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	IL6002059	A. BUILDING: _____ B. WING _____	C 05/30/2025

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APERION CARE OAK LAWN	9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453

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S 000	Initial Comments Investigation of Facility Reported Incident of May 13, 2025/IL192961 Complaint Investigation: 2594742/IL193147	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610a) 300.1210b)4)5) 300.1210c) 300.1210d)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 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	S9999		

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care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

This REQUIREMENT is not met as evidenced by:

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Based on interview and record review, the facility failed to ensure a resident was free from accident hazards, by not using the mechanical lift for a dependent resident transfer for 1 (R1) of 3 residents. This failure resulted in R1 sustaining a non-displaced oblique fracture through the lateral plateau of the right tibia and fibula. R1 was transferred to the local hospital and underwent a surgical procedure on 5/15/2025. This deficiency is past non-compliance that occurred from 5/13/2025 to 5/15/2025.

Findings include:

On 5/27/2025 at 1:30pm V3 (Certified Nursing Assistant/CNA) said that R1 requested to have incontinence care. V3 took R1 to the room, proceeded to retrieve the mechanical lift. R1 said no I can stand and pivot. V3 said I ask her twice and she continued to refuse the mechanical lift and insisted on the stand and pivot transfer which I had transferred R1 several times using this method. V3 said after she did the stand and pivot transfer into the bed, she completed incontinence care on R1, which R1 then complained about right leg pain she proceeded to inform the nurse that R1 wanted pain medication. V3 said I know which transfer method to use by reading the care card on the back of the closet door or in the plan of care. R1 is obese and I should have informed the nurse that she was refusing care and ask for assistance from a co-worker, I realize now that it was not a safe transfer.

On 5/27/2025 at 1:50pm V7 (CNA) said R1 will ask you to use the stand and pivot transfer and I inform her that I must follow what's on her care card. She is okay with the mechanical transfer. I do not transfer a resident without checking the care card or the plan of care in the computer. I

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will inform the charge nurse that the resident does not want to use the transfer method recommended on their care card.

On 5/27/2025 at 2:30pm V2 (Director of Nursing/DON) said I expect all certified nursing assistants to have safety awareness and use the method of transfer on the resident's care card or in the plan of care if a resident refuses, the CNA should inform myself or the nurse of that refusal so that we can contact therapy to assist in a transfer.

On 5/27/2025 at 2:45pm V1 (Administrator) said R1 refused her usual method of transfer, V3 transferred her by a stand and pivot motion and should not have done that transfer. The employee has been in-serviced and now understands a proper safe transfer.

An admission record indicates that R1 has a diagnosis of right knee pain, unilateral primary osteoarthritis of the right knee, morbid (severe) obesity due to excess calories, and pain in the left knee. An order summary dated 5/27/2025 indicates R1 had an order for (brand name) external gel 4% to left and right knee and bilateral shoulders.

A care plan intervention dated 4/17/2024 to transfer, using a mechanical lift with 2 staff for transfer.

A progress note dated 5/13/2025 that R1 was admitted to the local hospital for a non-displaced oblique fracture through the lateral plateau.

A report to the state surveying agency dated 5/13/2025 states that R1 had a new onset of swelling, discoloration and complained of pain to

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the right ankle and emergency room transfer and X-ray scan of the right ankle was ordered with a hospital diagnosis of non-displaced oblique fracture through the lateral plateau tibia and fibula. An x-ray scan dated 5/14/2025 result of right knee and right tib-fib there is a non-displaced oblique fracture through the lateral plateau. The final report the facility submitted to the state surveying agency dated 5/21/2025 states the resident underwent surgery on 5/15/2025.

Facility Policy: Transfers-Manual Gait Belt and Mechanical Lifts, Effective date 11-28-12, Revised 1-19-18. Purpose: In order to protect the safety and well-being of the staff and residents, and to promote quality care, this facility will use Mechanical Lifting devices for the lifting and movement of Resident. Responsibility: Licensed Nurse, C.N.A, Restorative, Therapy Guidelines: 1. Mechanical lifting devices shall be used by any resident needing a two person assist, to who cannot be transferred comfortably and /or safely or normal transfer technique. 2. Staff responsible for direct resident care will be trained in the use of mechanical lifting devices annually and as needed. Refer to Manufacturer's Guide for proper instructions for use of equipment for transfer and weighing. 6. Residents transferring and lifting needs shall be documented in care plans and reviewed via care plan time frame and as needed.

