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	03/13/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (R2) was free of physical abuse by another resident (R1) for two out of three residents reviewed for abuse in a total sample of nine. Findings Include: R1 is a [AGE] year old with the following diagnosis: schizophrenia and bipolar type schizoaffective disorder. R2 is a [AGE] year old with the following diagnosis: major depressive disorder, post-traumatic stress disorder and nonsuicidal self-harm. On 3/10/26 at 1:58PM, R2 was lying in bed and agreed to talk with the surveyor. R2 stated he got into a physical altercation with another resident (R1) about one to two weeks after R2 was admitted . R2 denied remembering the exact date of the altercation. R2 stated a heavy set black man hit R2 in the head and face more than once in the dining room. R2 denied remembering what led to the altercation but stated the other resident said words,' to R2 before hitting R2. R2 denied having any injuries. On 3/10/26 at 2:12PM, R1 was lying in bed and invited the surveyor into the room. When asked about an altercation at the end of January, R1 stated R1 hit R2 in the head because R1 thought R2 was making fun of the way R1 laughed. R1 reported R2 said something about R1's laugh so R1 hit R2 with a closed fist in the head. R1 stated R1 is aware that R1 should not be hitting anyone but was really mad at that time. R1 reported R1 was sent to the hospital and now feels better. On 3/11/26 at 10:40AM, V7 (PRSC) stated R1 became agitated to another resident in the dining room. V7 reported V7 was told this by another staff member but couldn't not remember who. V7 stated there was a back and forth between the residents which was verbal. V7 denied being informed any resident had gotten physical with each other. V7 reported if a resident hits another resident, then it is considered physical abuse. V7 denied speaking with R2 about the incident. On 3/11/26 at 12:30PM, V10 (LPN) stated V10 was told by other staff members that R1 was aggressive towards R2. V10 reported being told that R1 tried to hit R2. V10 stated R1 was sent to the hospital per physician orders after R1 was not able to be redirected. V2 denied speaking with R2. V10 reported V10 did not ask staff if the residents made contact with each other. V10 denied asking R1 if R1 hit R2. V10 stated V10 went off what V10 was told by other staff. V10 stated if residents touch or hit each other then it is considered abuse. On 3/11/26 at 2:35PM, the surveyor showed R2 the signed statement from V18 (Administrator) R2 allegedly made about the altercation with R1. R2 denied making the statement that is on the paper and denied signing the paper. R2 confirmed R1 hit R2 in the face a head and got multiple hits in before staff intervened. R2 said, There was definitely physical contact. R2 denied any staff members asking R2 about the incident the days after. R2 stated R1 hitting R2 was unwanted touching. R2 stated R2 did not think R1 was playing around because R1 was yelling. On 3/11/26 at 3:06PM, V16 (Behavior Aide) stated V16 did not physically see what happened at the beginning between R1 and R2 because others were in the way blocking V16's view. V16 reported heard a bunch of commotion and went to the area. V16 stated V16 saw R1 give R2 a couple taps but did not know if R1 was playing or not. V16 reported R1 hit R2 slower but with a closed fist. V16 stated this would be considered physical abuse because R1 hit R2. A Social Service note for R1 dated 1/29/26 documents social services were notified that R1 exhibited increased agitation toward a peer due to responding to internal stimuli. Social service educated R1 on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impulse control, reality orientation, healthy emotional regulation, and appropriate boundaries. Despite interventions, R1 was unable to be re-directed and denied a PRN medication. R1 was placed on 1:1 monitoring until the ambulance arrived. A Nursing note for R1 dated 1/29/26 documents R1 was responding to internal stimuli and had increased agitation towards a peer. Staff intervened. R1 was escorted to the sensory room and placed on 1:1 monitoring. No injuries were noted. R1 denied complaints of pain. A PRN medication was offered and R1 denied. The DON and physician were made aware. The physician ordered to send R1 to the hospital for a psych evaluation. A Nursing note for R1 dated 1/29/26 at 11:30PM documents per the hospital, R1 did meet requirements for a psych evaluation. The nurse practitioner was called and a voicemail was left.A Nursing note for R1 dated 1/30/26 documents the psych nurse practitioner ordered for R1 to go to a different psych hospital for an evaluation. The other hospital accepted R1's admission and admitted R1 around 12PM. The Illinois State Police Criminal History Record dated 10/8/18 documents R1 was convicted of aggravated battery with great bodily harm and attempted murder on 12/8/05. The Petition for Involuntary admission dated 1/29/26 documents R1 needs an emergency inpatient admission due to increased agitation towards a peer while responding to internal stimuli. R1 was threatening others and refused a PRN medication.The Behavior Management Team Review Meeting note dated 1/30/26 documents R1 displayed an increase in agitation towards a peer. Precipitating factors include poor impulse control, poor coping methods, delusions, and poor emotional regulation. R1 was referred to the hospital for a psychiatric evaluation. R1 will be re-evaluated