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 _____	06/09/2022

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APERION CARE WEST RIDGE	6450 NORTH RIDGE BLVD CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation: 2284411/IL147682	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 300.3210t) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.3240 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) 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. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a resident (R23) remained free from physical abuse. This failure resulted in R23 being slapped in the face and sustaining bruising to R23's eyes. Findings include: R23's Face sheet documents that R23 has diagnoses which include but not limited to: Schizophrenia, bipolar disorder unspecified, morbid obesity due to excess calories, and unspecified asthma uncomplicated. R23's Brief Mental Status Interview (BIMS) dated 03/16/22 documents that R23 has a BIMS score of 15 which indicates that R23 is cognitively intact however when R23 was interviewed by Surveyor	S9999		

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S9999	Continued From page 2 R23 was reluctant to respond to most of the Surveyors questions during R23's interview. On 06/07/22 at 1:51 pm, V3 (Assistant Director of Nursing/ADON) was interviewed regarding R23 on day of incident. V3 stated that on 06/03/22 around 3:30 pm, V17 (Licensed Practical Nurse/LPN) asked V3 to come to room R23's room to see R23's eyes. V3 stated that V3 and V17 observed R23's right eyelid was discolored red. V3 stated that R23 stated, "A staff member slapped me (R23) in the face and bruised my eyes." V3 stated that R23 described a staff member V12 (Certified Nursing Assistant/CNA) as the person who slapped R23. V3 also stated that V3 reported to V1 (Administrator) R23's allegations that V12 slapped R23, called the local police department, R23's physician and R23's family immediately upon R23's statement. V3 stated that V3 had already left the facility for the day. During surveyors review of R23's EHR (Electronic Health Record) progress note, there was no documentation that V3 informed V1(Administrator) of R23's allegations regarding V12. On 06/07/22 at 3:06 pm, Surveyor observed R23 in bed with reddish purple bruising to right and left upper eyelid areas. When R23 was asked what happened to R23's right and left upper eyelid areas R23 stated that R23 and a Certified Nursing Assistant (CNA) who was identified as V12 (CNA) got into a physical fight at the nurses' station a week ago after R23 threw a cup at V12 and grabbed V12 arms. R23 stated that V12 followed R23 into R23's room and slapped R23 in R23's face with an open hand causing R23's eyes to turn red.	S9999		

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S9999	Continued From page 3 On 06/08/22 at 11:40 am, Surveyor and V1 (Administrator) viewed the video recording from the second-floor unit nursing station area and elevator area from 06/03/22 at 7:27am. Surveyor and V1 observed at 7:26 am, R23 pacing down the second-floor hallway with an empty water pitcher in R23's hand. At 7:27 am, R23 was then observed at the nursing station throwing the empty water pitcher at nursing staff member identified as V12 (CNA) and hitting V12 on V12's left side. R23 then walked away from V12 after R23 threw the empty water pitcher and proceeded to pace down the Y hallway. R23 returned to V12 at the nursing station and hit V12 on V12's arms. V12 was then observed directing R23 to go near the elevator area. As R23 walked towards the elevator area V12 was observed following R23 towards the elevator and R23 began to grab and hit V12 again in V12's head and body. Another staff member identified as V19 (Certified Nursing Assistant/ CNA) was then observed holding R23's left arm. While V19 was observed holding R23's left arm, R23 grabbed V12's hair and V12 then swung at R23 striking R23's right eye and cheek bone area with V12's open right hand. At 7:28 am, V19 and V12 are observed directing R23 down the hallway towards R23's room. V12 and V19 followed R23 inside of R23's room and was observed staying inside of R23's room for approximately 15 seconds before leaving R23's room and returning to the second-floor hallway nurses' station area. On 06/08/22 at 11:57 am, V12 (CNA) was interviewed regarding the incident with R23 on 06/03/22. V12 stated that "on 06/03/22 around 7:30 am, V12 was passing breakfast trays at room XXX across from the nurses' station and R23 threw a pitcher at V12. V12 stated that no	S9999		

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S9999	Continued From page 4	S9999		

nurse was on the second-floor unit and that V12 informed V19 (CNA) that R23 threw a pitcher at V12. V12 stated that 2 minutes after R23 threw a pitcher at V12, V12 then started hitting V12 and V19 rescued V12 from R23 hitting V12. V12 stated that while R23 was hitting V12 and pulling V12's hair, V12 reached V12's arm out to stop R23. V12 stated that V12 and V19 then asked R23 to go back to R23's room. V12 denied escorting R23 inside of R23's room. V12 stated the nurse was still not on the second floor and that V12 reported the incident to V3 (Assistant Director of Nursing/ADON) on 06/03/22 around 8:00 am. V12 stated that V12 saw R23 again at lunch time on 06/03/22 and did not observe any bruising to R23's eyes. V12 stated that V12 saw R23 again around 2:00 pm on 06/03/22 coming from room YYY with no bruising from R23's eyes. V12 stated that V12 last saw R23 on 06/03/22 at 3:05 pm in bed sleeping and denies seeing bruising to R23's eyes. V12 stated that V12 is aware of the types of abuse and that all allegations of abuse are to be immediately reported to V1 (abuse coordinator). V12 stated that I (V12) was called at home on 06/04/22 and that I (V12) would be taken off the schedule while an abuse investigation with R23 is being conducted."

