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	05/06/2022

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

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(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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 29536 Based on record review and interview the facility failed to protect residents from being abuse by physically aggressive residents and failed to immediately intervene in situations before residents became physically aggressive towards their peers for ten (10) of twelve (12) residents (R2, R3, R6, R7, R8, R9, R10, R11, R12, R13) reviewed abuse. As a result, R8 was physically assaulted by R9. R8 sustained a partial dislocation of the C1-C2 to R8's neck and head abrasions. R3 punched R2 in the nose several times causing R2 to have a nosebleed and some facial swelling. R7 walked into R6's room uninvited and R7 began to hit R6 causing a skin tear and some scratches to R6's right arm. R10 and R11 were arguing and subsequently R11 slapped R10 on the leg. R12 and R13 were arguing and R13 slapped R12's face causing some redness to R12's eye. Finding Include: Facility's abuse prevention policy denotes the residents have the right to be free from abuse, neglect, misappropriation of resident property exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The facility desires to prevent abuse, neglect, exploitation, and mistreatment. This will be accomplished by Staff supervision. Situations such as inappropriate language, incentive handling, or impersonal care will be corrected as they occur. 1. R8's Nurses Note Narrative for 3/22/2022 5:40 PM documents resident escorted to the nursing station c/o (complain of) peer (R9) being physically aggressive. Upon assessment resident has approximately 6 superficial scratches to the right side of head, 5 on the scalp and 1 on the forehead. Site cleansed with normal saline and bacitracin applied. MD to be notified. Resident reports being hit by a white man. States he was hit with an unknown object. Area was cleansed and pressure applied to stop bleeding. Administration notified of incident. Dr. notified and gave orders to send resident to ER for head evaluation. Attempted to contact resident's father, however unable to contact. Neurology assessment initiated. Resident sent to hospital via ambulance. Resident alert & oriented. Verbally responsive. Vital signs obtained. (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 0600 Level of Harm - Actual harm Residents Affected - Few	R8's Nurses Note Narrative for 3/23/2022 1:05 AM documents resident returned from hospital, O/F with a neck collar. Vitals-1136/82 (SIC), 97.3, 80,18. Sp02 (blood oxygen) 97% on room air. Resident denies pain at this time. Resident in bed, call light with reach. Resident needs to stay in his neck collar until he follows up on appointment. Follow-up appointment with Dr., neurosurgeon. No apparent distress noted. Will cont. to monitor the resident. R8's Nurses Note Narrative for 3/23/2022 1:15 AM documents resident returned with dx: Subluxation (partial dislocation) of C1-C2 cervical vertebrae, initial encounter. CT head/brain and CT spine cervical carried out during hospital visit. No new orders received. R8's hospital records dated 3/23/23 denotes reason for visit head injury; Diagnosis: Subluxation of C1-C2 cervical vertebrae and Scalp abrasion. R9's care plan denotes R9 has potential to be verbally aggressive while experiencing mood swings. Ineffective coping skills. Interventions included, monitor behaviors every shift. Document observed behavior and attempted interventions. R9s' Behavior Late Entry: Note Text for 3/22/2022 5:10 PM documents it was reported to management that resident is allegedly being physically aggressive towards a male peer. Resident will not disclose any information regarding this incident. A complete body assessment was rendered and no physical signs of injury. Emergency contact and psych MD notified. Will continue to monitor. R9's SOCIAL SERVICE NOTE Text 3/23/2022 10:30 AM documents writer spoke to resident in regard to an altercation he got into with peer. Resident admitted to becoming physically aggressive with peer last night but alleged that he threatened to stab me with a pen, and I am the police, so I stopped him. Writer discussed with resident that he should always come to staff instead of becoming physically aggressive. Resident stated he understood. Staff will continue to monitor to ensure safety of resident and others. R8 stated on 5/5/22 at 3:10 PM that he was in a car accident a few weeks and his neck got hurt. R8 stated he wore the C-collar around his neck, but it is still sore sometimes when he turns his neck. R8 stated he feels okay and feels it is safe to stay in the facility. On 4/27/22 at 5:30 PM V8 (Mental Health Technician) stated R8 keeps to himself but likes to joke and be sarcastic. V8 stated