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	01/31/2023

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 39340 Based on interview and record review, the facility failed to follow their change in condition policy by timely notifying the guardian of a change in resident condition. This affected one resident (R57) in a sample of 35 reviewed for change in condition. Findings include: R57's face sheet under contacts documents: V52 (Guardian) as responsible party. On 1/10/23 at 10:47 am, V51 (R57's Guardian) said he was covering for V52 and is not the primary guardian. V51 said he received a call on 11/18/22 from V2(Director of Nursing/DON) to report that R57 was sent to the hospital and sustained a fracture. V51 said he reviewed call logs and they were no reports or calls received for R57. On 1/11/23 at 10:30 am, V2 (DON) said whoever is listed on the face sheet should be notified. V2 said usually the first contact would be called first and it would be documented in the medical record. On 1/10/23 at 12:16 pm, V33 (Minimum Data Set Nurse) said she notified the doctor about R57's broken arm and called R57's mom but did not call the guardian. V33 said she just called who she saw on the face sheet. R57's progress notes dated 11/11/22 at 9:36 pm documents: Transport called at this time stated pickup time will be in two hours. Resident's mother notified of resident's condition, informed her resident will be sent to hospital for evaluation. Facility policy Physician- Family Notification-Change in condition reviewed 1/22 documents: to ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient and effective manner. The facility will inform the resident; consult with physician and if known notify the legal representative when there is an accident involving the resident which results in injury.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 39340 There are multiple deficient practice statements. I. Based on observation, interview, and record review the facility failed to address and implement interventions to stop and/or prevent residents from sexually assaulting and exposing genitalia inappropriately to residents and visitors in the facility and failed to ensure female residents were protected from these behaviors. This failure resulted in R33 inappropriately touching female visitors (V43, V44 and V45) and exposing himself to other residents (R2, R113) in common areas with the potential to touch or harm other female residents within the facility. This affected 6 residents (R2, R113, R51, R98, R171 and R173). The Immediate Jeopardy began on 1/8/23 V1 (Administrator) was notified on 1/11/23 at 2:11 pm of the Immediate Jeopardy. The facility presented an initial removal plan on 1/11/23 at 4:08 pm. The plan was accepted, and 1/18/23 the surveyor conducted an onsite record reviews and interviews and could not confirm the removal plan was implemented. The facility presented a modified removal plan on 1/20/23 at 8:18 am. The surveyor conducted an onsite record reviews and interview on 1/20/23 to confirm the removal plan was implemented. V3 (Assistant Administrator) was informed the Immediate Jeopardy was removed on 1/20/23. Although the immediacy was removed, the facility remains out of compliance at severity level II until the facility can evaluate the effectiveness of the removal plan and maintain substantial compliance with this regulation. Findings include: A. R33's medical record notes R33 with diagnoses including paranoid schizophrenia, bipolar disorder, and major depressive disorder. R33 progress notes dated 7/28/22 documents: Writer witnessed resident displaying inappropriate behaviors, including exposing himself while in the central area in front of peers. Staff immediately redirected his behavior. R33 involuntary petition dated 8/23/22 documents: Resident is increasing agitated and socially inappropriate. He is slamming items in the facility to the floor, he is exposing himself to staff. R33's aggressive behavior assessment dated [DATE] documents resident has history of abuse/neglect either as a recipient or perpetrator including abusive and/or inappropriate sexual behavior: moderate problem. R33 progress notes dated 12/17/2022 at 13:02: Resident noted to be increasingly socially inappropriate. Res noted to be walking down the hall attempting to touch female staff and female residents on their breasts and behinds. Writer counseled resident on keeping hands to himself. Male MHT staff also redirecting resident. Staff will continue to monitor and redirect to ensure staff and resident safety. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R33's MDS (Minimum Data Set), dated 12/14/22, notes section E for behavior other behavior symptoms not directed towards others (physical symptoms such as hitting or scratches self, pacing rummaging, public sexual act, disrobing in public, throwing, or smearing food or bodily waste or verbal/ vocal symptoms like screaming, disruptive sounds) behavior of this occurred 1 to 3 days. Review of R33's behaviors care plan, initiated 2/7/22, notes R33 exhibits sexually inappropriate behavior towards staff and co-peers. This care plan was last updated on 5/20/22. It has a target date 3/20/2023 denotes I (R33) exhibit sexually inappropriate behavior toward staff & co-peers. These behavioral symptoms are manifested by making crude, sexually orientated, profane, or suggestive remarks, and co-peers displaying sexually inappropriate behaviors. On 6/26/19- I was verbally displaying sexually inappropriate behavior towards female peer. On 8/13/19- I was displaying sexually inappropriate toward staff (nurse practitioner). On 2/6/2020: I allegedly displayed sexually inappropriate behavior toward female co-peer. On 9/30/21: I touched a female staff on the behind. On 10/30/21: I touched two female staff inappropriately on the behind and breast. On 12/1/21 and 2/16/22: I touched a female staff on the behind. On 12/7/2021: I attempted to grab a female staff's chest inappropriately. On 5/20/22: I touched a female staff on her behind. I will accept redirection, behave in a safe and respectful manner, and refrain from displaying sexually inappropriate behave. I will refrain from making sexually inappropriate remarks and displaying sexually inappropriate behavior through next review. Administer PRN medication as ordered. Implement limit setting with me. Specify appropriate versus inappropriate behavior. If I attempt to touch inappropriately place your hand over mine and gently (but firmly) push it down and away, clarifying it is not appropriate. R33 redirected to maintain appropriate boundaries w/ staff and peers - 5/13/22. R33 will be placed on 1:1 monitoring. Staff will intervene and redirect me when sexually inappropriate behavior is observed - 2/16/22. I (R33) have a behavior problem touching others inappropriately, as evidenced by it has been reported by staff that resident has tried and/or touched their butt or chest area. 8/17/2021: I inappropriately grabbed activity staff on her buttocks. I will display minimal episodes of touching others inappropriate behaviors related to grabbing at staff's chest or behind through next review date. Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet the resident's needs. Assist the resident to develop more appropriate methods of coping and interacting with others. Encourage the resident to express feelings appropriately. Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. If reasonable, discuss R33's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Maintain an appropriate distance from resident when interacting. On 1/8/23 around 9:45 am, V43 (surveyor) was in the common hallway near central nursing office talking to another resident when R33 came from behind and touched her chest. On 1/8/23 around 10:00 am, V44 (surveyor) was talking with another resident when R33 touched her breast. Another female V45 (surveyor), was in the hallway facing R150's room when R33 walked behind her and touched right buttocks as he passed by. About 15 minutes later, V44 (surveyor) was speaking with other residents (R113, R2) in the hall when R33 came up and pulled his penis out. R33 then began making inappropriate comments and abruptly walked away. