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 _____	07/28/2023

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

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S 000	Initial Comments Annual Licensure and Certification Investigation of Facility Reported Incident of June 29, 2023/ IL161799 Investigation of Facility Reported Incident of July 2, 2023/IL161817 Investigation of Facility Reported Incident of July 2, 2023/IL161806	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	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) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect residents from resident-to-resident abuse (R11, R97) and staff-to-resident abuse (R18) for three of seven residents reviewed for abuse in the sample of 28. R11 sustained an injury to the head after being hit with a light fixture by R2. R97 sustained a cut on the nose after being hit by R109. Findings include: 1.) On 07/25/23 at 10:15 AM, R11 was observed in his room and said he was watching a movie. R11 stated that he and his roommate "got at it" a while ago because his former roommate (R2) always had his TV (Television) very loud, and this went on for like a year. R11 said that he had told R2 on several occasions to reduce his TV volume which R2 left on high volume day and night, but R2 would not listen to R11's request. R11 said he had told staff about it (No name provided), but nothing was done. R11 said that a few days ago, late at night, R2's TV was very loud, and R11 asked R2 to reduce the volume, then R11 went to the bathroom after asking R2 to reduce his TV. R11 said as he was in the bathroom, R2 followed	S9999		

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R11 to the bathroom and was trying to hit R11. R2 hit the bathroom light, which was on the ceiling and pulled it. The light broke off and hit R11 on top of his head. R11 said he started bleeding. When R2 saw R11 was bleeding, he(R2) started running towards the nurses' station. R11 said he got out of the bathroom and ran after R2 towards the nurses' station. No staff were on the hallways. R11 said it was not until he and R2 were close to the nurses' station that a staff member (no staff name provided), come towards R11 and R2, and that is when the staff saw R11 was bleeding from the top of his head. R11 pointed to a small scar on top of this head and said, "this is the scar from R2 hitting me with the bathroom light fixture."

On 07/25/23 12:11 PM, R2 was observed in the hallway, outside on the dining room talking to peers. R2 said he and R11 used to share a room, but one day, R2 went to the bathroom when R11 was there and wanted to see what was in the crystal light hanging in the bathroom ceiling. R2 said he pulled the light from the ceiling, and the light come down and hit R11 on the head, and R11 had blood coming out of R11's head. R2 said R11 then come towards R2 and tried to hit him. R2 ran out of the room and fell on the floor, as R11 was coming towards R2, swinging at R2, and saying, "I will kill you N....." R2 said the hallway was clear and there was no staff to be seen. R2 said he got up before R11 could get to him, and he reached the nurses' station. Staff (no name provided) came to R2 and R11 and separated them. R2 said it was very early in the morning when this happened, before breakfast.

On 7/26/2023 at 11:41, V7(Psychiatric Rehabilitation Service Director/PRSD) said

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S9999	Continued From page 3 residents have a right to be free of abuse. V7 said when residents have an altercation and call each other names or hit each other, that's resident-to-resident abuse. On 7/26/2023 at 3:21pm, V21(Mental Health Technician) said on the day R2 and R11 had a confrontation it was about 3am or 4am in the morning. She heard R2 and R11 screaming at each other and came out of their room, trying to fight each other. V21 said she broke up the fight then saw R11 was bleeding from his head. V21 asked R2 and R11 what happened. R11 said he was trying to use the bathroom, and R2 did not want the light on, therefore R2 kept cutting the light off. R2 told V21 that he got angry and pulled the light fixture off the bathroom ceiling and hit light fixture hit R11 on the head. V21 further said that R11 told her that R2 hit him on the head with the light fixture. V21 said after seeing some blood on R11's head, she took R11 to V36 (Licensed Practical Nurse/LPN), for assessment and treatment. V21 said hitting and calling names is a form of abuse and residents should be monitored to prevent resident to resident abuse. On 07/27/2023 at 10:55am, V36 (LPN) said on 7/2/2023 early in the morning, she was made aware by V21 and V28 (Mental Health Technician) that R2 and R11 were involved in an altercation and R11 was bleeding from the head. V36 said she assessed R2 and R11, and observed R11 was bleeding from a small cut on the head. V21 said she assessed R11 and cleaned the small cut, offered R11 pain medication, but R11 declined. V36 stated that residents should not be hitting each other. They are supposed to be redirected.	S9999		

