STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145180	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Chicago Heights	490 West 16th Place Chicago Heights, IL 60411

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse. This deficiency affects all four (R29, R81, R103 and R192) residents in the sample of 27 reviewed for Abuse prevention Program. Findings include: R192 is admitted on [DATE] with admitting diagnosis listed in part but not limited to Schizophrenia, Psychosis, Bipolar disorder, and anxiety disorder. No abuse/neglect screening assessment done upon admission and after incident of resident-to-resident alteration on 6/27/24. Care plan indicates: He is sexually active or has been sexually active during my tenure in this facility. He has history of criminal behavior related to battery. He has been deemed a moderate risk. He displays manipulative behavior by creating fabricating conversation. He uses psychotropic medications related to behavior management of Schizophrenia, bipolar and anxiety. No care plan formulated for abuse prevention. Care plan was not updated after incident of resident-to-resident altercation. R192's progress note dated 6/27/24 indicates: Nurse was notified that resident was involved in a physical altercation with peer. However other staff quickly intervened, immediately redirected and reoriented. Head to toe assessment done no injury noted, resident denied pain. MD aware, DON made aware. R192's psychosocial assessment done on 6/28/24 indicates: PRSD was made aware of resident being involved in an altercation with peer. R192's facility reported incident submitted to IDPH on 7/2/24 indicates: Resident abuse. R192 reported to hospital that his peer requested to be intimate. R192 is now emotional regarding the situation. R192 called 911 while attending the day program. He was taken to the hospital. R192 stated that he engaged in consensual acts with a male peer but then changed his account of the interaction. R192 stated that it was a peer- R81 that he engaged in consensual acts. R81 stated that R192 came to his room to engage in the intimacy. R192 discharged from the hospital to his family home unrelated to this alleged incident. R81 stated that R192 and him were friends. R192 has history of manipulation/fabricating situations to entice his family to take him out of facilities. R81 remains at baseline with no emotional distress. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

R81 is admitted on [DATE] with diagnosis listed in part but not limited to schizoaffective disorder bipolar type. Most recent abuse/neglect screening assessment done on 6/18/24 indicates that he is at moderate risk for abuse related to his mental illness and dysfunctional behaviors. Abuse prevention care plan was not updated, and no abuse/neglect screening assessment was done after an allegation of physical/sexual abuse on 7/2/24.

R103 is admitted on [DATE] with diagnosis listed in part but not limited to Schizophrenia, Mood disorder and schizoaffective disorder depressive type. Most recent abuse/neglect screening assessment done on 5/16/24 indicates that he is moderate risk for abuse. Care plan indicates that he is at moderate risk for abuse/neglect due to mental illness. He has history of physical altercation with peer. Abuse prevention care plan was not updated, and no abuse /neglect screening assessment was not done after incident of physical altercation with peer on 6/27/24 (with R192).

R29 is admitted on [DATE] with diagnosis listed in part but not limited to Schizophrenia, Bipolar disorder, schizoaffective disorder, anxiety disorder and Major depressive disorder. R29 had resident to resident physical altercation on 3/17/24 with another resident who was no longer resides in the facility. R29 sustained redness to right eye. Abuse assessment was not done, and abuse care plan was not updated after the incident occurred. Abuse assessment was done not until 5/16/24.

On 7/16/24 at 9:55AM, V16 Case Manager said that R192's family member called her on 7/3/24 and reported that R192 called 911 while he was at day program on 7/2/24. R192 reported that he was physically and sexually abused in the facility by another resident (R81) V16 spoke with R192 and found inconsistencies and discrepancies with his statement regarding the date, and the time the incident occurred. V16 said that she also reported this allegation to V15 Director of Behavioral services at the facility on 7/3/24.

On 7/16/24 at 11:40AM, Observed R81 ambulatory, alert, and responsed appropriately to questions asked. He denied the complaint allegation presented.

