

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/09/2025
NAME OF PROVIDER OR SUPPLIER  Aperion Care Chicago Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>34516</p> <p>Based on interview and record review, the facility failed to report an allegation of resident to resident abuse to the State Survey Agency for two of two residents (R292 &amp; R105) reviewed for abuse in the sample of 39 residents.</p> <p>Findings including:</p> <p>On 1/6/25 at 10:30 AM, survey team requested V1 (administrator and abuse prohibition coordinator) all reportable incidents within the last 90 days. V1 presented the survey team with 3 incidents reported to public health regional office (RO) however did not have the incident of 12/18/24 involving R292 and R105.</p> <p>On 1/7/25 at 11:15 AM, V1 (administrator) stated to survey team that the incident on 12/18/24 involving R292 did not warrant reporting as it did not involve another peer (resident). Surveyors asked who was involved in the incident altercation, V1 indicated that R292 struck the CNA V19. Surveyors clarified if R292 had any physical or verbal altercation with any resident during this incident, V1 stated, No, only with staff members.</p> <p>On 12/18/2024 at 19:20 PM, V8 (Social Services) wrote, Note Text: It was reported that this resident (R292) displayed increased agitation including making verbal threats towards peers (residents) and staff, making false allegations as exhibited by delusional thinking patterns. She was not easily redirected, despite attempts to intervene and decrease any further interventions by staff. Nurse offered PRN (as needed- medication) and this resident refused. She targeted female staff (striking and kicking female staff). Resident was escorted to the conference room removing her from other external stimuli. Police was called for assistance. Upon arriving to the facility, Officer and his partner entered the facility, attempted to calm and redirect this resident. She became assertive with the two officers. Nurse notified Physician and Mother/Guardian. There were orders to send her out to the hospital for a psych evaluation. Resident was transported with a petition to Hospital and escorted by EMT (Emergency Medical Technician) and police.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/7/25 at 11:40 AM V13 (CNA Scheduler) stated, I was the late night manager on duty and as I was coming in to the facility and (R292) was in the dining room/foyer area. She was aggressively trying to get to resident (R105) and she wanted to fight him. She said I am going to beat his ass and my CNA (V19) went around to get to the door and R292 hit her in the face. I grabbed R292 and walked her to the conference room to calm her down. We were sitting in conference room for a good hour. When she came in here to ensure to make sure she was okay we called police and she did the same thing to them (got aggressive) and they told her they would restrain her if she didn't calm down. Surveyor asked what R292 said to R105, V13 stated, She said that she was gonna beat his (expletive language) I don't know what triggered R292 and I don't think they had a relationship</p> <p>On 1/7/25 at 12:10 PM, R105 was in his room in bed. Surveyor asked about the incident that occurred on 12/18/24 with R292. R105 indicated that R292 disrespected him by threatening him with physical violence and demeaned him by calling him a (expletive language).</p> <p>Facility policy 11/28/2016 titled Abuse Prevention and Reporting reads in part, Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.</p> <p>When an allegations of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has informed, the resident's representative and the Department of public health's regional office shall be informed by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigation.</p>		