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	03/01/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 38796 Based on interview and record review the facility failed to follow their grievance policy and resolve a grievance regarding a missing computer tablet for over 25 days. This affected 1 of 2 (R5) residents reviewed for grievances. The findings include: On 2/16/23 at 9:57am R5 said R10 had her tablet, the facility was aware of it. R5 said she told V6 (Administrator) about her missing tablet and that R10 had it. R5 said the first time the altercation is when she tripped R10 and attacked R10 while he was on the floor. R5 said she then went into R10's room and busted up R10's television. R5 said R10 had her tablet and that's why she did that. R5 said the second time she went into R10's room and had a physical altercation with R10 resulting in R10's face being scratched. R5 said she did this because R10 had her tablet. R5 said V22 (PRSC/Psychiatric Rehabilitation Services Coordinator) told her (R5) that she has a new tablet, but they must keep it in the office because the tablet was locked due to putting the password in wrong. R5 said she did not make a password for the tablet. R5 said she did not see the tablet. On 2/14/23 at 1:27pm V6 (Administrator) said R5 complained of a missing tablet. V6 said R5 and R10 have the same exact blue tablet. V6 said the tablet R10 had in his possession, belonged to him, and the facility determined that because R10 had the password to unlock the tablet. V6 said R5 had been complaining about her missing tablet since 1/12/23. V6 said R5 went to the hospital and her things were packed up and placed in a closet and the facility could not get to R5's things initially. V6 said R5's tablet was located, and it was damaged. V6 said he was planning to take the tablet to get the screen fix because he was not sure if the screen was broken because of the manner the facility stored it. V6 said the broken tablet was in his office and he had not had time to take it to get fixed. V6 was asked what will stop R5 from attacking someone else if she thinks they have her tablet. V6 presented with R5 inventory sheet and said R5 had a black tablet not a blue tablet, but we ordered her another one anyway today. V6 was asked if this matter was investigated when R5 initially inquired about the missing tablet to prevent the altercation with R5 and R10. V6 said yes, he told R5 that R10 did not have her tablet. Using a reasonable person concept, V6 telling R5 that R10 did not have her tablet was not an effective intervention for resolving R5 grievance because R5 physically assaulted R10 again on 1/27/23 because R5 thought R10 had her tablet. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5 inventory sheet dated 7/16/2021 denotes in-part, (brand name) tablet 7 inch with android. R5 progress notes dated 1/12/23 denotes in-part resident noted increasingly delusional today. Reported to writer that she had a baby yesterday. She then broke a peer's television due to believing he had her tablet. MD (medical doctor) called, and the order was received to transfer resident to hospital. Ambulance service called with eta (expected time of arrival) of 45 minutes. R5's progress notes dated 1/12/23 Resident had a delusion that another resident stole her tablet, which resulted in a physical altercation. R5's progress notes dated 1/27/23 denotes in-part resident went to another resident room and hit him in the face, asked why she stated that peer stole her tablet MD (Medical Doctor), DON (Director of Nursing) aware. No injury at this time. Denies pain and discomfort. Will continue to monitor. R10's progress notes dated 1/12/23 denotes in-part writer met with resident after an altercation occurred with peer due to her delusional. Writer counseled resident on coming to staff about concerns instead of engaging in altercation with peers. Resident stated that he still felt safe and wants to remain in facility until resident moves into his apartment. Staff will continue to monitor. R10's progress notes dated 1/27/23 denotes in-part resident had physical altercation with female peer in his room, when asked what happened, Resident stated, peer came to my room and hit me in the face Female peer accused him of stealing tablet from her room, both were separated and redirected to their room. Nursing assessment revealed bruises in his face and neck, first aid rendered. MD (Medical Doctor), DON (Director of Nursing), brother notified, will continue monitor. Facility policy titled Grievances dated 11/28/12 denotes in-part to ensure prompt resolution of all grievances with respect to care and treatment which has been furnished as well as that which has been furnished, the behavior of staff and of other residents, and other concerns regarding their stay at this campus. The resident has the right to voice grievances to this facility or other agency entity that hears grievances without discrimination or reprisals and without fear of discrimination or reprisal. Grievances may be filed orally (meaning spoken) in writing or anonymously, grievance may also be filed anonymously through the corporate compliance hotline. Every effort shall be mad to resolve grievance in a timely manner, usually within 5 business days (excludes weekends and holidays). Under certain circumstance, additional time may be needed to complete an investigation and implement measures to resolve the grievance. In such case, the resident or complainant should be notified of the extension. Based on interview and record review, upon exit of this survey, it cannot be concluded that R5 grievance was resolved.

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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** 41758 There are multiple deficient practice statements. I of II. Based on interview and record review, the facility failed follow their abuse policy and prevent a vulnerable resident from being taking advantage of sexually by other residents. This affected 3 of 3 residents R15, R16 and R17 reviewed for manipulation and sexual abuse. This failure resulted in R16 and R17 manipulating R15 into performing sexual acts for a trade of money and food. The Immediate Jeopardy began on 2/1/23 when V35 (Emergency Medical Technician/EMT) witnessed R15 having a sexual encounter with R17 at the facility. V6 (Administrator) was informed of the Immediate Jeopardy on 2/21/23 at 12:18 pm. The surveyor confirmed by observation, record review, and interview that the Immediate Jeopardy was removed on 2/23/23. Although the immediacy was removed, the noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the removal plan. Findings Include: 1.R15 has the diagnosis of Schizophrenia. Brief interview for mental status dated 11/21/22 documents a score of ten which indicates moderately cognitively impaired. Care plan dated initiated (3/31/22) documents: I am at potential risk for abuse/neglect. On 2/2/23 at 1:02pm, R15 was assessed to be alert to self with a delusion thought process. R15 was unable to report the month, date, year, president's name, name of the facility, or type facility R15 resided. R15 reported she was the boss of the building. R15 said, I can fire/terminated you (state employee). Don't come in my room. Don't touch me. This is my room, and I don't have any room mates. R15 was not being touched by anyone. R17 observed standing outside of R15's doorway. R17 said, R15 is my lady friend. R15 was asked, who R17 was and what their relationship to each other was. R15 said, I don't know R17. On 2/2/23 at 1:10pm, R17 who was assessed to be alert to person, place, and time, said, R15 is my lady friend, and we have sex. R15 doesn't know any better. R15 is not right in the head. I can have sex with R15 for food or a few dollars ($2.00 or $3.00). R15 is always hungry. R15 doesn't have any money. I (R17) had sex with R15 for juice and a cracker. I (R17) did not have sex with R15 yesterday. On 2/23/23 at 11:40am R17 said the young ladies at the facility like older guys with money. R17 said he's one of the older guys that have money at the facility and the ladies know that. R17 said a lot of the women at the facility be hungry and they will have sex for chips, cigarettes, pop, money. R17 said it's one young lady, she's fine, she's pretty and if she approaches him for money, he's going to give it to her so that he can have sex with her. R17 said he will not turn her down, she's pretty. R17 did not give surveyor the name of the female that he was talking about. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/2/23 at 1:46pm, V34 (Mental Health Tech/MHT) said, I saw R15 giving R17 oral sex. I wasn't aware R15 was sexually active. R15's orientation comes and goes. R15 can keep a conversation at times and other times R15 is not able to engage in a tangential speech/thought process. On 2/2/23 at 3:05pm, V22 (Psychosocial Rehab Service Coordinator/PRSC) said, R15 does not have a capacity to consent for sex. The assessment was not done because R15 is not sexually active. We only complete that assessment if residents are participating is sexually activities. On 2/2/23 at 3:58pm, R16 said R15 asked me for five dollars. I gave R15 the money. It is expected that R15 performs a sexual act for the money. I have never had sex with R15 for free. R15 performed oral sex on me. On 2/23/23 at 2:15pm R16 said R15 approached him and said, You got money? R16 said when R15 ask for money, it's expected that the money is payment for sex. R16 said R15 does not say that the money is for sex. R15 has never said she will have sex with him for exchange of money. R16 said sex is expected. R16 said a lot of the women at the facility ask for money and it's understood that the money is an exchange for sex. R16 said it's like a prostitution ring at the facility. R16 said the chicks at the facility are hungry and they are needing money. On 2/7/23 at 8:56am V35 (Emergency Medical Technician/EMT) said, I entered R15's room after knocking. R15 and R17 were both naked from the waist down. R15 attempted to cover her vaginal area. R15 was unable to answered orientation questions related to date, month, year and unable to report R17's name. R15 started yelling, stop touching me, (R15 was not being touched) I'm a cop and I need help. R15 was alert and orient to self, had a psychiatric episode, and refused/failed to yield to verbal redirection. I could not de-escalate R15. I am normal good at de-escalation. On 2/7/23 at 10:05am, V36 (Psychotropic Nurse) said, I check orientation by asking basic questions that the average person with intact cognition will be able to answer. I checked R15 orientation on 2/6/23. I asked R15 questions about, the current date, year and who is the president was. R15 can recite the date if a calendar is around. R15 was unable to recite the date and who the president was. R15 knew where she was, able to tell me she was going to lunch, and walked away. Care plan dated initiated 6/29/2018 documents: I (R15) have a diagnosis and history of severe mental illness (SMI) as manifested by delusions-poor ability to reason. Care plan dated initiated (10/11/21) documents: I (R15) am able to exercise the right to engage in sexual/intimate relationship. I have received counseling, as appropriate regarding sexual practice and behavior, boundaries, respect for roommates, healthy relationship and only engaging in this type of relationship with consenting party. I will exercise safety and appropriateness when choosing to partake in sexual activity. R15's capacity for sexual consent dated 2/2/23 documents (Resident's awareness of relationship) Is the resident aware of who is initiating sexual contact - yes. (Resident's awareness of potential risk) documents: C2- can the resident described how (he/she) will react when the relationship ends- no. Conclusion: Resident (R15) is aware of what sexual activities she engages in. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Sexuality- Capacity to Consent Determination Policy dated 1-7-19, documents: Purpose: To establish criteria for determining the capacity to consent when resident to resident sexual activities occur. Capacity and Consent: Residents without the capacity to consent to sexual activity may not engage in sexual activity. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. Abuse policy dated 11/28/16 documents: The facility affirms the right of our residents to be free from abuse, neglect, or exploitation. Sexual abuse includes but is not limited to sexual harassment, sexual coercion or sexual assault including non-consensual or non-competent to consent sexual activity. Generally. Sexual contact is nonconsensual if the resident either appears to want the contact to occur but lacks the cognitive ability to consent. A resident's apparent consent to engage in sexual activity is not valid if it obtained through intimidation, coercion, or fear, whether it is expressed by the resident or suspected by staff. The surveyor confirmed via observation, interview and record review the following removal plan was implemented by the facility: Aperion Care Chicago Heights Abatement Plan, action taken: 1. R15, R16, and R17 has an updated capacity to consent for sex assessment. This was completed as of 2/2/23. R15 has not displayed any emotional distress and remains at baseline for mood and behavior. R15, R16, and R17's capacity to consent were reassessed and are determined that they have the capacity to consent to sexual relationships. 2/21/23 completed. 2. Residents that have been identified being at risk from sexual exploitation have had their care plans updated to reflect interventions to prevent abuse. List updated on 02/22/23. List of identified residents was provided to survey team. 2/22/23 completed. 3. Residents that have been identified for being at risk from sexual exploitation were interviewed if they have been taken advantaged of or manipulated to perform sexual acts. None of them responded yes. 2/21/23 completed. 4. Residents that have been identified for being at risk from sexual exploitation will be placed on 1:1 education with the assigned PRSC to meet weekly and discuss how to protect themselves from being sexually exploited, coerced, or manipulated. 2/21/23 completed. 5. Residents that have been identified for being at risk from sexual exploitation will be assigned to rooms that are in immediate view of nursing station for more frequent monitoring. 6. R15 is placed on 1 on 1 counseling with PRSC. R15 is placed on money management program. R16 and R17 is placed on 1 on 1 counseling with PRSC. R16 and R17 will sign behavior contract for sexual solicitation and bartering. IDT conducts assigned regular rounds during shift to ensure visual monitoring and staff supervision. 2/22/23 and ongoing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Staff will be in-serviced/trained on how to recognize sexual abuse and sexual exploitation and the facility's abuse protocol to prevent it from happening to other residents. The education will include Abuse prevention reporting policy specifically the definition of abuse, sexual abuse, sexual exploitation, sexual assault, rape and internal reporting requirements and identification of allegation and protection of residents. This training will include reporting of any observations or reports of exchange of money by residents and reporting any observations/reports of sex acts. Staff competency will be determined through a scenario based post- test and signature. 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. Administrator/Managers will continue to monitor all staff for compliance by a competency questionnaire. No revision of the current abuse policy has occurred. The noncompliance was a failure to follow current policy. 2/23/23 completed. 40066 II of II. Based on interviews and records reviewed the facility failed to follow their abuse prevention policy to prevent resident to resident physical assault. The facility also failed to ensure facility staff utilized safe crisis prevention intervention techniques during physical interactions with residents. This affected 6 of 8 residents (R5, R6, R8, R9, R10, and R14) reviewed for physical abuse prevention. Findings include: 1. R8's diagnosis includes but not limited to Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Schizophrenia, Type 2 Diabetes, Atherosclerotic Heart Disease, Major Depressive Disorder, and Dementia. R8 was admitted to the facility on [DATE]. R8 is moderately cognitively impaired. On 2/16/23 at 1:24PM V29 (Certified Nursing Assistant/CNA), said on 1/25/23 she was in the dining room when she heard another CNA say R8 has a black eye. V29 said she then went and reported the incident. V29 said V31 (Restorative CNA) spotted it first. V29 said I reported to V6 (Administrator). V29 said then V3 (Registered Nurse) and I went to speak to R8. V29 said V3 entered R8's room, but because R8 does not like V29 she waited in the hallway. V29 said she heard R8 say one of the staff came in the room and jumped her. V29 said R8 said a young lady hit her in the mouth and in the face. V29 said she heard R12 (R8's roommate) say she saw the person. On 2/16/23 at 3:24PM V21 (Assistant Administrator) said she was in the office when V29 reported R8's black eye to V6. V21 said V29 said she saw R8 with a black eye. V21 said I sent the initial report to IDPH and then went to speak with R8. V21 said I tried to speak with R8 a few times all R8 said was some b----- had hit her. V21 said R8 said someone with braids. V21 said she spoke with R8 about 15 minutes after V29 had initially reported. V21 said I thought possibly the roommate R14 had hit R8. V21 said V29 said R14 had done it. V21 said I did not speak with V31 about this incident. V21 said on the first day of the investigation I got interviews from all staff in the facility. The surveyor asked V21 if staff had reported to her that R8 said a lady hit her. V21 said not that I am aware of. V21 said R12 had initially said someone with braids came in and struck R8. V21 said R8 was the victim in this incident. V21 said residents should not be putting hands on each other. On 2/17/23 at 10:38AM V31 (Restorative CNA) said when R8 walked into the dining room on 1/25/23, I saw R8 had a black eye. V31 said she heard R8 say She got her a** whooped. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The surveyor attempted to interview R8 twice during the survey. R8 did not cooperate and cursed at the surveyor, both times. The surveyor attempted to interview R12 about the incident on 1/25/23, R12 stated I don't have a statement. R8's Abuse/Neglect Screening dated 12/8/22 notes resident triggers a potential high risk for abuse. R8's Abuse/Neglect Screening dated 1/25/23 notes R8's roommates reported I was struck in the face by an unknown person. R8's Risk Management documents R8 said a peer got aggressive with her. Progress notes dated 1/25/23 written by V5 (Director of Nurse/DON) documents it was reported that R8 was noted with discoloration to her right eye. Preliminary 24-hour Abuse Investigation Report dated 1/25/23 states R12 (R8's roommate) reported to V21 (Assistant Administrator) that R8 was struck in the eye by someone with braids. Review of R8's care plan revised on 6/18/22 does not include that R8 has been struck by another resident. Additionally, the care plan denotes I am at not current risk for abuse. The last intervention update is dated 7/12/22. 2. R14's diagnosis includes but not limited to Schizophrenia, Asthma, Diabetes, Anemia, and Delusional Disorder. R14's census list notes she was a roommate with R8 from 5/9/22 until 2/1/23. R14 had a room change on 2/1/23. R14's last Abuse/Neglect screening dated 12/2/22 notes she had an altercation with another resident. R14's Aggressive Behavior assessment dated [DATE] documents R14 has a history of recent episode of aggressive/agitated behavior and/or noncompliance with medications, treatment, regiment, and resisting care. R14 has a history of abuse/neglect either as a recipient or perpetrator including abusive and/or inappropriate sexual behavior. R14's care plan related to abuse was last updated on 12/2/22. No intervention noted following the 1/25/23 incident with R8. 3. R6's diagnosis includes but not limited to Schizoaffective Disorder, Psychotic Disorder, Physiological Condition, Schizophrenia, Adult Failure to Thrive, Delusional Disorder, Bipolar Disorder, Major Depressive Disorder, and Paranoid Personality Disorder. On 2/16/23 at 11:43AM V5 (Director of Nursing/DON) said I think R6 had an altercation with R8 on 1/29/23. On 2/16/23 at 12:42PM V28 (Licensed Practical Nurse/LPN) said R6 slapped R8. R6's progress notes denote It was reported to the writer that resident was aggressive towards peer in the hallway. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's Aggressive Behavior assessment dated [DATE] documents R6 noted to be in a physical altercation where she was the aggressor. No other assessments after this date were noted. R6's Behavior/Mood Charting dated 1/29/23 denotes R6 was Physically aggressive and wandered. R6's Petition for Involuntary/Judicial admitted d 1/30/23 denotes Resident physical aggressive towards a peer without provocation. R6's care plan denotes she has potential to be verbally aggressive towards staff with 2 incidents in September 2022. R6's care plan denotes an incident of responding to internal stimuli and became physically aggressive towards a peer. Care plan initiated date listed as 1/6/23. R8's risk management record date of incident 1/29/23 notes R8 said peer got aggressive with her in the hallway. Per the surveyors record review this is the second incident for R8 with an injury observed on 1/25/23 and this incident dated 1/29/23. 38796 4. Facility final report to the department dated 2/1/2023 denotes in part date of incident 1/27/23, physical abuse, yes for injuries, no medical attention, minor scratches to face, R5 is person accused. Summary of person reporting incident R10, she just came in my room and hit me in my face. V3 (Nurse) reports R10 came up to her with scratches on his face and told V3 that R5 scratched him. R5 then told me that he R10 stole my tablet, and I (V3) explained to her that he (R10) did not steal her tablet because that is his (R10). R10 has history of having poor boundaries and physically aggression with peers. R5 has history of being verbally and physically aggressive with peers. While R10 was in his room after dinner, R5 went into his room and struck him in his face, reacting to internal stimuli, thinking he had stolen her tablet. This resulted in small scratches to face. First aide was administered. R10 received full body assessment. Resident remains at his baseline, with no emotional stress verbalized or observed. R10 scores a 15 on the BIMS assessment. R5 scores a 15 on the BIMS assessments. On 2/16/23 at 9:57am R5 said R10 had her tablet, the facility was aware of it. R5 said she told V6 (Administrator) about her missing tablet and that R10 had it. R5 said the first time the altercation is when she tripped R10 and attacked R10 while he was on the floor. R5 said she then went into R10's room and busted up R10's television. R5 said R10 had her tablet and that's why she did that. R5 said the second time she went into R10's room and had a physical altercation with R10 resulting in R10's face being scratched. R5 said she did this because R10 had her tablet. R5 said V22 (Psychiatric Rehabilitation Services Coordinator/PRSC) told her (R5) that she has a new tablet, but they must keep it in the office because the tablet was locked due to putting the password in wrong. R5 said she did not make a password for the tablet. R5 said she did not see the tablet. On 2/14/23 at 1:35p.m V21 (Assistant Administrator) said R5 was having delusions that R10 stole her tablet and went into R10's room and struck R10 in the face. V21 said R5 was recently in the hospital and her belongs were in a closet and the facility could not access her belongings at that time. V21 said she does not know if anyone spoke to R5 about her belongings and ensured her that her things were not stolen, that the facility could not get to them at that time, and that R10 did not steal her tablet. V21 said R5 was having delusion prior to striking R10. V21 said the facility did not substantiate abuse but did substantiate the incident occurred. V21 said R5 struck R10 first. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R5's progress notes dated 1/12/23 denotes in-part resident noted increasingly delusional today. Reported to writer that she had a baby yesterday. She then broke a peer's television due to believing he had her tablet. MD (Medical Doctor) called, and the order was received to transfer resident to hospital. Ambulance service called with eta (expected time of arrival) of 45 minutes. R5's progress notes dated 1/12/23 Resident had a delusion that another resident stole her tablet, which resulted in a physical altercation. R5's progress notes dated 1/27/23 denotes in-part resident went to another resident room and hit him in the face, asked why she stated that peer stole her tablet MD (Medical Doctor), DON (Director of Nursing) aware. No injury at this time. Denies pain and discomfort. Will continue to monitor. Review of R5's inventory sheet dated 7/16/2021, it is denoted that R5, in fact does own a tablet while a resident of the facility. R10's progress notes dated 1/12/23 denotes in-part writer met with resident after an altercation occurred with peer due to her delusional. Writer counseled resident on coming to staff about concerns instead of engaging in altercation with peers. Resident stated that he still felt safe and wants to remain in facility until resident moves into his apartment. Staff will continue to monitor. R10's progress notes dated 1/27/23 denotes in-part resident had physical altercation with female peer in his room. When asked what happened, resident stated, peer came to my room and hit me in the face Female peer accused him of stealing tablet from her room, both were separated and redirected to their room. Nursing assessment revealed bruises in his face and neck, first aid rendered. MD (Medical Doctor), DON, brother notified, will continue monitor. During this survey it was concluded that R10 was the target of R5 physical aggression related to R5 believing that R10 had her tablet. The facility failed to present an initial concern form with resolution for R5 tablet from 1/12/23. R5 returned to the facility on [DATE] (after hospital stay for physical aggression). R5 continue to have concerns for her missing tablet on 1/27/23 prior to R5 physically assaulting R10, thinking R10 had her missing tablet. Facility policy titled abuse prevention and reporting with last revision date of 10/24/2022 denotes in-part 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 therefor prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatments of residents. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrence of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatments of residents. This will be done by establishing an environment that promotes residents' sensitivity, residents' security and prevent mistreatment, identifying occurrences and patterns of potential mistreatments. Abuse means any physical or mental injury, or sexual assault inflicted upon a resident other than by accidental means. Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. The term willful, in this definition of abuse, 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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	145180	A. Building B. Wing	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. R9's MDS dated [DATE], denotes R9 BIMS is 15. On 2/16/23 at 10:06am V26 (Mental Health Tech/MHT) said he worked on 12/23/22 on the 11:00pm to 7:00am shift. V26 said he did not refuse R9 to call the police. V26 said R9 was heard yelling at R13, about a cigarette, and R9 flipped over R13's table in his room. V26 said R9 did not hit R13. V26 said R9 was then redirected from R13's room to her room. R9 began throwing things in her room. R9 was standing in her doorway. V26 said R9 was saying You can't keep me in here. I didn't do anything. You can't trap me in here. I'm going to call the police. V26 said R9 start hitting him and scratched his face. V26 said he used CPI technique to restrain R9 from hitting him. V26 demonstrated that he held R9 by the wrist to stop her from hitting him, then he held R9 down on the bed and then brought R9 to the floor and continued to hold her down by holding her wrist. V26 said this was to prevent R9 from hitting him. V26 explained CPI is nonviolent techniques used to subdue a combative, aggressive resident. V26 said when a female staff arrived, he asked her to stay with R9 until she calmed down. V26 said once R9 calmed down he told the aide to let R9 up. (V26 does not know who the female CNA was) V26 said he called a 800 number and he reported the situation, and he was sent home for 2 days pending investigation. V26 said the police did come to the facility, but he does not have any information and he did not talk to the police. V26 said he doesn't know if a police report was filed, he left the facility pending investigation. V26 said the nurse did come to check R9 out, but he does not know who the nurse was. V26 said on 2/9/23 around 7:20-7:25am (after smoke break), R9 was having behaviors on the east wing. V26 said R9 asked the nurse for her meds or something and she became verbally aggressive and R9 was saying get the f away from me. V26 said the nurse told R9 to get water from the central nurse station (V26 said that's where R9 nurse is). V26 said when he responded to the code yellow (behavior) he observed R9 flaring her hands back and forth and yelling. V26 said he asked R9 to go to her room, R9 didn't. V26 said that when he and V37 (MHT) staff held R9 by the arms to escort her from that area, and R9 swung at V37. V26 said R9 stumbled and fell , R9's pants fell . R9 threw her pants. (V26 said this happen in the room next to the nurse station on east unit). V26 said they stood R9 up and R9 scratched his face. The nurse gave R9 a PRN (as needed medication). R9 was escorted to her room after that. V26 said there were no behaviors after that and R9 went to the hospital. V26 said he was not sent to home after that. On 2/16/23 at 12:41pm R9 is observed to be alert, and orient to person, place, time, and situation. R9 said around Christmas Eve her and R13 got into an altercation when she asked him for a cigarette. R9 said R13 threw a chair at her, but it did not hit her. R9 said she did not hit R13 either, it was a verbal altercation. R9 said she was escorted to her room by V26 (Mental Health Tech/MHT), and that's when V26 would not let her out her room. R9 demonstrated that V26 stood in doorway of her room, with his arms and legs spread out (blocking doorway). V9 said V26 also was trying to restrain her by holding her arms and hold her down to prevent her from leaving her room. R9 demonstrated that V26 was holding her by the wrist. R9 said V26 also hit her in the face after restraining her to the floor. R9 said she was trying to get out the room when V26 was blocking the doorway. R9 said at some point V26 got off her and the aide came in the room with her (R9). R9 said the police did arrive and spoke to her, and the police said she could stay at the facility. R9 said V26 should not be holding her by the wrist like that and V26 should not hit her in the face on 12/23/22. R9 said the facility don't listen to her or other residents when they report abuse to them and they're not going to do anything to V26. R9 said a man should not be handling a female like that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility final report to the department dated 2/11/23 denotes in-part R9's name, date of incident 2/9/23, date incident reported 2/10/23. R9 stated On December 25,2022, V26 did not allow me to contact the police after I was physically assaulted by another resident. V26 then began tussling with me while preventing to leave my room. Then on 2/9/23, V26 was verbally aggressive with me and hit me in my face. R9's document from the hospital social worker dated 2/10/23 denotes in-part R9 endorsed that a staff member named V26 has been physically abusive towards her during her stay at Aperion Care, with the first instance of abuse taking place on 12/25/22 in which R9 stated that V26 did not let allow her to contact the police after she was physically assaulted by another resident at Aperion Care and V26 began tussling with her while simultaneously preventing her from leaving her room. R9 endorsed that the second instance of abuse took place right before her admission at (hospital name listed), and she stated V26 was verbally aggressive towards her and physically assaulted her by hitting her in the face. On 2/14/23 at 1:27p.m V6 (Administrator) said the facility does not substantiate abuse and the facility waits for the department to investigate and substantiate the facilities abuse allegations. On 2/16/23 at 2:12pm V6 (Administrator) said he is not aware of any incidents with R9 and V26 on 12/23/22. V6 said he is not aware that V26 was sent home pending investigation for incident on 12/23/22. V6 said he is not aware of V26 sustaining and scratches to the face after attempting to redirect R9. Review of facility initial report to the department denotes V6 was CC in the email notification confirmation to the department on 2/10/23 at 4:34pm. Initial report to the department denotes R9 reported to the hospital that V26 (MHT), refused to let her call the police when another resident physically assaulted her. She also alleged that on 2/9/23, V26 struck her in the face and was verbally aggressive towards her. R9 did not report these allegations until she was at the hospital. MD (Medical Doctor), Ombudsman and (police department) notified. Full report to follow. On 2/16/23 at 2:37pm V21 (Assistant Administrator) said the hospital contact her and informed her that R9 reported being physically assaulted by V26 once on Christmas and on 2/9/23. V21 said she conducted the investigation of R9 allegation. V21 said the hospital sent her the email statement of R9. V21 said she did not ask V26 about the allegation of tussling with R9 because she did not know what that word meant. V21 said she did not look up the definition of tussling either. V21 said R9 has delusions. V21 said she watched the video recording of the incident with R9 and V26 on 2/9/23 and she observed R9 swing her arms out and kicking at V26. V21 was asked is it reasonable to believe that R9 did not want V26 to touch her since there was an altercation on 12/23/22. V21 said no, R9 has delusions. V21 was made aware that V26 alleged he used CPI on R9 and R9 scratched him in the face. V21 was made aware that R9 said V26 was physically aggressive with her and was holding her by the wrist. V21 said R9 has delusions, and she's not aware of anything happening on 12/23/22. V21 was made aware that V26 said he had to use CPI on R9 by hold her by the wrist. Webster dictionary defines, tussling/ tussled means engage in vigorous struggle. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/17/223 at 10:25am V5 (Director of Nursing) was asked if she was aware of the incident with R9 and V26 that occurred on 12/23/22. V5 said she was not aware of anything happening between V26 and R9. V5 was made aware that V26 alleged he used CPI on R9 and R9 scratched him in the face on 12/23/22. V5 was made aware that R9 said V26 was physically aggressive with her and was holding her by the wrist. V5 said R9 has delusions, and she's not aware of anything happening on 12/23/22. V5 was made aware that V26 said he had to use CPI on R9 by hold her by the wrist. V5 was asked is it reasonable to believe that R9 did not want V26 to touch her since there was an altercation on 12/23/22. V5 said yes, it's reasonable but R9 has delusions. V5 said she was aware of the incident when V26 used CPI on R9 on 2/9/23 and that entire situation arises due to R9 requesting water from the nurse and the nurse did not give R9 water. V5 was made aware that V26 alleged he used CPI on R9 and R9 scratched him in the face. V5 was made aware that R9 said V26 was physically aggressive with her and was holding her by the wrist. V5 said R9 has delusions, and she's not aware of anything happening on 12/23/22. During this survey, the facility failed to provide an incident report for R9 and V26 on 12/23/2022, and incident report for 2/9/23 when V26 used CPI on R9. The review of V26's timecard reveals V26 was on duty on 12/23/22 from 11:12pm until 12:32am. V26 employees report of injury dated 12/23/22 denotes in-part V26 was trying to stop a resident (R9) from attacking another resident when she punched him in the face and scratched him in the neck, under the left eye and above the nose. On 2/16/23 at 10:06 a.m.V26 denied that R9 had physical co [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40066 Based on interviews and records reviewed the facility failed to implement their policy for ensuring the reporting of an incident of resident-to-resident physical abuse to the State regulatory agency. This failure affected 2 of 6 resident (R6, R8) reviewed for abuse reporting. The Findings include: R8's diagnosis includes but not limited to Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Schizophrenia, Type 2 Diabetes, Atherosclerotic heart Disease, Major Depressive Disorder, and Dementia. R6's diagnosis includes but not limited to Schizoaffective Disorder, Psychotic Disorder, Physiological Condition, Schizophrenia, Adult Failure to Thrive, Delusional Disorder, Bipolar Disorder, Major Depressive Disorder, and Paranoid Personality Disorder. On 2/16/23 at 11:03AM V6 (Administrator) said for the incident involving R8 there was no injury. V6 said we don't report to IDPH when there is no physical or emotional distress. On 2/16/23 at 11:43AM V5 (Director of Nursing/DON) said I think R6 had an altercation with R8 on 1/29/23. V5 said the petition for R6 had to be done redone in the morning. V5 said the incident happened on 1/29/23 and R6 was sent out on the 11:00pm to 7:00am shift. On 2/16/23 at 12:42PM V28 (Licensed Practical Nurse) said R8 was my patient. V28 said she was in the nursing station when staff reported to me R6 slapped R8. V28 said I reported to V5 because it was abuse. On 2/16/23, during an interview that began at 2:34PM, V21 (Assistant Administrator) said I just heard about (R6) and (R8) when (V6) asked me for a report. V21 said if someone hit, slapped, touched, or punched someone it should be reported to the Abuse Coordinator. V21 said the purpose of reporting abuse allegations is to protect the residents. As of 2/16/23 the facility has not reported the incident from 1/29/23 involving R6 and R8. R6's progress notes denote it was reported to the writer that resident was aggressive towards peer in the hallway. R6's Behavior/Mood Charting dated 1/29/23 denotes R6 was physically aggressive and wandered. R6's Petition for Involuntary/Judicial admitted d 1/30/23 denotes resident physically aggressive towards a peer without provocation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse and Reporting policy revised 10/24/22 states resident to resident altercation should be reviewed as a potential situation of abuse. Training will include procedures for reporting incident/allegations of abuse. In addition, the policy states employee's obligation under the law for reporting a suspected crime to the facility or state agency and local law enforcement, the time frames for reporting.

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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. 40066 Based on interviews and records reviewed the facility failed to initiate an investigation and conduct a thorough investigation of an allegation of resident-to-resident physical abuse This affected 2 of 6 residents (R6 and R8) reviewed for investigation of abuse allegations. The Findings include: R8's diagnosis includes but not limited to Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Schizophrenia, Type 2 Diabetes, Atherosclerotic heart Disease, Major Depressive Disorder, and Dementia. R6's diagnosis includes but not limited to Schizoaffective Disorder, Psychotic Disorder, Physiological Condition, Schizophrenia, Adult Failure to Thrive, Delusional Disorder, Bipolar Disorder, Major Depressive Disorder, and Paranoid Personality Disorder. On 2/16/23 at 11:03AM V6 (Administrator) said there is no reportable for R6 and R8 because it is not reported when there is no physical or emotional distress. On 2/16/23 at 11:43AM V5 (Director of Nursing) said I think R6 had an altercation with R8 on 1/29/23. On 2/16/23 at 12:42PM V28 (Licensed Practical Nurse) said R8 was my patient. V28 said she was in the nursing station when staff reported to me R6 slapped R8. V28 said I reported to V5 because it was abuse. On 2/16/23 during an interview that began at 2:34PM, V21 (Assistant Administrator) said I just heard about (R6) and (R8) when (V6) asked me for a report. The surveyor asked V21 for an investigation regarding R6 and R8. V21 said if someone hit, slapped, touched, or punched someone it should be reported to the Abuse Coordinator. V21 said the purpose of reporting abuse allegations is to protect the residents. V21 said I have no report for R6 and R8 on 1/29/23. R6's progress notes denote it was reported to the writer that resident was aggressive towards peer in the hallway. R6's Behavior/Mood Charting dated 1/29/23 denotes R6 was physically aggressive and wandered. R6's Petition for Involuntary/Judicial admitted d 1/30/23 denotes resident physically aggressive towards a peer without provocation. The facility Abuse and Reporting policy revised 10/24/22 states resident to resident altercation should be reviewed as a potential situation of abuse. Implementing systems to promptly and aggressively investigate all reports and allegations of abuse.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796 Based on interview and record review the facility failed to follow their policy for notice of transfer and discharge. The facility also failed to give a written notice before discharge to include reason for discharge. This affected 1 of 3 (R1) residents reviewed for discharge notice. Findings include: R1's face sheet denotes R1 has diagnosis of schizophrenia disorders, major depressive disorders, anxiety disorder, extrapyramidal and movement disorder, vitamin deficiency, brief psychotic disorder, auditory hallucinations, visual hallucinations, cocaine use unspecified uncomplicated, cannabis use uncomplicated, and nicotine dependence. R1's face sheet denotes R1 was admitted to the facility on [DATE]. R1's MDS dated [DATE] section C shows BIMS score 15 (cognitively intact), section E denotes yes for hallucinations and delusions, overall presence of behavior: no is checked. R1's clinical record denotes R1 is pregnant. 1/3/23 progress note from psychiatry nurse practitioner states Reviewed medications. Patient is pregnant; in her first trimester. We discussed that antipsychotic medications could affect her pregnancy, plan to D/C for safety of the fetus. I was told by staff that patient is going to be discharged to a proper facility. Medication Changes: DISCONTINUE current psych meds, due to pregnancy. 1/8/23 10:49am nurse's note in part states Resident noted to have altered mental status as well as reports of visual and auditory hallucinations. Physician notified and ordered resident to be sent to nearest ER (emergency room) for psychiatric evaluation. DON and administrator notified as well. 1/8/23 3:30pm nurse's notes in part states Writer spoke with (individual's name and hospital's name) and was informed that resident was admitted inpatient r/t (related to) altered mental status. MDS dated [DATE] for discharge section A denotes return anticipated. On 2/11/23 at 2:19pm V5 (Director of Nursing) said R1 was not readmitted to the facility because she was past the 10-day bed hold. V5 said R1's bed is no longer available and now R1 would have to wait for a female bed. V5 said she does not know if R1 received a bed hold notice and referred surveyor to speak to V24 (Admissions Director). V5 said she does not know when hospital 1 and hospital 2 contact the facility regarding R1's readmission. V5 referred surveyor to V24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/2023 2:31pm V24 (Admission Director) said R1 was discharged from the facility because R1 past the 10-day bed hold. V24 then said she would have discharged R1 out on the 18th, but she discharged R1 out on the 19th, this is reflected on the census. V24 then said R1 was discharged because the facility could not meet R1 needs because R1 was pregnant. V24 said the facility has been trying to get R1 placement at a SMURF (Specialized Mental Health Rehabilitation Facility) that can provide service to R1 due to her pregnancy. V24 said the SMURF facility did not get back to her regarding accepting R1. V24 said the facility had R1 PASARR (Pre-Admission Screening and Resident Review) reevaluated for a SMURF facility so that R1 could be accepted. V24 was asked if R1 was considered a resident at the skilled facility until she is accepted to the SMURF facility, V24 said yes. V24 said the facility had been trying to find R1 placement since finding out R1 was pregnant. V24 said she does not handle the facility discharges. V24 said R1 was in a shelter right now. On 2/12/2023 at 10:30am V6 (Administrator) said V5, V24, and himself were working together to find R1 placement due to pregnancy. V6 said R1 has not been discharged and he has not given R1 a IVD (involuntary discharge). V6 said the facility has been working with R1 to find R1 placement due to her pregnancy. V6 said hospital 1 was also helping the facility to find R1 placement. V6 said he does not know why R1 was sent to hospital 2 (hospital name) after her stay at hospital 1 (hospital name). V6 said he thinks R1 is currently at a shelter right now. V6 was asked if hospital 2 contact the facility for R6 readmission. V6 said he does not know. V6 was asked why is R1 at a sheltered and not at her home at the skilled facility. V6 said that's a good question. V6 was asked if R1 has not been discharged why is V5 saying R1 bed was given away and that R1 would have to wait for another bed when the facility has an open female bed. V6 said he does not know. V6 said he did not contact the ombudsman regarding R1's transfer and discharge. V6 presented a document to show the facility has called several locations to get R1 placement. When ask about the notation that shows appointment needed schedule appointment, application process, must go in, call at any time to schedule. V6 was asked if the application process was started for R1, did R1 go into the facility, did anyone call to start the process? V6 said he must look into it. On 2/12/23 at 10:30 am the surveyor reviewed with V6 (Administrator) a review of the facility's census and available beds. V6 verified that there were 6 unoccupied female beds on the date of 1/20/23 when the hospital attempted to transfer R1 back to the facility. R1's PASARR (Pre-Admission Screening and Resident Review) level 2 dated 1/19/2023 denotes in-part your care needs are appropriate to be serviced in any nursing facility. Approved, you meet nursing facility level of care. R1's social service records dated 1/20/23 from hospital 2 denotes in part call from liaison at Aperion Care Chicago Heights, patient is not able to return to Aperion Care Chicago Heights because she is past her 10 days out of facility, and they gave away her bed. Liaison told hospital social worker he needs a level 2 assessment to be completed for patient (R1) to return to the nursing home. Level two completed facility dumped patient at (hospital 2). Records dated 1/16/2023 denotes in-part hospital social worker received call from (name noted) at Aperion Care, she reported that patient is pregnant, and she cannot return to their facility. 1/25/23 11:33 am social service notes from hospital 2 states in part Pt is being discharged today, 1/25/2023. Pt is being discharge to the New Day Program. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled notice of transfer and discharge with last review date 10/24/2022 denotes in-part prior to discharge or transfer, the facility will notify the resident and the resident representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. The facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care Ombudsman. This may be done by submitting a monthly list. Record the reason for transfer or discharge in the resident medical record. Residents who are sent emergently to an acute care setting, such as a hospital must be permitted to return to the facility. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident status at the time the resident seeks to return to the facility meet one of the criteria for reason A through D.