On 7/16/24 at 12:42PM, V5 Social Service Director said that Abuse /neglect screening assessment is done upon admission, quarterly, annual, and significant change of behavior or incident/ allegation of abuse. Informed V5 that R192 does not have abuse screening assessment upon admission. He is at risk for abuse due to his mental illness and behavior as indicated in his care plan. No abuse assessment was done after incident of resident-to-resident physical altercation on 6/27/24. V5 said that the assigned PRSC (Psychiatric Rehab service counselor) is the one completing and updating the abuse screening assessment.

On 7/16/24 at 1:48PM, V1 Administrator said that she is the abuse coordinator in the facility. The social service or PRSC is the one completing the abuse/screening assessment. Abuse assessment is done upon admission, quarterly, annually, and significant change of behavior or incident/allegation of abuse. Abuse Care plan should be updated after each incident or allegation of abuse. Informed V1 of concern identified that R192 did not have abuse/neglect screening assessment done upon admission. No abuse assessment was done after incident of resident-to-resident altercation on 6/27/24. No abuse resident to resident altercation incident report was completed on 6/27/24. V1 said that she was on leave on that date and V15 Director of Behavioral Services is in charge in her absence. V1 said that any abuse occurrence should have incident report completed.

(continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/19/24 at 10:30AM, Informed V5 Social Service Director that R29 had resident to resident altercation on 3/17/24 with another resident who is no longer residing in the facility. No abuse assessment and Abuse care plan were not updated after the incident occurred. On 7/18/24 at 11:10AM, V15 Director of Behavioral Services said that she does not need to complete an incident for resident-to-resident alteration because there was no physical injury occurred. On 7/19/24 at 12:04PM, Informed V1 Administrator of above concerns of failure to implement policy and procedure for their abuse prevention program. V1 made aware that surveyor left message to V25 LPN (Licensed Practical Nurse) to call back. V1 said that they are also trying to get hold of V25 but unsuccessful. Facility's policy on Abuse Prevention and Reporting-Illinois reviewed 12/17/21 indicates: 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 residents. To do so, the facility has attempted to establish as resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is written 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 *Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment and making the necessary changes to prevent future occurrences. *Filing accurate and timely investigative reports. Establishing a Resident Sensitive Environment: This facility desires to prevent abuse, neglect, exploitation, mistreatment, and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident assessment: As part of the resident's life history on the admission, assessment, comprehensive care plan and MDS assessments, staff will identify resident increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property who have needs, triggers and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would lead reduce the chances of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary. Internal reporting requirements and identification of allegations: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reports should be documented, and a record kept for the documentation. Supervisors shall immediately inform the administrator or person designated to act as administrator in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property. Upon learning the report, the administrator or designee shall initiate an incident report investigation. Internal investigation: All incidents will be documented whether abuse, neglect, exploitation, mistreatment, or misappropriation of resident property occurred was alleged or suspected. Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will result in an investigation. Facility' s policy on Incident and accident- Illinois effective date 11/28/12 indicates: Policy: The incident/accident report is completed for all unexplained bruises or abrasions, all accidents, or incidents where there is or the potential to result in injury, allegations of theft and abuse registered by residents, visitors, or other and residents to resident altercations. Procedure: An incident is defined as any happening, not consistent with the routine operations of the facility that does not result in bodily or property damage. Physical or mental mistreatment (abuse-actual or suspected) of a resident is considered an incident whether actual injury has occurred. An accident is defined as any happening, not consistent with routine operation of the facility that results in bodily injury other than abuse. An incident/accident report will be completed for: 3. All unusual occurrences 4. Any type of abuse. 1. An incident/accident report is to be completed by a RN or LPN and is to include: a. Date and time of an incident/accident b. Full written statement and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered and notification of appropriate parties. 2. An RN or LPN must notify the following if an actual injury occurs: Physician and Legal representative or interested family members within 24 hours. 3. The Director of Nursing (DON), assistant DON or nursing supervisor must notify the following of an actual injury occurs: 4. Documentation in nurses' notes is to include: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Description of the occurrence, the extent of injury (if any), the assessment of the resident, vital signs, treatment rendered, and parties notified. b. A minimum of 72 hours of documentation by all 3 shifts on resident status after the incident. Vital signs, mental and physical state, follow up, tests, procedures and findings are to be documented. 5. All incident/accident reports are reviewed, signed, and investigated by: Administrator and DON or ADON

