STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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. (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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F 0600 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 their policy to ensure one resident (R6) was free from abuse. This failure affects 1 resident (R6) reviewed for abuse.Findings include: According to R6 face sheet provided by facility, R6 has diagnoses that include but not limited to moderate protein-calorie malnutrition, autistic disorder, bipolar disorder, anxiety disorder, and chronic obstructive pulmonary disease with (acute) exacerbation. R6's MDS (Minimum Data Set), dated 7/17/2025, indicates R6 has a BIMS (Brief Interview for Mental Status) score of 8, indicating moderately impaired cognition. According to R9 face sheet provided by facility, R9 has diagnoses that include but not limited to autistic disorder, Tourette's disorder, epileptic seizures, schizoaffective disorder, generalized anxiety, major depressive disorder, Asperger's syndrome, violent behavior. R9's MDS, dated [DATE], indicates R9 has a BIMS score of 11, indicating moderately impaired cognition. According to R9's Aggressive Behavior Assessment, dated 5/7/2025, comment section, on 5/7/25 R9 was physically and verbally aggressive with staff, punched a staff member in the face, slammed doors, banged on facility property. Facility Reported Incident, incident date 6/26/25, documents: In the early morning hours of 6/26/25 resident R9 woke up and stood up in the middle of the night and walked towards the bathroom. Resident's roommate R6 was startled and got up out of bed quickly. While R9 was trying to go around R6, R9 became agitated, and his shoulder made contact with R6. Resident R9 was sent out for a psychiatric evaluation. R6 refused to go to the hospital for a medical evaluation. 8/13/25 at 1:30 PM, V1 (Administrator) stated, I am the Abuse Coordinator. Some types of abuse are physical, verbal, mental, misappropriation of funds/property, sexual, neglect. All staff are in-serviced on abuse. Within the last three months, the entire building has been in-serviced on abuse. When abuse is witnessed, staff have to immediately report to the Abuse Coordinator. For resident-to-resident abuse, staff separate the residents, they are put on one-to-one, staff do a room change, we notify family, physician, police, IDPH (Illinois Department of Public Health). We hospitalize as needed, investigate, and conduct interviews (staff and residents), conclude investigation and act accordingly, notify IDPH of final conclusion. For the incident involving (R6) and (R9), (R9) woke up to go to the bathroom. (R6) got startled and got out of bed quickly. (R9) got startled and agitated and (R9's) shoulder made contact with (R6). Staff heard something coming from the room and went to the room. Staff did not witness anything. (R9) was relocated to a different room. (R9) bumped into (R6) in the middle of the night when going to the bathroom. On 8/14/25 at 3:10 PM, V22 (Certified Nursing Assistant) stated V22 just started working in the facility, part-time, overnights. The nurse told me there was a fight between the two residents (R6 and R9) and there would be a room change. I did not hear or witness anything. I accompanied the resident to the new room. I don't remember the name of the resident I accompanied. The resident did not say anything about what happened. On 8/15/25 at 10:16 AM, V23 (Licensed Practical Nurse) stated, (V33, Certified Nursing Assistant) notified me that (R6) was getting up from bed. (V33) was in the hallway and saw (R6) coming towards the door. I asked (R6) 'what is the problem'. (R9) was getting up from bed to go to the bathroom. (R6) was thinking (R9) was coming to (R6), so (R6) stood up from the bed, and (R9) thought (R6) was coming for (R9). They each thought the other was coming for them. (R9's) arms were swinging and bumped (R6). (R6) told me (R9) touched (R6) on the shoulder and in the face. (R9) told me that (R9) was trying to maneuver around (R6) to go to the toilet. I assessed both of them, separated them, and put them on one-to-one. Because (R6) stated (R6) was touched in the face, the Medical Doctor ordered for (R6) to be sent to the hospital for evaluation. (R6) refused. We called the police. They came. (R6) refused to go to the hospital. (R9) was not sent to the hospital. I observed drainage from (R6's) eyes. R6's Nurses progress note, dated 6/26/25 at 07:27, reads: Resident had altercation with roommate. Writer observed resident bleeding from left eye. Resident stated roommate choked resident on the neck. The writer cleaned the resident's bleeding with normal saline and moved resident to another room. Psych doctor was notified and ordered resident's transfer to hospital for medical evaluation and send roommate to hospital for psych evaluation. Paramedics came to pick up resident, but resident refused to go to hospital. Police was called (sic) and came to talk to resident, but resident also refused. Police acknowledged they will come back whenever the resident change mind (sic). Currently resident is sleeping, no bleeding at this time and we will continue to monitor. Nurses progress note, dated 6/26/25 at 16:15, reads: Concerned of resident having difficulty opening eyes with mild drainage, mild swelling and bruising on left eye likely due to prior incident R9's Behavior progress note, dated 6/26/2025 at