STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145830	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care West Chicago	201 West North Avenue West Chicago, IL 60185

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on interview and record review, the facility failed to ensure residents' rights to be free from acts of physical abuse by their peers. This included 10 of 10 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10) reviewed for abuse. The findings included: On June 18, 2024 at 9:10 AM, V1 (Administrator) was asked to provide a list of physical altercations. V1 provided a list of Abuse Reportables. The list provided did not include the incident with R1 and R2. V1 was asked to provide any information he had on an incident that occurred on April 23, 2024. V1 said he has a list in his office of incidents he did not report because he said the direction he was given was if the incident did not cause emotional distress or physical injury, the incident did not need to be reported to IDPH (Illinois Department of Public Health). V1 later stated this directive came from corporate. At 1:42 PM, record review showed 10 residents had been involved in physical altercations with a peer and incidents were not reported to the state. 1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, anxiety, paranoid schizophrenia, and altered mental status. R1's MDS (Minimum Data Set), dated June 5, 2024, showed R1 was alert and oriented. R1's care plan showed R1 had potential to be verbally aggressive towards peers related to mental/emotional illness as evidenced by a verbal altercation with a peer on April 23, 2024. Facility provided a form titled, Report to IDPH (Illinois Department of Public Health) Regional Office, dated April 26, 2024. It identified the incident between R1 and R2 and showed on April 23, 2024, (R1) and (R2) had a dispute in the elevator. (R2) had asked (R1) to press the button in the elevator and (R1) refused. (R2) called (R1) some names and (R1) got upset. (R2) 'reflexively experiencing an acute onset of agitation' pushed (R1) to the floor (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 17, 2024, at 11:53 AM, R1 said he was on the elevator going downstairs to get some snacks when this guy he didn't know (R2) got on the elevator and asked him to push a button. R1 said he told R2 no, he was going downstairs. The next thing R1 remembered was falling towards R2, and R2 pushing him to the floor. On June 17, 2024, at 11:56 AM, V5 (RN/Registered Nurse) said she was working when the incident with R1 and R2 occurred. V5 said she did not witness the incident, but was told by another staff member what happened. V5 was unable to name the staff member that reported incident to her. V5 said R1 and R2 were in the elevator. R1 was going downstairs to the basement to get some snacks and R2 wanted to go upstairs. R2 had asked R1 to push the button for second floor and R1 said no. R2 called R1 some names, R1 punched R2 and when R2 put up his fists, R1 leaned back and fell on to the floor. R2 admitted to calling R1 names, but said R1 punched him. 2. R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE], with diagnoses that included anxiety, and schizoaffective disorder bipolar type. R2's MDS (Minimum Data Set), dated May 14, 2024, showed R2 was cognitively intact. R2's care plan showed R2 has the potential to be physically aggressive as evidenced by altercation with peer on April 23, 2024. On June 17, 2024, at 12:07 PM, R2 stated he got on the elevator on the first floor and R1 was standing in front of the buttons. R2 said he asked R1 to push the button for second floor as he moved to the back of the elevator. R2 said R1 ignored him at first and R2 said he called R1 an asshole. R1 turned and punched him on the left side of his head. R2 said he put his arms up to block R1, and R2 said when he put his arms up, R1 leaned back quickly probably thinking he was going to get hit and he lost his balance and fell backwards onto the floor. 3. R3's EMR (Electronic Medical Record) showed R3 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder, schizophrenia, major depressive disorder, developmental disorder, unspecified psychosis not due to a substance or known physiological condition, and unspecified disorder of psychological development. R3's MDS (Minimum Data Set), dated May 20, 2024, showed R3 had moderately impaired decision-making skills and required cues/supervision. R3's care plan showed R3 has the potential to be physically aggressive related to poor impulse control as evidenced by physical aggression towards a peer on May 5, 2024, and May 19, 2024. Facility form titled, Report to IDPH Regional Office, dated April 25, 2024, identified an incident between R3 and R4 on April 22, 2024. (R3) reported to the nurse that her roommate (R4) bit her heel while she laying in bed unprovoked slight redness noted on (R3's) heel. 4. R4's EMR (Electronic Medical Record) showed R4 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder depressive type, major depressive disorder, and dementia. R4's MDS (Minimum Data Set), dated May 2, 2024, showed R4 was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's care plan showed R4 has the potential to be physically aggressive related to dementia, depression, and poor impulsive control as evidenced by biting a peer's foot on April 22, 2024. 