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/8/23 10:30 am, V45(surveyor) said R169 stopped V45 in the hallway. V45 her back against wall. R33 approached V45, leaned forward, and touched V45's left breast and then walked away. R33 returned a few minutes later and attempted to touch V45 again. On 1/8/23 at lunchtime, R33 pulled penis out at the central monitoring station area, in front of mental health techs, residents, and V43. On 1/9/23 around 10:15AM, V44 (surveyor) was in the dining room speaking with a resident when R33 came from behind V44, R33 touched her bottom and made inappropriate comments. On 1/9/23 12:34 pm, V7(Mental Health Tech) said she heard the residents say R33 just touched a surveyor. R33 walked and sat down and V7 asked him if he touched the surveyor he just said [NAME], [NAME]. V7 said she told R33 about personal space and he sat in central area for about 5 minutes and left. V7 said she reported the incident to V13(Supervisor) on 1/8/23 at 12:13PM. On 1/10/23 at 9:55am, V9 (PRSC/psychiatric rehabilitation services coordinator) stated that R33 exhibits sexually inappropriate behaviors, R33 touches the buttocks and breasts of female staff. V9 stated that R33 was on V28's (former PRSD) caseload until she resigned in early December 2022. At 3:00pm, V9's documentation on 12/17/2022 of R33's behavior was reviewed with V9. V9 stated that V9 does not recall which staff or residents R33 touched. V9 stated that if she documented it, then it happened. V9 stated that V9 does not recall reporting this incident to any staff other than the MHT staff. V9 stated that R33 does not exhibit sexually inappropriate behaviors daily, possibly weekly. V9 stated that right before V9 came to speak with this surveyor, R33 attempted to touch her inappropriately. V9 stated that staff are expected to report all behaviors to the PRSCs . On 1/10/23 at 2:40pm, V13 (Mental Health Supervisor) stated that V7 (MHT) notified V13 of an incident of inappropriate behaviors with a female, possibly CNA (Certified Nurse Assistant). When questioned if V13 reported this incident to V1 (Administrator), V13 responded No. V13 stated I guess I should have reported it to V1. When questioned if V13 reported it to V1 on 1/9/23, V13 responded 'V13 did not work yesterday. When questioned if he notified V1 today, V13 stated that he thought it resolved on own. On 1/10/23 at 2:58pm R113 was interviewed about the incident with R33 that occurred on 01/08/23. R113 stated. He took out his private parts while we were standing here talking. He will show it to people for no reason. When I see him in the halls, he is always bothering people. I would say he pulls out his penis about once or twice a week that I see. He shows it to all different people. Sometimes staff is there and see him do it. They will just tell him to put it away. Sometimes he listens and other times they must give him a shot because he won't calm down. They don't do much more than that. I do see him touching people. I don't really see how many times he does that, but he grabs at girls' breasts and their butts. He does it to staff and other residents. On 1/13/23 at 11:14AM, R113 who was alert and oriented at time of interview said it made her feel bad and not safe at that time because she knew it was wrong. On 1/12/23 at 3:19PM, V28 (former PRSD) said R33 has history of sexual inappropriate actions towards staff. V28 said she never received report about inappropriate behaviors towards resident. We educated staff on what to do if R33 became inappropriate with them. Interdisciplinary team was aware of his behaviors. Unable to recall any further staff names that were affected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/13/23 at 10:15am, V7 (MHT) stated that R33 exhibits sexually inappropriate behaviors daily. V7 stated that all staff are aware of R33's inappropriate behaviors. V7 stated that R33 frequently pulls his pants down in front of staff/residents or pulls penis out. V7 stated on 1/8/23, R33 was calm and walking at a normal pace. V7 stated that the behaviors R33 was exhibiting were level one behaviors. V7 stated that R33 does not get sent out to the psychiatric hospital until he is exhibiting behaviors at a level 5, such as running through hallway, cursing staff and other residents, and destroying property. Facility census dated 1/12/23 documents: 59 female residents. Facility census dated 1/8/23 documents 171 residents. Facility abuse prevention and reporting policy revised 4/2022 documents: The resident has the right to be free form abuse, neglect, misappropriation of resident property and exploitation. Sexual abuse is nonconsensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to unwanted intimate touching of any kind especially breast and perineal area: all types of sexual assault battery such as rape, sodomy and coerced nudity; forced observation of masturbation and/or pornography. On 01/20/23 the surveyor verified by observations, record review and interview that the facility implemented the following to remove the immediacy: 1.R33 is no longer at the facility. Psychiatrist ordered a discharge to the hospital for a psychiatric evaluation on 1/10/23. Resident was placed on supervision prior to transfer to hospital. Facility will re-evaluate R33 after completion of treatment. Upon return, resident will be placed on increased staff supervision, provided a room change closer to the nurses' station, evaluated by the psychiatrist, and assessed for appropriate therapeutic programming. 1/10/23 started and ongoing. 2.Staff were in-serviced/trained on how to recognize sexual abuse and the facility's abuse protocol to prevent it from happening to other residents. All staff will be re-educated prior to next scheduled shift including staff that are on leave and are on vacation. Administrator and Assistant administrator are conducting the training. The training includes the Abuse prevention reporting policy, specifically the definition of abuse, Sexual abuse, sexual assault, rape and internal reporting requirements and identification of allegation and protection of residents. Staff acknowledged information via signature. Administrator/Managers will continue to monitor all staff for compliance by a competency questionnaire. The abuse prevention training program posttest questionnaire is the material utilized. No revision of the current abuse policy has occurred. The noncompliance was a failure to follow current policy IDT conducts assigned regular rounds during shift to ensure visual monitoring and staff supervision. 1/10/23 started at 2:45pm. 3.Residents that have been identified for being at risk for sexual abuse have had their care plans updated to reflect interventions to prevent abuse. List of identified residents was provided to survey team. Intervention implemented 1/10/23 . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4.Resident identified with sexually inappropriate behavior was counseled and placed on close staff supervision, was educated on symptom management, maintaining boundaries and importance of utilizing coping skills to manage symptoms, and will be followed up with by staff and/or psychiatrist regularly. QA tool titled Abuse reporting, interventions and investigation will be completed weekly by the Administer or Assistant Administrator. Observations noted during regular rounds will be discussed at the QA Committee. Concerns will be discussed among the members, a plan of action is devised, and past plans of actions evaluated. Intervention implemented 1/10/23 B. R51 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder, schizoaffective disorder, panic disorder and borderline personality disorder. R51's Minimum Data Set, dated dated dated [DATE] documents a brief interview for mental status score 15/15 which indicates cognately intact. On 1/13/23 at 1205PM, R51 who was alert and oriented at time of said she does not feel safe in the facility due to R25 behaviors. R51 said about 3 weeks ago R25 licked her chest and she hit him. R51 said she told an activity aide. On 1/13/23 1:31pm, V1 (Administrator) denied any knowledge of incidents for R51. On 1/13/23 at 4:12PM, V24 (Mental Health Tech/MHT) said he saw R51 and R25 in the hallway. R51 reported that R25 licked her chest. V24 said he told V19(MHT Supervisor). Facility abuse reportable dated 1/13/23 documents under staff interviews: V24 (Mental health tech, MHT) I saw it happened. R51 was fully clothed during the incident. I corrected R25 action and redirected him. C. R128 was admitted to the facility on [DATE] with a diagnosis major depressive disorder and psychotic disorder. R128's Minimum Data Set, dated dated dated [DATE] documents a brief interview for mental status score 15/15 which indicates cognately intact. On 1/13/23 at 12:05 pm, R128 who was alert and oriented at time of interview said one month ago, R25 grabbed her butt and it happened 3 months prior as well while waiting in line for smoking. R128 said she was unclear if she reported second inappropriate touch but the first time, she thinks she reported the incident to V1 (Administrator). R128 said she does not feel safe in the facility due to R25 behaviors. On 1/13/23 1:31pm, V1 (Administrator) denied any knowledge of incidents for R128. D. R98 was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder, alcohol abuse, major depressive disorder, homicidal ideations, and psychosis. R98's Minimum Data Set, dated dated dated [DATE] documents a brief interview for mental status score 15/15 which indicates cognately intact. On 1/19/23 at 1:50 pm, R98 who was alert and oriented at time of interview said R25 grabbed her butt 2 times while waiting in line for smoking. R98 said she threatened R25 and was sent to the hospital. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R98's hospital record dated 1/11/23 documents under chief complaint: Patient stated, I threatened to cut a man's d*** off because he smacked me on my a**. E. R171 admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder and conduct disorders. R171's Minimum Data Set, dated dated dated [DATE] documents a brief interview for mental status score 14/15 which indicates cognitively intact. On 1/18/2023 at 2:57 pm, R171 who was alert and oriented at time of interview stated that 3 days ago, R74 entered R171's room without permission. R171 stated that R171 was lying in bed after breakfast. R171 stated that R74 approached R171 and started pulling down R171's pants to perform oral sex. R171 stated that R171 grabbed R171's pants to prevent R74 from R74 removing pants any further and yelled. R171 stated that R171 informed R74 to stop and pushed R74's head away. R171 stated that R74 then pulled R74's pants down and attempted to get in bed with R171. R171 stated that again R171 pushed R74 away. R74 pulled pants up and exited R171's room. R171 stated that R171 felt like he was being molested. R171 stated that during smoke break in the evening, R171 reported incident to V59 (activity aide). On 1/18/23 at 3:40pm, R171 identified R74 at smoke break as the resident who pulled R171's pants down. On 1/19/23 at 2:16pm, R171 reported the same story. On 1/18/2023 at 3:19pm, R173 who was alert and oriented at time of interview, stated that 3 days ago R173 was talking with R171 in their room when R74 came into R173's room without permission and asked R173 if R173 wanted to have sex. R173 stated that R173 declined and told R74 to leave. R173 stated that R173 witnessed R74 go to R171 and began pulling R171's pants down to try to have sex with R171. R173 said he heard R171 say no and then R74 left the room. R173 stated that R173 did not report the incident. On 1/18/23 at 3:54 pm, V59 (Activity aide) said R171 reported to her during smoke break that R74 was going into R171's room and trying to pull his pants down. V59 does not recall which Mental Health Tech she spoke with. On 1/19/23 at 11:25 am V29 (PRSC/Psychiatric Rehabilitation Services Coordinator) said that R74 said R74 had sex with R171 but could not provide date of incident. V29 stated that a capacity for sexual consent was completed yesterday. V29 stated that it has not been determined if R74 understands no means no because of R74's intellectual disability. V29 stated that R171 informed V29 that this incident was not consensual and R171 would not like this behavior to happen again to him. V29 stated that R74 went into R171's room and pulled R171's pants down and then pulled his own pants down. II. Based on interview and record review, the facility failed to implement appropriate crisis prevention intervention techniques during a behavioral episode for one resident (R57). This failure resulted in R57 sustaining a left wrist fracture. Findings include: R57 was admitted to the facility on [DATE] with a diagnosis of paranoid schizophrenia, anxiety and major depressive disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R57's progress notes dated 11/11/22 at 6:31 pm documents: Writer notified by Mental Health Tech that resident was responding to internal stimuli and not able to be redirected. Resident unable to give description. Resident given prescribed medication. After medication was administered, resident charged at Mental Health Tech and staff-initiated Crisis prevention intervention (CPI). R57's progress notes dated 11/11/22 at 8:55 pm documents: Mental Health Tech informed writer resident left lower arm wrist area was swollen. Writer assessed area noted left lower arm /wrist area swollen, displaced and discolored. R57's hospital record dated 11/12/22 documents: left wrist distal radius fracture. severely displaced, comminuted distal radial fracture wit radial and palmar displacement. On 1/10/23 at 10:30 am, V1 (Administrator) said V48(Mental Health Tech) was terminated due to improper Crisis Prevention intervention by placing his hands on the resident which resulted in a fall and fracture. V48's employee file notice of corrective action dated 11/14/22 documents: Violation of company policy. After extensive investigation, it has been determined that associate used improper CPI on a resident. Associate was seen via camera footage lunging at resident and grabbing the resident's wrist, pushing her backwards, causing resident to fall. Residents left wrist was broken. Facility abuse prevention and reporting policy revised 12/17/21 documents: Abuse means any physical assault inflicted upon another resident other than by accidental means. 40066 III. Based on interview and record review the facility failed to prevent incidents of resident-to-resident physical assault. These failures affected 6 (R119, R29, R56, R60, R96, and R167) residents reviewed for physical abuse in the sample of 35. This failure resulted int R56 being assaulted and sustaining an abrasion to the chin area and a laceration to the left side of her head requiring 21 staples to the occipital area and treated for occipital condyle fracture. Findings include: A. R56's diagnosis including, but not limited to Parkinson's Disease, Bipolar Disorder, Anxiety, Alzheimer's Disease, Dementia, Schizoaffective Disorder, and Dementia. R56's Abuse/Neglect Screening dated 9/6/22 notes a score of 4= Moderate. Presents with a moderate level for abuse and neglect. Progress Notes dated 1/6/23 notes R56 verbalized to writer that she was hit in the head from the back by peer, noted with slight blood at the side of her head. Noted with laceration in the scalp. First aid rendered and 911 called. Progress Notes dated 1/8/23 notes R56 back from hospital with 21 staples in the head and neck brace because of fracture of the neck. R119's diagnosis including, but not limited to Psychotic Disorder and Schizophrenia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R119's Aggressive Behavior assessment dated [DATE] documents she was involved in a physical altercation with a male peer and admitted to being the initial aggressor. R119's care plan initiated on 11/14/18 documents she has the potential to be physically aggressive related to a diagnosis of psychosis. Documented behaviors directed towards other residents include scratching, pushing, physical altercations and