STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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 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. (continued on next page)

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

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

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its abuse policy by failing to report an injury of unknown origin for a resident who was dependent on staff for Activities of Daily Living (ADLs). This failure affected one resident (R1) of three residents reviewed for injuries. Findings include:R1 has resided at the facility since August 2025, past medical history includes but not limited to Epilepsy, unspecified, other cerebral palsy, pressure ulcer of sacral region, unspecified stage, history of falling, other lack of coordination, dysphagia phase, essential primary hypertension, bipolar disorder, etc.On 10/16/2025 at 11:21AM, V3 (Family member) said, she discovered a black eye and bruises around R1's left eye when she visited the facility on 10/3/2025 and reported this to staff. The administrator said, staff saw R1 hitting her head on the table and caused the injury to herself. V3 added, R1 does not have such behavior and could not have done that to herself.On 10/16/2025 at 2:40PM, R1 was in the dining room sitting at the table, awake and alert but non-verbal, just smiled at greeting. Resident is unable to answer any questions, staff stated that she was sleeping and just woke up. R1 no longer had any visible bruising or discoloration around her eyes, none observed on her arms.Minimum Data Set (MDS) assessment dated [DATE] scored R1 with a BIMs score of 99 (resident unable to complete interview). R1 is also assessed as frequently incontinent for bowel and bladder and requiring staff assistance for all ADL care, no mood or behaviors was documented for R1. On 10/16/2025 at 12:47PM, V1 (Administrator) said, R1 had some bruises around her right eye, she was in the dining room, thrashes around, staff witnessed it, so it was not reported to the state surveying agency.On 10/16/2025 at 2:58PM, V2 (Director of Nursing/DON) said, an activity aide (V4) reported to the nurse on 9/25/2025 that resident hit her head, V2 was not present at the time but advised the nurse to open the risk management. The nurse did not complete the risk management so V2 completed it and signed it on 10/7/2025. Surveyor inquired of any documentation from both the nurse and the activity aide who observed resident hit her head and V2 said that the nurse did not write any progress note, V2 is trying to educate them now. V2 added that the activity aide who supposedly observed resident hitting her head did not report it when it happened, and she should have reported it.On 10/16/2025 at 4:15PM, V4 (Activity aide) said that she worked with R1 on Thursday, 9/25/2025 during activities. She recalled that R1 dropped her paper on the floor, bent down to pick it and when she came up. It looked like she bumped her head but V4 said she was not sure. V4 was off from work on Friday 9/26/2025, returned to work on Saturday 9/27/2025 and saw R1 with a black eye, she asked what happened and no one knew what happened to resident, she was told that resident woke up like that.Surveyor interviewed multiple staff (Nurses and Certified Nursing Assistants) that worked with R1 on 9/24/2025, 9/26/2025 and 9/27/2025 and none witnessed R1 hitting her head on the table, no one knew how R1 got the black eye and bruising on her left eye. On 10/20/2025 around 3:10PM, V1 (Administrator) said that he thought they had an eyewitness for the injury, if he knew that V4 was not sure that resident hit her head, they would have reported it.Abuse prevention policy revised 10/24/2022 stated 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. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of --- and mistreatment of residents.Injuries of unknown source: An injury should be classified an injury of unknown source when both of the following conditions are met; the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury.Under internal reporting, the document states in part that any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. The nursing staff is additionally responsible for reporting on a facility report the appearance of suspicious bruises, lacerations, or other abnormalities as they occur.

