

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145830	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/22/2025
NAME OF PROVIDER OR SUPPLIER  Aperion Care West Chicago		STREET ADDRESS, CITY, STATE, ZIP CODE  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 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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to report an abuse allegation. This applies to 1 of 3 (R1) residents reviewed for reporting abuse allegations. The findings include: On October 17, 2025, multiple requests were made for abuse allegations for October 2025 to V1 (Administrator) and V2 (DON/Director of Nursing), with none provided. On October 17, 2025 at 1:50 PM, R1 said she was in pain a lot and it hurt her when she was changed, especially when V3 (CNA/Certified Nurse Assistant) would change her. V3 said she told the staff she was in pain because she felt they pull and hurt her when they change her. R1 said when V3 changed her, she would lift her leg high up, and when she would say she was in pain, V3 would apologize. R1 said she told the nurse she did not want V3 to care for her anymore. The EHR (Electronic Health Record) shows R1 was admitted to the facility with diagnoses including hemiplegia and hemiparesis, major depressive disorder, seizures, persistent mood (affective) disorder, generalized osteoarthritis, contracture of the left hand and left ankle, and schizophrenia. R1's MDS (Minimum Data Set) dated October 2, 2025 showed R1 was cognitively intact and was dependent on staff for showers/bathing. On October 17, 2025 at 3:46 PM, V3 (CNA) said she was the CNA on duty on October 11, 2025. V3 said she gave R1 a shower and after the shower, was approached by V9 (Nurse) saying R1 complained about the care. V3 said she was called by V10 (Psychotropic Nurse/Manager on Duty). V3 said she was sent home because when someone reports you, they send the staff home because of the investigation. On October 17, 2025 at 4 PM, V10 said he was the manager on call on October 11, 2025. V10 said there was an incident where the nurse called and said V3 had an issue with R1. V10 said she notified V2 (DON/Director of Nursing) and she called the consultant, who advised him to suspend the CNA. V10 said they got a statement from R1, and a body check was completed. V10 said the nurse filled out a grievance form with R1 and the plan was for management to do a further investigation. V10 said he was not sure what happened after regarding the investigation. On October 17, 2025 at 3:05 PM, V7 (CNA) said he was the second assist for R1's shower on October 11, 2025. V7 said he heard V3 was told to leave the shift pending the investigation. On October 21, 2025 at 9:45 AM, V9 (Nurse) said she was R1's nurse on October 11, 2025. V9 said she was passing medications when she heard R1 crying and when asked what happened, R1 told her she was given a shower in the shower stretcher and the CNA was rough with her. V9 said she reported it to the supervisor right away and the supervisor sent her home, and they would start an investigation. V9 said she was not interviewed by anyone, including V1 (Administrator) or V2 (DON) regarding the allegation by R1. On October 17, 2025 at 2 PM, V4 (CNA) said she worked on October 11, 2025, and R1 complained to her that V3 put cold water on her and pulled her arms and legs. V4 said she thinks V3 was trying to wash her face and maneuver her on the shower bed but did not take into account R1's painful sides. On October 17, 2025 at 2:06 PM, V5 (CNA) said she worked on Saturday, October 11, 2025, and she heard R1 crying and yelling loudly in the shower room. V5 said R1 told her V3 pulled her arms and legs and put cold water on her face. V5 said she knew the nurse started the investigation. V5 said she gave a statement to the administrator about the incident. On October 21, 2025 at 11:16 AM, V5 said she wrote a statement about the incident. On October 21, 2025 at 11:11 AM, V6 (CNA) said she wrote a statement and put it in V1's mailbox, which was what they did when an incident happened. V6 said the incident should be reported. V6 said she felt the situation was abnormal because of the way R1 was crying after coming from the shower. V6 said V3 was sent home. On October 17, 2025 at 2:17 PM, V2 (DON) said she did not work on October 11, 2025, but was called by V10 and notified of the incident. V2 said she was told R1 received a shower in the shower bed but wanted it in the shower chair. V2 said V10 said R1 complained of pain, and she instructed the nurse to do an assessment to check for bodily injury. V2 said she contacted the consultant, and a grievance form was written regarding the shower. V2 said V1 (Administrator) was notified and did not respond to the allegation until Monday. V2 said V1 spoke with R1 and interviewed the staff. V2 said to ask V1 for the information regarding the investigation. V2 said if there was an issue with the staff and residents, their protocol was to suspend the staff and investigate what happened. V2 said it was not really an abuse investigation. V2 said she had not received any written statements from the staff. On October 21, 2025 at 2:45 PM, V1 (Administrator) said he was not working on October 11, 2025 and saw the messages regarding the incident late on Saturday night. V1 said R1 had a history of pain and complaining about pain. V1 said the staff told him R1 screamed of pain, especially in the leg, and more recently complained about pain in the abdomen and back. V1 said he was told V3 and V7 were giving R1 a shower and she was screaming about the pain in her leg in the shower. V1 said R1</p>		