aggression. Progress Notes for R119 dated 12/28/22 documents R119 is reported to be aggressively throwing punches when no one is there and talking to self. On 1/8/23 the surveyor observed R56 during initial observation made between 10:30-11:00 am. R56 was lying in bed, flat on her back, and wearing a neck brace. R56 was in an isolation room. Staff sitting, V23 (Certified Nurse Assistant/CNA) outside her room said she has COVID. The surveyor asked V23 what happened to R56. V23 replied I don't know what happened to her, it was last night . Surveyor did not enter the room to finish screening all other residents and then returned to kitchen for observations. Upon return to the unit 2:00 pm R56 was no longer in the facility. On 1/9/23 at 12:00 V6 (Registered Nurse) said she was on break in the Central Nurses' stations and R56 walked in and said R119 hit me from the back and she mad, she hit me. V6 said R56 said I don't know with what. V6 said R56 was alert. V6 said R119 won't speak to say why she hit R56. V6 said R119 was hallucinating, and I sent her out immediately. V6 said I saw the laceration on R56, and I called 911. V6 said I saw the laceration on the top of R56's head. V6 said R119 and R56 was walking in the hallway. V6 said R119 is no one's friend. V6 said this happened in the evening. V6 said I asked the CNAs about the incident, and they said they didn't see anything. V6 said R56's behavior does not include fighting; she has occasional anxiety. V6 said R119 always talks to herself, hallucinates, and when the psych doctor comes in, I tell them to evaluate R119. She talks like she is in conversations with 10 people. She was compliant with her medication. V6 said whatever they have done, it was not effective. V6 said R119 had been yelling and hollering all the time and verbally aggressive. V6 said when she spoke to Psych doctors about the behavior, they said that was her baseline. V6 said I told them she was not a baseline. V6 said I don't know what R119 used to hit R56 with. V6 said the incident happened in the back hallway. On 1/9/23 at 12:24 pm V20 (Licensed Practical Nurse) said R119 and R56 are not physically aggressive, I never seen her hit anyone. On 1/9/23 at 2:01 pm V9 (Social Services) said I am not aware of the situation with R56 and R119. V9 said she was not notified to perform an assessment or implement new intervention for R56 or R119. On 1/10/23 at 9:57 pm V22 (CNA), said R119 is pleasant, calm, does not cause any problems, quiet, and she does not bother anyone. On 1/10/23 at 2:06 pm V23 (CNA) said on 1/8/23 she sat outside of R56's room to monitor her. V23 said before the incident R56 used to walk around. On 1/11/23 V35 (Doctor) was asked by the surveyor if he expects his patients to be safe in the facility? V35 responded Yeah, absolutely. V35 said I would want my residents to be safe in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. R60's diagnosis including, but not limited to Paranoid Schizophrenia, Unspecified Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. Abuse investigation form documents on 10/13/22 R60 has history of poor boundaries and impaired thought process. R29 has history of poor boundaries and physical aggression. It is documented that R60 and R29 were served at lunch and sat at the same table. R60 attempted to grab food off R29's tray. [This is different than V22's interview with surveyor.] R29 displayed poor boundaries and impulse control by striking R60. Nursing staff attempted to apply first aid to R60's superficial cut on lip, but R60 refused treatment. R60's care plan initiated on 4/21/20 documents R60 displays poor boundaries. Care plan initiated on 9/20/16 notes R60 has a behavior problem, poor insight regarding mental illness, noncompliance with medications related to diagnosis of Schizophrenia. Care plan initiated on 11/10/16 documents R60 has impaired cognitive function/dementia or impaired thought process as evidenced by disorientation, recall deficit, disorganized thoughts. R29's diagnosis including, but not limited to unspecified Psychosis, Schizoaffective Disorder, Bipolar Type, and Restlessness and Agitation. R29's PAS/MH Level II Notice of Determination dated 10/5/18 identified R29's findings to benefit from aggression/anger management R29's care plan dated 10/13/22 documents I have the potential to be physically aggressive towards others related to Anger and poor impulse control. R29's Aggressive Behavior assessment dated [DATE] notes R29 was involved in a physical altercation with a female peer and admitted to being the aggressor after she snatched food items off his breakfast tray. On 1/9/23 at 12:00 pm V6 (Registered Nurse) said I didn't see the incident with R29 and R60. V6 said R29 does not get along with others. He does not have friends. He just talks to himself. V6 said R29 still eats in the dining room. On 1/10/23 at 9:57 am V22 (Certified Nursing Assistant) said on 10/13/22 R60 grabbed R29's food tray. V22 said R60 and R29 were sitting at separate tables. V22 said R60 grabbed R29's food in front of him. V22 said R60 took the food off the tray, R29 got up and hit R60 and then R60 sat back down. V22 said R29 quickly fisted R60 and made direct contact with her lip. V22 said I was sitting at back table in the dining room. V22 said I saw R60 grab the food. V22 said I did not get up the Mental Health Tech was walking towards R29 and R60. On 1/11/23 at 10:31AM V2 (Director of Nursing) said residents should not be hitting other residents. V2 said that is considered abuse. V2 said the residents should absolutely be safe in the facility. C. R96's diagnosis including, but not limited to Epilepsy, Schizophrenia, Depressive Disorder, Anxiety Disorder, Insomnia, and Tremor. R167's diagnosis including, but not limited to Schizoaffective Disorder, Bipolar Type, Vitamin D Deficiency, Cannabis Dependence, Nicotine Dependence, Delusional Disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R167's care plan initiated on 9/20/22 notes he has the potential to be aggressive. On 11/8/22 R167 was in a physical altercation with a peer due to hallucinations. R167's Aggressive Behavior assessment dated [DATE] notes R167 has a history of aggressive/agitated behavior or noncompliance with medications, treatment, regimen, or resisting care. R167 was involved in a physical altercation with a peer as he admitted to being the aggressor. Due to his hallucinations, he mistakes peer saying something disrespectful to him, resulting in physical aggression. Progress note dated 12/12/22 notes a peer(R167) entered R96's room and became physically aggressive towards R96. Incident report dated 12/12/22 documents physical abuse allegation. Summary of interview witness documents V19 said he observed R167 becoming physically aggressive towards R96. R167's statement was R96 was peeing on my bed. R96's statement was I didn't do anything. Investigation Findings states R167 has a history of physical Aggression, hallucinations, and confabulations. R167 was having hallucinations at the time of the incident believing R96 had urinated in R167's room. R167 approached R96 and struck him. On 1/9/23 at 1:17 pm V15 (PRSC) said she followed up with R167 following the incident with R96. V15 said I was not in the facility the day of the incident. V15 said when she spoke with R167 he would not give me more information. V15 said I spoke with R167 about better ways to cope with his anger. V15 said I think R167 has a history of behaviors, he has shown aggression in the past. V15 said R167 can be aggressive with staff and residents, he was yelling at me the other day. On 1/9/23 at 2:01 pm V9 (Social Services) said R167 was hallucinating and thought that R96 had gone into his room and peed on the towels. V9 said R167 is known to be delusional. V9 said R167 was the on schedule for anger management group. V9 said the goal of programs is to maintain safety. On 1/10/23 at 1:22 V19, (Mental Health Tech Supervisor/MHT) said on 12/12/22 R167 struck R96. V19 said I did not see R167 hit R96. V19 said I went into the resident room to break it up. V19 said R167 said it was because R96 peed on his stuff. V19 said R96 had not been up that night shift, he was in his room, in his bed. V19 said I believe he (R167) just wanted to get him (R96). V19 said he checked both resident's rooms and didn't see anything wet with urine. On 1/11/23 at 10:31 am V2 (Director of Nursing) said resident should not be hitting other residents. V2 said that is considered abuse. V2 said the residents should absolutely be safe in the facility. The facility policy titled Abuse Prevention and Reporting revised 4/29/22 states as follows: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 41758 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	IV. Based on interview and record review the facility failed to prevent a resident-to-resident sexual assault. This failure affected 4 (R39, R74, R171, and R427) residents reviewed for sexual assault. This failure resulted in R39 being sexually attacked by R427 and R74 to pull R171's pants down and attempt to provide R74 with oral sex. Findings Include: A. Police report dated 11/3/22 documents: while in R39's room, R427 used forced to push R39 backwards onto her bed. While lying on her back R427 laid his body on top of R39. R427 place his hand on R39's mouth, place his ot [TRUNCATED]