not seen or heard of R8 being aggressive. V8 stated R8 came out of his room for dinner and saw a laceration on R8's head. V8 stated V8 asked R8 what happened and R8 told them he did not want to talk about it. V8 stated V8 told the nurse. They investigated it and discovered that R8 was in an altercation with R9. On 4/27/22 at 5:00 PM V13 (Mental Health Technician) stated V13 was working when around dinner time when R8 came to eat and noticed R8 was bleeding from several scratches on his head. V13 stated the Administrator came to the dining room and talked to R8 and found out that R9 had attacked him. V13 stated V13 had seen R9 have in the past verbal altercations with other residents but this is the first time he seen/heard R9 have a physical altercation another resident. V13 stated they sent R8 out to the hospital right away and R9 was sent to the hospital later. V13 stated because R8 and R9 were roommates, their rooms were changed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/21/22 at 4:15 PM V4 (Administrator) stated staff reported to him that R8 had a small abrasion on the side of his head. V4 stated R8 would not say or tell them what happened. V4 stated V4 interviewed R8's roommate who was R9 at that time and R9 denied doing anything. V4 stated V4 interviewed a resident that saw the incident and saw R9 sitting on R8's head then walked away. V4 stated during course of the investigation it was discovered that R8 had a neck injury. V4 stated R9 was sent out to the hospital that day when they found out what had happened and R9 has not returned to the facility. On 4/27/22 at 5:15 PM V15 (Psyche Social Rehab Coordinator) stated she has been working at the facility and R9 was on her case load. V15 stated R9 was alert to self and believed he was a police officer or the president. V15 stated R9 had flight of ideas and delusions of Grandeur. V15 stated R9 was invited to attended groups but refused to go sometimes. V15 stated when R9 did go to group he would do the assignments. V15 stated R9 was seen talking to himself and responded to others aggressively. V15 stated R9 did have in the past of aggression towards other residents, which from what they saw were unprovoked. V15 stated the best way to handle R9 was to intervene or redirect R9 before or when he is getting upset. V15 stated R8 is very timid but has delusions at times. V15 stated R8 interacts with select peers but mainly keeps to himself. V15 stated R8 did not have a history of being an aggressor of any type. V15 stated R8 can report if something happened to him and if asked right away or a few weeks later. V15 stated R8 internalizes and have flight of ideas and trouble verbalizing the exact details on the incident he had with R9. On 5/5/22 at 4:00 PM V19 (Doctor) stated subluxations mean the vertebrae of the neck is out of alignment or slightly off. V19 stated the C-collar was given to R8 and it helped to put the vertebrae back into alignment. V19 stated it seemed that R8 sustained an injury but because R8 did not require surgical interventions nor display any neurological damage he and others in the health care field classify it has a minor injury. V19 stated R8's injury would only been a major injury if R8 had displayed some neurological deficit/injury and/or required surgical intervention. V19 stated has seen R8 and he is healing, doing well and showing no neurological deficiency. V19 stated there are several causes of subluxation but one cause is if a person sits on another person neck that can cause a subluxation. On 5/5/22 at 4:45 PM V18 (Psyche Rehab Service Director) stated she is over the case managers and mental health technicians. V18 stated the mental health tech (MHT) should be able to intervene in a situation when they see a resident getting upset or aggressive and attempt to redirect that resident from the situation. V18 stated the MHT are also trained in crisis prevention intervention so they and the residents do not get help and last option to use when the resident might be a danger to themselves or others. V18 stated the MHT are to make rounds frequently during their shift making sure residents are where they are supposed to be. 2. R3's Nurses Note Narrative for 2/24/2022 10:07 PM documents writer was responding to code yellow, when MHT informed staff that two residents had been involved in a physical altercation. The MHT staff separated the two residents. Body assessment rendered to the above resident, it was noted that resident had slight swelling to right side of face, lips, and nose with moderate blood loss(from nose). First aid administered. Resident denies pain, however, resident received prophylactic pain medication. MD was called and orders carried out. The administrator was informed of incident. Writer left non- emergency message for Contact. DON, also informed of incident. Resident to be monitored for 72 hours. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/5/22 at 2:50 PM, R3 stated a few weeks ago I was in the hall walking going down the corridor and saw R2 come out a room. R3 stated, R2 approached him and punched him in the face and nose a few times. R3 stated staff came and grabbed R2 and took R2 to a room. R3 stated the nurse looked at his face and gave him some ice for his nose. R3 stated his nose was not broken just sore at that time but is fine now. On 4/21/22 at 4:00 pm V3 (Psyche Social Rehab Coordinator) stated R2 was on his case load for three months and did not attend groups like he was supposed to and had to meet with R2 for 1:1 counseling. V3 stated some days R2 is normal and other days his delusions/hallucination became heightened, and he would be unpredictable. V3 stated V3 would get reports of R2 getting physical/aggressive and counseled him on keeping his hand to himself. V3 stated a lot of R2's behaviors happened in the evening time when he was not there physically at the facility. V3 stated if staff see that R2 is upset or that his symptoms are heighten staff should intervene. V3 stated interventions are in R2's plan of care that they should do before or when R2 was getting upset. V3 stated R2 did not take his medications like he should and when they asked R2 why he did something inappropriate his thought process was so disorganized he could not explain why he did what he did. V3 stated R2 was sent out of the facility the hospital and not expected to return to the facility. On 4/21/22 at 4:30 PM,V9 (Licensed Practical Nurse) stated she has worked at the facility for ten years. V9 stated R2 was tall resident that tried to bully residents if he could. V9 stated R2 was non-compliant with meds and ADL's. V9 stated was working and heard some commotion and saw R2 punching R3 several times in the face. V9 stated, I called code yellow which means residents are having altercation or behavior issues. V9 stated, staff came, and they separated both residents. V9 stated , she assessed R3 face and noted blood on his nose. V9 stated notified the doctor and he gave order first aide to R2 and monitor. V9 stated tried to give R2 Haldol shot but he refused, and they called the 911. V9 stated the police came and paramedics arrived but they had to get more officers because R2 was acting belligerent. V9 stated the police and paramedics restrained R2 to a stretcher and took him to the hospital. V9 stated asked R3 what happened and told them that he did not say anything to R2 and that R2 just attacked him for no reason. On 4/21/22 at 4:45 pm V7 (Mental Health Technician) stated, V2 was working the second shift at the desk monitoring the cameras and checking on the residents. V7 stated V2 was standing by another resident that needed assistance and saw R2 swinging his arms in R3's in direction. V7 stated he ran towards R2 and R3 and they separated them and saw R3 had a blood on his nose. V7 stated R2 was offered shot but he refused so he was on 1:1 until the ambulance arrived. V7 stated asked R2 what happened but refused to talk about it. On 4/27/22 at 5:00 pm V13 (Mental Health Technician) stated a nurse called a code yellow and arrived. R2 and R3 had been separated and saw R3 with blood on his nose and shirt. V13 stated R2 had his good days and bad days. V13 stated R2 always refused his medicine before and had to physically pull him away from attacking other residents in the past. V13 stated R3 was quiet and kept to himself. On 4/21/22 at 5:00 pm V6 (Licensed Practical Nurse) stated she was working when R2 had an altercation with R3. V6 stated from what she recalled the residents were separated and noted small scratch on R3's nose that was bleeding. V6 stated asked R2 what happened, and he replied that he was tired of R3 coming by his room and hit him. V6 stated residents were separated and R3 sent out psych evaluation. V6 stated R2 refused to go out to the hospital and told them he was okay and to leave him alone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/21/22 at 4:15 pm V4 (Administrator) stated staff reported to him that R2 and R3 were in an altercation. V4 stated R2 had history on being noncompliant with his medications. V4 stated from their investigating R2 was walking down the hall, became delusional and struck R3 in the face. V4 stated staff intervened and separated both residents. V4 stated that R3 had no significant injury just scratches on his nose. V4 stated R2 is no longer in the facility. 