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	145180	A. Building B. Wing	03/01/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796 Based on interview and record review the facility failed to allow a resident to return to the facility after a hospital stay. This affected 1 of 3 resident (R1) review for bed hold policy and procedures. Findings include: R1's face sheet denotes R1 has diagnosis of schizophrenia disorders, major depressive disorders, anxiety disorder, extrapyramidal and movement disorder, vitamin deficiency, brief psychotic disorder, auditory hallucinations, visual hallucinations, cocaine use unspecified uncomplicated, cannabis use uncomplicated, and nicotine dependence. R1's face sheet denotes R1 was admitted to the facility on [DATE]. R1's MDS dated [DATE] section C shows BIMS score 15 (cognitively intact), section E denotes yes for hallucinations and delusions, overall presence of behavior: no is checked. R1's clinical record denotes R1 is pregnant. 1/3/23 progress note from psychiatry nurse practitioner states Reviewed medications. Patient is pregnant; in her first trimester. We discussed that antipsychotic medications could affect her pregnancy, plan to D/C for safety of the fetus. I was told by staff that patient is going to be discharged to a proper facility. Medication Changes: DISCONTINUE current psych meds, due to pregnancy. 1/8/23 10:49am nurse's note in part states Resident noted to have altered mental status as well as reports of visual and auditory hallucinations. Physician notified and ordered resident to be sent to nearest ER (emergency room) for psychiatric evaluation. DON and administrator notified as well. 1/8/23 3:30pm nurse's notes in part states Writer spoke with (individual's name and hospital's name) and was informed that resident was admitted inpatient r/t (related to) altered mental status. 1/8/23 ultrasound of pelvis with transabdominal and transvaginal imaging was performed at hospital 1. Impression: Single live intrauterine gestation measuring 9 weeks 0 days by today's ultrasound with estimated date of delivery 8/13/23. Per hospital 1 records, R1 was sent to the emergency roiagnom on [DATE] and transferred to hospital 2 on 1/13/23. R1's emergency department record stated chief complaint was Hallucinations and the visit diagnosis listed as First trimester pregnancy. Psychosis. Hospital 1's discharge information states discharged [DATE] and discharge disposition was documented as Psychiatric Hospital. 1/16/23 2:42pm social service notes from hospital 2 states SW (social worker) received a call from (first name) of Aperion Care. She reported that pt (patient) is pregnant and she cannot return to their facility. (continued on next page)

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's PASARR (Pre-Admission Screening and Resident Review) level 2 dated 1/19/2023 denotes in-part your care needs are appropriate to be serviced in any nursing facility. Approved, you meet nursing facility level of care. R1's social service records dated 1/20/23 from hospital 2 denotes in part call from liaison at Aperion Care Chicago Heights, patient is not able to return to Aperion Care Chicago Heights because she is past her 10 days out of facility, and they gave away her bed. Liaison told hospital social worker he needs a level 2 assessment to be completed for patient (R1) to return to the nursing home. Level two completed facility dumped patient at (hospital 2). 1/25/23 11:33 am social service notes from hospital 2 states in part Pt is being discharged today, 1/25/2023. Pt is being discharge to the New Day Program. MDS dated [DATE] for discharge section A denotes return anticipated. On 2/11/23 at 2:19pm V5 (Director of Nursing) said R1 was not readmitted to the facility because she was past the 10-day bed hold. V5 said R1's bed is no longer available and now R1 would have to wait for a female bed. V5 said she does not know if R1 received a bed hold notice and referred surveyor to speak to V24 (Admissions Director). V5 said she does not know when hospital 1 and hospital 2 contact the facility regarding R1's readmission. V5 referred surveyor to V24. On 2/11/2023 2:31pm V24 (Admission Director) said R1 was discharged from the facility because R1 past the 10-day bed hold. V24 then said she would have discharged R1 out on the 18th, but she discharged R1 out on the 19th, this is reflected on the census. V24 then said R1 was discharged because the facility could not meet R1 needs because R1 was pregnant. V24 said the facility has been trying to get R1 placement at a SMURF (Specialized Mental Health Rehabilitation Facility) that can provide service to R1 due to her pregnancy. V24 said the SMURF facility did not get back to her regarding accepting R1. V24 said the facility had R1 PASARR (Pre-Admission Screening and Resident Review) reevaluated for a SMURF facility so that R1 could be accepted. V24 was asked if R1 was considered a resident at the skilled facility until she is accepted to the SMURF facility, V24 said yes. V24 said the facility had been trying to find R1 placement since finding out R1 was pregnant. V24 said she does not handle the facility discharges. V24 said R1 was in a shelter right now. On 2/12/2023 at 10:30am V6 (Administrator) said V5, V24, and himself were working together to find R1 placement due to pregnancy. V6 said R1 has not been discharged and he has not given R1 a IVD (involuntary discharge). V6 said the facility has been working with R1 to find R1 placement due to her pregnancy. V6 said hospital 1 was also helping the facility to find R1 placement. V6 said he does not know why R1 was sent to hospital 2 (hospital name) after her stay at hospital 1 (hospital name). V6 said he thinks R1 is currently at a shelter right now. V6 was asked if hospital 2 contact the facility for R6 readmission. V6 said he does not know. V6 was asked why is R1 at a sheltered and not at her home at the skilled facility. V6 said that's a good question. V6 was asked if R1 has not been discharged why is V5 saying R1 bed was given away and that R1 would have to wait for another bed when the facility has an open female bed. V6 said he does not know. V6 said he did not contact the ombudsman regarding R1's transfer and discharge. V6 presented a document to show the facility has called several locations to get R1 placement. When ask about the notation that shows appointment needed schedule appointment, application process, must go in, call at any time to schedule. V6 was asked if the application process was started for R1, did R1 go into the facility, did anyone call to start the process? V6 said he must look into it. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/23 at 10:30 am the surveyor reviewed with V6 (Administrator) a review of the facility's census and available beds. V6 verified that there were 6 unoccupied female beds on the date of 1/20/23 when the hospital attempted to transfer R1 back to the facility. Facility policy titled notice of transfer and discharge with last review date 10/24/2022 denotes in-part prior to discharge or transfer, the facility will notify the resident and the resident representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. The facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care Ombudsman. This may be done by submitting a monthly list. Record the reason for transfer or discharge in the resident medical record. Residents who are sent emergently to an acute care setting, such as a hospital must be permitted to return to the facility. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident status at the time the resident seeks to return to the facility meet one of the criteria for reason A through D. Facility bed hold policy denotes in-part conditions for return to facility: residents whose hospitalization or therapeutic leave exceeds the bed-hold periods may return to the facility to their previous room of available or immediately upon the first availability of bed in a semi-private room if the resident requires the services provided by the facility and, is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services and the facility is able to meet the needs of the resident. Facility policy titled notice of transfer and discharge with last review date 10/24/2022 denotes in-part prior to discharge or transfer, the facility will notify the resident and the resident representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. The facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care Ombudsman. This may be done by submitting a monthly lit. Record the reason for transfer or discharge in the resident medical record. Residents who are sent emergently to an acute care setting, such as a hospital must be permitted to return to the facility. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident status at the time the resident seeks to return to the facility meet one of the criteria for reason A through D. (continued on next page)

