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	11/03/2022

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to follow their abuse policy and failed to prevent a resident-to-resident assault. This affected 2 of 3 residents (R5,R6) reviewed for physical abuse. This failure resulted in R6 being hit in the face by R5 with his closed fist. Findings Include: R5's diagnosis: schizophrenia. R5 was admitted to the facility on [DATE]. R6's diagnosis: schizophrenia. R6 was admitted to the facility on [DATE]. A Nursing note dated 9/3/22 documents R5 was observed with a discoloration to the left eye. R5 was unable to give an account of what happened to R5's eye and stated to the floor nurse, It's not that serious. I don't know. The Final Incident Report dated 9/9/22 documents the nurse observed R5 lying in bed with the discoloration to the eye. When asked what happen R5 denied knowing what happened. On 9/9/22, R5 reported that R6 hit R5. R6 was interviewed and endorsed R5 was screaming all the time and was getting on R6's nerves so R6 hit R5. On 10/29/22 at 2:13PM R6 stated, Yes, I hit R5. Oh my god, why are we still talking about it. I hit R5 with a closed fist in the face. R5 wouldn't shut up. I don't want to be asked any more questions about it. R6 then walked away from this surveyor and refused to answer any further questions regarding the incident. On 10/30/22 at 11:54AM R5 stated, Yes, R6 hit me. Now shut the f*** up about it. R6 hit me in the face a long time ago. I don't talk to R6 anymore. At this point in the interview, R5 began screaming profanities and asked the surveyor to leave. R5 refused to answer any further questions. On 10/30/22 at 2:18PM V1 (Administrator) stated, It was brought to my attention that R5 was noted with a black eye. R5 is pretty aggressive verbally and physically so you can't push R5 too far. I took us a couple days to get out of R5 who hit R5. We found out that R6 was the one who did it. When I went and asked R6 if R6 hit R5, R6 admitted to it. R6 told me that R6 was sick of R5 always yelling so R6 hit R5. (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 - Actual harm Residents Affected - Few	On 11/1/22 at 9:57AM, V18 (Nurse) stated, I came in that morning and when I saw R5 in R5's room it looked like R5's eye was bruised. I asked R5 what happened and R5 refused to tell me at first. R5 said that R5's boyfriend hit R5, and it wasn't a big deal. It was just a dark area under her eye that was just like a black eye would be. Anytime someone else hit someone it's physical abuse. On 11/1/22 at 1:32PM, V20 (PRSC) stated, All I know is that R6 hit R5. When I talked to R5, R5 did have a bruise around R5's eye. It was just under R5's eye and a purple color. I don't believe R5 hit R6 back or was verbally aggressive with R6 before from what I was told. This would be physical abuse. The Care Plan dated 8/24/20 documents R5 is at a potential risk for abuse/neglect related to factors that increase vulnerability, psychiatric history and/or present mental health diagnosis, denial and/or evasiveness when discussing mental health issues, minimizing significance of mental health/psychosocial issues, diagnosis of depression and/or history of depressive illness, and history and presence of dysfunctional behavior. On 9/3/22, R5 was involved in a physical altercation with a male peer (R6) as a result of my delusions that caused me to scream and display poor boundaries with my peers. Appropriate interventions are documented. The Abuse/Neglect Screening dated 9/3/22 documents the score as a 6 which indicates R5 is at a potential high risk of abuse due to history of dysfunctional behaviors and poor boundaries with others. R5 was involved in physical altercation with R6 due to screaming and delusions. The Psychosocial Assessment date of 9/3/22 documents R5 was involved in a physical altercation with R6. R5 was observed by nursing staff with a slight discoloration to the face. R5 initially reported being struck in the hallway by a peer but was unsure of the person's identity. R5 then reported R5 did not recall much other than yelling and having an altercation with a peer. R5 mentioned that R5 was fine and that it was not a big deal. The Skin Condition Report dated 9/3/22 documents R5 has bruising to the left eye. No other skin concerns are noted. The Care Plan dated 9/3/22 documents R6 became physically aggressive with a female peer on this day. Appropriate interventions are documented. The Minimum Data Set, dated dated dated [DATE] documents the Brief Interview for Mental Status score as 13 (no cognitive impairment). A Social Service note dated 9/12/22 documents the social service department spoke with R6 following an incident with R5. R6 was counseled on using coping skills to prevent R6 from becoming aggressive with peers. R6 was encouraged to seek staff with any issues that R6 may be having. R6 reported feeling safe in the facility. The Aggressive Behavior Assessment date of 9/3/22 documents R6 as a history or recent episode of aggressive/agitated behavior and/or noncompliance with medication, treatment, regimen, and resistant care. R6 was involved in a physical altercation with R5. R6 displayed poor impulse control due to R5's delusions causing R5 to scream out in display poor boundaries. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Psychosocial Assessment date of 9/9/22 documents R6 was involved in a physical altercation with R5. R6 admitted to striking R5 as R5 was reacting to active delusions by yelling out and displaying poor boundaries towards R6. R6 has full recollection and awareness of the event. Triggers for R6 are documented as loud noises and fighting or angry outbursts. The policy titled, Abuse Prevention and Reporting - Illinois, dated 10/24/22 documents, Guidelines: The facility affirmed the right of a residence to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or miss treatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and miss treatment of residents .Definitions: Abuse - abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident . The term willful in the definition of abuse means individual must have acted deliberately, not the individual must have intended to inflict injury or harm .Physical Abuse - is the inflection of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40987 Based on observation, interview, and record review, the facility failed to thoroughly investigate an allegation of abuse made by a resident and failed to identify and act immediately to prevent potential further abuse and mistreatment from occurring. This failure applied to two (R36 and R37) of 12 residents reviewed for abuse in the sample of 38 residents. Findings include: R36's diagnoses include in part with schizophrenia, major depressive disorder, muscle wasting and atrophy. R36's MDS (minimum data set) dated 4/3/2023 documents a BIMS (brief interview for mental status) score of 15 out of 15 (indicates that resident is cognitively intact). Review of R36's MDS Minimum Data Set Section E Behavioral Symptoms dated 4/5/2023 related to physical symptoms such as hitting or scratching self. Documentation does not include that R36 exhibits any behaviors. R36's care plan indicates potential moderate risk for abuse dated 4/2/23. There is no care plan in the record noted to document that R36 has any self-harm behaviors. 4/19/23 at 12:15 PM, R36 was observed standing in line in the main dining room area awaiting lunch. R36 was noted to have a large dark colored bruise beneath his right eye. 4/19/23 at 1:22 PM, V15 (Certified Nurse Assistant/CNA) was interviewed regarding R36's bruise to the right eye. V15 stated, R36 was in bed when I did my rounds this morning. I didn't see him at breakfast. His roommate is R37. 4/19/23 at 1:26 PM, V12 (Licensed Practical Nurse/LPN) was interviewed regarding R36's bruise to the right eye. At this time, V12 initially stated that she did see R36 and gave him meds but didn't see anything new. V12 then recanted and stated that she had actually noticed his eye (the new bruise in question) but wasn't sure when he got it. V12 said she then asked V18 (Assistant Director of Nursing/ADON) and was directed to V9 (Director of Behavioral Health) because V9 had already taken care of it. V12 added that R37 is R36's roommate and that she assessed R36 this morning and he didn't tell her that anything happened. Review of R36's medical record documented that V3 (Psychiatric Services Rehabilitation Director/PSRD) held a one-to-one social service group with R36 on 4/19/23 at 10:30 AM. 4/19/23 at 1:42 PM, V3 (PSRD) was interviewed and asked if they made any observations during one to one with R36 that morning. V3 stated, I didn't see nothing on his face. I usually meet with him once a week. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/19/23 at 12:57 PM, two surveyors met with R36 in his room. R36 was behind a closed and darkened room where R36 was lying in bed with his bed sheets drawn up to his neck. R36 had visible bruising and black color under his right eye. Observed a peri orbital hematoma to the right eye, blacked in color with a crescent shape that extended from the right interior to the exterior of the eye measuring approximately two centimeters in size. R36's left eye was noted with a small fading yellowish bruise. Surveyor asked what happened to him. R36 became visibly shaken and hesitated to speak with surveyors. After assuring R36 that he was safe to speak with surveyors, R36 stated, It happened a couple of days ago. Someone from the dining room asked me. It happened in this room. He's done this to me before. Surveyor asked who gave him the black eye and R36 pointed to