3. R6's Nurses Note Narrative 3/17/2022 21:57 (9:57pm) : resident observed in physical altercation with male peer (R7). Resident stated peer just walked to her room and started an altercation. Assessment shows skin tear to right arm. Cleansed area with saline and applied antibiotic ointment MD made aware of incident. Neuro checks initiated. Will monitor. R6's social service note text 3/18/2022 8:15am: Writer met with resident to follow up after her incident with a male staff the night prior. Resident reported that she was feeling fine and expressed gratitude for writer checking on her. Writer encouraged resident to stay away from her male peer, as well as to speak w/ staff when she has any further conflicts with peers. Resident verbalized understanding. R7's care plan denotes the potential to be verbally and/or physically aggressive, experience auditory hallucinations and demonstrate an unstable mood r/t schizophrenia diagnosis. Interventions include when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation, If response is aggressive, staff to walk calmly away, and approach later. 3/5/2022 9:00 am R7s' social service note text: Writer responded to a code yellow that resident was involved in. There was a verbal altercation between resident and peer, resident attempted to get physical, but staff was able to intervene prior to physical contact with peer. Writer brought resident into the office to counsel and separate from peer. Resident expressed that he was upset that peer had called him the N word and he was also trying to get in his room. It is my room and not his, he cannot have my stuff or their stuff. Writer verbalized understanding of his feelings of agitation but went over with resident better ways to handle this situation, i.e., seeking out staff. Resident stated he understood. Resident then showed writer his nail which he stated, I think I split my nail on the wall Writer brought resident to the nurse who attended to his nail. Staff will continue to monitor. 3/13/2022 7:00 pm R7's physician progress note text: Psychiatric progress note male with history of schizophrenia and auditory hallucination evaluated for a psychiatric follow up. NOD reports occasional agitation. Can be redirected with non-pharmacological approach at this time. Upon encounter no s/s of depression, anxiety or agitation. No active psychosis. Patient denies SI, HI, AVH at the time of my evaluation. 3/17/2022 9:26 pm R7's nurses note narrative: Resident observed in physical altercation with female peer in her room. Resident was observed leaving the scene staff intervention. No injury or distress noted upon assessment. MD and family notified of incident. Orders received from MD to send out to hospital for psych evaluation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3/18/2022 9:00 am R7s' social service note text: Writer along with PRSD spoke to resident in regard to altercation with peer that had happened last night. Resident apologetic and states, I are sorry I don't know what happened I just lost control. Resident counseled on appropriate ways of handling feelings of anger or loss of control, such as seeking out staff and asking for help. Resident verbalized understanding. Explained to resident that he will be sent out help him understand why he lost control. Resident is being sent out for psychiatric evaluation. On 5/5/22 at 3:05 pm R6 stated a few weeks ago R6 was in her room watching TV minding her own business when suddenly R7 came in her room grabbed her by her arms shook and hit her on the head a few times. R6 stated staff came escorted R7 out of her room. R6 stated nurse looked at saw her and cleaned the scratches on her arm that R7 had did with an alcohol pass. R6 stated since the incident R7 has not bothered and not seen R7 since the incident. V15 (Psyche Social Rehab Coordinator) she stated on 4/27/22 at 5:15 pm been working at the facility for a year and R7 was in her case load. V15 stated R7 responds to internal stimuli and at times gets aggressive talking in third person. V15 stated R7 had episodes in the past with other residents being aggressive or attempting to be aggressive. V15 stated V15 would counsel R7, and he always responded that he did not know why he did what he did. V15 stated the best way to handle R7 is to intervene or redirect R7 before or when he is getting upset. V15 stated V15 heard that R7 had grabbed R6, and he was sent to the hospital. V15 stated R7 has not returned to the facility and R7 not been in the facility several weeks. V6 stated R6 can tell you what happen to her and capable of verbalizing to staff if something had happened to her. V15 stated R6 is delusional at times and respond to internal stimuli but there are times but not all the time. V15 stated is not one that would become physical maybe verbal with others when she is having delusional moment. On 4/21/22 at 4:30 pm V9 (Licensed Practical Nurse) she stated was working on the unit and recalled R6 was in her room. V9 stated heard a noise from R6's room and went into R6's room and saw R7 on top of R6 hitting her. V9 stated R6 and R7 were immediately separated. V9 stated R6 was assessed and noted scratches on her arm and R6 did complain that her head was hurting. V9 stated R7 was monitored until he was sent to the hospital. V9 stated in the past with R7, and his roommate got into