STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015333	A. BUILDING: _____ B. WING _____	C 05/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

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S 000	Initial Comments Complaint Investigation 2493253/IL172358	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.690a) 300.690b) 300.690c) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of	S9999		

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S9999	Continued From page 1	S9999		

that resident.
b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to notify the Department of any serious incident or accident for 1 (R1) of 5 residents reviewed for accident hazards in the sample.

Findings include:

On 4/26/24 at 10:40 AM, Surveyor asked V2 (Assistant administrator) and V3 (director of nursing) to provide any recent accidents, incidents or deaths that occurred in the past week or in the month of April.. At 10:50 AM, V3

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S9999	Continued From page 2	S9999		

returned and presented surveyor with several incidents but did not include any incident pertaining to R1's death on 4/22/24. Surveyor asked V2 specifically about any incident that may have occurred on 4/22/24 pertaining to R1, V2 returned later and stated, "Yes, R1 was found in the bathroom unresponsive, without a pulse and lying in the bathroom floor in a fetal position, but we did not report it to your department." Surveyor asked the rationale for not reporting the serious incident involving R1 who was missing for almost 5 hours and then being found dead in the bathroom, V2 stated that the decision was decided upon by the interdisciplinary team but ultimately, he (V2) had made the decision not to report the incident. V2 later stated, "In hindsight, we should have reported the incident to your department."

R1 was a 52 year old with diagnosis including Chronic Respiratory Failure with Hypoxia, Atherosclerosis of Coronary Artery Bypass Grafts, Type 2 Diabetes, Acute/chronic Diastolic Heart Failure, and Presence of Automatic (implantable) Cardiac Defibrillator.

R1's POLST (Practitioner Order for Life-Sustaining Treatment) form signed by the resident on 10/3/22 showed resident's wishes for no CPR: Do Not Attempt Resuscitation (DNAR).

On 4/22/24 at 11:46 AM, R1 was discovered on the floor of his bathroom without a pulse, without blood pressure, not breathing and presumed dead. V4 (LPN) the nurse who found the resident in the bathroom, yelled for help, called a code blue, and initiated CPR on R1 for an undetermined amount of time until V3 (Director of Nursing) took over and continued chest compressions. V5 (LPN Manager) responded to

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S9999	Continued From page 3	S9999		

the code by obtaining the crash cart discovered that R1 had a DNR status, ran to the room to inform V3 and V4 to stop CPR.

On 4/26/24 at 1:00 PM, V4 (LPN) stated, "After so long I noticed I hadn't seen him (referring to R1) and I went to his room and still wasn't in his room and so I opened up the bathroom and he was in the bathroom. He was laying in fetal position. I checked for pulse and had none and he wasn't breathing." Surveyor asked if pupils were checked or whether the resident's skin was cold, V4 stated, No I didn't check his pupils and I don't remember if he was cold to touch. I just yelled down the hall for the other nurse to come help. I started CPR and then V3 (Director of Nursing) came in and took over chest compressions. I started compressions but I can't remember how long. It wasn't long though but the whole thing went so fast. V5 (LPN Manager) went to get the crash cart and she came and told us to stop CPR because R1 was a DNR."

Multiple efforts to contact V9 (CNA) assigned to R1 could not be reached for interview.

On 4/26/24 at 11:50 AM, V3 (Director of Nursing) stated, "I was up there on 3rd floor doing rounds and was checking on my nurses. V4 told me she couldn't find (R1) and I went to check on this room check on (R1). I went in there and he was in the bathroom by the toilet in fetal position and puddle of blood on floor. It was puddle of fresh blood. The nurse on duty (V4) found the resident on the floor in a fetal position and we positioned him straight on the floor, his color was off. The nurse said he has no pulse. I tried to locate the pulse and no pulse." Surveyor asked the approximate amount of blood loss observed on the floor, V3 stated, "I don't know how many cc's

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S9999	Continued From page 4	S9999		

(cubic centimeters), it was just a puddle of blood. So I took over CPR on the resident but it wasn't very long because (V5) came and told us to stop because she saw that the resident was a DNR." Surveyor asked how long chest compressions were being conducted on the resident, V3 stated, "I don't know it was seconds." Surveyor asked to clarify how many seconds, V3 stated, "Yes it probably was more so minutes, less than 5 minutes, I'd have to say."