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident rights for people in the long-term care facilities denotes in-part your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. Your discharge plan and steps to achieve the goal should be included in your care plan. You must be given written notice if your facility wants you to move from the facility. The reasons for asking you to leave must only be for the following reasons: you are a danger to yourself or others; your needs cannot be met by the facility; your health has improved, and you no longer need the services of a long-term care facility. You have not paid your bill after reasonable notice; your facility closes. The notice must: tell you why your facility wants you to move; tell you how to appeal the decision to the Illinois Department of Public Health; provide a stamped and addressed envelope for you to mail your appeal in; and be received 30 days prior to the day they want you to move from a Medicare or Medicaid certified facility be received 21 days prior to the day they want you to move from a State licensed facility. You have the right to appeal to the Illinois Department of Public Health and if you choose to appeal: a Department of Public Health hearing officer will travel to your facility to hear why you believe you should stay in the facility and why the facility believes you should move, and usually your facility cannot make you leave until the appeal is decided by the Department of Public Health. If you do not appeal the decision, you are agreeing to the transfer or discharge. Before your facility can transfer or discharge you, it must prepare you to be sure that your discharge is safe and appropriate. You must be allowed to return to your facility after you are hospitalized as long as you still need that level of care. If you get Medicaid and are hospitalized for ten or fewer days, your facility must let you return when you leave the hospital even if the facility has given you a written discharge notice. If you are hospitalized for more than ten days, your facility must let you return if it has a bed available and you still need that level of care. If your facility is full, you must be allowed to have the first available bed if you still need that level of care.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796 Based on interview and record review the facility failed to follow their discharge planning policy and develop, coordinate, and implement a safe discharge for a vulnerable resident. This affected 1 of 3 residents (R1) reviewed for discharge planning. Findings include: R1's face sheet denotes R1 has diagnosis of schizophrenia disorders, major depressive disorders, anxiety disorder, extrapyramidal and movement disorder, vitamin deficiency, brief psychotic disorder, auditory hallucinations, visual hallucinations, cocaine use unspecified uncomplicated, cannabis use uncomplicated, and nicotine dependence. R1's MDS dated [DATE] section C shows BIMS score 15 (cognitively intact), section E denotes yes for hallucinations and delusions, overall presence of behavior: no is checked. R1's clinical record denotes R1 is pregnant. R1's face sheet denotes R1 was admitted to the facility on [DATE]. R1's clinical record denotes R1 is pregnant. 1/3/23 progress note from psychiatry nurse practitioner states Reviewed medications. Patient is pregnant; in her first trimester. We discussed that antipsychotic medications could affect her pregnancy, plan to D/C for safety of the fetus. I was told by staff that patient is going to be discharged to a proper facility. Medication Changes: DISCONTINUE current psych meds, due to pregnancy. 1/8/23 10:49am nurse's note in part states Resident noted to have altered mental status as well as reports of visual and auditory hallucinations. Physician notified and ordered resident to be sent to nearest ER (emergency room) for psychiatric evaluation. DON and administrator notified as well. 1/8/23 3:30pm nurse's notes in part states Writer spoke with (individual's name and hospital's name) and was informed that resident was admitted inpatient r/t (related to) altered mental status. On 2/11/23 at 2:19pm V5 (Director of Nursing) said R1 was not readmitted to the facility because she was past the 10-day bed hold. V5 said R1's bed is no longer available and now R1 would have to wait for a female bed. V5 said she does not know if R1 received a bed hold notice and referred surveyor to speak to V24 (Admissions Director). V5 said she does not know when hospital 1 and hospital 2 contact the facility regarding R1's readmission. V5 referred surveyor to V24. (continued on next page)

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/2023 2:31pm V24 (Admission Director) said R1 was discharged from the facility because R1 past the 10-day bed hold. V24 then said she would have discharged R1 out on the 18th, but she discharged R1 out on the 19th, this is reflected on the census. V24 then said R1 was discharged because the facility could not meet R1 needs because R1 was pregnant. V24 said the facility has been trying to get R1 placement at a SMURF (Specialized Mental Health Rehabilitation Facility) that can provide service to R1 due to her pregnancy. V24 said the SMURF facility did not get back to her regarding accepting R1. V24 said the facility had R1 PASARR (Pre-Admission Screening and Resident Review) reevaluated for a SMURF facility so that R1 could be accepted. V24 was asked if R1 was considered a resident at the skilled facility until she is accepted to the SMURF facility, V24 said yes. V24 said the facility had been trying to find R1 placement since finding out R1 was pregnant. V24 said she does not handle the facility discharges. V24 said R1 was in a shelter right now. On 2/12/2023 at 10:30am V6 (Administrator) said V5, V24, and himself were working together to find R1 placement due to pregnancy. V6 said R1 has not been discharged and he has not given R1 a IVD (involuntary discharge). V6 said the facility has been working with R1 to find R1 placement due to her pregnancy. V6 said hospital 1 was also helping the facility to find R1 placement. V6 said he does not know why R1 was sent to hospital 2 (hospital name) after her stay at hospital 1 (hospital name). V6 said he thinks R1 is currently at a shelter right now. V6 was asked if hospital 2 contact the facility for R6 readmission. V6 said he does not know. V6 was asked why is R1 at a sheltered and not at her home at the skilled facility. V6 said that's a good question. V6 was asked if R1 has not been discharged why is V5 saying R1 bed was given away and that R1 would have to wait for another bed when the facility has an open female bed. V6 said he does not know. V6 said he did not contact the ombudsman regarding R1's transfer and discharge. V6 presented a document to show the facility has called several locations to get R1 placement. When ask about the notation that shows appointment needed schedule appointment, application process, must go in, call at any time to schedule. V6 was asked if the application process was started for R1, did R1 go into the facility, did anyone call to start the process? V6 said he must look into it. On 2/12/23 at 10:30 am the surveyor reviewed with V6 (Administrator) a review of the facility's census and available beds. V6 verified that there were 6 unoccupied female beds on the date of 1/20/23 when the hospital attempted to transfer R1 back to the facility. R1's PASARR (Pre-Admission Screening and Resident Review) level 2 dated 1/19/2023 denotes in-part your care needs are appropriate to be serviced in any nursing facility. Approved, you meet nursing facility level of care. R1's social service records dated 1/20/23 from hospital 2 denotes in part call from liaison at Aperion Care Chicago Heights, patient is not able to return to Aperion Care Chicago Heights because she is past her 10 days out of facility, and they gave away her bed. Liaison told hospital social worker he needs a level 2 assessment to be completed for patient (R1) to return to the nursing home. Level two completed facility dumped patient at (hospital 2). Records dated 1/16/2023 denotes in-part hospital social worker received call from (name noted) at Aperion Care, she reported that patient is pregnant, and she cannot return to their facility. 1/25/23 11:33 am social service notes from hospital 2 states in part Pt is being discharged today, 1/25/2023. Pt is being discharge to the New Day Program. MDS dated [DATE] for discharge section A denotes return anticipated. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/23 at 11:22AM V4 (Social Services) said R1 was on his case load. V4 said discharge planning would go smooth. It would consist of planning, determining where the resident plan to go (community, home, another facility), and getting the address of the discharge location. V4 said the nurse would review medication(s) with the resident. V4 said the resident would take their belongings with them. The facility would set up transportation. V4 said if appropriate, the facility would arrange for equipment for the resident. V4 said R1 has been discharged from the facility because she is pregnant. V4 said he was told by V5 that the facility cannot meet R1 needs. V4 said he does not know what needs that can't be met. V4 said he would have to guess, i.e., pregnant stuff, like getting prenatal vitamins, and ultrasounds. V4 said he really don't know. V4 said he did not plan a discharge for R1. Facility policy titled Discharge planning guidelines with effective date 10/27/22 denotes in-part, discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan. It involves the interdisciplinary team working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting. Discharge planning begins at admission and is based on the resident's assessment and goals for care, desire to be discharged , and the resident's capacity for discharge. It also includes identifying changes in the resident's condition, which may impact the discharge plan, warranting revisions to interventions. Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan should be updated, as needed, to reflect these changes. Involve the interdisciplinary team, in the ongoing process of developing the discharge plan. Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. Address the resident's goals of care and treatment preferences. Inquire about their interest in receiving information regarding returning to the community. If the resident indicates an interest in returning to the community, the facility will document any referrals to local contact agencies or other appropriate entities made for this purpose. Update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. If discharge to the community is determined to not be feasible, the facility should document who made the determination and why. Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information should be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident rights for people in the long-term care facilities denotes in-part your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. Your discharge plan and steps to achieve the goal should be included in your care plan. You must be given written notice if your facility wants you to move from the facility. The reasons for asking you to leave must only be for the following reasons: you are a danger to yourself or others; your needs cannot be met by the facility; your health has improved, and you no longer need the services of a long-term care facility. You have not paid your bill after reasonable notice; your facility closes. The notice must: tell you why your facility wants you to move; tell you how to appeal the decision to the Illinois Department of Public Health; provide a stamped and addressed envelope for you to mail your appeal in; and be received 30 days prior to the day they want you to move from a Medicare or Medicaid certified facility be received 21 days prior to the day they want you to move from a State licensed facility. You have the right to appeal to the Illinois Department of Public Health and if you choose to appeal: a Department of Public Health hearing officer will travel to your facility to hear why you believe you should stay in the facility and why the facility believes you should move, and usually your facility cannot make you leave until the appeal is decided by the Department of Public Health. If you do not appeal the decision, you are agreeing to the transfer or discharge. Before your facility can transfer or discharge you, it must prepare you to be sure that your discharge is safe and appropriate. You must be allowed to return to your facility after you are hospitalized as long as you still need that level of care. If you get Medicaid and are hospitalized for ten or fewer days, your facility must let you return when you leave the hospital even if the facility has given you a written discharge notice. If you are hospitalized for more than ten days, your facility must let you return if it has a bed available and you still need that level of care. If your facility is full, you must be allowed to have the first available bed if you still need that level of care.

