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	01/31/2026

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 - 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** Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from resident-to-resident physical abuse. This failure resulted in a resident experiencing severe shoulder pain with a possible fracture, and subsequent psychosocial harm. This applies to 1 of 2 residents (R131) reviewed for abuse in a sample of 38. The findings include: R131's Electronic Medical Record (EMR) indicated that progress notes, dated 1/18/2026, documents at approximately 10:15 PM, R131 was suddenly attacked by another male resident (R200) without provocation when R200 attempted to place his arm around R131's neck. V9 (RN) documented that he and another resident (R37) intervened and were able to separate the two residents, and that R200 stated, I'm not on for the 3rd floor (secure unit), adding, I'm here for murder, which was also heard by R131. On 1/20/2026 at 6:11 AM, V12 (LPN) documented that R131 reported 8/10 left shoulder pain, for which PRN Acetaminophen-Codeine was administered; assessment revealed stinging pain with upward shoulder movement. R131's Minimum Data Set (MDS) dated [DATE] reflects that his cognition was intact. R200's Orders-Administration Note by V9, dated 1/18/2026 at 11:33 PM, states R200 was agitated, impulsive, and aggressive toward another male resident. On 1/27/2026 at 10:37 AM, R131 was observed sitting in bed, holding his left shoulder and wincing in pain. R131 reported a history of chronic cervical and back pain from a decades-old accident but stated his left shoulder pain was new and began after the incident on 1/18/2026. R131 described his pain as severe, rating it as 8 to 10 out of 10 on the pain scale (with 10 being the worst pain he had ever experienced). R131 said he was holding a cup and standing in front of the ice machine when R200 suddenly charged at him, grabbed him, placed both arms around his upper torso, and put him in a headlock. R131 reported being caught off guard and unable to defend himself. He stated the pain in his left shoulder had not been relieved by his current pain medications and he had been requesting an X-ray and to be sent to the hospital to assess the injury. On 1/27/2026 at 10:48 AM, R145 (R131's Roommate) confirmed the events of the night of R131's attack. R145 said R37, another resident in their hallway, was the first to intervene to separate R200 from R131. R145 reported the incident was unprovoked and noted R131 appeared to be in significant pain and distress following the event. The staffing assignment sheet for 1/18/2026 indicated V8 (RN-Registered Nurse) was assigned as R200's nurse. V9 (RN) was assigned as R131's nurse, and V10 (CNA-Certified Nursing Assistant) was the CNA assigned to the unit that evening. On 1/28/2026 at 11:42 AM, V8 (RN) said on the evening shift of 1/18/2026, she heard screaming and observed R200 physically holding R131's neck area. V8 stated R200 had to be moved to the facility's secure unit due to his aggressive, unprovoked behavior towards R131. V8 classified the incident as physical abuse. On 1/28/2026 at 1:48 PM, V10 (CNA) said she saw R200 approach R131 and attack him. V10 stated R131 was screaming as R200 aggressively put his arms around R131's upper torso and shoulder area. V10 described the altercation as physical abuse. An X-ray was ordered, and the result was reported to facility on 1/28/2026. The result (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	showed an acute or subacute glenoid fracture of the left shoulder. On 1/28/2026 at 10:48 AM, V13 (ADON-Assistant Director of Nursing) documented radiology results showing linear bone density inferior to the glenoid consistent with an inferior glenoid fracture fragment, prompting a physician order to send R131 to the hospital. V1 (Administrator) and V2 (DON-Director of Nursing) stated R131 returned to the facility without hospital paperwork and were unable to provide R131's hospital discharge paperwork prior to the end of the survey. On 1/29/2026 at 12:05 PM, R131 reported continued pain, rating it 8 out of 10 (severe), increasing to 10 out of 10 with sideward shoulder extension. R131 described the pain as unbearable. On 1/29/2026 at 12:27 PM, V36 (RN) assessed R131 and confirmed compromised ROM (Range of Motion) to his left shoulder and severe pain. On 1/29/2026 at 12:45 PM, R131 stated since the incident on 1/18/2026, he had been feeling on edge, anxious, and preoccupied with what had happened. R131 reported he remained deeply disturbed by R200's statement of I'm here for murder, which he had heard R200 say during the altercation. R131 stated R200's remark plays over and over in his mind and causes fear and distress. R131 state he was afraid of encountering R200 again and he was now hesitant to use common areas of the facility, including the ice machine and hallway where the abuse occurred. During the interview, R131 was observed pacing back and forth in his room, appearing restless and visibly tense when recounting the event. He stated his pain and fear made it difficult for him to sleep, he had been waking frequently at night, and he felt more depressed and withdrawn than usual. R131 reported he no longer felt safe in the facility and expressed concern a similar incident could happen again. On 1/29/2026 at 10:46 AM, an interview was