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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 - Immediate jeopardy to resident health or safety 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** 34072 I.Based on observations, interviews, and record reviews, the facility failed to adequately supervise/monitor and implement effective interventions for one male resident (R33) with a history of having sexually inappropriate behaviors. The facility failed to prevent an incident of sexual assault of three female visitors as well as inappropriate exposure of himself. The lack of the adequate supervision and effective interventions upon the onset of R33's behaviors had the immediate potential to affect all 59 female residents who has the potential to encountered R33. The Immediate Jeopardy began on 1/8/23 V1 (Administrator) was notified on 1/11/23 at 2:11 pm of the Immediate Jeopardy. The facility presented an initial removal plan on 1/11/23 at 4:08 pm. The plan was accepted, and 1/18/23 the surveyor conducted an onsite record reviews and interviews and could not confirm the removal plan was implemented. The facility presented a modified removal plan on 1/20/23 at 8:18 am. The surveyor conducted an onsite record reviews and interview on 1/20/23 to confirm the removal plan was implemented. V3 (Assistant Administrator) was informed the Immediate Jeopardy was removed on 1/20/23. Although the immediacy was removed, the facility remains out of compliance at severity level II until the facility can evaluate the effectiveness of the removal plan and maintain substantial compliance with this regulation. Findings include: 1. R33's medical record notes R33 with diagnoses including: paranoid schizophrenia, bipolar disorder, and major depressive disorder. R33's MDS (minimum data set), dated 12/14/22, notes section E for behavior shows R33 has hallucinations, delusions, verbal symptoms directed towards others (threating others, screaming at others) that occurred 1 to 3 days, other behavior symptoms not directed towards others (physical symptoms such as hitting or scratches self, pacing rummaging, public sexual act, disrobing in public, throwing or smearing food or bodily waste or verbal/ vocal symptoms like screaming, disruptive sounds) behavior of this occurred 1 to 3 days. R33 has behaviors of wandering, behavior of this occurred 1 to 3 days. Section E1100 shows R33 current behavior status in comparison to prior assessment is the same. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R33's behaviors care plan, initiated 2/7/22, notes R33 exhibits sexually inappropriate behavior towards staff and co-peers. This care plan was last updated on 5/20/22. It has a target date 3/20/2023 denotes I (R33) exhibit sexually inappropriate behavior toward staff & co-peers. These behavioral symptoms are manifested by making crude, sexually orientated, profane, or suggestive remarks, and co-peers displaying sexually inappropriate behaviors. On 6/26/19- I was verbally displaying sexually inappropriate behavior towards female peer. On 8/13/19- I was displaying sexually inappropriate toward staff (nurse practitioner). On 2/6/2020: I allegedly displayed sexually inappropriate behavior toward female co-peer. On 9/30/21: I touched a female staff on the behind. On 10/30/21: I touched two female staff inappropriately on the behind and breast. On 12/1/21 & 2/16/22: I touched a female staff on the behind. On 12/7/2021: I attempted to grab a female staff's chest inappropriately. On 5/20/22: I touched a female staff on her behind. I will accept redirection, behave in a safe and respectful manner, and refrain from displaying sexually inappropriate behave. I will refrain from making sexually inappropriate remarks and displaying sexually inappropriate behavior through next review. Administer PRN medication as ordered. Implement limit setting with me. Specify appropriate versus inappropriate behavior. If I attempt to touch inappropriately place your hand over mine and gently (but firmly) push it down and away, clarifying it is not appropriate. R33 redirected to maintain appropriate boundaries w/ staff & peers - 5/13/22. R33 will be placed on 1:1 monitoring. Staff will intervene and redirect me when sexually inappropriate behavior is observed - 2/16/22. I (R33) have a behavior problem touching others inappropriately, as evidenced by it has been reported by staff that resident has tried and/or touched their butt or chest area. 8/17/2021: I inappropriately grabbed activity staff on her buttocks. I will display minimal episodes of touching others inappropriate behaviors related to grabbing at staff's chest or behind through next review date. Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet the resident's needs. Assist the resident to develop more appropriate methods of coping and interacting with others. Encourage the resident to express feelings appropriately. Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. If reasonable, discuss R33's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Maintain an appropriate distance from resident when interacting. Per PAS/MH Level II Notice of Determination, I (R33) may be able to benefit from: medication monitoring/ management; - ADL (activities of daily living) training/reinforcement; - mental health rehabilitation; illness self-management; - incentive program to improve participation in treatment and community re-integration activities. I will meet with my PRSC as needed to address symptom management issues as well as negative behaviors through next review date. Encourage group attendance, encourage resident to participate in mental health treatment. PRN one on one sessions with PRSC to address behaviors and symptom management. 2. On 1/8/23 around 9:45am, R33 was observed in the common hallway near the central nursing office approach V43 (surveyor) from behind and touch her breast. V7 MHT (Mental Health Tech/MHT) and other residents were present. V7 re-directed R33 away and into an area between the dining room and hallway. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/8/23 around 10:00 am, V44 (surveyor) was walking through the central station area after leaving the dining room. R33 was observed approaching V44 from the opposite direction and touch her right breast. Staff's back was turned while this happened. About 15 minutes later, V44 was speaking with R2 and R113 in the hall when R33 came up and pulled his penis out. V44 attempted to redirect R33 back to his room but was unsuccessful. R33 then began making inappropriate comments and abruptly walked away. No staff witnessed these incidents. On 1/8/23 at 2:58pm, R113 was interviewed about the incident with R33 that occurred on 01/08/23. R113 stated. He took out his private parts while we were standing here talking. He will show it to people for no reason. When I see him in the halls, he is always bothering people. I would say he pulls out his penis about once or twice a week that I see. He shows it to all different people. Sometimes staff is there and see him do it. They will just tell him to put it away. Sometimes he listens and other times they have to give him a shot because he won't calm down. They don't do much more than that. I do see him touching people. I don't really see how many times he does that, but he grabs at girls' breasts and their butts. He does it to staff and other residents. On 1/8/23 at 10:20am, R33 was observed walking past V45 (surveyor) and touch her right buttocks. At 10:30am, V45 was speaking with R169 in the hallway. R33 was observed approaching V45, leaning forward, and touching her left breast. R33 then abruptly walked away. A few minutes later, R33 approached V45 and attempted to touch her lower abdomen. There were no staff present during these incidents. On 1/9/23 around 10:15am, V44 was observed in the dining room speaking with a resident. R33 was observed approaching female visitor touching her buttocks and making inappropriate comments. V44 re-directed R33 not to touch her. R33 quickly walked away. On 1/9/23 12:34pm, V7 (MHT) stated V7 heard the residents say R33 just touched a female visitor. R33 walked and sat down. V7 asked R33 if he touched the visitor, R33 just said [NAME], [NAME]. V7 told R33 about personal space and he sat in central area for about 5 minutes and then left. According to V7 there were only two mental health techs working day shift for 174 residents. V7 texted V13 (mental health supervisor) at 12:13pm about the incident with R33 and the visitor. V7 stated that V13 telephoned V7 and acknowledged that he received her text message. 3. Additional interviews were conducted regarding R33's behavior and planned intervention for recognized behaviors as follows: On 1/9/23 at 2:00pm, V9 (Psychiatric Rehabilitation Services Coordinator/PRSC) stated that at this time, there is no facilitator for group therapy programs. V9 reported, the PRSC staff are doing 1:1 session with each resident. V9 stated, social services discuss with the resident the behaviors identified in group therapy. V9 stated, there is no PRSD (psychiatric rehabilitation services director). On 1/10/23 at 9:55am, V9 reported R33 exhibits sexually inappropriate behaviors, R33 touches the buttocks and breasts of female staff. V9 stated R33 was on V28's (former PRSD) caseload until she resigned in early December 2022. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 3:00pm, the surveyor reviewed with V9, V9's documentation on 12/17/2022 of R33's inappropriate behavior. V9 reported, she does not recall which staff or residents R33 touched. V9 stated that if she documented it, then it happened. V9 stated she does not recall reporting this incident to any staff other than the MHT staff. V9 stated, R33 does not exhibit sexually inappropriate behaviors daily, possibly weekly. V9 reported to the surveyor, right before she came to speak with this surveyor, R33 attempted to touch her inappropriately. V9 stated that staff are expected to report all behaviors to the PRSCs On 1/10/23 at 9:00am, V1 (Administrator) stated that the group facilitator and PRSCs should be doing 1:1 session with every resident. V1 stated that the group facilitator resigned in early December. V1 stated that the last day for group programs was on 12/9/22. V1 stated 1:1 session with residents should be weekly same as the frequency group meetings were held. V1 stated that V1 can't recollect if he told staff right away to start doing 1:1 session with residents after the group facilitator resigned. V1 stated 1:1 session is documented in the resident's progress notes. On 1/10/23 at 10:30am, V15 (PRSC) stated that V15 has been covering R33 since PRSD left in December, about 2-3 weeks. V15 stated that R33 is receiving 1:1 session. V15 stated that R33 is not receiving any group therapy programs. V15 stated that she is not aware of R33 exhibiting any behaviors since R33 was readmitted to facility in December 2022 when R33 was hospitalized for aggressive behaviors. On 1/10/23 at 2:40pm, V13 (Mental Health Supervisor) stated that V7 (MHT) notified V13 of an incident of inappropriate behaviors with a female, possibly CNA (certified nurse aide). When questioned if V13 reported this incident to V1 (Administrator), V13 responded 'no'. V13 stated I guess I should have reported it to V1. When questioned if V13 reported it to V1 on 1/9/23, V13 responded 'V13 did not work yesterday. When questioned if he notified V1 today, V13 stated that he thought it was resolved. On 1/13/23 at 10:15am, V7 (MHT) stated R33 exhibits sexually inappropriate behaviors daily. V7 stated that all of the staff are aware of R33's inappropriate behaviors. V7 stated that R33 frequently pulls his pants down in front of staff/residents or pulls penis out. V7 stated on 1/8/23, R33 was calm and walking at a normal pace. V7 stated the behaviors R33 was exhibiting were level one behaviors. V7 stated that R33 does not get sent out to the psychiatric hospital until he is exhibiting behaviors at a level 5, such as running through hallway, cursing staff and other residents, and destroying property. On 1/13/23 at 11:25am, V9 stated that the PRSCs talk to residents 1:1 as needed, not once a week. V9 stated that the expectation is for the PRSC to document in the resident's care plan and progress notes. V9 stated that the PRSCs should be documenting every 1:1 session with a resident in his/her progress notes. V9 acknowledged that these 1:1 session should be occurring routinely, not after the resident exhibits inappropriate behaviors. V9 acknowledged that if it isn't charted, it didn't happen. On 1/17/23 at 10:20am, V46 (Psychiatric Doctor) stated that R33 should have been placed on 1:1 supervision after the first incident on 1/8/23, to prevent the second and the third incidents of inappropriate touching. A behavior contract should have been created. V46 stated that V46 was not informed about R33 touching the staff the first time. V46 stated that V46 would have sent R33 to the nearest hospital at that time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/8/23 at 4:22 pm, V4 (Nurse) said she observed R43 wandering, and staff reported that he bumped his head into something. V4 said R43 had dried blood on his head. V4 said she did not notify the doctor or conduct neuro checks on the residents. V4 said R43 was placed on one-to-one monitoring with staff. On 1/8/23 5:30 pm, V34(Nurse) said R43 head was swollen. V34 said she did not call the doctor or the family about change in condition and the nurse who was assigned prior should have completed notification. V34 said they were not conducting any neuro checks at this time. On 1/11/23 at 10:30AM, V2(Director of Nurse) said any resident that experiences a head injury the doctor should be notified, and neuro checks should be initiated, documented in the resident chart. V2 unable to provide any further monitoring for R34. R43's progress note dated 1/11/23 11:51 am documents: R43 was sent to local hospital. On 1/11/23 at 6:00 pm documents resident returned with a diagnosis of head trauma and abrasion. On 1/12/23 at1 12:35 pm, V36(MD) said he was notified of incident with R43 but unable to recall who contacted him and instructed staff to conduct neuro checks. V36 said he would expect staff to follow orders. III. Based on observation, interview, and record review, the facility failed to monitor residents during smoking breaks to prevent resident from bringing in smoking materials and smoking in an undesignated area. This affected 1 resident R98 reviewed for inappropriate smoking in the sample of 35. Findings include: R98 was admitted to facility on 5/2/22 with a diagnosis of schizoaffective disorder, alcohol abuse, major depressive disorder, nicotine dependence. R98 smoking risk assessment dated [DATE] documents: minimal problem for potential risk recommended require supervision only not able to store smoking materials. On 1/8/23 at 10:04 am, R98 was observed smoking in her room. R98 said she took cigarettes in from smoke break this morning. R98 had a pop bottle on nightstand with 5 cigarette buds in it and verified with V7 (Mental Health Tech). R98 denied having a lighter. On 1/8/23 at 10:40 am, the East smoking area was observed with multiple cigarette buds scattered on the ground. R98's care plan revised on 7/11/22 documents: I am an inappropriate smoker with following interventions dated 5/2/22: Resident will keep smoking materials in a secured location. Resident requires supervision while smoking; intervention dated 7/11/22. Resident will watch a smoking cessation video. R98's care plan and progress notes did not document any smoking violations on 1/8/23. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Smoking Policy documents: Staff responsibilities: staff will monitor residents removing cigarette buds from ashtrays or form the ground. Staff will empty and sweep before leaving the smoking areas as needed. All reports of residents who have smoking violations must be reported, documented, and followed up. IV.Based on observation, interview and record review, the facility failed to develop and implement effective fall prevention interventions for 2 residents (R68, R327) with a history of falls. This affected 2 residents (R68, R327) reviewed for fall prevention in the sample of 35. This failure results in R327 sustaining a fall requiring 6 sutures to her lower lip and R68 falling and sustaining bruising to his left eye. Findings include: 1. R327 was admitted to the facility on [DATE] with a diagnosis of epilepsy, unsteadiness on feet and schizophrenia. R327's Minimum Data Set, dated dated dated [DATE] documents under balance during transitions a score of one which indicates not steady but able to stabilize without staff assistance for moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfer. Under mobility device it indicates a walker. R327's therapy notes 9/24/22 under fall assessment documents: does patient feel unsteady when standing-Yes; Does patient feel unsteady when walking- Yes; Does patient worry about falling- Yes. Under ambulation documents walk 10 -50 feet requires partial to moderate assistance. R327's progress note dated 9/26/22 at 5:30 pm, Narrative: Writer notified by Mental Health Tech resident had fallen as she was coming out her room. Resident assisted to her bed. R327's Progress note 10/2/22 at 9:07 am documents: Nurse was informed by residents' roommate that she found her on the floor after coming in from breakfast. Full body assessment was preformed, vitals were checked and were within normal limits. Resident states that she hit her head and busted her lip on the nightstand. R327's hospital record dated 10/2/22 documents: R327 states she tripped on something and fell on her face. 6centimeter laceration to lower lip down to subcutaneous tissue. Six sutures placed to lower lip. R327's fall care plan dated 1/9/23 documents: 9/26/22 Physical therapy consult for strength and mobility; assessed for injury. 10/2/22 documents: continue with physical therapy for strengthening and mobility; neuro checks for 72 hours; refer to pharmacy for medication review. On 1/10/23 at 12:30 pm, V17(Restorative Nurse) said she was unsure if R327 was on therapy prior to first fall. V17 said the interventions were to continue therapy for strength and mobility. V17 said they offered R327 a walker after the second fall, but she refused. V17 said she was unable to provide any documentation related to medication review or neuro checks performed. V17 was unable to provide another care plan with initiated dates for care plan interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/13/23 at 3:56PM, V21 (Mental Health Tech) said he recalls R327 falling a couple of times but unable to recall exact dates. V21 said R327 could not stand by herself, and he would sit outside her room to assist with getting things for her. R327 needed to hold on your arm or side rail to keep herself up when walking. R327's fall risk assessment dated [DATE] documents not at risk for falls. Under gait/balance documents: balance problem when walking. Facility fall prevention program reviewed 1/22 documents: care plan incorporates identification of all risk/issue, addresses each fall; interventions are changed with each fall; preventative measure. Resident environment will be kept clear of clutter which would affect ambulation and remove hazards. 40066 2. R68's diagnosis includes but not limited to Epilepsy, Schizoaffective Disorder, Dementia, Psychotic Disturbances, Mood Disturbances, and Anxiety, and Severe Intellectual Disability. Incident report dated 11/26/21 notes R68 noted running in the hallway when he slipped and fell . Progress Notes dated 10/22/22 documents maintain fall/safety precautions. Incident report dated 1/2/23 notes R68 was running in the hallway and fell . Report noted R68 was unable to provide description. Nothing was cited on precipitating and contributing factors. Report notes R68 sustained a swollen eye. Fall Initial Occurrence for R68 dated 1/2/23 documents a fall occurred in the hallway. Description notes R68 was running in the hallway and fell . It is documented R68 was unable to provide a description. Precipitating and Contributing Factor has nothing selected. [NAME]-checks notes the this was witnessed and R68 struck his head. Orientation of R68 notes e is alert and oriented to time, person, place, and situation. New injury observed swollen eye. Report completed by V20 (Licensed Practical Nurse/LPN). On 1/8/23 at 9:58 am, the surveyor observed R68 walking in the hallway without socks or shoes. On 1/8/23 during initial round approximately 10:00 am R68 was observed ambulating without shoes or socks on in the hallway. On 1/8/23 between 10:30 am-11:00 am R68 was walking barefoot, no shoes or socks on in the hallway. R68 was observed with dark bruised, black eye, to left eye. On 1/9/23 between 10:30 am-11:00 am R68 was observed by the surveyor walking from the west unit to the central unit with no socks or shoes on. The surveyor did not observe any staff offering him socks, grip socks, shoes, approach, or redirect R68 for footwear. On 1/9/23 at 12:00 pm V6 (Registered Nurse) said they told me R68 fell . V6 said she was told R68 fell face down and got a black eye. V6 said R68 goes running in the halls. V6 said she saw R68 running in the hall on 1/2/23 and I told his nurse to do something. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/9/23 at 12:24 pm V20 (Licensed Practical Nurse/LPN), said I was told earlier that R68 was running up and down the hall (V20 unable to say who told her or when). V20 said V21 (Mental Health Tech/MHT), called me and said R68 fell in the hallway. V20 said I didn't see him on the floor. V20 said R68 had been at baseline before he fell . V20 said after the fall I assessed R68. V20 said R68 is not verbal, he just made his noises, his vitals were normal, and the bruising and swelling started later that day. V20 said the bruising and swelling progressed overnight. The surveyor asked V20 if R68 was at risk for falls and V20 said R68 doesn't have falls. V20 said I think R68 was running, and he fell . On 1/9/23 at 12:36 pm V21 (MHT), said he saw R68 was running in the halls on 1/2/23. V21 said when R68 is running we usually redirect him. V21 said he told R68 to stop running and then R68 fell . V21 said he saw R68 tripped and hit the wall or the floor, and then bounced up like nothing happened. V21 said it was loud when he fell , you heard it. The surveyor asked what footwear R68 was wearing when he fell , V21 responded he is almost positive barefoot. On 1/9/23 at 12:46 pm V7 (MHT), said I have seen R68 running in the halls. On 1/10/23 at 9:57 am V22 (Certified Nurse Assistant/CNA) said R68 is compliant. V22 said R68 gets the zoomies, fast running like he is doing the track. On 1/10/23 at 10:20 am the surveyor observed R68 sitting in his bed with regular socks on. The surveyor asked V32 (CNA) to show the surveyor R68's shoes. V32 said R68 doesn't have any shoes. 