an altercation it and staff had to separate them. On 4/27/22 at 5:00 pm V13 (Mental Health Technician) stated he was working, and nurses called a code yellow regarding R6 and R7. V13 stated when arrived to R6's room R7 had already been escorted out and noticed that R6 had a couple of scratches on her arm. V13 stated the nurse gave R6 some pain medicine and heard R6 tell them she was okay. V13 stated not seen or heard of R7 attacking other residents before. On 4/21/22 at 4:15 pm V4 (Administrator) stated staff reported to him that R7 was delusional and got into an altercation with R6. V4 stated R6 does have verbal outburst for no reasons but none were witness that day. V4 stated after interviewing R7 he told them that R6 was yelling and that got him upset and ran into her room and grabbed her arm and in the process scratched R6's arm. V4 stated staff did intervene afterwards and separated both residents. V4 stated R7 was send out to the hospital and has not returned. 4. 2/22/2022 3:45 am R10's nurses note narrative: As per MHT, he said he witnessed resident and roommate having physical altercation. Writer assessed resident; no injury observed. Denies pain and discomfort. Resident is responsible for herself. MD paged. Will continue to monitor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2/22/2022 12:27 pm R10's social service note text: Writer spoke with resident in regard to altercation she got into with peer. Resident states it is over I am good. Resident states that other peer slapped her but she is not scared of her. Writer encouraged resident to come to staff if she was having issues and not to exchange words with others. Resident verbalized feeling safe and secure at this time. R11's Care plan denote potential for behavioral events, physical aggression. I use psychotropic medications R/T diagnosis of schizophrenia Date Initiated: 11/02/2021 intervention included Encourage R11 to come to staff for assistance and refrain from acting in an aggressive manner. 2/22/2022 3:45 am R11's nurses note narrative text: As per MHT said he witnessed resident and roommate having physical altercation. Resident denies having altercation with roommate. Writer assessed resident; no injury noted. No bruise or redness noted. Resident denies pain and discomfort, no distress noted. Resident does not have any contact on face sheet and MD paged. Will continue to monitor. On 4/27/22 at 5:00 pm V13 Mental Health Technician) stated R10 and R11 were having a verbal argument when V11 suddenly slapped V10 on her leg/foot. V13 stated residents were separated, administrator notified, and a room change was done. On 4/27/22 at 5:30 pm V8 (Mental Health Technician) stated R10 is middle aged woman that likes to keep her rooms cleans. V8 stated R10 will follow directions and take her medicine. V8 stated R11 has verbal outburst and likes to scavenge in the garbage or seek food. V8 stated V8 has never seen R11 attack other residents, the most seen R11 do is scream and make outburst at no one in particular. On 4/21/22 at 4:15 pm V4 (Administrator) stated staff reported to him that they (R10, R11) were having a verbal argument and then V11 slapped V10 on her leg/foot. V4 stated R11 denied the incident took place and never admitted to hitting R10. V4 stated staff witnessed R11 hitting R10 on her foot while she was lying in her bed. V4 stated R10 told them that R11 got mad at her because she was eating her food too loudly. V4 stated they were roommates at that time and since the incident are no longer roommates. V16 (Psyche Social Rehab Coordinator) she stated on 4/27/22 at 5:20 pm has worked at the facility for over a year and R11 was in her case load. V16 stated R11 was sweet and not typical for her to hit another resident. V16 stated R11 is in the process of trying to move out of the facility back into the community. V16 stated when told that R11 hit R10, that hitting anyone is not allowed and next time to come to the staff feel their upset or if they have any issues or concerns. V16 stated since R11 hit R10 not aware of any other incident like that taking place since then. V16 stated R11 is supposed to go to groups and does not attend them on a regular basis so they have to do more 1:1 therapy and sit down talk to her about different topics and educate her on life issues. V16 stated they do coping skills or stress management exercise with R11. V16 stated regardless of the what the residents go through they do not have the right to hit/strike another resident. On 5/5/22 at 3:15 pm R10 stated she did not want to discuss any altercation that she had with R11 or any other resident. On 5/5/22 at 3:18 pm R11 stated she did not know who R10 was and did not hit R10. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	5. 