conducted with V14 (In-house NP - Nurse Practitioner), and on 1/30/2026 at 9:37 AM, an interview was conducted with V34 (Psychiatric NP). Both stated pain is a subjective experience, meaning it is based on the resident's personal perception and report rather than solely on observable or objective findings. They emphasized regardless of a resident's mental or psychiatric status, if a resident reports pain, it must be taken seriously, appropriately assessed, and treated as real pain. V34 further explained that the symptoms reported to her regarding R131 following the 1/18/2026 altercation - including heightened anxiety, hypervigilance, disrupted sleep, and worsening mood - were not consistent with his baseline presentation. V34 explained that these symptoms are characteristic of an acute traumatic response to a threatening event, particularly when the resident continues to experience ongoing physical pain and fear of recurrence. V34 stated such a response can manifest as rumination about the incident, avoidance of common areas, sleep disturbance, emotional withdrawal, and increased distress, and may warrant additional psychiatric support, monitoring, or interventions. V34 further emphasized psychological distress, like pain, is a subjective experience, and clinicians must take a resident's report of distress seriously rather than discount it based solely on objective findings. On 1/28/2026 at 3:12 PM, V1 (Administrator) stated he reviewed the facility's security camera footage from 1/18/2026 and observed R200 making contact with R131. Per V1, the video showed R200 with his arms around R131 after approaching him from behind. V1 also confirmed he is the facility's Abuse Coordinator, and he was made aware of the incident on the night it occurred. V1 stated if a staff member had attacked a resident in the same manner as R200 attacked R131, he would consider that to be physical abuse and a reportable event. The facility's policy titled Abuse and Retaliation Prevention and Reporting (effective 1/8/2026) states, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish to a resident. The policy also showed Physical abuse (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interview, and record review, the facility failed to identify abuse, investigate an incident of resident-to-resident abuse, implement interventions to prevent further recurrence, and report the incident. This applies to 2 of 2 residents (R131 and R200) reviewed for abuse in a sample of 38. The findings include: On 1/27/2026 at 10:37 AM, R131 was observed sitting in bed, holding his left shoulder and wincing in pain. R131 stated he was experiencing severe left shoulder pain that began on 1/18/2026 when he was physically attacked by R200. According to R131, R200 suddenly charged at him, grabbed him, and placed both arms around his upper torso, putting him in a headlock. On 1/28/2026 at 3:12 PM, V1 (Administrator/Abuse Coordinator) stated he had reviewed the facility's security camera footage from 1/18/2026 and confirmed he was made aware of the incident that night. V1 described the footage showed R200 approaching R131 from behind and placing both arms around his upper torso. V1 stated he did not report the incident to the Illinois Department of Public Health (IDPH) at that time because he did not believe it met the facility's definition of abuse, reasoning there was no serious injury, bodily harm, or psychosocial effects. V1 further acknowledged the incident was not reported to IDPH until 1/27/2026, nine days later. He indicated an internal investigation had not yet been conducted but would be initiated. Requests for staff statements, interviews and/or any other documentation related to the incident (including incident reports), had been made; however, the facility was not able to provide any of these records prior to the end of the survey. Review of R131's EMR (Electronic Medical Record) shows following the 1/18/2026 incident, R131 did not have new care plan interventions or protective measures initiated to address the outcomes of the incident, including severe left shoulder pain and psychosocial distress (which he verbalized experiencing on 1/29/2026 at 12:45 PM). R131's care plan had not been updated following the incident. Care plan sections related to abuse (created 1/29/2026) and psychosocial wellbeing, including mood triggers (created 1/27/2026), were added only during the survey. Review of R200's EMR shows diagnoses including anxiety disorder, insomnia, schizophrenia, and schizoaffective disorder. R200's care plan had not been updated after the incident involving R131. Care plan sections related to mood triggers (created 1/30/2026), abuse (created 1/28/2026), behaviors (created 1/28/2026), and physical and verbal aggression (created 1/28/2026) were added during the survey. The facility's policy titled Abuse and Retaliation Prevention and Reporting (effective 1/8/2026) states The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse.and mistreatment of residents This will be done by: identifying occurrences and patterns of potential mistreatment immediately protecting residents involved in identified reports of possible abuse .implementing systems to promptly and aggressively investigate all reports and allegations of abuse .and making necessary changes to prevent future occurrences .filing accurate and timely investigative reports The policy further states: Any