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40001 Based on observation, interview and record review the facility failed to administer medications as ordered for 1 of 3 residents (R135) reviewed for medication administration in a sample of 27. Findings include: On 7/17/2024 at 11:00am V13 (Licensed Practical Nurse-LPN) was asked did R135 have an appetite stimulant available. V13 said yes, I administered it to R135 this morning and threw away the bottle R135 does not receive another dosage until tomorrow in the am, here's R135 two bottles of appetite stimulant, observed un-opened seals unbroken. On 7/17/2024 at 12:00 noon R135 was observed in the dining area completing his lunch, R135 was asked did the nurse administer any medication before eating lunch? R135 said no I didn't have any medication I never do; I did not refuse it. On 7/17/2024 at 12:05pm surveyor asked V13 to observe the two bottles of appetite stimulant, both bottles were un-opened seals not broken. V13 and the surveyor read the order for the appetite stimulant. Which said megestrol acetate oral suspension give 5ml by mouth before each meal for appetite stimulant before meals. V13 was asked why the medication wasn't administered as ordered, V13 said oh well he refused it. On 7/17/2024 at 12:40pm V2 (Director of Nursing-DON) said I expect the nurses to administer medication as ordered and refusal should be reported to the physician. On 7/19/2024 A record review of the admission record indicated that R135 has a diagnosis of type 2 diabetes mellitus without complications. An order summary report dated 7/17/2024 indicates that R135 has an order dated 6/11/2024 to start 6/12/2024 for megestrol acetate oral suspension 40mg/ml megestrol acetate give 5 ml by mouth before meals for appetite stimulant before meals. A care-plan dated 4/16/2024 a focus of a nutritional problem or potential nutritional problem related to schizophrenia, diabetes. Facility policy: Medication Administration General Guidelines. Policy Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Administration 2. Medications are administered in accordance with written orders of the prescriber. Refusals of Medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Medication refusal must be reported to the prescriber after 3 doses are reused and there must be documentation of prescriber notification of such.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50469 Based on observation, interview and record review the facility failed to provide a functional Eyewash Station where hazardous chemicals are used. This deficiency affects all units, reviewed for environmental safety. Findings include: On 7/17/24 at 2:02PM, V11(Maintenance Director) said that the eyewash station has not been logged since February 2024 because in January 2024 the caps for eyewash station were broken. V11 said that an order for replacing the eyewash caps was done in January 2024, however, V11 did not present an invoice for order dated January 2024. V11 said no further logs available because they were not done. On 7/17/24 at 2:30PM, V11 provided an invoice dated 7/17/2024 for order of eyewash float-off dust covers. On 7/18/24 at 10:48AM, V3 (Infection Preventionist) said the eyewash station is used in case of emergency where hazardous chemicals are used, and it should be always functional. V3 said she was unaware eyewash station was not functional. On 7/18/24 at 1:22PM, V1 (Administrator) said eyewash station should be functioning at all times. V1 said she was unaware that eyewash station was not functional since January 2024. V1 said that an order for the eyewash caps was placed on 7/17/24 when V11 (Maintenance Director) mentioned that caps needed to be replaced. V1 said that eyewash station will be repaired and will be functioning and checked weekly per facility policy. Review of Maintenance log for Eyewash Station Weekly Check dated: January 2024 1/2/2024- caps broken, ordered new ones 1/10/2024- caps broken 1/17/2024- caps broken 1/24/2024- caps broken February 2024 log: empty. No further logs available. Facility's policy on Environmental Health & Safety: Emergency Eyewash Operating and Cleaning Location Reviewed 6/2023 A. Emergency showers and eyewash stations are required in areas where hazardous chemicals are used. (continued on next page)

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Responsibilities iv. Maintain accurate record of location of all emergency eyewash stations and showers. v. Provide equipment required to perform testing and flushing. vi. Ensure that all emergency eyewash stations within the facility are activated weekly. vii. Request immediate replacement or repair of any defective equipment.