upon return from the hospital for further recommendations.The Hospital Record dated 1/30/26 documents R1 physically assaulted a peer at the nursing facility and is unpredictable due to acute psychosis.The Care Plan dated 12/9/19 documents R1 has a criminal behavior that fits the criteria for an identified offender. R1 has an offense of aggravated battery with great bodily harm and attempted murder. R1 appears stable and is deemed a moderate risk.The Care Plan dated 9/5/22 documents R1 has the potential to be physically/verbally aggressive towards others related to anger and poor impulse control.R1's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score at 15 (no cognitive impairment).A Social Service note for R2 dated 1/29/26 documents a wellness check was conducted on R2. R2 was observed in the dining room and presented with a stable mood. No behavioral changes were noted. R2 reported feeling safe.A Social Service note for R2 dated 1/30/26 documents a wellness check was performed on R2. R2 was in a stable mood with no changes to behavior. R2 reported feeling safe in the facility. R2 was encouraged to seek out staff to express feelings or concerns.There is no documentation about the altercation in R2's notes. The Abuse/Neglect Screening dated 1/15/26 documents a score of four indicating R2 is at moderate risk for abuse/neglect due to history of substance abuse, history of depression, psychiatric history, and R2's vulnerability. R2's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score of 15 (no cognitive impairment).The Care Plan dated 3/10/26 documents R2 is at risk for abuse/neglect related to major depressive disorder. V18 provided an alleged statement from R2 about the incident with R1. There is a signature on the paper but no date. R2 denied ever seeing or signing the paper. R2 then signed the paper and showed the surveyor how R2 normally signs documents. The two signatures do not match. The policy titled, Abuse Prevention and Reporting-Illinois, dated 10/24/22 documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, on reasonable (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. the term willful and the definition of abuse means the individual must have acted deliberately, not that individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of physical abuse to the state survey agency for one out of three residents reviewed for abuse reporting in a total sample of nine. Findings Include: R1 is a [AGE] year old with the following diagnosis: schizophrenia and bipolar type schizoaffective disorder. R2 is a [AGE] year old with the following diagnosis: major depressive disorder, post-traumatic stress disorder and nonsuicidal self-harm. On 3/10/26 at 1:58PM, R2 was lying in bed and agreed to talk with the surveyor. R2 stated he got into a physical altercation with another resident (R1) about one to two weeks after R2 was admitted . R2 denied remembering the exact date of the altercation. R2 stated a heavy set black man hit R2 in the head and face more than once in the dining room. R2 denied remembering what led to the altercation but stated the other resident said words,' to R2 before hitting R2. R2 denied having any injuries. On 3/10/26 at 2:12PM, R1 was lying in bed and invited the surveyor into the room. When asked about an altercation at the end of January, R1 stated R1 hit R2 in the head because R1 thought R2 was making fun of the way R1 laughed. R1 reported R2 said something about R1's laugh so R1 hit R2 with a closed fist in the head. R1 stated R1 is aware that R1 should not be hitting anyone but was really mad at that time. R1 reported R1 was sent to the hospital and now feels better. On 3/11/26 at 10:40AM, V7 (PRSC) stated R1 became agitated to another resident in the dining room. V7 reported V7 was told this by another staff member but couldn't not remember who. V7 stated there was a back and forth between the residents which was verbal. V7 denied being informed any resident had gotten physical with each other. V7 reported if a resident hits another resident, then it is considered physical abuse. V7 denied speaking with R2 about the incident. On 3/11/26 at 12:30PM, V10 (LPN) stated V10 was told by other staff members that R1 was aggressive towards R2. V10 reported being told that R1 tried to hit R2. V10 stated R1 was sent to the hospital per physician orders after R1 was not able to be redirected. V2 denied speaking with R2. V10 reported V10 did not ask staff if the residents made contact with each other. V10 denied asking R1 if R1 hit R2. V10 stated V10 went off what V10 was told by other staff. V10 stated if residents touch or hit each other then it is considered abuse. On 3/11/26 at 2:35PM, the surveyor showed R2 the signed statement from V18 (Administrator) R2 allegedly made about the altercation with R1. R2 denied making the statement that is on the paper and denied signing the paper. R2 confirmed R1 hit R2 in the face a head and got multiple hits in before staff intervened. R2 said, There was definitely physical contact. R2 denied any staff members asking R2 about the incident the days after. R2 stated R1 hitting R2 was unwanted touching. R2 stated R2 did not think R1 was playing around because R1 was yelling. On 3/11/26 at 3:06PM, V16 (Behavior Aide) stated V16 did not physically see what happened at the beginning between R1 and R2 because others were in the way blocking V16's view. V16 reported heard a bunch of commotion and went to the area. V16 stated V16 saw R1 give R2 a couple taps but did not know if R1 