allegation of abuse, retaliation, or any accident resulting in serious bodily injury be reported to IDPH immediately, but no more than two hours after the allegation, [and that] any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to conduct a thorough investigation of physical abuse between 2 residents. This applies to 2 of 2 residents (R131 and R200) reviewed for abuse in a sample of 38. The findings include: On 1/27/2026 at 10:37 AM, R131 was observed sitting in bed, holding his left shoulder and wincing in pain. R131 stated he was experiencing severe left shoulder pain that began on 1/18/2026 when he was physically attacked by R200. According to R131, R200 suddenly charged at him, grabbed him, and placed both arms around his upper torso, putting him in a headlock. On 1/28/2026 at 3:12 PM, V1 (Administrator/Abuse Coordinator) stated he reviewed security camera footage from 1/18/2026 and confirmed awareness of the incident that night. V1 stated he did not report the incident to IDPH (Illinois Department of Public Health) at that time because he did not believe it met the definition of abuse, reasoning there was no serious injury, bodily harm, or psychosocial effects. V1 further acknowledged the incident was not reported to IDPH until 1/27/2026. Review of V1's Initial Report to IDPH regarding the physical altercation involving R131 and R200 included a fax confirmation sheet indicating it was sent on 1/27/2026 at 2:59 PM. The report confirmed a date of occurrence of 1/18/2026 and stated the incident category as Resident Abuse. The reported also stated, Facility will conduct a thorough investigation with complete report to follow, indicating an investigation had been initiated 9 days later. The facility's policy titled Abuse and Retaliation Prevention and Reporting (effective 1/8/2026) states, The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse.and mistreatment of residents. The policy also states: All incidents will be documented, whether or not abuse, neglect.was alleged or suspected as any incident or allegation involving abuse. will result in an investigation and that upon learning of the report, the administrator or designee shall initiate an incident investigation. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident, and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical record or other documents.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure pain assessment and management was provided for a resident's new onset of pain. This applies to 1of 1 resident (R131) reviewed for pain management in a sample of 38. The findings include: On 1/27/2026 at 10:37 AM, R131 was observed sitting in bed holding his left shoulder and wincing in pain. R131 reported his shoulder pain began ten days earlier on 1/18/2026 following a physical altercation with another resident. R131 described his left shoulder pain as severe, rating it 8-10/10, with 10 being the worst pain he has ever experienced. R131 stated his current pain medication was not relieving his left shoulder pain and he had been requesting an X-ray and transfer to the hospital to have the injury evaluated. Review of R131's N Adv - Long Term Care Evaluation documented a pain level of 8, categorizing it as severe, with indicators including vocal complaints of left anterior shoulder pain and facial expressions consistent with pain. The assessment identified this as a new issue and further documented the pain as sharp and non-radiating. Additionally, R131's MDS (Minimum Data Set) dated 10/23/2025 documented that prior to the incident, his pain had been mild, occasional, and did not affect sleep. The MDS also noted that R131's cognition was intact, with no behavioral issues or limitations in bilateral upper extremity Range of Motion (ROM). R131's Physician Order Sheet (POS) and Medication Administration Record (MAR) showed:Acetaminophen-Codeine Oral Tablet 300-30?mg - Give 1 tablet every 9 hours as needed for pain (ordered 11/26/2025). The January 2026 MAR documented 11 administrations after the 1/18/2026 incident, on the following dates: 1/18/2026, twice on 1/20/2026, 1/21/2026, 1/22/2026, twice on 1/23/2026, 1/26/2026, 1/28/2026, and twice on 1/29/2026; andTylenol Extra Strength 500?mg (Acetaminophen) - Give 2 tablets by mouth every 6 hours as needed for back pain. The January 2026 MAR showed 3 administrations after the incident, on 1/26/2026 and twice on 1/27/2026. R131's Pain Level Summary from 1/18/2026 to 1/30/2026 showed R131's pain levels were documented as severe (7 to 10 out of 10 on pain scale) on 1/22/2026, 1/24/2026, 1/26/2026, 1/28/2026, and twice on 1/29/2026, and were documented as moderate (4-6 out of 10 on pain scale) on 1/18/2026, 1/20/2026, 1/21/2026, 1/23/2026, 1/25/2026, 1/26/2026, and twice on 1/27/2026. On 1/29/2026 at 12:05 PM, R131 stated that although medications were being administered, he still experienced severe left shoulder pain since the 1/18/2026 incident. On 1/27/2026, an X-ray was scheduled after V2 (DON-Director of Nursing) was asked about the plan to address R131's ongoing left shoulder pain. R131's 1/28/2026 X-ray results showed findings consistent with a left glenoid fracture and R131 was sent to the Emergency Department. On 1/29/2026 at 10:46 AM, an interview was conducted with V14 (In-house NP-Nurse Practitioner) and on 1/30/2026 at 9:37 AM, an interview was conducted with V34 (Psychiatric NP). Both stated pain is a subjective