STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Westchester	2901 South Wolf Road Westchester, IL 60154

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their abuse policy by not reporting an allegation of physical abuse to the Illinois Department of Public Health's Regional Office for one out of three residents reviewed for abuse in a total sample of nine. Findings Include: R4 is a [AGE] year old with the following diagnosis: spastic quadriplegic cerebral palsy, chronic kidney disease, heart failure, mild cognitive impairment, and contracture of the right hand and wrist. On 5/27/26 at 12:52PM, R4 was able to state name and birthdate correctly. R4 stated the date was 5/20/16 and R4 was in [NAME], IL. When asked if R4 has any issues or concerns in the facility, R4 stated no. When asked if R4 felt safe in the facility, R4 stated no. R4 reported a lady tried to drown R4 in the shower last week. R4 was unsure of the exact date and was unable to name the CNA. R4 described the CNA as a black female with long black hair. R4 reported the CNA sprayed R4 in the face with the water hose. R4 stated R4 was able to breath while being sprayed but did have some coughing throughout the day. R4 was unable to state how long the CNA sprayed the water in R4's face. R4 denied telling the CNA to stop spraying R4 in the face or telling the CNA that it was too much water. R4 also denied telling any other staff about the incident in the shower. When asked why R4 didn't tell the CNA to stop spraying or why R4 didn't report the incident to management, R4 said, I forgot. R4 stated R4 knows to report all concerns to the administrator and was able to state the administrator's name. R4 reported this is the only time this CNA has ever been rude to R4. When asked if the CNA said anything to R4 during the shower, R4 stated the CNA told R4 that since the CNA had gotten into it with R4's mom the CNA was going to hurt R4 and didn't like R4. When asked what R4 meant by gotten into it, R4 reported the CNA and R4's mom had a fight about what took place in the shower. When asked if there was any other incident that took place before the shower, R4 said, no. R4 was unaware of R4 and R4's mom had any altercations before the shower incident. R4 denied working with the CNA since the shower incident. R4 denied being aware if the facility reported the incident to Illinois Department of Public Health. On 5/26/26 at 2:24PM, V9 (CNA) stated R4's family member began having issues with V9 when V9 told the family member to get out from behind the nurse's station because private information from for residents was behind the nurse's station. V9 reported V9 and V2 gave R4 a shower without any issues. V9 stated R4's family member came into the facility that same evening about 8 PM and immediately called the police after finding out V9 worked with R4. V9 stated R4's family member reported to the police that V9 tried to drown R4 by spraying water in R4's face. V9 denied ever being suspended pending an investigation. On 5/27/26 at 1:05PM, V18 (DON) stated the facility did an internal investigation on the allegations R4's family member reported against V9. V18 reported R4 was unable to verbalize the same story the family member was reporting to staff. V18 stated R4 did not have any breathing or choking issues so they did not send in an official report to IDPH. On 5/27/26 at 1:31PM, V19 (Administrator) stated the facility has a long history of R4's family member's behavior. V19 reported V9 gave R4 a shower with another CNA present due to past allegations. V19 stated R4's family member saw V9 when visiting that evening and fabricated the story to get V9 terminated. V9 stated R4's family member called the police and spoke with the police about the allegation, but R4 (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	denied any issues during the shower. V19 reported there was no indication that any abuse occurred. V19 stated V19 did an internal investigation for this incident. V1 denied sending in the incident report to Illinois Department of Public Health's Regional Office because R4 was able to verbalize that R4 was fine and the police did not do anything when they were called. A Behavior note dated 4/21/26 documents R4's family member was being verbally aggressive by the nurse's station and started shouting at a particular CNA. The nurse was able to redirect the family member. The nurse stated R4 was OK and had no concerns. R4 had a shower and no unusual behaviors were noted during the shower. The family member called police because the family member did not like the CNA. The family member was redirected and R4 remains at baseline.The Facility Reported Incident with the date of the occurrence being 4/21/26 documents the incident category as resident abuse. The incident description reports that R4's family member alleged that V9 put water on R4's face. R4's family member reported the incident to the police. V9 was not assigned to R4. R4 was interviewed and stated V9 did not attempt to drown R4 but had just washed R4's face. R4 is at baseline and had no concerns. V9 was interviewed and stated V9 showered R4 around 7:00 AM with assistance of another CNA. V9 denied any incidents occurred and once R4 was bathed, R4 was dressed and stayed in the dining room. Another staff member was near the area during the shower and did not hear R4 scream out or see any incidents during the shower. There is a care plan for R4 in regards to R4's family members who has poor boundaries. Social services checked on R4 to monitor psychosocial and emotional well-being. R4 remained at baseline for mood and behavior and feel safe in the facility. This report was not sent to Illinois Department of Public Health's Regional Office. This was documented as an internal investigation.The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as 6 (severe cognitive impairment). The policy titled, Abuse and Retaliation Prevention and Reporting- Illinois, dated 1/8/26 documents, . Abuse means any physical or mental injury; retaliation; or sexual assault inflicted upon a resident other than by accidental means. Internal Reporting Requirements and Identification of Allegations - Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, exploitation, retaliation, mistreatment, or appropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or a compliance officer. Reports will be documented, and a record will be kept of the documentation. Any allegation of abuse, retaliation, or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.