and said R36 had something in there about self-harm. The consultant advised the nurse to do a skin assessment. V1 was asked if any other residents or staff were interviewed regarding R36 and V1 stated, we talked to V12 (LPN) today after we became aware of the situation. V1 was asked if this was the conclusion that he determined regarding the injury to R36's right eye. V1 stated, based on what I know, yes, R38 said that R36 hit himself. V1 added that he knew what happened, so there was no abuse. V1 was asked how he came to this conclusion without conducting an investigation. V1 stated, there is nothing else to say about it, abuse didn't occur. R36 would not speak to me when I tried to speak with him. R38 was off baseline yesterday, he was verbally aggressive toward me, he had repetitive thoughts and it's not his normal. Just because R38 was delusional it doesn't mean there is no truth to what he said. I was made aware round 12ish today (about R36). Initially, I didn't know what happened. Based on what I've investigated I believe this is what happened. R37 is refusing to talk to us.

4/19/23 at 3:51 PM, V1 (Administrator) returned to the conference room and stated, after speaking with the consultant, I'm doing a report of

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injury of unknown origin.

On 4/20/23 at 9:30 AM, V1 was inquired of R37 being involved in any incidents. V1 stated, I don't have any except that R37 has a history of verbal aggression. V1 was asked to provide documentation of any incidents.

During this survey, the facility was asked and did not provide any documentation to show that a thorough injury of unknown origin or potential abuse investigation was completed regarding R36, including any steps taken to protect R36 from abuse.

Facility provided Abuse Prevention and Reporting-Illinois policy (dated 12/17/21), which includes:

Guidelines: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment.

The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.

Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident

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other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish.

The term "willful" in the definition of "abuser" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm ...

Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions.

Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment ...

Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.

Resident to Resident Abuse (any type): A resident to resident altercation should be reviewed as a potential situation of abuse: Not all resident-to-resident altercations result in abuse. Resident to resident altercations that include any willful action that results in physical injury, mental

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anguish or pain must be reported in accordance with regulations.

Protection of Residents

The facility will take steps to prevent potential abuse while the investigation is underway.

Residents who allegedly abused another resident 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. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents.

"B"

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300.3240e)

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 lêast 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.
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.

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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
e) 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:

Based on observation, interview, and record review, the facility failed to protect a resident from physical and mental abuse. This failure applied to two (R36 and R37) of twelve residents reviewed for abuse in a sample of 38 and resulted in R36 verbalizing fear and feeling unsafe in the facility after alleging that he was abused by R37; the facility also failed to act immediately to prevent any potential further abuse between (R36 and R37) after being made aware of an injury of unknown origin.

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status) score of 15 out of 15 (indicates that resident is cognitively intact).

Review of R36's MDS Section E Behavioral Symptoms dated 4/5/2023 related to physical symptoms such as hitting or scratching self. Documentation does not include that R36 exhibits any behaviors.

R36's care plan indicates potential moderate risk for abuse dated 4/2/23. There is no care plan in the record noted to document that R36 has any self-harm behaviors.

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Review of R36's medical record documented that V3 (Psychiatric Services Rehabilitation Director/ PSRD) held a one-to-one social service group with R36 on 4/19/23 at 10:30 AM.

On 4/19/23 at 1:42 PM, V3 was interviewed and asked if they made any observations during one to one with R36 that morning. V3 stated, "I didn't see nothing on his face. I usually meet with him once a week."

4/19/23 at 12:57 PM, two surveyors met with R36 in his room. R36 was behind a closed and darkened room where R36 was lying in bed with his bed sheets drawn up to his neck. R36 had visible bruising and black color under his right eye. Observed a peri orbital hematoma to the right eye, blacked in color with a crescent shape that extended from the right interior to the exterior of the eye measuring approximately two centimeters in size. R36's left eye was noted with a small fading yellowish bruise. Surveyor asked what happened to him. R36 became visibly shaken and hesitated to speak with surveyors. After assuring R36 that he was safe to speak with surveyors, R36 stated, "It happened a couple of days ago. Someone from the dining room asked me. It happened in this room. He's done this to me before." Surveyor asked who gave him the black eye and R36 pointed to the bed next to him and stated, "It was my roommate." Surveyor asked how he felt, R36 began shaking and crying and stated, "It makes me afraid. I don't feel safe. It hurt. I didn't tell anyone." Surveyor asked whether this was the first time this happened to him with his roommate (R37) and R36 stated, "No, this is the second time."