Prior to the survey date of 5/30/25, the facility had taken the following action to correct the noncompliance:

1. On 5/14/25 an in-service for nurses and CNAs

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was conducted on transfers, gait belt use at all times, and to use 2-person assistance for mechanical lifts.
2. QA nursing observation from 5/14-5/29/2025 on 5 residents a week to ensure the facility is in compliance with transfers.
3. On 5/14/25 the transfer policy was reviewed by the interdisciplinary team with no changes.
4. A house wide audit was performed to monitor compliance with transfers.
5. On 5/14/25 an Ad hoc QAPI meeting was held to review the event and action plan. Reviewed with the medical director. Policy review was discussed.

"A"

Statement of Licensure Violations II of II:
300.610a)
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 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or

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S9999	Continued From page 6 psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident was free from physical abuse by another resident for 1 of 3 residents reviewed for abuse. This failure resulted in R2 being sent out to the local hospital and sustaining a human bite to the right forearm and required treatment of antibiotics. This deficiency is past non-compliance that occurred from 5/17/2025 to 5/22/2025. Findings include: Incident report submitted to the state surveying agency for the incident of 5/17/25 in part states the incident occurred in the facility dining room at around 6:30am on 5/17/25. R5 is non-verbal with a low BIMS score. R5 stood up from his wheelchair, lost his balance and fell to the floor in a seated position. R2 was sitting at a table next to where R5 was sitting. R5 was not aware that R2's arm was stretched out along the edge of the table, so instead of grabbing on to the table, R5 grabbed on to R2's forearm to get off the floor. R2 was startled when R2 felt someone touching her arm and immediately attempted to move her arm away. In the process, R2's arm raised up and pressed against R2's mouth. R5 reacted by biting R2's arm. R2 was escorted to nurse's station and evaluated. MD (medical doctor) was notified, and orders were given to send R2 to the nearby hospital for precautionary evaluation. R5 was escorted to R5's room and placed on	S9999		

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one-to-one monitoring. R5's MD was notified, and orders were given to transfer to hospital for psychiatric evaluation. R2 returned from hospital after being evaluated and receiving treatment for bruising to the right forearm. R5 was re-admitted to the facility after following psychiatric evaluation and treatment. R5 has been placed on temporary one-to-one monitoring to ensure his safety and the safety of residents within the facility.

R5 has an admission record dated 5/27/2025 indicates that R5 has a diagnosis of delusional disorders, dysphasia, and schizophrenia, restlessness and agitation, delusional disorder, other genetic related intellectual disability, and autistic disorder. An order summary report indicates that R5 was transferred to the local hospital on 5/17/2025, a care plan revision on 4/15/2025 that indicates R5 has exhibited physical abuse to other staff and resident's related to poor impulse control.

R2's discharge summary dated 5/17/25 from local hospital states in part being seen and evaluated for human bite. Take antibiotics as directed. Augmentin 875-125mg (milligram) 1 tablet administered.

R2's progress note dated 5/30/25 signed by V2 (Director of Nursing/DON) states "IDT (interdisciplinary team) note. Attendees present: DON, Admin (Administrator), SS (Social Service), Wound Care. Summary of IDT meeting: Resident involved in resident-to-resident altercation resulting in bite to right forearm. Area cleaned, dried, and covered with DCD (dry clean dressing). MD contacted and informed of incident; order received for ER (emergency room) transfer. Family made aware. Resident returned to facility from ER, tetanus shot received abt

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(antibiotic) therapy initiated for 7 days. Wound care consult performed, treatment orders received and carried out. Resident pain will be managed by MD orders. Care plan reviewed and updated.

On 5/27/2025 at 10:30am V1(Administrator) said it was reported by the housekeeper that was in the dining area at the time, that R5 stood up by the two tables, then fell between the tables. Upon getting up from the floor R5 tried to grab the table and grabbed R2's arm. R2 tried to pull away and R5 bit R2's arm. R5 was immediately separated from R 2. R5 was sent to the local hospital.