1/10/23 at 12:52 pm V17 (Restorative Nurse) said when a fall occurs, we do team root cause analysis. V17 said I will enter the intervention in the care plan once determined. V17 said I would expect staff to carry out the interventions listed on the care plan. V17 said R68 is complaint with care. On 1/11/23 at 10:31 am V2 (Director of Nursing) said on 1/2/23 R68 was observed by staff running in the hall and fell and hit his face on the floor. V2 said running is not a new behavior for R68. V2 said when R68 is observed running staff can redirect him. V2 said most of the time R68 responds to redirection, is cooperative, and I don't think he has fallen before. V2 said I do not think he was wearing footwear when he fell on [DATE]. V2 said R68 is notorious for walking barefoot. V2 said staff should be offering to apply footwear if R68 has no shoes on. V2 said if R68 refuses then the staff should let the nurse know that they offered footwear and R68 said no. V2 said interventions for R68 can be trying to walk with him, offer a snack, and offer nonpharmacological interventions. V2 said R68 responds fairly well to nonpharmacological interventions. V2 said when R68 is running back and forth, it is not every day, and I would have someone with him to monitor him. Care plan initiated on 4/5/17 notes R68 has impaired cognitive function and impaired thought process related to impaired decision making related to Dementia. On 11/16/21 a care plan was initiated for potential for falls related to use of psychotropic medication and seizure disorder Intervention dated 11/16/21 noted appropriate footwear. No intervention is documented on the care plan following R68's fall on 1/2/23. No behavior of R68 running while inside the facility is documented. Additional, care plan initiated on 11/30/21 notes I am at risk for fall/injury related to wandering/poor safety awareness. (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	01/31/2023

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Fall Prevention Program revised on 11/21/17 states the program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Care plan incorporates identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, preventative measures. Footwear will be monitored to ensure the resident had proper fitting shoes and/or footwear is non-skid.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review the facility failed to provide therapeutic programing including anger management and conflict resolution, welcoming back to the community, boundaries and social skills, substance abuse, managing symptoms, depression and coping skills, and creative expression for residents that has been assessed to benefit from therapeutic programing this affects 54 of 171 (R2, R4, R5, R8, R13, R16, R20, R29, R30, R38, R42, R44, R49, R51, R52, R54, R56, R59, R64, R67, R69, R80, R81, R83, R84, R85, R93, R95, R98, R105, R107, R114, R121, R122, R126, R128, R132, R133, R136, R137, R141, R143, R148, R149, R151, R158, R159, R161, R163, R164, R165, R166, R168 and R227) residents reviewed for therapeutic programming. Finding include: R98 was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder, alcohol abuse, major depressive disorder, cannabis use, homicidal ideations, and psychosis. R98's Minimum Data Set, dated dated dated [DATE] documents a brief interview for mental status score 15/15 which indicates cognately intact. On 1/19/23 at 1:50 pm, R98 who was alert and oriented at time of interview said she has not attended any substance abuse groups and currently smokes marijuana. On 1/20/23 at 4:10 pm, V9(Psychiatric Rehabilitation Services Coordinator/PRSC) said if a resident has history of drug use or tests positive for substances, they would be placed in substance abuse group and plan of care updated. Resident's community pass may be restricted. V9 confirmed R98 was not included in the substance abuse group. Facility substance group list did not document R98. R98's medical record did not document any substance abuse groups attended. R98's hospital record under substance abuse history dated 1/11/23 documents: Toxicology screen positive for opiates and fentanyl. Patient denied current substance use. R98's hospital record under toxicology screen dated 7/26/22 documents: positive results for fentanyl and cannabis. 38796 On 1/10/22 V9 presents a list of residents that are currently assigned to the therapeutic programs of welcome back to the community, boundaries and social skills, substance abuse, managing your symptoms, depression and coping skills, anger management and conflict resolution, creative expression. R2, R4, R5, R8, R13, R16, R20, R29, R30, R38, R42, R44, R49, R51, R52, R54, R56, R59, R64, R67, R69, R80, R81, R83, R84, R85, R93, R95, R98, R105, R107, R114, R121, R122, R126, R128, R132, R133, R136, R137, R141, R143, R148, R149, R151, R158, R159, R161, R163, R164, R165, R166, R168 and R227. (continued on next page)

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	145180	A. Building B. Wing	01/31/2023

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/10/23 at 11:39am V1 (Administrator) said the facility does not have any therapeutic programing for the resident at this time. V1 said the social service staff is supposed to complete 1 to 1 visit with residents weekly. On 1/17/23 V1 said the 1 to 1 visit with the (outside social services) social worker does not replace the therapeutic programing that the facility is responsible for providing to the identified residents. On 1/13/23 at 11:50am V9 (Social Services) said upon admission and when needed that resident are assessed for the need for therapeutic programming, the facility reviews the PASSAR and gather information based on the resident needs and wants. V9 said the residents that benefits from these programs are resident with severe mental illness. V9 said the facility is not currently conducting therapeutic programming for the residents that currently reside in the facility. V9 said the facility does not have a social service director at this time. V9 said residents have been assessed and it was determined that they would benefit from specific group therapy. V9 said the therapeutic programs that were being offered is welcome back to the community, boundaries and social skills, substance abuse, managing your symptoms, depression and coping skills, anger management and conflict resolution, creative expression. V9 said the facility also works with a group from (outside social services) for 1 to 1 monitoring with some of the residents. V9 said the therapeutic programming stopped when the director resigned on 12/2/22. V9 said she does not know when the last therapeutic program was conducted. V9 said the welcome back to the community group is for residents, that are planning to reintegrate into the community and are working with the [NAME] Decree program for independent living. V9 said boundaries and social skills are to help resident with behavior in setting boundaries limits and personal space. V9 said the substance abuse is for the resident that has a history of substance abuse or relapse with substance use, V9 said managing symptoms group is for medication management, helping resident identify and discuss physical symptoms. V9 said Depression and coping skills are for resident that express sadness, has a history of suicidal ideations, it's to teach the resident how to cope when feeling depressed. V9 said anger management and conflict resolution is to teach resident appropriate skills to handle conflicts. V9 said creative expression was created for lower functioning residents, resident that does not have the capacity to maintain attention span to participate in the other groups. V9 said the facility is not offering any therapeutic programing but they try to talk to the residents at least monthly. V9 said this is not documented. V9 denied that the social service staff are doing 1 to 1 visit with residents at this time. V9 said the facility has not had any therapeutic programs since the social service director resigned, V9 said she thinks the director resigned on 12/2/22. V9 said the programs are not being done because there's no social service director to facilitate the programs. V9 said she is not the acting social service director nor is she the interim social service director.