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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** 40066 Based on interviews and records reviewed the facility failed to supervise and monitor R3 during outdoor activity. This failure resulted in R3 leaving the facility while facility staff were playing basketball. The facility also failed to determine the pass privilege policy for R4. This failure resulted in the facility staff opening the door and allowing R4 that was assessed to be an elopement risk to leave the facility without checking the elopement book or verifying R4's pass privilege. The Immediate Jeopardy began on 1/31/23 when staff used the door code to allow R4 to leave the facility without checking that R4 was on elopement protocol and did not have pass privileges. V6 (Administrator) was notified of the Immediate Jeopardy on 2/16/23 at 12:15 pm. The surveyor confirmed by observation, record review, and interview that the Immediate Jeopardy was removed on 2/22/23 but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the removal plan. The findings include: 1.R3 has cognitive impairment. R3's diagnosis include, but are not limited to Schizoaffective Disorder, Bipolar, Suicidal Ideations, Patient's other non-compliance with Medication Regimen, Asthma, Cocaine Abuse, Depressive Disorder with Psychotic Symptoms, Auditory Hallucinations, and Dorsalgia. R3 admitted to the facility on [DATE] following a psychiatric hospitalization . R3's Notice of PASRR (Pre-Admission Screening and Resident Review) Level II dated 12/21/22 states you came to hospital psychiatric unit on 12/13/22 as you were having increased mental health symptoms with thoughts to end your life by jumping in front of a car. When you are not at the hospital, you do not have a place to live. Important for a provider to know (in part) you need help from others to make safe decisions. You believe things to be true that others don't find to be true. You have a history of Cocaine abuse; you tested positive for Cocaine when you got to the hospital. R3's PASRR Grouping You fall into the category of having a diagnosis that the PASRR program was designed to assess. Your condition is likely to require expert treatment in the future. That diagnosis is A serious mental health condition. R3's smoking safety risk assessment dated [DATE] states R3 requires supervision only (no assistance) with smoking. This is the only smoking assessment in R3's record. Elopement risk assessment dated [DATE] denotes R3 does not have dementia and/or severe mental illness. (R3 has Schizoaffective disorder, Bipolar Type, Suicidal Ideations, and Major Depressive Disorder.) This assessment denotes R3 is not at risk for elopement. Community survival skills dated 12/29/23 denotes R3 does not appear to be capable of unsupervised outside pass privileges at this time. R3's Cognitive assessment dated [DATE] notes R3 has a score of 5, severely impaired. (continued on next page)

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	145180	A. Building B. Wing	03/01/2023

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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	R3's Functional Status assessment dated [DATE] notes R3 requires supervision for bed mobility transfers and walking in the room. R3's care plan initiated on 1/4/23 denotes a history of severe mental illness (Schizoaffective) as manifested by: Delusions persecutory, delusions - paranoia, delusions - poor ability to reason, hallucinations -auditory, need for ongoing psychoactive medications. R3's care plan denotes he wishes to discharge to another facility and has a history of substance abuse, and R3 is a smoker. R3's orders do not state a pass privilege. R3's progress notes for 2/5/23-2/8/23 read eloped. On 2/11/23 at 11:38AM V3 (Registered Nurse) said R3 came in homeless. He had fingers and toes amputated in the past, but not recently. V3 said R3 would occasionally ask if I could give him a ride. V3 said she would ask him to where, but he was unable to give an address, somewhere on the northside. V3 said R3 was always sleeping. He was cooperative. He eats and then go back to bed. V3 said R3 walked stable. V3 said I was told that R3 eloped and I saw in the computer. V3 said the CNAs (Certified Nurse Assistants) stated, He ran out and He eloped. V3 said the CNAs stated they don't know how he got out. On 2/11/23 at 11:53AM V9 (Certified Nursing Assistant/CNA), said R3 would ask Can you call someone?. V9 said I don't know who he wanted to call so I would tell him to tell the nurse. V9 said R3 can walk and has a normal pace. V9 said R3 is not here today. I don't know where he is. I have not seen him. V9 said I asked my nurse (V3) where R3 was and V9 stated She said he eloped. V9 said she is expected to do a head count 3 times a day at 7:00AM, 10:00AM, and at 2:00PM. On 2/11/23 at 12:24PM V13 (CNA) said after 5:00PM we started looking for R3. V13 said we found out R3 was not there. V13 said we called a code pink and started looking. V13 said I was not assigned to R3 that day (2/5/23). On 2/11/23 at 12:32PM V11 (Licensed Practical Nurse) said on 2/5/23 V14 (CNA) reported he could not find R3. V11 said I went to go look for R3 and could not find him. V11 said we checked the whole building we called the Administrator and the Director of Nursing (DON). V11 said the police were called and they came out. V11 said it was around 5:00PM. V11 said I had not seen (R3) that day. V11 said I am not sure when they last saw him. V11 said I don't know what happened to him. No one has told me anything. V11 said R3 did not tell me he was leaving on 2/5/23. V11 said we called a code pink. V11 said we were still looking for R3 when the police came. V11 said we stopped looking after about an hour of searching. On 2/11/23 at 12:43PM V12 (CNA) said I worked on 2/5/23 but I did not see R3 at all that day. On 2/11/23 at 12:53PM V14 (CNA) said a Code Pink is elopement. V14 said a code pink was called for R3 on 2/5/23. V14 said we did not find him. The code started around 5:00PM or 5:30PM. V14 said when I didn't see him after taking him his dinner, I realized he was not there. V14 said I started my shift on 2/5/23 at 3:00PM. V14 said I did not see R3 on 2/5/23 at all. V14 said we don't have a head count until 6:00PM on my shift. V14 said We wait for after dinner to look for them. V14 said we could not find R3, and we stopped looking. V14 said I am not sure if someone looked outside for R3. V14 said I was the first person to report R3 missing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/11/23 at 1:22PM V16 (Mental Health Tech) said R3 walked slow, he does not move fast, his thinking process is not there. V16 said R3 would not stay outside for long, he would not even finish his cigarette, he was always cold. When V16 was talking about R3 he said you would have to ignore him for him to get out. On 2/11/23 at 1:43PM V15 (CNA) said I started my shift on 2/5/23 at 3:00PM. V15 said we had cigarette breaks and then dinner. V15 said I was outside for smoke break from 3:15PM and 3:30PM. V15 said I did not see R3 at that break. V15 said R3 usually walks around the facility, he walks normal at a normal pace. V15 said a code pink was called for R3 on 2/5/23. V15 said I don't know when the last time anyone saw him was. V15 said we stopped looking for him after dinner time. V15 said I did not go outside to look for him. V15 said I believe staff is supposed to look outside for a code pink. V15 said I don't think anyone knows where he is. On 2/11/23 at 3:11PM V1 (CNA) said during the 6:00PM head count it was noticed that R3 was missing. V1 said R3's baseline was to walk normal without assistive devices. V1 said R3 had a normal pace. V1 said during a code pink, no one is assigned to look outside. V1 said I did not look outside on 2/5/23. V1 said I don't know if anyone looked outside. V1 said the code pink was called clear code for (R3), but that is not clear. V1 said R3 was not found during the code pink on 2/5/23. On 2/11/23 at 3:35PM V2 (Human Resources) said V18 (Former Mental Health Tech) was terminated due to not supervising the residents during the smoke break between 1:15PM and 3:15PM on 2/5/23. On 2/12/23 at 9:12AM V6 (Administrator) said V18 was terminated for not being in his assigned spot, in the building working on 2/5/23. V6 said V18 was playing basketball. V6 said he was told the activity room patio door was open. V6 said V19 and V20 (Activity Aide) were terminated because the activity door was open and V19 and V20 were not doing a good enough job to supervise the residents. V6 said I did the investigation because during the 6:00PM head count on 2/5/23, it was reported that R3 was missing. V6 said he watched the surveillance video and saw R3 playing basketball on the activity patio around 2:40PM. V6 said then I saw him leave thru the gate. V6 said he was able to see R3 went east on the street saw him go past 1 house on the video. V6 said I did not see staff go after him. V6 said from the video the 2 activity aides (V19 and V20) were inside the facility while the doors were open. V6 said there was no staff on the patio while the residents were outside. V6 said V19 and V20 were telling me they were watching the patio from the doorway. V6 said I could not see them watching from the doorway on the video. V6 said We are unsure where R3 is at this time. At 9:42AM V6 provided V11's phone number as the person who spoke with the police. V6 provided the police report number. V6 said when he came to work on Monday, 2/6/23, the gate latch to the sidewalk/street at the end of the driveway that leads to the patio, was not latched. On 2/12/23 at 9:31AM V8 (Activity Aide) accompanied the surveyor on a tour of the activity patio. V8 said the residents play basketball out here. V8 said if we open the patio, we have a Mental Health Tech or Activity Aide sitting by the chairs by the gates. The surveyor observed 3 gates with latches. 