the bed next to him and stated, It was my roommate. Surveyor asked how he felt, R36 began shaking and crying and stated, It makes me afraid. I don't feel safe. It hurt. I didn't tell anyone. Surveyor asked whether this was the first time this happened to him with his roommate (R37) and R36 stated, No, this is the second time. Records reviewed on 4/19/23 at 2:00 PM, showed no reports or incidents of abuse involving R36. As of this date/time, there are no progress notes regarding R36's bruised right eye. Efforts were made to speak with R37 throughout the afternoon of 4/19/23 but facility staff informed surveyor that R37 was out of the building at a day program. Upon return to the facility on [DATE] at 2:57 PM, V1 (Administrator) confirmed to the survey team that R37 refused to speak with the survey team regarding the incident. V1 stated, R37 is refusing to talk to anyone. V9 Director of Behavioral Health Director did a psychosocial assessment on R36 and stated that a peer saw R36 hit himself. R37's diagnoses include in part as unspecified Psychosis, Schizoaffective Disorder, Delusional Disorders, Auditory Hallucinations, Homicidal Ideations and Suicidal Ideations. R37 is the roommate of R36. R37's care plan indicates 2/1/23 I (R37) have auditory hallucinations. I (R37) am at risk for suicidal/homicidal issues AEB: voicing thoughts and/or intentions. I (R37) have the potential to become delusional and have false beliefs due to my hallucinations and diagnosis of delusional disorder 2/1/23. A review of progress notes showed on 3/22/23, V22 (Social Worker/SW) wrote, Resident (R37) was noted to have aggressive behavior when playing games. Writer counseled resident about his aggressive behavior and resident understands. 4/19/23 at approximately 12:17 PM, V20 (Assistant Administrator) was interviewed regarding the bruise noted on R36's right eye. V20 stated, I'm not sure what happened, let me find out. 4/19/23 at approximately 12:19 PM, V9 (Director of Behavioral Health) approached surveyor and stated that she believed that R36 had an old bruise but would find out. At this time, surveyor asked V9 to provide any documentation for any incident reports and/or supporting documentation related to the bruise observed on R36's right eye. V9 then provided surveyor with a screening assessment for evaluation of self-harm/suicide, signed by V9 and dated 4/19/23; the assessment documentation read: Resident was noted to have a bruise on his face. Resident was nonchalant about his face. Resident does have a history of physical aggression. A peer (later identified as R38) reported that resident struck himself the evening before. The assessment did not include any description or location of the bruise. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/19/23 at 3:12 PM, R38's electronic medical record was reviewed and documented that R38 was on a hospital leave effective 4/18/23 and was not currently in the facility. Progress note dated 4/18/23 at 3:07 PM (written by) V9 (Director of Behavioral Health), reads: R38 was verbalizing paranoia regarding money, cigarettes, and his stay at the facility. R38 was redirected by staff. R38 was receptive of the redirection, however continued to escalate in his paranoia. Resident remained on staff supervision until he left for the hospital. 4/19/23 at 3:02 PM, during interview with V9 (Director of Behavioral Health Director), V9 was asked if R36 had hit himself within the past year. V9 stated, no, it's a new behavior. V9 added, I noticed his eye when you asked me about it in the dining room. I thought it was an old bruise, so I went to look into it. I tried to ask R36 about his eye, but he told me to get the (expletive) away from him. I don't know what time it was today. Then I went to ask V1 (Administrator) about it. V1 and other staff started looking into the bruise on R36's eye. I believe I spoke to R38 yesterday (4/18/23) and he told me that R36 hit himself. Surveyor then asked V9 how it was possible that R38 was questioned about R36 yesterday if R38 was transferred out to the hospital yesterday and the bruise on R36 had not come up until today (4/19/23). V9 responded by stating that this was before R38 was transferred and that it was while he was cycling and having delusional and psychotic behaviors; he just said it without anyone asking him about it. V9 was asked if this allegation made by R38 was documented and V9 stated, I don't write anything down. I was taught that in school. I think R38 was sent out to the hospital yesterday. At this time, V9 then asked to step out of the interview. 