Records reviewed on 4/19/23 at 2:00 PM, showed no reports or incidents of abuse involving R36.

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As of this date/time, there are no progress notes regarding R36's bruised right eye.

Efforts were made to speak with R37 throughout the afternoon of 4/19/23 but facility staff informed surveyor that R37 was out of the building at a day program. Upon return to the facility on 4/19/23 at 2:57 PM, V1 (Administrator) confirmed to the survey team that R37 refused to speak with the survey team regarding the incident. V1 stated, "R37 is refusing to talk to anyone. V9 (Director of Behavioral Health Director) did a psychosocial assessment on R36 and stated that a peer saw R36 hit himself."

R37's diagnoses include in part as unspecified Psychosis, Schizoaffective Disorder, Delusional Disorders, Auditory Hallucinations, Homicidal Ideations and Suicidal Ideations. R37 is the roommate of R36.

R37'S care plan indicates 2/1/23 I (R37) have auditory hallucinations. I (R37) am at risk for suicidal/homicidal issues AEB: voicing thoughts and/or intentions. I (R37) have the potential to become delusional and have false beliefs due to my hallucinations and diagnosis of delusional disorder 2/1/23.

A review of progress notes showed on 3/22/23, V22 (Social Worker) wrote, "Resident (R37) was noted to have aggressive behavior when playing games. Writer counseled resident about his aggressive behavior and resident understands."

4/19/23 at approximately 12:17 PM, V20 (Assistant Administrator) was interviewed regarding the bruise noted on R36's right eye. V20 stated, I'm not sure what happened, let me find out.

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{S9999}	Continued From page 6	{S9999}		

4/19/23 at approximately 12:19 PM, V9 (Director of Behavioral Health) approached surveyor and stated that she believed that R36 had an old bruise but would find out. At this time, surveyor asked V9 to provide any documentation for any incident reports and/or supporting documentation related to the bruise observed on R36's right eye.

4/19/23 at 3:20 PM, V9 returned to speak with surveyor, along with V1 (Administrator). V9 stated, I talked to R38 yesterday and he said that guy and pointed to R36. R38 was cycling. He was having psychotic behavior and was delusional. At the time, R36 didn't have a bruise. I noticed the bruise today when the surveyor asked me about it then I went and told V1. V9 was then asked if she took R38's statement about R36 hitting himself and investigated it further or if the statement was considered credible, given that R38 was actively having psychotic behaviors and being delusional. V9 responded by stating that she had asked R38 something else and he was able to answer it clearly.

4/19/23 at 3:23 PM, V1 (Administrator) was asked about what had been reported to him regarding R36. V1 stated, I am the abuse coordinator. I went to talk with R36 (today), and he just told me to go (expletive) myself. No staff were aware that anyone struck R36. I spoke with V9 again and concluded that R36 hit himself based on the interview that R38 had provided in passing to V9 yesterday. The consultant looked at R36's past care plan and said R36 had something in there about self-harm. The consultant advised the nurse to do a skin assessment. V1 was asked if any other residents or staff were interviewed regarding R36 and V1 stated, we talked to V12

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{S9999}	Continued From page 7	{S9999}		

(LPN) today after we became aware of the situation. V1 was asked if this was the conclusion that he determined regarding the injury to R36's right eye. V1 stated, based on what I know, yes, R38 said that R36 hit himself. V1 added that he knew what happened, so there was no abuse. V1 was asked how he came to this conclusion without conducting an investigation. V1 stated, there is nothing else to say about it, abuse didn't occur. R36 would not speak to me when I tried to speak with him. R38 was off baseline yesterday, he was verbally aggressive toward me, he had repetitive thoughts and it's not his normal. Just because R38 was delusional it doesn't mean there is no truth to what he said. I was made aware round 12ish today (about R36). Initially, I didn't know what happened. Based on what I've investigated I believe this is what happened. R37 is refusing to talk to us.