1 gate off the activity patio leading into the smoking patio. Second gate leads from smoking patio to the facility driveway, where the facility vehicles are parked. This gate is shorter, about 4 feet. A third gate was noted at the end of the driveway from the driveway leading to the sidewalk and street. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/12/23 at 11:20AM the surveyor was accompanied by V17 (Maintenance Staff) who measured the distance from the activity patio to the street. Total distance was 144 feet. R3 walked about 144 feet around the outside of the facility to leave. On 2/12/23 at 11:28AM V3 said we always have done head count forever. V3 said we started doing this specific head count (green sheet) on 12/2/22. V3 said the CNAs take a census sheet and sign off when the resident is here. V3 said I take the papers and leave them on the table. On 2/12/23 at 12:49PM V5 (Director of Nursing/DON), said CNAs are expected to do rounds on residents every 2 hours. V5 said CNAs should do a bed check at the start of the shift. V5 said CNAs should lay eyes on everyone at the start of the shift. On 2/14/23 at 12:13PM V6 said I was told surveyors can't watch the video. At 12:20PM V6 said I did not report to IDPH that R3 was missing because I was told we would report if there were an injury. At 12:27PM V6 said I do not know what staff searched the surrounding areas. At 1:37PM V6 said the staff did not document the date or time the hospitals were contacted in search of R3. 2. R4's diagnosis includes but not limited to Bipolar, Moderate Intellectual Disabilities, Hypertension, Hyperlipidemia Type 2 Diabetes, Constipation, Morbid Obesity, and Nicotine Dependence, Cigarettes. R4 was admitted on [DATE] from another facility. On 2/12/23 at 12:49PM V5 (DON) said she was informed on 1/31/23 that R4 was not located. V5 said she as notified around 2:00PM from the head count. V5 said a code pink was called. V5 stated while doing the search, R4's family called and spoke with V4 (Psychiatric Rehabilitation Services Coordinator/PRSC) and said R4 was at his sister's house. V5 said R4's sister did not pick R4 up from the facility. V5 said I have no idea how he got out. V5 said R4 left unauthorized. V5 said the sister brought R4 back to the facility a couple of days later. On 2/14/23 at 10:21AM V6 (Administrator) said R4 was trying to obtain a community pass and wanted to visit his sister. V6 said R4 had told his caseworker (V4). V6 said on 1/31/23 V23 (Minimum Data Set/MDS Coordinator) did not verify R4's pass status and entered the code and let R4 out of the facility. V6 said he was made aware that R4 was missing after a head count. V6 said R4 went to his sister's house, and she brought him back. At 2:33PM the surveyor asked V6 if a resident comes missing and the whereabouts of the resident are found, does the facility have the ability to pick up the resident. V6 said We have the capability with 3 vans to pick up residents. We would coordinate the transport back to the facility. The surveyor asked if the family asked the facility to come pick up the resident from an unauthorized leave, would the facility pick the resident up? V6 said yes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/14/23 at 10:47AM V4 (PRSC) said V4 completes the elopement assessments when a resident comes into the facility. V4 said R4 had expressed he wanted to go to another facility, specifically he wanted to go to a condominium, a 1 bedroom. V4 said he was working with R4's family towards that. V4 said R4 had said he did not want to share a room. V4 said R4's judgment was off. V4 gave the examples of R4 saying he wanted to leave and go to a shelter with four dollars, leaving his personal items out, he constantly left his shoes and phone out. V4 said R4 makes poor decisions. V4 said he did a second elopement risk assessment on 1/30/23 because he was at my office door a lot and expressed he wanted to leave. V4 said R4 gave him the thought that R4 might elope. V4 said there had been a couple times when R4 expressed he wanted to get a pass. V4 said he reported those times to V5 or V6. V4 said I sent out an email about it. (V4 did not provide a requested copy of the email.) At 10:58AM V4 said he was in the facility on 1/31/23 when they noticed R4 was gone. V4 said R4's mother called me and asked how he got a pass because R4 was at his sister's house. V4 said I put R4's mother on hold and called the Mental Health Techs and they did a room search and that is when we were aware that R4 was missing. R4 said we did a code pink. V4 said I was the first to be aware that R4 was gone. V4 said R4 was not eligible for a community pass because he was still within his 30- or 60-day review period. V4 said at 21 days R4 would have been able to go out with family. V4 said R4 had just reached the limit to be considered for a pass. V4 said I think we were going to be deny his community pass. V4 said when speaking with R4's family they told him that R4 could not be out on his own. V4 said R4's sister said R4 got on the bus to get to her house. V4 said a Community Skills Assessment is to be done on admission, or within 72 hours from admission. On 2/14/23 at 11:57AM V22 (PRSC) said Community Skills Assessment are done initially after admission, update quarterly, change of condition, or if the resident requests a pass. V22 said the purpose of the Community Skills Assessment is to find out if residents are capable of functioning in the community. V22 said these are done within a week from admission. V22 said the nurses should communicate expressions of residents requesting to leave or if residents are making statements of wanting to leave. V22 said from there we would do an elopement assessment or update the care plan. V22 said if a resident is found at risk for elopement it should be on the care plan. On 2/14/23 at 12:30PM V25 (R4's family) said on 1/31/23 R4 came by here. I called the facility and they said they did not know he got out. V25 said R4 grabbed his coat but had no shirt on when he arrived at her house. R4 said I live in XXXX and R4 got on the bus to get here. V25 said R4 walked from the bus stop to her house. V25 said she was told by V4, that the facility could not come out and get him and that she needed to bring him. V25 said she gave R4 twenty dollars and told him to go back to the facility. V25 said later she called the facility and they said he was not back. V25 said 2 days later R4 returned to her home and asked for more money. V25 said she took R4 back to the facility. On 2/14/23 at 12:56PM R4 was asked how he got out of the facility on 1/31/23 and R4 told the surveyor I left out, I walked out the front door. R4 said he walked to Lincolnwood Highway. R4 said he left after lunch. R4 said he took the bus, and it dropped him off at the mall and he we walked a couple blocks to his sister's home. R4 said it took him about 30 minutes to get to his sister's home. The surveyor asked R4 where he stayed the 2 nights he was not in the facility. R4 said I stayed on the bus. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's progress notes dated 1/20/23 at 3:00PM document R4 was increasingly aggressive toward staff, exit seeking behavior and difficulty in redirection. A social service progress note documents R4 approached the writer (V4) about signing out against medical advice (AMA). R4 reported he did not want to be in the facility anymore. R4 said he would prefer to be at the shelter. Per progress notes R4 was taken to the hospital. R4 returned to the facility on [DATE]. R4's progress notes dated 1/31/23 at 9:32 written by V4 documents R4 approached V4 (for the seventh time) about getting an independent pass. V4 denied R4's request and said R4 was just readmitted from the hospital and was ineligible for a pass. V4 documented R4 understood. R4's progress notes dated 1/31/23 at 2:30 document it was brought to the writer's attention V5 that R4 has an unauthorized exit from the facility. R4's mother notified the facility that R4 visited his sister and was provided funding to return to the facility. Facility aware of resident exit. At this time, a missing person's report has been filed and awaiting resident return. R4's progress notes dated 2/2/23 documenting R4 was brought back to the facility by his sister. R4's elopement/unauthorized leave risk review dated 12/22/23 notes 1b.is there a diagnosis of dementia and/or severe mental illness - No. (R4's diagnosis includes Bipolar.) 2b. Signs of compromised decisional capacity and substantially impaired judgement and/or physical status limitations that would place the resident at risk in the community -yes. 4e. Has the physical ability to leave the building? No 5a. Elopement risk decision 3. Not at risk. R4's elopement/unauthorized leave risk review dated 1/30/23 at 6:59PM notes 1b.is there a diagnosis of dementia and/or severe mental illness -yes. 4c. Verbalizes a serious/strong intent to leave the facility in the absence of an appropriate discharge plan. 4e. Has the physical ability to leave the building? No 5a. Elopement risk decision 1. At risk to elope and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. R4's smoking risk assessment dated [DATE] denotes he can smoke independently with supervision only. Review of R4's January - February 2023 physician orders do not include an order for a community pass or outing. Review of R4's hospital records dated 1/21/23 note R4's petition states R4 was displaying exit seeking behaviors. R4's care plan printed by the facility on 2/14/23 does not include his risk for elopement. Review of a facility provided letter dated 1/24/23 at 8:36AM denotes R4 reported to staff that he became aggressive and wanted to leave the facility. Census report for R4 denotes he was on therapeutic leave of the facility on 1/31/23. Facility Human Resources Notice of Correction Action for V23 (MDS Coordinator) dated 2/1/23 documents on 1/31/23 employee opened door from secured section of facility for resident without verifying resident community access. (continued on next page)

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