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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. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its abuse policy by failing to initiate and thoroughly investigate an injury of unknown origin for a resident who is dependent on staff for Activities of Daily Living (ADLs). This failure affected one resident (R1) of three residents reviewed for injuries. Findings include:R1 has resided at the facility since August 2025, past medical history includes but not limited to Epilepsy, unspecified, other cerebral palsy, pressure ulcer of sacral region, unspecified stage, history of falling, other lack of coordination, dysphagia phase, essential primary hypertension, bipolar disorder, etc.On 10/16/2025 at 2:40PM, R1 in the dining room sitting at the table, awake and alert but non-verbal, just smiled at greeting. Resident is unable to answer any questions, staff stated that she was sleeping and just woke up. R1 no longer had any visible bruising or discoloration around her eyes, none observed in her arms.Minimum Data Set (MDS) assessment dated [DATE] scored R1 with a BIMs score of 99 (resident unable to complete interview). R1 is also assessed as frequently incontinent of bowel and bladder and requiring staff assistance for all ADL care, no mood or behaviors was documented for R1. On 10/16/2025 at 11:21AM, V3 (Family member) said that she discovered a black eye and bruises around R1's left eye when she visited the facility on 10/3/2025 and reported that to staff, the administrator said that staff saw R1 hitting her head on the table and caused the injury to herself. V3 added that R1 does not have such behavior and could not have done that to herself.On 10/16/2025 at 12:47PM, V1 (Administrator) said that they do not have any investigation for R1's injury, R1 had some bruises around her right eye, she was in the dining room, thrashes around, staff witnessed her hit her face on the table and hit herself with her hand. The facility did not investigate the bruises because it was witnessed, V1 added that he will send the DON (Director of Nursing) to speak to the surveyor regarding resident's injury because she has more details on that.On 10/16/2025 at 2:58PM, V2 (DON) said that an activity aide (V4) reported to the nurse on 9/25/2025 that resident hit her head, V2 was not present at the time but advised the nurse to open the risk management. The nurse did not complete the risk management so V2 completed it and signed it on 10/7/2025. Surveyor inquired of any documentation from both the nurse and the activity aide who observed resident hit her head and V2 said that the nurse did not write any progress note, V2 is trying to educate them now. V2 added that the activity aide who supposedly observed resident hitting her head did not report it when it happened, and she should have reported it.Review of R1's medical record did not show any documentation of a behavior or incident on 9/25/2025, there was no progress note or documentation of any assessment by any staff. IDT note dated 10/9/025, late entry form 9/30/2025 states in part, resident noted to have discoloration to right eye, NOD (Nurse on Duty) made aware, assessed resident, investigation initiated, staff interview completed.On 10/16/2025 at 4:15PM, V4 (Activity aide) said that she worked with R1 on Thursday, 9/25/2025 during activities. she recalled that R1 dropped her paper on the floor, bent down to pick it and when she came up. It looked like she bumped her head but V4 said she was not sure, that's why she went and told the nurse who came and assesses resident but did not notice anything. V4 was off from work on Friday 9/26/2025, returned to work on Saturday 9/27/2025 and saw R1 with a black eye, she asked what happened and no one knew what happened to resident, she was told that resident woke up like that.On 10/20/2025 at 10:50AM, V6 (Licensed Practical Nurse/LPN) said that she works at the facility part time, maybe 2 days a week, she was assigned to R1 on 9/25/2025, day shift and does not recall anyone reporting any incidents to her on that day. V6 does not recall assessing any resident for injuries and added, I would remember such incident and would have documented it.Surveyor interviewed multiple staff (Nurses and Certified Nursing Assistants) that worked with R1 on 9/24/2025, 9/26/2025 and 9/27/2025 and none witnessed R1 hitting her head on the table, no one knew how R1 got the black eye and bruising on her left eye. On 10/20/2025 around 3:10PM, V1 (Administrator) said, he thought they have an eyewitness for the injury, if he knew that V4 was not sure that resident hit her head, they would have done more investigation.Abuse prevention policy revised 10/24/2022 stated in part: This facility affirms the right of our residents to e free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The purpose of this policy is to assure that the facility is doing al that is within its control to prevent occurrences of ---------- and mistreatment of residents.Injuries of unknown source: An injury should be classified an injury of unknown source when both of the following conditions are met; the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is