STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145830	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care West Chicago	201 West North Avenue West Chicago, IL 60185

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** 48944 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse. This applies to 2 of 3 residents (R1 and R3) reviewed for resident-to-resident physical abuse. The findings include: The facility's 4/29/2025 Facility Reported Incident showed On 4/16/2025 resident [R2] had an altercation with her roommate [R1]. Staff immediately separated . On 5/01/2025 at 11:30 AM, R2 was in bed. R2 was confused and unable to be interviewed. R2's EMR (Electronic Medical Record) showed she had multiple diagnoses including paranoid schizophrenia, dementia with anxiety, and major depressive disorder. R2's MDS dated [DATE] showed R2 was cognitively impaired. R2's MDS also said she had symptoms of being short-tempered and easily annoyed nearly every day. R2's care plan initiated on 3/06/2018 documented, I have a hx (history) of becoming physically and verbally aggressive with my peers and staff due to my medications/treatment noncompliance, poor coping skills, and diagnosis of mental illness. The care plan said R2 had become aggressive towards a peer in 2023 and on 4/07/2021 also struck a peer on the shoulder. R2's progress note dated 4/16/2025 from V7 (Psychiatric Nurse) said Psych NP notified about increased aggression irritability and explosive behaviors, received new order to reinstate Haldol 5 mg PO and IM Q 12 HRS, and cont to monitor. R1's MDS (Minimum Data Set), dated 4/07/2025, documented R1 was cognitively intact. On 5/01/2025 at 11:00 AM, R1 said on the morning of 4/16/2025, R2 hit her on the right side of the face and head with her closed fist. R1 said R2 was unprovoked when she started yelling and then hitting her. R1 said she did not sustain an injury, but had pain 6 out of 10 (10 being the worst). R1 said then R2 left the room and hit R3. R1 said she reported the incident to V10 (Registered Nurse/RN) and her daughter. R1 said V1 (Administrator) and the local police then interviewed her regarding the incident. R1 said she felt abused after R2 physically assaulted her. R1 said she felt safe after R2 was moved to a secure unit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/01/2025 at 1:00 PM, V10 (RN) said R1 reported to him on 4/16/2025 that R2 attacked her in the room. V10 said he reported the incident to the facility's administration. R3's MDS dated [DATE] said R3 was cognitively intact. On 5/01/2025 at 11:15 AM, R3 said on 4/16/2025 around noon, R2 approached her at the nurses' station and unprovoked, started to hit her on the right side of the head with her closed fist. R3 said she did not sustain an injury, but had pain 7 out of 10. R3 said the nursing staff that was present then took R2 to her room. R3 said she reported the incident to V6 (Social Worker/SW), V14 (SW), and V12 (Certified Nurse Assistant/CNA). R3 said she felt safe after R2 was moved to a secure unit. On 5/01/2025 at 3:40 PM, V12 (CNA) said R3 reported to her on 4/16/2025 that R2 had hit her. V12 said she reported the incident to the nurse on duty. On 5/01/2025 at 2:00 PM, V1 (Administrator) said he was the Abuse Coordinator and investigated the incidents involving R1, R2, and R3. V1 said R2 was agitated when she hit R1 and R3 on 4/16/2025. V1 said R2 was moved to a secured unit for behavior management after the incidents to ensure no further incidents occurred. V1 said the facility's abuse policy considers abuse when an incident results in a resident being in pain or physical or emotional anguish. The facility's policy titled Abuse Prevention and Reporting, dated 10/24/2022, documented, This facility affirms the right of our residents to be free from abuse .In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment .Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach .Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental accidental actions. Physical abuse includes hitting slapping, pinching, kicking .