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S9999	Continued From page 4 Facility Reported Incident Report (FRI) dated 7/2/2023 documents: On 7/2/2023 at 4:30am, V28(Mental Health Technician) heard and saw R2 and R11 yelling in the hallway. V28 saw R11 was bleeding from the head. FRI further documents 7/2/2023 V21 heard R2 and R11 yelling and coming out of their room and R2 hit R11. R11 was bleeding some from the head. 2.) R97 has diagnoses that include but are not limited to schizoaffective disorder, bipolar type. Minimum Data Set (MDS) dated 6/22/23, indicates R97 is cognitively intact. R97's care plan indicates R97 is a potential risk for abuse/neglect related to factors that increase vulnerability. R97's Abuse/Neglect Screening dated 4/20/2023, indicates R97 is a potential high risk for abuse. R97's Nurses Note dated 6/29/2023, documents in part: Received resident with bleeding nose with the report that resident got into physical altercation with roommate. R109 has diagnoses that include but are not limited to schizoaffective disorder, major depressive disorder, bipolar disorder, auditory hallucinations. MDS dated 7/24/2023, indicates R109 is cognitively intact and experiences hallucinations. R109's care plan indicates R109 has the potential to be verbally/physically aggressive and is at potential moderate risk for abuse/neglect. R109's Abuse/Neglect Screening dated 4/24/2023, indicates R109 is a potential moderate risk for abuse. R109's Behavior Note dated 6/29/2023, documents in part: Resident reported that resident was talking to self when peer told resident to shut up. Resident stated that peer	S9999		

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was angry, and resident felt threatened and that's when the physical altercation began. Resident sustained a laceration to the back of right hand.

On 7/25/23 at 10:50 AM, R109 stated R109 had an altercation with R97 in their room. R109 said R97 asked R109 why did R109 push the door open like that. R109 had just come in the room from a smoke break. R109 said R109 was singing to self and R97 told R109 to shut up. R109 said R97 was looking at R109 with a mean look. R109 said R97 was "mean mugging" R109 and started walking towards R109. R109 said R109 started swinging. R109 said R109 hit R97 in the face. R109 said R109's hand started bleeding and R97 left out of the room. R109 said R109 feels safe.

On 7/25/23 at 11:05 AM, R97 stated R97 did not want to talk about the incident. R97 said R97 was hit and got a cut on the nose. R97 said R97 does not feel safe because R97 got hit.

On 7/26/23 at 1:10 PM, V13 (Mental Health Tech) stated V13 was at the central behavior desk at approximately 3 PM. R97 came from the east wing drenched in blood on face. R97 said R109 beat me. V13 notified the nurse, V7 (Psychiatric Rehab Service Director), and V3 (Director of Nursing). V13 said R97 had an injury on the nose and R109 had a scrape on the knuckles on the right hand. V13 said V13 took R109 for 1 to 1 in the sensory room. R109's room was changed. R109 told V13 that R109 was listening to music. R97 said to cut the s*** down and cussing at R109. R109 told R97 to watch R97's mouth. R109 said R109 got up and hit R97. V13 said R97 and R109 were friends beforehand. V13 said R97 gets smart at the mouth sometimes, gets verbally aggressive to residents and staff.

