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	IL6001713	A. BUILDING: _____ B. WING _____	01/10/2024

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APERION CARE WEST CHICAGO	201 WEST NORTH AVENUE WEST CHICAGO, IL 60185

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.340 c)3)C)iii) Section 300.340 Incorporated and Referenced Materials c) The following statutes and State regulations are referenced in this Part: 3) State of Illinois rules C) Department of Public Health: iii) Food Code (77 Ill. Adm. Code 750) This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure three food service staff received their food handler's certification within 30 days of hire, and two long-term employees had current and valid food handler's certifications. This has the potential to effect all residents residing in the facility. The findings include: The facility's CMS 671, dated 1/8/24, shows there are 199 residents residing in the facility. Facility provided Dietary Schedule for 12/28/23 to 1/10/24 shows V23 (Dietary Aide), V24 (Dietary Aide), V25 (Dietary Aide), V26 (Dietary Aide), and	S9999		

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S9999	Continued From page 1 V27 (Dietary Aide) as active employees with scheduled shifts. Facility provided hire dates shows V23's hire date was 8/15/23, V24's hire date was 5/9/23, V25's hire date was 9/24/21, V26's hire date was 9/16/16, and V27's hire date was 5/18/23. On 1/8/24 at 9:23 AM, V22 (Cook) said V31 (former Food Service Director) left about six months ago, and V22 has been helping V1 (Administrator) complete tasks V31 would do. On 1/8/24 at 2:05 PM, facility kitchen schedule and employee food handler's certificates were reviewed and V23, V24, V25, V26, and V27 did not have current and active food handler's certificates. On 1/9/24 at 11:36 AM, V1 did not know the time frame Dietary Aides had to complete their food handler's certification. On 1/10/24 at 10:15 AM, V1 said V1 was unable to find up-to-date certificates for V23, V24, V25, V26, and V27, and that V1 will get them retested. As of 1/10/24 at 12:28 PM, V1 was unable to provide current and valid food handler's certifications for V23, V24, V25, V26, and V27. V1 said the facility will make sure V23, V24, V25, V26, and V27 receive and renew their food handler's certifications. (C) 2 of 2 300.610 a)	S9999		

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S9999	Continued From page 2 300.1210 b) 300.3210 t) 300.3240 a) 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. 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or	S9999		

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neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents were free from physical abuse. This failure resulted in R108 receiving sutures after R304 hit him in the face two times. This applies to 2 of 35 residents (R108 & R304) reviewed for abuse in the sample of 35.

The findings include:

1. R304's care plan, date initiated 8/24/23, shows, "Focus: I am/have the potential to be physically aggressive. AEB (as evidenced by) I Punched a fellow resident in the face on December 23, 2023 r/t (related to) dx of other schizophrenia, generalized anxiety disorder, and schizoaffective disorder, bipolar type. Interventions: ...12/23/2023- res punched another resident after going into res room to hug them and fellow res punched them. Res punched res back cutting them on the face ..."

R108's nursing progress note, dated 12/23/23, shows, "Call light activated and aide went to room to check on the light. Resident was at the doorway bleeding from a 2-3 inch laceration on his left eyebrow and ½ inch on middle of forehead ... Resident stated that co-peer (R304) hit him twice."

R304's nursing progress note, dated 12/23/23, shows, "Resident was noted to be watching as staff was rendering first aide to co-peer (R108). Co-peer (R108) stated that resident had hit him twice. Resident stated co-peer (R108) hit him

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first ..."

R108's local hospital after visit summary, dated 12/23/23, shows, "Reason for visit: Close Head Injury; Diagnosis: Cut on face. Instructions: Please return to the emergency department or to primary care doctor in 7-10 days to have your sutures removed ..."

R108's nursing progress notes, dated 12/24/23, shows, "Per ER (emergency room) nurse report, resident has a CT (computed tomography) scan-result is neg (negative). DX (diagnosis) cut on face ... Noted 8 stitches to L (left) eyebrow and to forehead ..."

The facility's incident log, dated 1/2/24, shows, "On 12/23/2023, (R304) was calmly pacing the halls. He went into (R108's) room and got close to him (R108) did not like that, so he hit him, causing (R304) to experience an acute onset of agitation and poor impulse control and reflexively hit (R108) ..."