2/19/2022 11:34 pm R12's nurses note narrative: Resident physically attacked by peer (R13); resident assessed for LOC and apparent injuries; redness to right eye noted. Ice compression given for redness all appropriate parties notified. Will continue to monitor. R13's care plan denotes R13 has the potential to be physically aggressive r/t (related to) ineffective coping skills interventions included When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away, and approach later. 2/19/2022 11:30 pm R13's nurses note narrative: Resident physically attacked peer (R12); Resident unable to recall incident when asked by writer. Resident placed on 1:1 behavior monitoring; Resident became increasingly combative with staff attempting physically attack staff and peers; 911 called to facility. Resident taken to hospital via fire department. All appropriate parties notified. On 4/21/22 at 4:15 pm V4 (Administrator) stated staff reported to him that R12 and R13 were in line for medication pass. V4 stated R13 was banging on the nurse's window when R12 asked R13 to stop hitting the window. V4 stated R13 and R12 exchanged words then R13 slapped R12 in the face. V4 stated they were immediately separated and R13 taken to the hospital for psych evaluation. V4 stated R12s' doctor notified, no orders to send to the hospital but for staff to apply ice to her face. On 4/21/22 at 4:00 pm V3 (Psyche Social Rehab Coordinator) stated R13 was in his case load. V3 stated R13 had some delusions and hallucinations. V3 stated R13 had issues with controlling her temper would verbally/aggressive with other residents and staff. V3 stated they try to intervene before R13 gets physically aggressive or verbally aggressive by counseling her with 1:1 or ask the nurse to give prn meds. V3 stated R12 is sweet residents and does at times make false reports. V3 stated was made aware that R13 had an altercation with R12 and R13 was sent out to the hospital for eval. On 4/27/22 at 5:00 pm V13 (Mental Health Technician) stated he was working and heard that R13 got mad at R12 and slapped R12. V13 stated has seen R13 in the past hit other residents in the past and they would have to intervene, and the nurse give her medicine to calm her down. On 4/27/22 at 5:30 pm V8 (Mental Health Technician) stated R12 was very young,19, energetic and will get into awkward situations with other residents therefore needed to be supervised more. V8 stated R12 felt like people were against her because she was so immature. V8 stated R13 was bi-polar but mentally knew right from wrong. V8 stated R13 got along with some residents and some residents she did not get along well with. On 4/27/22 at 4:30 pm V9 (Licensed Practical Nurse) stated R13 was mentally in and out of it, easily agitated and did not want to follow the smoking rules. V9 stated it is hard to redirect R13 and wanted to do what she wanted to do.

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	05/06/2022

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29536 Based on interview and record review facility failed to follow their Security, Supervision and Safety policy for one resident (R14) out of four residents reviewed for supervision. This failure resulted in staff not doing consistent and regular rounds therefore R14 was able to leave the facility and go unnoticed for 3-4 hours. It wasn't until the hospital called the facility to inform them that R14 was picked up by the police and taken to the hospital for psyche evaluation that the facility staff realized that R14 had left the building without permission/supervision. Findings Include: Facility's Security, Supervision and Safety policy denotes the facility employs a number of measures to ensure the ongoing security and close supervision of all residents. The facility has incorporated the practice of making regular rounds at regular identified intervals throughout each day. R14's quarterly elopement assessment dated [DATE] denotes no prior elopements. 2/17/2022 2:30 AM R14's Nurses Note Late Entry: Narrative: LPN (from hospital) called requesting the face sheet and medication list to be faxed to the hospital. She complied with the request. 2/18/2022 11:34 AM R14's Behavior Note Text: This writer received a call from indicating that resident has been admitted there. SW (social worker) indicated that resident said he eloped from the facility and arrived. This writer pulled information from (hospital system) for resident and it is indicated he arrived there on 2/17/22 @ 1:57am. Resident was brought in by local police. Notes uploaded to (facility system). 