On 5/27/2025 at 12:30pm R2 said that she was sitting in the dining area table in the early morning before breakfast and R5 was also sitting at the table next to her. He fell between the two tables, upon trying to get himself off the floor he grabbed my arm. I tried to pull away and that's when R5 bit my arm. I don't think he knew it was my arm. The housekeeper moved my wheelchair immediately.

On 5/27/2025 at 12:40pm R3 said she was sitting two tables away from R2 and R5 who were both at other tables. R5 was throwing a slipper at another resident. R5 fell out his chair next to R2's table. While trying to get himself off the floor, R2's arm was in front of him. R5 tried to pull himself up by the table in turn he grabbed her arm, and when R2 tried to move her arm R5 bit her on the arm. He did it quickly.

On 5/27/2025 at 1:10pm V8 (House Keeping) said she heard someone yelling and when she went into the dining area R5 was getting off the floor. I did not see R5 bite anyone.

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On 5/27/2025 at 1:15p V9 (Housekeeping) said I was in the dining area when R5 fell to the floor between two tables. R2 was at the table next to R5. He lost his balance fell to the floor between the two tables. Upon getting off the floor, he grabbed R2's arm. R2 tried to pull away, that's when he bit R2 on the arm. He did it so quick. I immediately called for help and moved R2 away from the table to safety.

On 5/27/2025 at 2:40pm V10 (Wound Care Nurse) said I observed R2's right forearm on Monday morning. This occurred over the weekend. I classified it as penetrating trauma to the right arm. It was an open area pink and red full thickness 4.30 cm (centimeter) x 4.40 cm x 0.20cm no signs of infection to the area. Antibiotics were ordered.

On 5/30/2025 at 1:30pm V2 (Director of Nursing/DON) said that R2 was bitten by R5. R5 apparently had fallen to the floor and while trying to get himself off the floor he grabbed R2's arm. R2 pulled away and he bit her arm. R5 was immediately transferred to the local hospital and remains out. R2 sustained a bite area to the right forearm 4.30 cm x 4.40 cm x 0.20cm bright pink or red drainage was noted at the time.

Facility Policy: Abuse Prevention and reporting-Illinois Revisions, Reporting of crimes 11-20-17, 5-24-18, 1-22-19, 10-24-22. 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 and mistreatment of

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residents. 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.
This will be done by: Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment.
Identifying occurrences and patterns of potential mistreatment. Resident-to-Resident abuse (Any Type): A resident-to-resident altercation should be reviewed as a potential situation of abuse. Resident-to Resident altercation 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 abuse 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 steps necessary to ensure the safety of residents including but not limited to the separation of the residents.

Prior to the survey date of 5/30/25, the facility had taken the following action to correct the noncompliance:
1. R2 and R5 assessed by nursing, MD informed, orders received for transfer for evaluation on 5/17/25.
2. Psychosocial Assessment completed on R2 and R5 on 5/17/25 and 5/22/25.
3. Updated Abuse and neglect screening

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completed on R2 and R5 on 5/17/25 and 5/22/25.
4. Families made aware of incident on 5/17/25.
5. House wide audit performed to identify residents with behaviors by Social Services on 5/19/25.
6. Facility wide audit of current residents abuse/neglect screening were reviewed and updated as needed by Social Services on 5/20/25.
7. QA Audit tool will be conducted on 5 residents a week for 4 weeks then 3 times a week for 5 months or as needed to monitor that the facility is in compliance with current resident being assessed for abuse/neglect, care plans updated, interventions are in place and residents are supervised by staff.
8. In-serviced all staff on Abuse Prevention and Reporting Policy including resident to resident altercations and supervision from date 5/17-5/18/2025.
9.In-service from date 5/17/2025 Abuse Supervision, emergency QAPI/Abuse prevention & Supervision policy revised, and care plan update.
10. Implementation of the dining room monitoring schedule for the 11pm to 7am shift.
11. Abuse Prevention and Reporting policy review by IDT with no changes made on 5/17/25.
12. Care plan of R2 and R5 updated on 5/18/25 and 5/22/25.
13. Ad hoc QAPI meeting was held to review event and action plan. Reviewed with medical director on 5/17/25.

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