4/19/23 at 3:51 PM, V1 (Administrator) returned to the conference room and stated, after speaking with the consultant, I'm doing a report of injury of unknown origin.

On 4/20/23 at 9:30 AM, V1 was inquired of R37 being involved in any incidents. V1 stated, I don't have any except that R37 has a history of verbal aggression. V1 was asked to provide documentation of any incidents.

During this survey, the facility was asked and did not provide any documentation to show that a thorough injury of unknown origin or potential abuse investigation was completed regarding R36, including any steps taken to protect R36 from abuse.

Facility provided Abuse Prevention and

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{S9999}	Continued From page 8 Reporting-Illinois policy (dated 12/17/21), which includes: Guidelines: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The term "willful" in the definition of "abuser" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm ...	{S9999}		

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Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions.

Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment ...

Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.

Resident to Resident Abuse (any type): A resident to resident altercation should be reviewed as a potential situation of abuse: Not all resident-to-resident altercations result in abuse. Resident to resident altercations that include any willful action that results in physical injury, mental anguish or pain must be reported in accordance with regulations.

Protection of Residents

The facility will take steps to prevent potential abuse while the investigation is underway.

Residents who allegedly abused another resident 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. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the

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{S9999}	Continued From page 10 residents. "B"	{S9999}		

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{S 000}	Initial Comments First Certification Revisit Complaint Investigation: 2391259/IL156425 2391023/IL156128 2390971/IL156063 2390832/IL155910 Investigation of Facility Reported Incident of January 25, 2023/IL156382 Investigation of Facility Reported Incident of January 27, 2023/IL156381	{S 000}		
{S9999}	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.3210t) 300.3240e) 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.	{S9999}	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{S9999}	Continued From page 1 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. 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. 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 e) 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	{S9999}		

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the facility.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect a resident from physical and mental abuse. This failure applied to two (R36 and R37) of twelve residents reviewed for abuse in a sample of 38 and resulted in R36 verbalizing fear and feeling unsafe in the facility after alleging that he was abused by R37; the facility also failed to act immediately to prevent any potential further abuse between (R36 and R37) after being made aware of an injury of unknown origin.

Findings include:

R36's diagnoses include in part with schizophrenia, major depressive disorder, muscle wasting and atrophy.

R36's MDS (Minimum Data Set) dated 4/3/2023 documents a BIMS (brief interview for mental status) score of 15 out of 15 (indicates that resident is cognitively intact).

Review of R36's MDS Section E Behavioral Symptoms dated 4/5/2023 related to physical symptoms such as hitting or scratching self. Documentation does not include that R36 exhibits any behaviors.

R36's care plan indicates potential moderate risk for abuse dated 4/2/23. There is no care plan in the record noted to document that R36 has any self-harm behaviors.

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lunch. R36 was noted to have a large dark colored bruise beneath his right eye.

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eye. Observed a peri orbital hematoma to the right eye, blacked in color with a crescent shape that extended from the right interior to the exterior of the eye measuring approximately two centimeters in size. R36's left eye was noted with a small fading yellowish bruise. Surveyor asked what happened to him. R36 became visibly shaken and hesitated to speak with surveyors. After assuring R36 that he was safe to speak with surveyors, R36 stated, "It happened a couple of days ago. Someone from the dining room asked me. It happened in this room. He's done this to me before." Surveyor asked who gave him the black eye and R36 pointed to the bed next to him and stated, "It was my roommate." Surveyor asked how he felt, R36 began shaking and crying and stated, "It makes me afraid. I don't feel safe. It hurt. I didn't tell anyone." Surveyor asked whether this was the first time this happened to him with his roommate (R37) and R36 stated, "No, this is the second time."

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R37's diagnoses include in part as unspecified

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Psychosis, Schizoaffective Disorder, Delusional Disorders, Auditory Hallucinations, Homicidal Ideations and Suicidal Ideations. R37 is the roommate of R36.