2/23/2022 5:00 PM R14's SOCIAL SERVICE NOTE Text: Writer met with resident upon his return to follow up on his wellbeing. Resident is stable with no signs or symptoms of emotional distress and is willing to remain within the facility for placement. Resident also verbalized feeling physically fine. Writer counseled resident on the risks of leaving the facility unauthorized and encouraged him to seek staff when having any issues within the facility with either staff or his peers. Resident verbalized understanding and agreed to be more vocal going forward. V13 (Mental Health Technician) stated on 5/5/22 at 5:00 PM there were four of them working the overnight shift when R14 eloped. V13 stated if resident elopes, they are trained to call a code pink. V13 stated the dining hall has security locks on it and takes 15 seconds before if opened and it does make an alarm sound. V13 stated at the time of the incident V13 was assigned to the west wing not the dining room. V13 stated usually an employee is assigned to the central part of the building where the double door is to the dining room. V13 stated the dining room is closed after 10 PM every day and no one would or should be in there. V13 stated he saw R14 around 10 pm going to his room but did not see him afterwards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V24 (Certified Nurse Aide) stated on 5/5/22 at 4:35 PM that V24 has been working at the facility for three months and works the 11 PM-7 AM shift. V24 stated when she comes to work , staff get their assignment from the nurse. V24 stated after getting their assignment go to the unit they'll be on, do rounds, checking to see if residents are in their beds. V24 stated if the resident is not in the bed or the washroom, they will start looking for that particular resident. V24 stated when she got to work on 2/17/22 she did her rounds and saw R14 in his room. V24 stated after that did not see R14 and heard that R14 had run out of the building until sometime in the early morning. V24 stated if R14 left out of the door, the alarm was not loud enough to hear it from where she was in the building. V12 (Metal Health Technician) stated on 5/5/22 at 4:30 PM had been working at the facility for three months still getting familiar with the residents and their faces. V12 stated was working and did not hear any door alarm going off. V12 stated V12 didn't know when R14 left the building. V12 stated they only found out that R14 left when they got a call from the police. V14 (Registered Nurse) she stated on 5/5/22 at 4:25 PM had no history of elopement and was alert and oriented times three. V14 stated that R14 had history that he would go to other resident's rooms and sleep in other resident beds. V14 stated V14 does not recall the exact time when R14 left the building unauthorized. V14 stated they got a call from the hospital around 2 AM asking her for a list of R14's medications and that he was there for psych eval. V4 (Administrator) stated on 4/21/22 at 4:15 PM that V4 was told that R14 had went out the dining room door. V4 stated V4 did an investigation and discovered staff did not hear the door alarms going off. V4 stated the doors were checked and the alarms were working but not sounding loud enough. V4 stated V4 had a lock company come out. They replaced the three main exit doors alarms and added new keypads with extremely loud alarms. V4 stated that now when staff do rounds, they are to document they actually saw the resident on a rounds form. V18 (Psyche Rehab Service Director) stated on 5/5/22 at 4:45 PM V18 is over the case managers and mental health technicians. V18 stated the mental health tech (MHT) are and should be able to intervene in a situation when they see a resident getting upset or aggressive and attempt to redirect that resident from the situation. V18 stated the MHT are also trained in crisis prevention intervention so they and the residents do not get help and last option to use when the resident might be a danger to themselves or others. V18 stated the MHT are to make rounds frequently during their shift making sure residents are where there supposed to be. V18 stated the dining is shut down and closed around 10 pm at night. V18 stated when R14 returned to the facility tried to talk to him about why he left the facility but his answer where off and he was still delusional. V18 stated they did put interventions in place such as moving R14 further from the door, making more frequent rounds on R14 and counsel R14 to seek out staff if he was having issues with other residents. V18 stated the part that perplexed them was that R14 had never made attempts in the past to leave the facility without supervision. R14 stated on 5/5/22 at 4:15 PM that he got up during the night because he wanted to go to the hospital. R14 stated he walked through the dining room doors and walked to the back of the dining room. R14 stated he pushed on the emergency exit door for 15-20 seconds until it released, and the alarm went off but was not that loud. R14 stated he walked down the street to the gas station and called the police to come pick him up. R14 stated the police came with the ambulance and they took him to the hospital. R14 stated he did not remember how long he was gone from the facility. R14 stated he was not attacked or assaulted by anyone while he was walking to the gas station.