4/19/23 at 3:20 PM, V9 returned to speak with surveyor, along with V1 (Administrator). V9 stated, I talked to R38 yesterday and he said that guy and pointed to R36. R38 was cycling. He was having psychotic behavior and was delusional. At the time, R36 didn't have a bruise. I noticed the bruise today when the surveyor asked me about it then I went and told V1. V9 was then asked if she took R38's statement about R36 hitting himself and investigated it further or if the statement was considered credible, given that R38 was actively having psychotic behaviors and being delusional. V9 responded by stating that she had asked R38 something else and he was able to answer it clearly. 4/19/23 at 3:23 PM, V1 (Administrator) was asked about what had been reported to him regarding R36. V1 stated, I am the abuse coordinator. I went to talk with R36 (today), and he just told me to go (expletive) myself. No staff were aware that anyone struck R36. I spoke with V9 again and came to the conclusion that R36 hit himself based on the interview that R38 had provided in passing to V9 yesterday. The consultant took a look at R36's past care plan and said R36 had something in there about self-harm. The consultant advised the nurse to do a skin assessment. V1 was asked if any other residents or staff were interviewed regarding R36 and V1 stated, we talked to V12 (LPN) today after we became aware of the situation. V1 was asked if this was the conclusion that he determined regarding the injury to R36's right eye. V1 stated, based on what I know, yes, R38 said that R36 hit himself. V1 added that he knew what happened, so there was no abuse. V1 was asked how he came to this conclusion without conducting an investigation. V1 (Administrator) stated, there is nothing else to say about it, abuse didn't occur. R36 would not speak to me when I tried to speak with him. R38 was off baseline yesterday, he was verbally aggressive toward me, he had repetitive thoughts and it's not his normal. Just because R38 was delusional it doesn't mean there is no truth to what he said. I was made aware round 12ish today (about R36). Initially, I didn't know what happened. Based on what I've looked into I believe this is what happened. R37 is refusing to talk to us. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/19/23 at 3:51 PM, V1 (Administrator) returned to the conference room and stated, after speaking with the consultant, I'm doing a report of injury of unknown origin. On 4/20/23 at 9:30 AM, V1 (Administrator) was inquired of R37 being involved in any incidents. V1 stated, I don't have any except that R37 has a history of verbal aggression. V1 was asked to provide documentation of any incidents. Based on interviews and record reviews, there is no documentation to show that the facility initiated any injury of unknown origin or abuse investigation involving R36, prior to the State survey team's questions surrounding R36's observed eye injury. During this survey, the facility was asked and did not provide any documentation to show that a thorough injury of unknown origin or potential abuse investigation was completed regarding R36. 4/20/23 at 10:45 AM, V21 (Medical Doctor) was contacted for an interview regarding R36. At 2:53 PM, V21 was interviewed regarding any knowledge and notification of the bruise to R36's right eye. V21 stated, nobody has contacted me in the last few months for R36. They should call me when they find something and tell me how they found it, then investigate, talk to the patient, and staff, and document their actions. I would order x-rays, neurological checks, and vital signs and tell them to call me with any changes. If the patient is not responding, then send them out to the hospital. Facility provided Abuse Prevention and Reporting-Illinois policy (dated 12/17/21), which includes: 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, deprivation of goods and services by staff or mistreatment of residents. In order 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. Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The term willful in the definition of abuser means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment . Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Resident to Resident Abuse (any type): A resident to resident altercation should be reviewed as a potential situation of abuse: Not all resident-to-resident altercations result in abuse. Resident to resident altercations 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 abused 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 all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents. Internal Investigation All investigations will be documented, whether or not abuse, neglect, exploitation, mistreatment, or misappropriation of resident property occurred, was alleged or suspected. Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or the misappropriation of resident property will result in an investigation. Investigation procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment, or misappropriation of resident property by the accused individual.