On 4/26/24 at 1:45 PM, V5 (LPN Nurse Manager) stated, "Me and (V3-DON) were making rounds at the time, me and the nurse (V4) went in to (R1's) room and found him on the floor, we yelled for help. The other nurse (V6 LPN) was near and also went to the room, came out to call a code. I grabbed the crash cart and they began CPR." Surveyor asked who did CPR on the resident, V5 stated, "(V4) started chest compressions, and then (V3 DON) also did chest compressions and they were alternating. In the meantime I was looking into the DNR binder (black binder) found on the crash cart and I told them to stop CPR because he (referring to R1) was a DNR. They were conducting DPR almost 5 minutes but we stopped the CPR. V4 checked for pulse and didn't get a pulse. They did CPR on the floor and then they put him back in bed. " Surveyor asked if she saw blood on the floor, V5 stated, "I did see blood on the floor, It was approximately 10 cc."

On 4/26/24 at 3:07 PM, V7 (physician/ medical director) stated, "I am the primary for (R1) and medical director of the facility. R1 had coronary artery disease and very advance heart problems. He came here for rehab. A few nights back they found him pulseless and initiated CPR and soon after found out the resident was DNR. I need to go over the chart in detail but they told me the

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	IL6015333	A. BUILDING: _____ B. WING _____	C 05/11/2024

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APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

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S9999	Continued From page 5	S9999		

resident was in a fetal position with blood pouring out his nose. I'd give probabilities that he (R1) passed out during a syncopal episode and hit his head on the floor. The blood would have been caused by the fall."

Code Blue policy revised 8/14/2018 reads in part, "Purpose: to provide basic life support when a resident is observed with absence of respirations and pulse. The following guidelines will be followed when a code is called: 1. assess for pulse and respirations. 2. Verify code status/advanced directives."

Advance Directives policy revised 8/114/2018 reads in part, "Purpose: To ensure that all residents and/or resident representatives are informed concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. Advanced Directives shall not be required as a provision of service or admission. Guidelines: For purposes of this policy and procedure "Advanced Directives" means a written instrument, such as living will or life prolonging procedure declaration, appointment of health care representative and power of attorney for health care purposes. These directives are established under state law and relate to the
provision of medical care when the individual is incapacitated."

(B)

Statement of Licensure Violations 2 of 2

300.610a)
300.1210d)6)
300.3210t)

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	IL6015333	A. BUILDING: _____ B. WING _____	C 05/11/2024

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S9999	Continued From page 6 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 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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:	S9999		

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S9999	Continued From page 7	S9999		

Based on interview and record review, the facility failed to protect a resident (R2) of 4 residents in the sample (R1, R2, R4 and R5) from physical abuse inflicted by his roommate (R3). This failure caused R2 to be struck with a metal rod multiple times to the face resulting in a laceration requiring stitches to the right eyebrow, facial contusions and lacerations and R2 requiring an emergent transfer to the hospital.

Findings include:

R2 is an 83 year old with significant cognitive impairment and diagnoses including dementia, stage 3 chronic kidney disease and otsteoarthritis.

R3 is an 86 year old with significant cognitive impairment and diagnoses including dementia, hemiplegia and hemiparesis, and aphasia following cerebral infarction.

On 4/6/24 at approximately 4:10 AM, R2 was lying awake in bed and was suddenly physically assaulted by his roommate (R3) with a metal rod taken from the closet. R3 used this metal rod to strike R2 multiple times in the face with no apparent provocation.

On 5/10/24 at 11:10 AM, V11 (CNA Certied Nurses Aide) stated, " I heard screaming when I was in the hallway and went and saw (R3) standing over (R2's) bed and hitting the man. R3 was hitting R2 in the head area as he was sitting in bed. I immediately went to the guy with the pole and tried to calm him. I was successful in calming him down but when the man (R2) tried to get up, R3 said that he was going to hit him again. I called another CNA (V12) and I told her to got some towels to stop the bleeding from R2's head.

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S9999	Continued From page 8	S9999		

We both got V10 (Agency LPN Licensed Practical Nurse) , who I think was an agency nurse who came and took over to help with R2's bleeding. I really don't know this man R3 but I know that R2 is a nice guy and that he gets up in the middle of the night and walks around and that's probably what might have got R3 going."