experience, meaning it is based on the resident's personal perception and report rather than solely on observable or objective findings. They emphasized regardless of a resident's mental or psychiatric status, if a resident reports pain, it must be taken seriously, appropriately assessed, and treated as real pain. V34 explained for residents with psychiatric diagnoses, such as R131, uncontrolled pain can act as a trigger that exacerbates anxiety, agitation, or emotional distress, and therefore must be promptly assessed and addressed. V34 stated failing to adequately evaluate or manage a resident's reported pain could contribute to worsening psychological symptoms and an overall decline in wellbeing. On 1/29/2026 at 12:27 PM, R131 continued to report ongoing left shoulder pain, rating it 8/10 (severe), which increased to 10/10 with sideward shoulder extension. R131 again stated his current pain medication that he had been receiving prior to the 1/18/2026 incident, was not effective in relieving his left shoulder pain. V36 (RN) assessed R131, acknowledged his severe left shoulder pain, confirmed compromised range of motion (ROM) to his left shoulder, and stated she would notify the provider (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the pain was not relieved by R131's current pain regimen, adding she would ask about an Occupational Therapy (OT) evaluation. On 1/30/2026 at 10:14 AM, V2 (DON) stated her expectation is for nursing staff to assess residents' pain levels, including determining whether the pain is new and whether it is relieved by current interventions. V2 further stated any pain rated above 6 out of 10 on the pain scale is considered severe and requires immediate action. She explained if the current medications are insufficient, nursing staff are expected to offer available PRN (as needed) medications as appropriate and notify the provider. The facility's policy titled Pain Management Program (Revised 7/6/2018) states the purpose of the policy is to establish a plan to manage pain in order to reduce adverse physiologic and psychological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. The policy further outlines that the pain management program includes the following components:Documentation of pain assessment and ongoing monitoring;Informed resident participation in care decisions, including decisions related to pain management;Recognition of pain as the fifth vital sign, along with temperature, pulse, respiration, and blood pressure. The facility's policy also specifies that the pain assessment protocol must be initiated whenever there is a change in the resident's condition that requires pain control or when there is a change in the identification of pain. Per policy, care plans must be reviewed and updated whenever the resident's pain management plan is found to be ineffective and at least during each quarterly care conference. Lastly, the policy requires documentation of the resident's response to the pain management plan to ensure ongoing evaluation and effectiveness.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to serve meals at palatable temperatures.This applies to all residents who receive food from the kitchen.The findings include:The CMS (Centers for Medicare and Medicaid Services) shows the survey start date of 1/27/26 and a resident census of 211. On 01/30/2026 at 2:39 PM, V2, DON (Director of Nursing), confirmed all residents residing in the facility at the time of survey start on 01/27/26 receive services from the Dietary department.On 01/27/2026 at 12:19 PM during the dining observation, R118 stated the food isn't always served to them while it is hot.R207 stated the food served is usually barely warm.R100 stated the meals are usually not served hot.On 01/27/2026 at 12:51 PM, R40 stated the food isn't usually served hot. R40 stated she will request staff to reheat her food, but she is told they can't reheat if for her. R40 stated staff will not get her a new tray from the kitchen, so she must eat it cold.On 01/28/2026 at 12:23 PM, food holding temperatures were done with V4, Dietary Director and V39 Cook. The following foods were noted held in degrees Fahrenheit (F): Broccoli- 100 degrees FSweet and Sour Pork carbohydrate-controlled Low Concentrated Sweets- 95 degrees FPlain Rice- 100 degrees FGrilled Cheese Sandwiches- 90 degrees FPureed Grilled Cheese- 120 degrees FCarrots- 120 degrees FPureed Broccoli- 120 degrees F On 01/27/2026 at 1:05 PM, the test tray sent to the conference room had two cookies, chili in a bowl, carrots, and crumbly corn bread on a Styrofoam plate.On 01/28/2026 at 12:23 PM, V4, Dietary Director, stated because of budget constraints, he is unable to purchase real plates, so the residents' meals are served on Styrofoam. V4 stated Styrofoam impacts how food temperatures are maintained. V4 stated there is no plate warmer and the delivery carts are not insulated, which also makes it difficult to maintain food temperatures. V4 stated there have been occasions he has gone to the units and meal trays are left unpassed up 20 minutes after being sent from the kitchen.The facility provided an undated policy which stated foods that are meant to be served and displayed for a long time require elevated temperatures for storage. Foods are held at 135 degrees F or above to stop the growth of harmful microorganisms and preserve food safety

