

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2025
NAME OF PROVIDER OR SUPPLIER Aperion Care Lakeshore		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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

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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 - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent and protect residents from physical abuse. This failure affected one (R3) out of three residents reviewed for abuse. This failure resulted in R2 sustaining a closed fracture of orbital wall. Findings include: R3's admission record shows admission date on 12/31/24, with diagnoses not limited to Chronic Kidney Disease, Hypo-Osmolality and Hyponatremia, Hypokalemia, Osteoarthritis, Hypertension, Other Abnormalities of Gait and Mobility, Fracture of Other Specified Skull and Facial Bones, Left Side, Initial Encounter for Closed Fracture (added 09/14/25). R3's MDS (Minimum Data Set), dated 06/26/25, reveals R3 is cognitively intact and requires supervision or touching assistance for mobility. R3 has a care plan initiated on 01/03/25 stating he is at risk for abuse/neglect and will be cared for in a safe manner. R6's admission record shows admission date on 06/27/25, with diagnoses not limited to Psychotic Disorder with Delusions due to Unknown Physiological Condition, Unspecified Dementia with Other Behavioral Disturbance, Alcohol Dependence with Withdrawal, Bipolar Disorder, Anxiety Disorder. R6's MDS, dated [DATE], indicates R6's cognition is moderately impaired and R6 has adequate vision. R6's Admission/re-admission Observation Assessment, dated 09/08/25, documents R6 requires supervision or touch assistance with mobility and R6's Activities of Daily Living care plan indicates R6 requires supervision with mobility. R6 has a care plan in place for verbal aggression initiated on 08/12/25 which documents, (R6) has the potential to be verbally/physically aggressive/threatening staff and others related to ineffective coping skills, mental/emotional illness, and poor impulse control. R6 has a care plan for diagnosis and history of severe mental illness as manifested by delusions-paranoia. R6's electronic health records reveal R6 was hospitalized from [DATE] to 08/15/25 due to verbally threatening facility staff by saying, I will beat your ass. Bit** ass nig**. R6's admitting hospital diagnosis for this hospitalization was aggressive behavior. R6 was also hospitalized from [DATE] to 09/01/25 due to increased agitation and odd behavior of defacing facility property with gang signs and attempting to smoke in his room. R6's admitting hospital diagnosis for this hospitalization was for acute psychosis. R6 was also hospitalized from [DATE] to 09/08/25. On 09/02/25, R6 was threatening to hurt staff inside and outside the facility and searching for staff with an object in his hand saying he was going to hit the staff with it. R6's hospital admitting diagnosis for this hospitalization was aggressive behavior. R6 readmitted to the facility on [DATE]. On 09/08/25 at 11:45 AM, R3 was in the lounge sitting in a chair. R3 had black and blue marks under R3's right eye and right eye was bloodshot. R3's response to questions was garbled, with R3 mumbling in a low voice which was difficult to understand. R3 provided responded to questions with short responses. R3 stated he does not remember what happened to his eye. R3 indicates he did not fall and was not pushed. When asked if R3 remember R6, R3 said, maybe. R3 stated R6 did not bump into him or push him. When asked if anyone punched R3, he said, I'm not sure. On 09/18/25 at 8:20 AM, V36 (Housekeeper) stated via an interpreter, V29 (Food Service Director), on 09/09/25, V36 was cleaning a resident's room on the 4th floor when she heard a thud sound, so she went to see what was going on. V36 stated when she went to the 4-North Lounge, she saw R3 lying on his back on the floor and R6 was on top of R3. V36 stated she ran to get help. On 09/16/25 at 2:39 PM, V19 (Social Service Director) stated he was doing rounds on the 4th floor on 09/09/25 and while in the 4-North Lounge, he saw R6 walk into the dayroom aggressively. V19 remembers R3 was the only resident in the lounge at that time. V19 stated R6 was angry and walking quickly. V19 stated at that time, R3 in the process of getting up from his chair, and V19 saw R6 aggressively bump into R3 causing R3 to fall to the ground. V19 stated he asked R6 what was going on and R6 told V19, I'm mad, man. I'm mad. I'm pissed off and I don't want to talk. I'm pissed off. I'm pissed off. V19 stated R6 was not specifically going after R3, it is just that R3 was in the wrong place at the wrong time. V19 stated R6 was angry about something leading up to this, but he does not know what happened. V19 stated the goal is to always protect the residents to keep them safe and free from abuse. V19 stated R6 did make physical contact with R3, which is considered abuse. On 9/17/25 at 12:45 PM, V19 reenacted what he saw on 09/09/25 in the 4-North Lounge with the surveyor acting as R3 and V19 acting as R6. V19 stated it looked as if R3 was in the process of getting up from a chair when R6 made physical contact with R3. V19 acting as R6 charged head on directly toward surveyor as surveyor was attempting to get up from a chair. V19 demonstrated how the front of R6's right shoulder area made contact with R3's face. V19 stated this is what caused R3 to fall, but he not sure if R3 fell backwards or forward. V19 stated R6 was mad and there was some type of trigger that caused R6's anger, but he does not know what it</p>		