On 5/10/24 at 12:10 PM, V1(administrator) stated, "V2 (assistant administrator) did most of the investigation as I was off that week. The facility contacted me on that day 4/6/24 to let me know that (R3) had hit his roommate (R2) with a piece of metal in the face and the CNA (V11) was documenting in the hallway close to the room at the time and heard yelling and went in to the room saw R3 standing over R2 who was lying in bed at the time. Staff reported that V11 pulled R3 pulled away from (R2.) V12 CNA entered the room and grabbed a towel to apply first aide on the resident and the other CNA V11 was calming R3 down. The nurse V10 came in and assessed and provided first aide to R2; and R3 was escorted out to the room and he was allegedly calm and did not continue to be aggressive and taken to the dining room to be monitored 1:1. 911 was called and R2 was transported to the ER and R3 was sent to a psychiatric hospital. I was told in the hospital that the family of R2 did not want the resident to come back. I saw R2 in the ER on 4/6/24 and spoke with ER staff who said he had stitches on right eye and were admitting him for observation. R2 had facial contusions and laceration. one above right eye was stitched up across the eyebrow. As for R3, he was diagnosed with a psychotic episode in the hospital. R3 was experiencing a psychotic episode which led to the resident walking over to R2 and struck the resident multiple times across his face and head. " Surveyor asked who provided this information

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	IL6015333	A. BUILDING: _____ B. WING _____	C 05/11/2024

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S9999	Continued From page 9	S9999		

pertaining to R3, V1 indicated that it was the psychiatric hospital staff but did not specificity as to which staff person.

On 5/10/24 at 12:15 PM, V2 (assistant administrator) stated, "It was reported to me by my administrator what occurred and I did the actual investigation of the incident involving (R2) and (R3). I spoke with (V11/CNA) and she notified me that she heard screaming coming from R2 and R3's room and saw (R3) with a metal object in hand and hit (R2). She mentioned she called for assistance from (V12/CNA) and arrived to help her and that R3 reportedly took the metal pole from the closet rod away from R3. They then called for the nurse V10 to provide first aide and assured everyone was separated and called an ambulance around 4:20 AM. R3 was given 1:1 in the common area in the nursing station. Both CNA's were providing 1:1 to R3 in the nursing station until the police arrived. The police and fire arrived at around 4:30 AM and then R2 was sent to hospital for treatment and we issued an involuntary notice petition for R3 and sent to the psychiatric hospital. It was not reported to me R3 was having a psychotic episode and that the resident just got physically aggressive. There were no occurrences between the two residents and it seemed that it came out of the blue and no antecedent to it all. We couldn't pinpoint any factor in my investigation."

Efforts to reach V10 LPN and V12 CNA three times were left with unanswered calls. V1 (administrator) tried to facilitate the efforts and explained that both staff were currently working in alternative facilities at the time.

Facility's internal investigation showed an interview with V10 (Agency LPN) which reads, "At

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	IL6015333	A. BUILDING: _____ B. WING _____	C 05/11/2024

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APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

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S9999	Continued From page 10	S9999		

approximately 4:20 AM, writer was notified of room needing assistance. upon enteringroom patient in bed 2 (R2) was siting at bedside bleeding profusely from face. Assessed patient and applied pressure to bleeding. 911 called and vitals recorded. Nursing assistant stated the patient in bed 3(R3) hit paitent in bed 2 (R2) with metal object. Metal object was confiscated. The aggressor (R3) stated he will hit him again and needs to die. Patient removed from room, while waiting for ambulance."

Facility's internal investigation showed interview with V12 (CNA) which reads, "At about 4:30 AM, V11 (CNA) called for help. I quickly got up and hurried over to room and helped redirect the resident who hit the resident with the piece of metal. I called the nurse from the hall and told her to call the ambulance. I then took the metal object from the resident."

Facility abuse policy and procedures titled "Abuse Prevention and Reporting" reads in part, "The 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." The policy and procedures however did not specifically address the management and/ or handling related to resident-to- resident abuse.

Hospital records dated 4/26/24 reads in part, "82yo M with PMH of dementia, DM, HTN, HLD, who is admitted to trauma service after being assaulted at nursing home. Medicine consulted for co-management of chronic medical conditions. Pt unable to provide much history to me - somewhat limited by facial swelling and

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S9999	Continued From page 11 appears to be confused, trying to get out of restraints/bed. Spoke to son who also was unable to provide much history or medication list. PMH:Patient seen and examined with resident staff; their full history and physical is pending. Patient presented as a trauma level 2, from scene; I was present in the ED soon after patient arrival. 82 yo male, status post assault by roommate at nursing facility, struck by pole. Denies Loss of consciousness. Primary survey with airway intact, bilateral breath sounds, palpable pulses equal pupils. Secondary survey with multiple facial lacerationss and swelling. Labs and imaging reviewed. Hgb 11.5 CT head, c-spine, face pendingA/P: s/p assault, facial lacs and likely fractures- OMFS consulted - if requires admission, will admit to Trauma." (A)	S9999		