was playing or not. V16 reported R1 hit R2 slower but with a closed fist. V16 stated this would be considered physical abuse because R1 hit R2. V16 reported all altercations have to be reported to a supervisor or administrator. V16 stated V16 told V18 (Administrator) about the incident and described the altercation to V18 exactly as it was explained to the surveyor. V16 reported staff receive abuse training every other month where staff are told what is abuse, what the kinds of abuse are, and how to report it. On 3/12/26 at 2:41PM, V18 (Administrator) stated V18 did an internal investigation about the incident between R1 and R2. V18 reported R1 claimed R1 didn't do anything and R2, along with other staff, described the incident as horse playing. V18 stated R1 did admit to tapping R2 in the shoulder area. V18 reported that according to the policy there was no need to report the incident. A Social Service note for R1 dated 1/29/26 documents social services were notified that R1 exhibited increased agitation toward a peer due to responding to internal stimuli. Social service educated R1 on impulse control, reality orientation, healthy emotional (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regulation, and appropriate boundaries. Despite interventions, R1 was unable to be re-directed and denied a PRN medication. R1 was placed on 1:1 monitoring until the ambulance arrived. A Nursing note for R1 dated 1/29/26 documents R1 was responding to internal stimuli and had increased agitation towards a peer. Staff intervened. R1 was escorted to the sensory room and placed on 1:1 monitoring. No injuries were noted. R1 denied complaints of pain. A PRN medication was offered and R1 denied. The DON and physician were made aware. The physician ordered to send R1 to the hospital for a psych evaluation. A Nursing note for R1 dated 1/29/26 at 11:30PM documents per the hospital, R1 did meet requirements for a psych evaluation. The nurse practitioner was called and a voicemail was left.A Nursing note for R1 dated 1/30/26 documents the psych nurse practitioner ordered for R1 to go to a different psych hospital for an evaluation. The other hospital accepted R1's admission and admitted R1 around 12PM. The Illinois State Police Criminal History Record dated 10/8/18 documents R1 was convicted of aggravated battery with great bodily harm and attempted murder on 12/8/05. The Petition for Involuntary admission dated 1/29/26 documents R1 needs an emergency inpatient admission due to increased agitation towards a peer while responding to internal stimuli. R1 was threatening others and refused a PRN medication.The Behavior Management Team Review Meeting note dated 1/30/26 documents R1 displayed an increase in agitation towards a peer. Precipitating factors include poor impulse control, poor coping methods, delusions, and poor emotional regulation. R1 was referred to the hospital for a psychiatric evaluation. R1 will be re-evaluated upon return from the hospital for further recommendations.The Hospital Record dated 1/30/26 documents R1 physically assaulted a peer at the nursing facility and is unpredictable due to acute psychosis.The Care Plan dated 12/9/19 documents R1 has a criminal behavior that fits the criteria for an identified offender. R1 has an offense of aggravated battery with great bodily harm and attempted murder. R1 appears stable and is deemed a moderate risk.The Care Plan dated 9/5/22 documents R1 has the potential to be physically/verbally aggressive towards others related to anger and poor impulse control.R1's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score at 15 (no cognitive impairment).A Social Service note for R2 dated 1/29/26 documents a wellness check was conducted on R2. R2 was observed in the dining room and presented with a stable mood. No behavioral changes were noted. R2 reported feeling safe.A Social Service note for R2 dated 1/30/26 documents a wellness check was performed on R2. R2 was in a stable mood with no changes to behavior. R2 reported feeling safe in the facility. R2 was encouraged to seek out staff to express feelings or concerns.There is no documentation about the altercation in R2's notes. The Abuse/Neglect Screening dated 1/15/26 documents a score of four indicating R2 is at moderate risk for abuse/neglect due to history of substance abuse, history of depression, psychiatric history, and R2's vulnerability. R2's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score of 15 (no cognitive impairment).The Care Plan dated 3/10/26 documents R2 is at risk for abuse/neglect related to major depressive disorder. V18 provided an alleged statement from R2 about the incident with R1. There is a signature on the paper but no date. R2 denied ever seeing or signing the paper. R2 then signed the paper and showed the surveyor how R2 normally signs documents. The two signatures do not match. All Abuse Reportables were reviewed for the last three months and there was no documentation of an incident report that was sent to IDPH regional office. The policy titled, Abuse Prevention and Reporting-Illinois, dated 10/24/22 documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infliction of injury, on reasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. the term willful and the definition of abuse means the individual must have acted deliberately, not that individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment .Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hereabout, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.