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S9999	Continued From page 6 7/26/23 at 2:50 PM, V1 (Administrator) stated I was administrator at that time. Around 11 AM, I heard a Mental Health Tech page, which means there is a situation. I went to the central desk. I observed R97 had blood on the nose and shirt. R97 said R109 was doing a lot of talking and R97 told R109 to shut up. R109 hit R97. R97 said it happened in the room. First aid was given to R97. R109 said R109 got a cut on the hand. R109 was assessed by the nurse. We did a room change, initiated an investigation, reported to the State Agency. Doctors were notified. Neither residents were sent out to the hospital. 7/26/23 at 3:13 PM, V7 (Psychiatric Rehab Service Director) stated V7 heard an uproar. R109 was at one end of the hallway with staff. R97 was at central desk with staff. I saw blood on R97's face. R97 said R97 was hit by that guy. Staff told me R97 was hit by R109. R109 said R109 hit R97 because R97 was in R109's space. Facility Resident Abuse Investigation Form, date incident occurred: 6/29/2023, documents in part: R109 has history of poor boundaries and was responding to external stimuli. R97 and R109 were in their room. R109 started talking to R97 and R97 told R109 to be quiet. R109 then displayed poor boundaries and struck R97. Facility policy Abuse Prevention and Reporting-Illinois, revised 10/24/22, documents in part: 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, and mistreatment of residents. Abuse means any	S9999		

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physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

3.) R18's medical record (Face Sheet and MDS) document R18 is a severely cognitively impaired, admitted to the facility on 11/16/2022 with diagnoses including but not limited to: Polyosteoarthritis, Schizophrenia, Schizoaffective Disorder Bipolar Type, Restlessness and Agitation, and Major Depressive Disorder.

On 7/25/2023 at 11:50 AM, R18 was observed sitting on the side of the bed in his room. R18 was asked about the incident involving him and V37 (Former Housekeeper). R18 said, "I don't want her (V37) in here. She hit me with a garbage can."

On 7/26/2023 at 9:34 AM, V13 (MHT) said, I heard yelling. The housekeeper (V37) was yelling for a MHT (Mental Health Tech). She was standing in front of his (R18's) room, sweating, holding a garbage can in her hands. He (R18) was sitting up on his bed. She (V37) said to me, "come get this n*****." I separated them. I told (V37) to go down the hall so that I could remove (R18) from his room and take him to the sensory room. He told me she hit him with the garbage can. I told the manager on duty (V39 (Admissions/Marketing Director). I think she (V39) heard the yelling.

Attempts were made to contact V37. V37 was not available for interview.

Facility's final incident report of 7/7/2023 documents in part: Type of Alleged Abuse:

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S9999	Continued From page 8 Verbal. Summary of interview of person reporting the incident: V13 (MHT): "I saw the resident (R18) sitting on his bed and (V37) the housekeeper was standing outside of his (R18) room holding a garbage can and cussing. I told her (V37) to calm down and took her away from his room and I let the manager on duty know." Summary of interview with person involved: V37 (Former Housekeeper): "I went into the room and as soon as I walked in the room (R18) started cussing at me. I tried to go into the bathroom to clean the trash, and when I walked out, he called me B****. I was mad and I cussed back at him." Summary of investigator's findings: MOD (Manager on Duty V39 Admissions/Marketing Director) reported that (V37) and (R18) were in a verbal altercation. (V37) went in to clean (R18's) room and (R18) did not want his room clean(ed) at the time. (V37) kept going in there and (R18) was getting agitated, which lead to (R18) becoming verbally inappropriate and spitting on (V37). This then led to (V37) responding verbally inappropriately. MHT (V13) intervened and separated. V37's statement, obtained by V39 on 7/2/2023 at 1:07 PM, documents in part, V37 went to R18's room. R18 started "cussing" at V37, telling her to leave his room. V37 ignored R18 and tried to go into bathroom to clean out trash. R18 called V37 "f***** b****" and pushed V37 out of his (R18) room. V37 tried to get back into the room. V37 went to adjoining room, entering R18's room through the shared bathroom. R18 spit on V37, V37 left room. V37 said (in statement), "I didn't react. Yes, that's what I said. I wouldn't put my hands on anyone. I was mad, then you got cameras." On 7/25/2023 at 3:38 PM, V1 (Administrator) said, V37 was terminated for inappropriate staff behavior and V39 was not available for interview.	S9999		

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S9999	Continued From page 9 Facility's Abuse Prevention and Reporting-Illinois policy (Reviewed/Approved by: IDT 12/17/2021) documents in part, The facility affirms the rights 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, and mistreatment of residents. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, fear, shame, agitation, or degradation. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse may include but are not limited to: Harassing a resident; Yelling or hovering over a resident, with the intent to intimidate. "B"	S9999		