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F 0689 Level of Harm - 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** 40102 Based on interview and record review, the facility failed to monitor and supervise a resident that is known to respond to internal stimuli to prevent an avoidable accident. This affected 2 of 3 residents (R2, R3) reviewed for supervision, accident, and incidents. This failure resulted in R3 spontaneously throwing a chair resulting in R2 being hit in the face with the chair sustaining a laceration which required 4 sutures. Findings Include: R2's diagnosis: schizoaffective disorder and auditory hallucinations. R2 admitted to the facility 2/17/22. R3's diagnosis: schizophrenia, bipolar disorder, and psychosis. R3 admitted to the facility on [DATE]. A Behavior note dated 9/27/22 at 7:24AM documents R2 was hit by a chair on the forehead in the day room by another resident. Bleeding to forehead was noted with a deep laceration. 911 was called for immediate transfer to the hospital. R2 is alert oriented times 3 and conscious to the situation. No distress was noted. A Nursing note dated 9/27/22 at 10:32 AM documents R2 returned to the facility from the hospital with 4 sutures to the forehead. An IDT note dated 9/28/22 documents the summary of the IDT meeting is that R2 was injured as a result of R3's non-targeted outburst. R2 was struck by a chair. R2 will be assisted by intervening when R2 is observed in the vicinity of peers responding to internal stimuli. The Hospital Records dated 9/27/22 document R2 presented to the emergency room with a facial laceration. R2 reported being struck by a chair this morning when another resident threw the chair. R2 denied loss of consciousness, syncope, pain, or uncontrolled bleeding. R2 was seen for a laceration repair and was sent back to the facility. The Final Incident Report of all dated 10/1/22 documents R2 was accidentally hit by a chair while sitting in the TV room. An open area to the forehead was noted. Four sutures were noted to the forehead upon return from the hospital. R3 was placed on behavior management skills program. No abuse was identified as this was a non-targeted outburst from R3. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/28/22 at 12:22PM, R2 had a laceration to the left upper forehead about 3 inches long. The laceration was glued and is healing. When asked what happened to R2's head, R2 stated, R3 hit me with a chair one morning. R3 just picked up the chair and threw it across the room. We were in the TV room. It was an accident. R3 didn't act mad before the threw it. R3 was just sitting down then R3 stood up and threw the chair. R3 was strong enough to throw it far enough to hit me. R3 didn't say anything to me. I never talked to R3 before. R3 is usually very quiet. I know R3 has some problems with R3's brain. No one was in the TV room that was staff. It was only 3 or 4 residents in the TV room early that morning. During this investigation, no staff were noted supervising the residents in the TV room. The number of residents ranged from 2 - 10 people at one time. Staff would look into the TV room as they walked down the hall, but no staff ever entered the TV room to check on the residents. On 10/30/22 at 11:33AM, When asked about the incident when R3 threw the chair at R2, R2 stated, Yes, I threw it. I don't remember who got hit. I didn't mean to hit anyone. I don't remember why I threw it. I don't have any problems with anyone here. R3 had a very flat affect and would not respond to most questions. On 10/30/22 at 12:51PM, V11 (Nurse) stated, I didn't see this happen, but they were both in the TV room when staff started calling for me to come down there. R2's head was bleeding. It was not gushing but R2 did have blood dripping down R2's head. I called 911 right away and got R2 sent out to the hospital. I was told that R3 hit R2 in the head with a chair in the TV room. No, there was no one (staff) in the TV room when R3 did that. I don't know who was supposed to be in there but when this happened it was just the residents. When I asked R2 what happened R2 said that R2 was in the TV room and R3 was in there with R3 and just picked up the chair and threw it. R2 said R3 didn't say anything before R3 threw it. R3 didn't even talk to R2. R3 just picked up the chair and threw it across the room. On 10/30/22 at 2:18PM, V1 (Administrator) stated, That incident R3 was responding to some internal stimuli while R3 was in the TV room. R3 picked up the chair and threw it across the room which ended up hitting R2. There was no screaming or any other behaviors before R3 picked up the chair and through it. He never really has aggressive behaviors. I know the maintenance man was walking down the hall and heard a chair fall over, so he went into the TV room to see what was going on and saw that the chair was on the ground next to R2 and R2's head