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light system was working in resident rooms. This applies to 28 of 28 (R102, R6, R156, R103, R77, R47, R202, R4, R206, R13, R209, R171, R96, R108, R177, R52, R24, R25, R31, R44, R8, R19, R109, R183, R10, R90, R113, and R210) residents reviewed for call lights.On 1/27/2026 at 10:05 AM, R113 was in bed. R113 said he was extremely upset because his call light had not worked since yesterday. R113 said the facility reported they fixed the call system problem, but it frequently continued to malfunction, causing the call lights for his entire hall to stop working for extended periods of time. R113 pressed his call light, but it was not sending a call signal outside his door and to the nurses' station main panel. R113 said it was very upsetting because he had no way of getting assistance with his care needs and for emergency situations. R113's MDS (Minimum Data Set), dated 11/17/2025, said he was cognitively intact and required moderate to maximal staff assistance with his ADLs (Activities of Daily Living).On 1/27/2026 at 10:10 AM, R90 was in her wheelchair, upset. R90 said it was horrible trying to get assistance with her toileting needs because her call light was not working. R90 said the call lights stopped working yesterday and were yet to be fixed. R90 said the call lights in the hallway where she resided had frequently stopped working in the past month. R90 said it was a recurrent problem because the facility failed to fix it properly. R90 said it was difficult to request assistance, and she frequently had to resort to yelling or banging on the wall to get the staff's attention. R90's MDS, dated [DATE], said she was cognitively intact and required touch to substantial staff assistance with her ADLs.On 1/27/2026 at 10:20 AM, R19 was sitting on the bed, yelling for assistance. R19 was visually impaired. R19 continued to yell out louder for staff to assist him with his hydration. R19 became more upset because the staff was not responding to his call for help. R19's MDS, dated [DATE], said he had cognitive impairment and required moderate to maximal staff assistance with his ADLs.On 1/27/2026 at 10:15 AM, V17 (Certified Nurse Assistant/CNA) said she was assigned to the unit hall. V17 said when she started her morning shift, the room call lights for the unit were not working. V17 said they stopped working yesterday, and she was informed a company was scheduled to come today to fix the call light panel. V17 said residents in the unit were upset because it had also occurred a few weeks prior. V17 said she was not given further instructions on the facility's plan regarding monitoring residents while the call light system was not working.On 1/27/2026 at 10:30 AM, V15 and V16 (Maintenance Staff) said they had just fixed the main call light panel located at the nurses' station. They said the panel had a missing wiring connection, causing the call lights for some rooms to not work. They said V3 (Maintenance Director) informed them an outside company was coming to assess the panel because it was a recurrent problem. They continued to say there was no work order created but were informed the call lights stopped working yesterday at approximately 4:30 PM.On 1/29/2026 at 9:40 AM, V2 (Director of Nursing/DON) said the call lights for the hall would frequently stop working. V2 said she was unsure when they stopped working on 1/26/2026 but was informed an outside company came to assess the panel that evening but was unsure when they stopped working again that evening. V2 said the call light system needed to be working properly to ensure residents could be assisted with their care needs and for safety emergencies.On 1/29/2026 at 11 AM, V3 (Maintenance Director) said on 1/26/2026 at approximately 3 PM, the call lights on the unit for some rooms stopped working, and an outside vendor came at 6 PM to fix the panel. V3 said he was going to place another call on 1/27/2026, but the facility maintenance staff was able to rewire the panel at approximately 10:30 AM. V3 said the panel wiring had become faulty at a minimum of three times in the past month. V3 said he had no work order (continued on next page)

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	01/31/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	request logs for the call lights. The facility's untitled document, dated 1/26/2026, said staff rounded every 30 minutes on 1/26/2026 from 3 PM-6 PM. The document does not provide information regarding the type of rounds completed and for which residents. The document also does not show further entry logs from when the call light system stopped working again on the evening of 1/26/2026 through the morning of 1/27/2026.The facility's Daily Census report, dated 1/27/2026, showed R102, R6, R156, R103, R77, R47, R202, R4, R206, R13, R209, R171, R96, R108, R177, R52, R24, R25, R31, R44, R8, R19, R109, R183, R10, R90, R113, and R210 resided in the hall with the faulty call light system.The facility's policy titled Call Light, dated 2/2/2018, said the facility was to respond to residents' requests and needs in a timely and courteous manner. If needed, hand bells will be provided for alert dependent residents when positioned out of reach of the permanent call light when needed. Call bell system defects will be reported promptly to the Maintenance Department for servicing, and room checks will be done until the system is repaired.