5. R5's EMR (Electronic Medical Record) showed R5 was admitted to the facility on [DATE], with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, schizophrenia, schizoaffective disorder, delusional disorder, anxiety, and auditory hallucinations. R5's MDS (Minimum Data Set), dated May 8, 2024, showed R5 was cognitively intact. R5's care plan showed R5 had the potential to be physically aggressive as evidenced by multiple physical aggressive episodes at previous placements with both staff and peers. R5's progress note showed on May 19, 2024, at 7:20 PM, R3 and R5 were observed in a physical altercation. R3 said R5 was talking crap about her saying she was going to take her man. Ice given to R3 for her cheek. R5 said R3 has been talking about her for days and she had had enough and that is why they were fighting. R5 had a scratch to her left knee. Facility provided form titled, Report to IDPH Regional Office, dated May 21, 2024, showed on May 19, 2024, R3 and R5 were waiting to go outside to smoke. R3 started talking about R5 to other residents, causing R5 to experience an acute onset of agitation, and R5 hit R3. 6. R6's EMR (Electronic Medical Record) showed R6 was admitted to the facility on [DATE], with diagnoses that included schizophrenia, unspecified psychosis not due to a substance or known physiological condition, sleep disorder, anxiety, and depression. R6's MDS (Minimum Data Set), dated April 24, 2024, showed R6 had moderately impaired cognition. R6's care plan showed R6 uses psychotropic medications relate to behavior management. Progress note for R3 was reviewed and showed an incident with R6. The progress note showed, (R3) came to the nurses' station yelling that peer (R6) punched her in the face. (R3) stated she was trying to push away (R6) because she did not want him inside her room; (R3) claimed (R6) punched her in the face because she was trying to push him and then (R6) scratched (R3) on the face. 7. R7's EMR (Electronic Medical Record) showed R7 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder, bipolar type. R7's MDS (Minimum Data Set), dated April 3, 2024, showed R7 was cognitively intact. R7's care plan showed R7 was at risk for abuse/neglect related to R7 reported a physical altercation at previous facility. R7's progress note, dated April 27, 2024, showed (R7) was seen attempting to attack (R8) in a resident-to-resident altercation. (R7) was aggressive and had increased psychosis yelling 'fight me.' (R7) then became agitated and physical with writer and staff member, spitting in staff faces while yelling 'fight me' and 'send me to jail.' Nurse entered (R7's) room and found the wall punched in with fist prints and dots of blood explaining why residents knuckles looked battered. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility provided form titled, Report to IDPH Regional Office, dated April 29, 2024, showed R7 was seen running down the hallway towards R8's room. Shortly after, both residents came out of the room. (R7) appeared in a state of psychosis and was threatening (R8). 8. R8's EMR (Electronic Medical Record) showed R8 was admitted to the facility on [DATE], with diagnoses that included other schizoaffective disorders. R8's MDS (Minimum Data Set), dated June 12, 2024, showed R8 had moderately impaired decision making and required cues and supervision. R8's care plan showed R8 had potential to display poor boundaries with staff and residents by demonstrating inappropriate interactions through physical touch related to my mental health diagnosis. R8's progress note, dated April 27, 2024, showed R8 was in a resident-to-resident altercation where R8 was the defender. R8 was seen attempting to guard himself from peer R7, who was being aggressive to him R8 was ok only having their fingernail cut in which nurse placed band aid but may or may not had been from the altercation. 9. R9's EMR (Electronic Medical Record) showed R9 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia, schizoaffective disorder bipolar type, major depressive disorder, severe intellectual disabilities, and adult failure to thrive. R9's MDS (Minimum Data Set), dated April 24, 2024, showed R9 had severely impaired cognitive skills for daily decision making. R9's care plan showed R9 presents with mood/behavioral distress related to mental illness. R9 has poor frustration tolerance and limited ability to express himself in an appropriate manner. R9 can become aggressive when agitated. 10. R10's EMR (Electronic Medical Record) showed R10 was admitted to the facility February 14, 2019, with diagnoses that included residual schizophrenia, major depressive disorder, and anxiety disorder. R10's MDS (Minimum Data Set), dated April 10, 2024, showed R10 was cognitively intact. R10's care plan showed R10 has history of the following: wandering ., verbally aggressive ., physical aggressive per medical record , as evidenced by R10 pushed a resident to the floor attempting to take my pop on April 29, 2024. Facility provided form titled, Report to IDPH Regional Office dated May 1, 2024, showed R9 attempted to take R10's soda. R10 experienced an acute onset of agitation and pushed R9. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility provided their policy titled, Abuse Prevention and Reporting- Illinois, with a revision date of October 24, 2022, showed . The term willful in the definition of abuse means the individual must have acted deliberately An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his or her reach as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby . Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. (42 CFR 483.12 Interpretive Guidelines).