R37'S care plan indicates 2/1/23 I (R37) have auditory hallucinations. I (R37) am at risk for suicidal/homicidal issues AEB: voicing thoughts and/or intentions. I (R37) have the potential to become delusional and have false beliefs due to my hallucinations and diagnosis of delusional disorder 2/1/23.

A review of progress notes showed on 3/22/23, V22 (Social Worker) wrote, "Resident (R37) was noted to have aggressive behavior when playing games. Writer counseled resident about his aggressive behavior and resident understands."

4/19/23 at approximately 12:17 PM, V20 (Assistant Administrator) was interviewed regarding the bruise noted on R36's right eye. V20 stated, I'm not sure what happened, let me find out.

4/19/23 at approximately 12:19 PM, V9 (Director of Behavioral Health) approached surveyor and stated that she believed that R36 had an old bruise but would find out. At this time, surveyor asked V9 to provide any documentation for any incident reports and/or supporting documentation related to the bruise observed on R36's right eye.

4/19/23 at 3:20 PM, V9 returned to speak with surveyor, along with V1 (Administrator). V9 stated, I talked to R38 yesterday and he said that guy and pointed to R36. R38 was cycling. He was having psychotic behavior and was delusional. At the time, R36 didn't have a bruise. I noticed the bruise today when the surveyor

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	IL6008064	A. BUILDING: ______ B. WING ______	R-C 04/20/2023

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APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
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asked me about it then I went and told V1. V9 was then asked if she took R38's statement about R36 hitting himself and investigated it further or if the statement was considered credible, given that R38 was actively having psychotic behaviors and being delusional. V9 responded by stating that she had asked R38 something else and he was able to answer it clearly.

4/19/23 at 3:23 PM, V1 (Administrator) was asked about what had been reported to him regarding R36. V1 stated, I am the abuse coordinator. I went to talk with R36 (today), and he just told me to go (expletive) myself. No staff were aware that anyone struck R36. I spoke with V9 again and concluded that R36 hit himself based on the interview that R38 had provided in passing to V9 yesterday. The consultant looked at R36's past care plan and said R36 had something in there about self-harm. The consultant advised the nurse to do a skin assessment. V1 was asked if any other residents or staff were interviewed regarding R36 and V1 stated, we talked to V12 (LPN) today after we became aware of the situation. V1 was asked if this was the conclusion that he determined regarding the injury to R36's right eye. V1 stated, based on what I know, yes, R38 said that R36 hit himself. V1 added that he knew what happened, so there was no abuse. V1 was asked how he came to this conclusion without conducting an investigation. V1 stated, there is nothing else to say about it, abuse didn't occur. R36 would not speak to me when I tried to speak with him. R38 was off baseline yesterday, he was verbally aggressive toward me, he had repetitive thoughts and it's not his normal. Just because R38 was delusional it doesn't mean there is no truth to what he said. I was made aware round 12ish

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today (about R36). Initially, I didn't know what happened. Based on what I've investigated I believe this is what happened. R37 is refusing to talk to us.

4/19/23 at 3:51 PM, V1 (Administrator) returned to the conference room and stated, after speaking with the consultant, I'm doing a report of injury of unknown origin.

On 4/20/23 at 9:30 AM, V1 was inquired of R37 being involved in any incidents. V1 stated, I don't have any except that R37 has a history of verbal aggression. V1 was asked to provide documentation of any incidents.

During this survey, the facility was asked and did not provide any documentation to show that a thorough injury of unknown origin or potential abuse investigation was completed regarding R36, including any steps taken to protect R36 from abuse.

Facility provided Abuse Prevention and Reporting-Illinois policy (dated 12/17/21), which includes:

Guidelines: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment.

The purpose of this policy is to assure that the

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facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.

Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish.

The term "willful" in the definition of "abuser" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm ...

Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions.

Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment ...

Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or

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degradation.

Resident to Resident Abuse (any type): A resident to resident altercation should be reviewed as a potential situation of abuse: Not all resident-to-resident altercations result in abuse. Resident to resident altercations that include any willful action that results in physical injury, mental anguish or pain must be reported in accordance with regulations.

Protection of Residents

The facility will take steps to prevent potential abuse while the investigation is underway.

Residents who allegedly abused another resident 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. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents.

"B"