On 06/08/22 at 12:38 pm V19 (CNA) was interviewed regarding the incident that occurred on 6/3/2022 with V12 and R23. V19 stated, "R23 on 06/03/22 at around 7:30am, I (V19) heard V12 (CNA) yelling out from the nursing station that R23 threw a cup at V12 while V12 was serving breakfast trays in the hallway near room XXX. V19 stated that after R23 threw the cup at V12, R23 asked for a mask and then started hitting V12 while V12 was standing at the food cart at the nurses' station. V19 stated (V19) told R23 to

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stop and for R23 to go to R23's room. V19 denied seeing V12 hit R23 during the altercation. V19 stated that V19 and V12 escorted R23 to R23's room but denied entering R23's room. V19 stated that V19 and V12 called V3 to the second floor and reported the altercation with R23 around 8:30 am. V19 denied ever seeing R23's eyes discolored on 06/03/22. V19 stated that V19 is aware of the types of abuse and that all allegations of abuse are to be immediately reported to V1, the abuse coordinator."
On 06/08/22 at 3:27 pm, V17 (Licensed Practical Nurse/LPN) was interviewed regarding R23's reddish purple discolored right and left upper eyelids and V17 stated that on 06/03/22 V17 arrived on the second-floor unit around 3:30 pm and began rounding in residents' rooms. V17 stated that when V17 entered R23's room R23 was observed with red discoloration to both of R23's upper eyelids. V17 stated that V17 tried to wake R23 to ask R23 what happened to R23's eyes but R23 was not responding. V17 stated that V17 then asked the 7:00 am- 3:00 pm nurse, V10 (Licensed Practical Nurse/LPN) what happened to R23's eyes and V10 stated that V10 was not aware. V17 stated that V17 called V3 (ADON) to the second-floor unit to inform V3 of the discoloration to R23's eyes.

On 06/09/22 at 1:49 pm, Surveyors and V1 reviewed the video recording from the second-floor unit nursing station and elevator area dated recorded on 06/03/22 at 7:27 am. During the video review, V1 was asked where did R12's right open hand land on R23 from the observation in the video. V1 stated, "It landed on R23's face." When V1 was asked if V12 and V19 followed the facility's abuse policy V1 stated, "No they (V12 and V19) did not. I am still investigating this allegation." V1 was asked if V12 and V19 had

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S9999	Continued From page 6 abuse training at the facility. V1 stated, "Yes." On 06/09/22 at 2:27 pm, V27 (R23's Physician) was interviewed regarding R23's right and left upper eyelid areas. V27 stated that "I (V27) was notified on 06/03/22 that R23 was having behaviors and threw a cup of water at staff and had a cut over R23's left eye area. V27 stated that I (V27) gave orders for R23 to be placed on 1:1 monitoring and for the psychiatrist to be notified of R23's behavior. V27 denied that I (V27) was made aware that R23 was in an altercation with staff and was hit by staff on R23's right side of R23's face." V27 was asked what could happen to R23 if R23 is hit in the face by staff with an open hand striking R23's right eye and right cheek area. V27 stated, "It (referring to being struck with an open hand in the right eye and right cheek area) is dangerous and can cause a scratch, an abrasion, a break in the skin, or bleeding in the eyes." R23's Treatment Administration Record (TAR) with orders dated June 7, 2022, documents monitor skin discoloration to the left eyelid every shift for 7 days. R23's Progress notes dated 06/03/22 at 17:03 authored by V3 documents, in part: "During rounds resident (R23) observed with left eye lip (referring to R23's right eyelid) discoloration ... MD call ice pack applied, bacitracin apply for 7 days." V12's timecard report reviewed for 05/29/22 through 06/11/22 documents, V12's last "In punch" on 06/03/22 at 7:05 am, and "Out punch" on 06/03/22 at 3:13 pm. Facility's document dated May 2, 3, 4, 2022 and	S9999		

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S9999	Continued From page 7 titled "Abuse" documents, in part that V12 was in-serviced regarding the facility's abuse policy. On 06/09/22 at 2:00 pm, Surveyor requested for V19's abuse in-servicing, V1 was unable to provide. Facility's document dated 11/28/16 and titled "Abuse Prohibition Policy and Procedures" documented, in part: "Guidelines: The resident has the right to be from abuse, neglect, misappropriation of resident property, and exploitation ... Definition: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish ... Internal Investigation: All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation ... Orientation and Training of Employees: Staff obligations to prevent and report abuse, neglect, exploitation, mistreatment and misappropriation of residents property ... An employee's obligation under the law for reporting a suspected crime to the facility, the state survey agency and local law enforcement; the time frames for reporting; and state survey agency and local law enforcement; the timeframes for reporting and management's obligation to prohibit retaliation against anyone who makes a report. On an annual basis, staff will receive a review of the above topics. On an annual basis, supervisory personnel will receive training on their obligations under law when receiving an allegation of abuse, neglect or misappropriation of resident property, and how to monitor and correct inappropriate or insensitive staff action, words or body language. ... Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential	S9999		

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S9999	Continued From page 8 abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator ... Reports should be documented and a record kept of the documentation ... External Reporting: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or results in serious bodily injuries ... Five-day Final Investigation Report: Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health." (B)	S9999		