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on interview and record review the facility failed to report allegations of abuse to the IDPH (Illinois Department of Public Health) Regional Office within two hours of the notification of the allegation of abuse. This applies to 10 of 10 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10) reviewed for allegations of abuse. The findings included: On June 17, 2024 at 10:25 AM, V1 (Administrator) said he was given the directive that if an allegation of abuse did not cause emotional distress or physical injury, then the allegation did not need to be reported to IDPH. V1 said this directive came from the facility's corporation. On June 17, 2024 at 3:00 PM, V4 (PRSD/(Psychiatric Rehabilitation Service Director), said, When we have a physical altercation between two residents, we follow the chain of command and we first notify (V1, Administrator), and if he is not available, then the DON (Director of Nursing), if can't reach her, then the staff contact PRSD. We also involve corporate. After an incident happens, we fill out the form that gets sent to IDPH. We then notify the authorities, meaning the local Police Department. They will either come to the facility to talk to the residents or they talk to us on the phone and start a report. We are then given the report number. We look for witnesses to the incident and will take their statement to help try and figure out what happened. Sometimes there are no witnesses. The nurses will assess the resident and call the primary physician, psychiatrist, resident's family/POA(Power of Attorney)/guardian to make them aware of the situation and if the resident was sent out for further evaluation and/or treatment. If the resident does not get sent out then we place them on 72 hour safety checks, which means a staff member has to locate the resident and physically lay eyes on them making sure the resident is safe. If the incident was more severe and we need to send the resident out, we will put them on 15 minute safety checks until the EMS (Emergency Medical Services) arrive to take them to the hospital. After a resident is placed on safety checks, the Social Service Department will follow up and write a progress note once or twice a day. We like to try and check in with the resident in the morning and again in the afternoon. We can extend the safety check if we need to based on behaviors. After an incident, the PRSD/PRSC (Psychiatric Rehabilation Service Coordinator) can add interventions to a resident's care plan based on what would be appropriate. Every morning at 10:00 AM, there is a meeting with the Administrator, DON, ADON (Associate Director of Nursing), PRSD, MDS (Minimum Data Set) Coordinator, Dietary manager, Activities Director, and Restorative. If any resident had had behavior concerns, we will discuss them and brainstorm on what could be done to help that resident. Social services meets every Tuesday and will again discuss resident behaviors and add interventions to care plan and we will also discuss mediation if there are ongoing issues between residents. 1. R3's EMR (Electronic Medical Record) showed R3 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, schizophrenia, major depressive disorder, developmental disorder, unspecified psychosis not due to a substance or known physiological condition, and unspecified disorder of psychological development. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's MDS (Minimum Data Set) dated May 20, 2024, showed R3 had moderately impaired decision making skills and required cues/supervision. R3's care plan showed R3 has the potential to be physically aggressive related to poor impulse control as evidenced by physical aggression towards a peer on May 5, 2024, and 5/19/2024. R6's EMR (Electronic Medical Record) showed R6 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, unspecified psychosis not due to a substance or known physiological condition, sleep disorder, anxiety, and depression. R6's MDS (Minimum Data Set) dated April 24, 2024, showed R6 had moderately impaired cognition. R6's care plan showed R6 uses psychotropic medications related to behavior management. On June 17, 2024 at 4:30 PM, V1 said he could not find a Report to IDPH Regional Office form for the incident involving R3 and R6 on May 5, 2024. V1 provided a list of resident to resident incidents that were not reported to the IDPH (Illinois Department of Public Health) Regional Office. On May 5, 2024 at 3:50 PM, , R3's progress note showed R3 came to the nurses' station yelling claiming that peer (R6) punched her in the face; R3 said she was trying to push R6 to keep him from coming into her room when R6 punched her in the face and that was when she scratched R6's face. No report of this incident was submitted to IDPH Regional Office. 2. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, anxiety, paranoid schizophrenia, and altered mental status. R1's MDS (Minimum Data Set), dated June 5, 2024, showed R1 was alert and oriented. R1's care plan showed R1 had potential to be verbally aggressive towards peers related to mental/emotional illness as evidenced by a verbal altercation with a peer on April 23, 2024. R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on [DATE] with diagnoses that included anxiety, and schizoaffective disorder bipolar type. R2's MDS (Minimum Data Set), dated May 14, 2024, showed R2 was cognitively intact. R2's care plan showed R2 has the potential to be physically aggressive as evidenced by altercation with peer on April 23, 2024. V1 (Administrator) provided a form titled Report to IDPH Regional Office, dated April 26, 2024. It identified an incident between R1 and R2 that occurred on April 23, 2024, which was three days prior to the initial/final investigation provided to this surveyor. The form showed on April 23, 2024, (R1) and (R2) had a dispute in the elevator. (R2) had asked (R1) to press the button in the elevator and (R1) refused. (R2) called (R1) some names and (R1) got upset. (R2) reflexively experiencing an acute onset of agitation pushed (R1) to the floor. V1 did not send this allegation of abuse to IDPH Regional Office. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R4's EMR (Electronic Medical Record) showed R4 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder depressive type, major depressive disorder, and dementia. R4's MDS (Minimum Data Set), dated May 2, 2024, showed R4 was cognitively intact. R4's care plan showed R4 has the potential to be physically aggressive related to dementia, depression, and poor impulsive control as evidenced by biting a peers foot on April 22, 2024. V1 (Administrator) provided form titled, Report to IDPH Regional Office, dated April 25, 2024. It identified an incident between R3 and R4 that occurred on April 22, 2024, which was three days prior to the initial/final investigation provided to this surveyor. The form showed on April 22, 2024, (R3) reported to the nurse that her roommate (R4) bit her heel when she was laying in her bed. The nurse assessed the area and there was some redness to the area. V1 did not submit this allegation of abuse to the IDPH Regional Office. 4. R5's EMR (Electronic Medical Record) showed R5 was admitted to the facility on [DATE] with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, schizophrenia, schizoaffective disorder, delusional disorder, anxiety, and auditory hallucinations. R5's MDS (Minimum Data Set), dated May 8, 2024, showed R5 was cognitively intact. R5's care plan showed R5 had the potential to be physically aggressive as evidenced by multiple physical aggressive episodes at previous placements with both staff and peers. V1 (Administrator) provided form titled, Report to IDPH Regional Office, dated May 21, 2024. The form identified an incident between R3 and R5 that occurred on May 19, 2024, which was two days prior to the initial/final investigation provided to this surveyor. The form showed on May 19, 2024, R3 and R5 were waiting to go outside to smoke. R3 started talking about R5 to other residents, causing R5 to experience an acute onset of agitation and R5 hit R3. V1 did not submit this allegation of abuse to the IDPH Regional Office. 5. R7's EMR (Electronic Medical Record) showed R7 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type. R7's MDS (Minimum Data Set), dated April 3, 2024, showed R7 was cognitively intact. R7's care plan showed R7 was at risk for abuse/neglect related to R7 reported a physical altercation at previous facility. R8's EMR (Electronic Medical Record) showed R8 was admitted to the facility on [DATE] with diagnoses that included other schizoaffective disorders. R8's MDS (Minimum Data Set), dated June 12, 2024, showed R8 had moderately impaired decision making and required cues and supervision. R8's care plan showed R8 had potential to display poor boundaries with staff and residents by demonstrating inappropriate interactions through physical touch related to my mental health diagnosis. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V1 (Administrator) provided form titled, Report to IDPH Regional Office, dated April 29, 2024. The form identified an incident between R7 and R8 that occurred on April 27, 2024, which was two days prior to the initial/final investigation provided to this surveyor. The form showed on April 27, 2024, showed R7 was seen running down the hallway towards R8's room. Shortly after, both residents came out of the room. (R7) appeared in a state of psychosis and was threatening (R8). V1 did not submit this allegation of abuse to the IDPH Regional Office. R7's progress note dated April 27, 2024, showed (R7) was seen attempting to attack (R8) in a resident to resident altercation. (R7) was aggressive and had increased psychosis yelling 'fight me.' (R7) then became agitated and physical with writer and staff member, spitting in staff faces while yelling 'fight me' and 'send me to jail'. Nurse entered (R7's) room and found the wall punched in with fist prints and dots of blood explaining why residents knuckles looked battered. R8's progress note dated April 27, 2024 showed R8 was in a resident-to-resident altercation where R8 was the defender. R8 was seen attempting to guard himself from peer R7 who was being aggressive to him R8 was ok only having their fingernail cut in which nurse placed band aid but may or may not had been from the altercation. 6. V1 (Administrator) provided form titled, Report to IDPH Regional Office dated May 1, 2024. The form identified an incident between R9 and R10 that occurred on April 29, 2024, which was two days prior to the initial/final investigation provided to this surveyor. The form showed on April 29, 2024, showed R9 attempted to take R10's soda. R10 pushed R9 to the floor. V1 did not submit this allegation of abuse to the IDPH Regional Office. Facility provided their policy titled, Abuse Prevention and Reporting- Illinois, with a revision date of October 24, 2022, showed, 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.