On 1/8/24 at 10:30 AM, R108 had two sutures to the left side of his forehead. He stated, "I got attacked by a black guy. He tried to kiss me. There was blood everywhere. He punched me. I hope he's in jail." At 11:23 AM, R108 was sitting at the nursing station. He had more sutures to his left eyebrow. V7, Registered Nurse (RN), stated, "he was hit by another resident."

On 1/10/24 at 10:13 AM, V8, Licensed Practical Nurse (LPN), stated he was working the night R304 hit R108 in the face. He was at the nursing station, and the call light for R108's room went off. He walked down there and saw R108 bleeding from the left eyebrow. He stated the laceration was pretty deep and he knew he

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needed stitches. "(R108) said (R304) came in and hit him twice in the face. (R108) went to the hospital and came back with stitches to his left eyebrow and forehead."

2. R304's care plan, date initiated 8/24/23 shows, "Focus: I am/have the potential to be physically aggressive. ...r/t (related to) dx of other schizophrenia, generalized anxiety disorder, and schizoaffective disorder, bipolar type. Interventions: ...When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive staff to walk calmly away, and approach later ..." R304's nursing progress notes, dated 9/19/23shows, "3:30 PM Resident trying to leave the unit for smoke break, behavior aide trying to redirect resident by grabbing and applying inappropriate CPI (crisis prevention intervention) ..."

The facility's Resident Abuse Investigation Form, dated 9/26/23, shows, "(V4) Behavioral Aide (BA) mistakenly called the north hall to come down to smoke when she meant the west hall. (R304) who resided
on the north hall went to the gate to go down for his smoke break. (V4) told him that is was not yet his turn, but he said they called my hall and walked past her. (V4) started to firmly guide (R304) back onto the unit and argument broke out between them ..."

On 1/9/24 at 2:32 PM, V5, BA, stated she had problems with V4, BA, before this incident happened. She didn't like the way V4, BA, talked to the residents. She would "snap at them and had a very rude tone. She was never calm and always yelling at them." On the day of the

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incident, V4, BA, and V5, BA, were working 3rd floor and getting ready to take the residents out for a cigarette. "(V4, BA) accidentally called (R304's) hall. He heard it and started coming up to the gate. (V4, BA) was on the other side of the gate and told (R304) that it was not his turn and he had to wait. He said, 'I heard you call my hall.' She continued to tell him that it wasn't his turn and he had to go back. She was nasty about it. Her tone was rude. (R304) ended up going through the gate. He was asking her nicely to please let him go smoke. Then they got into each others faces. She pushed and shoved him towards the elevator door. (R304) took off his headphones and said, 'don't touch me! Don't put your hands on me!' (V4, BA) kept saying, 'why didn't you listen?'" V5, BA, ended up getting between them and separating them. "I was holding (V4, BA) back. We usually do that with the residents. She was causing more damage to this whole fight. If anything she was going to hurt him."

On 1/9/24 at 3:11 PM, V4, BA, stated all she did was hold him back. "I was defending myself. I had to grab him and hold him back." She admitted she got emotional in the moment and should have controlled her emotions. She stated the facility was accusing her of abuse and fired her. She stated R304 was attacking her and she was under a lot of stress, and didn't know what to do in that moment.

On 1/9/24 at 12:11 PM, V1, Administrator, stated, "(V4, BA) was terminated after the incident with (R304). She called the wrong hall by accident and (R304) came. She told (R304) it was the wrong hall and he couldn't go smoke. She grabbed him. Unprofessional really."

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S9999	Continued From page 7 V4's, BA, Human Resources notice of corrective action, dated 9/19/24 shows, "Rule or Policy involved: inappropriate interaction with a resident." The form shows, this was a final warning resulting in discharge. The facility's abuse prevention policy (no date) shows, " ...The abuse, neglect, or other mistreatment of residents in the facility, physically, mentally, or emotionally, is unlawful and is prohibited ... Definitions of Abuse and Neglect: Abuse and neglect exist in many forms and to varying degrees. A. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish ... iii. Physical abuse includes hitting, slapping, pinching, and kicking." (A)	S9999		