was bleeding. On 11/1/22 at 9:11AM, V16 (Nurse) stated, The other resident (R2) that was hit said that R3 just stood up from the chair R3 was sitting in and picked it up and threw it. R2's head was bleeding, and we could not get it to stop so R2 had to be sent out for sutures. No other staff saw it. No one was monitoring the TV room at the time this happened. Someone should be monitoring this area, but I don't know where they were at. When I asked the tech what was happening, she said she was busy doing something else. I told her that someone always needs to be monitoring them. On 11/1/22 at 9:57AM, V18 (Nurse) stated, I later found out that morning that R3 threw a chair. R3 must have just been responding to some stimuli that let R3 to have that behavior. I was not here so I do not know if anyone is monitoring the TV room. I don't know who monitors the TV room. (continued on next page)

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	11/03/2022

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/1/22 at 1:13PM, V5 (Maintenance Director) stated, It was maybe around 6:30 in the morning, I was walking down the hallway and I heard a chair fall over in the TV room. I went into the TV room and saw a resident (R2) who had blood coming from R2's head and the chair was on the floor next to R2. I tried asking what happened, but no one was answering me at first. I came back down, and another resident was telling me that R3 threw the chair. I know R2 had a laceration on R2's head but I don't know about anything else. R2 did have some blood coming down R2's forehead but it wasn't spraying out or anything. There was no screaming or yelling or anything before I heard the chair fall. The only thing that made me go look in the TV room was the sound of the chair hitting the ground. There was no staff in the TV room when this happened. It was only the residents. I think there was 3 or 4 of them in there. I don't know who is supposed to be watching the room. The Psychosocial assessment dated [DATE] documents R2 is injured as a result of R3's non-targeted outburst. R2 reported being hit by a chair thrown by R3. R2 has not had any prior negative interactions with R3. R2 was not interacting with R3 at the time of the incident. R2 was observed to be calm immediately following the incident and did not express being in much pain. The Care Plan dated 7/12/22 documents R2 is at a potentially moderate risk for abuse/neglect related to depression and mental illness. On 9/27/22, R2 was injured due to a peers non-targeted outburst. A Nursing note dated 9/27/22 documents it was reported R3 had a physical altercation with R2. R3 refused to give account of the incident. Both residents were separated and 1:1 monitoring was implemented. Education was provided to R3 to keep R3's hands to self and report issues or concerns to staff. A doctor's order was given to send R3 to the hospital for psychiatric evaluation. R3 left the facility in a calm and cooperative demeanor. An IDT note 9/28/22 documents R3 displayed a non-targeted outburst resulting in an injury to R2. R3 reported R3 had no intention of harming R2. R3 was responding to internal stimuli. R3 was counseled to seek staff to utilize the sensory room when feeling negative urges. There is no other documentation of R3 having any physical altercations or aggressive outbursts with other residents since R3 was admitted . The Behavior/Mood Charting dated 9/27/22 documents R3 was physically aggressive as shown by throwing a chair across the room that hit another resident. R3 had no triggers to this behavior. R3 was educated during 1:1 monitoring. The Psychosocial assessment dated [DATE] documents R3 displayed a non-targeted outburst resulting in R2 being injured. R3 reported feeling angry and had an urge to act on it. R3 threw a chair blindly that hit R2 by mistake. R3 has partial recollection and awareness of the event. R3 was observed to be somewhat remorseful as mentioned R3 was responding to internal stimuli and had no intention of harming R2. R3 has no indicated triggers that would set off a physical altercation. R3 is known to respond to internal stimuli. The Care Plan dated 4/27/22 documents R3 has a potential to be verbally and physically aggressive related to history of aggressive behavior. On 9/27/22, R3 displayed a non-targeted outburst resulting in a female peer's (R2) injury. Interventions include the educating and counseling R3 to develop insight into aggressive behavior. R3 was encouraged to seek staff to utilize the sensory room when feeling negative urges. (continued on next page)

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	145180	A. Building B. Wing	11/03/2022

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Minimum Data Set Section E dated 10/3/22 documents R3 experiences hallucinations and delusions. There is no documentation of R3 having any physically aggressive behaviors.