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	05/27/2026

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 - 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** Based on interview and record review, the facility failed to keep residents free from verbal and mental abuse. This failure applies to 2 of 6 residents (R1 and R2) reviewed for abuse in a sample of 8 residents. The findings include: R1's EMR (Electronic Medical Record) shows R1 is a [AGE] year-old male with diagnoses that include a single episode of major depressive disorder, alcohol dependence in remission, insomnia, and peripheral vascular disease. R1's current care plan-initiated September 12, 2025, shows he has a history of verbal aggression and poor impulse control. R2's EMR shows R2 is a [AGE] year-old male with diagnoses that include anxiety disorder and problems related to social environment. On May 26, 2026, at 11:10 AM, R2 said there was altercation between him and R1 on May 14, 2026, at approximately 8:00 AM, in the dining room. R2 said R1 was teasing R5. He was making fun of his name by mispronouncing it. R2 said he could see that R5 was getting upset, so R2 asked R1 to stop it and pronounce his name correctly. A few minutes later, another resident, R6, jumped into the conversation and told R2 he heard R1 say he was going to get out of his chair and fight him. R2 said his response to R6 was that he would like to see R1 try it. R1 heard the comment and became angry and told R2 to bring it on you [profane derogatory name]. R2 stated R1 stood up and headed towards R2 to attack him. R2 said R1's words were verbally abusive and R1 was threatening to kill him. R2 said he was shaking and moving away when R1 attempted to attack him. R2 said R1 had threatened residents before, and he has seen R1 yelling and threatening other residents. R2 said he becomes nervous when R1 comes around during smoke breaks and he would be uncomfortable with R1 moving back to the floor he is located on. On May 26, 2026, at 12:32 PM, R1 said he and R2 had an altercation because R2 was up in his business. R1 said on May 14, 2026, in the dining room, R2 commented about R1 mispronouncing R5's name and this led to an argument. R1 said he was sitting across from V5 (Restorative Aide) talking and R2 was at another table staring him down. R1 said he stood up, threw off his jacket and lunged toward R2 and R2 said, C'mon I'm not afraid of you. R1 said he was going after R2. R1 said R2 fled, and he screamed out at R2 come back you little (profane derogatory name), I'll kick your ass. R1 said during the incident he went after R2 to throw a punch. On May 26, 2026, at 3:40 PM, R2 said since their altercation on May 14, he still gets paranoid each time R1 comes down for smoke breaks. R6 said she was present during R1 and R2's altercation and she heard R1 threaten to kill R2. On May 26, 2026, at 2:25 PM, V5 (Restorative Aide) said on May 14, 2026, he was sitting at a table with R1 in the dining area, facing and talking with R1. R2 was sitting at another table behind him when V5 said suddenly R1 stood up and threw off his jacket and moved towards R2 who was then standing behind him. V5 said he held R1 back from approaching R2 and R1 said to R2 I'll kill you. On May 26, 2026, at 11:59 AM, V3 (Psychosocial Rehabilitation Services Director) said on May 14, 2026, R1 and R2 had an altercation in the 1st floor common area. V3 said he responded to a code yellow (behavior code) that was called over the speaker system for an incident happening on the first floor. V3 when he arrived the staff had separated the residents. V3 went to R1's room where R1 was saying, someone needs to beat him up, he needs to learn. V4 (Psychosocial Rehabilitation Services Coordinator) was present during interview with V3 and said she was present during the incident (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 - Minimal harm or potential for actual harm Residents Affected - Few	between R1 and R2. V4 said R1 was verbally aggressive to R2, saying I'm going to (profane language) kill you or kick your ass. V3 said V5 and V7 (Restorative Aides) had to physically block R1 from attacking R2. R1 was attempting to push past staff. On May 26, 2026, at 3:01 PM, V1 (Administrator) said staff reported that R1 and R2 had a disagreement and that R1 became more escalated than R2. V1 said staff reported R1 and R2 were arguing over another resident. R2 didn't like what R1 said about R5, and they began arguing. V1 said staff stated the argument became heated. The facility's Abuse and Retaliation Prevention and Reporting Policy received May 26, 2026, shows: This facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse. Verbal Abuse is the use of oral or gestured language that willfully includes disparaging and derogatory terms to residents or within their hearing distance. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident.

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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	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 report an incident of abuse to the State Agency. This failure applies to 2 of 6 residents (R1 and R2) reviewed for abuse in a sample of 8 residents. The findings include: R1's EMR (Electronic Medical Record) shows R1 is a [AGE] year-old male with diagnoses that included a single episode of major depressive disorder, alcohol dependence in remission, insomnia, and peripheral vascular disease who was admitted to the facility August 1, 2025. R1's current care plan-initiated September 12, 2025, shows he has a history of verbal aggression and poor impulse control. R2's EMR shows R2 is a [AGE] year-old male with diagnoses that included anxiety disorder and problems related to social environment who was admitted to the facility March 28, 2024. On May 26, 2026, at 11:10 AM, R2 said on May 14, 2026, at approximately 8:00 AM while in the dining room, R1 was teasing R5 by mispronouncing his name. R2 said you could see it was bothering R5, so R2 said he asked R1 to stop the behavior and state R5's name correctly. R2 said awhile later, R6 informed him R1 was going to get out of his chair and fight him. R2 said his response to R6 was that he would like to see R1 try it. R2 said R1 heard the comment and became angry saying to R2 bring it on you (profane derogatory name). R1 stood up and headed towards R2 to attack him. R2 said R1's words were verbally abusive and R1 was threatening to him. R2 said he was shaking and moving away when R1 attempted to attack him. R2 said R1 has threatened residents before, and he has seen R1 yelling and threatening other residents. R2 said he becomes nervous when R1 comes around during smoke breaks and he would be uncomfortable with R1 moving back to the floor he is located on. R2 said the incident was reported to V1 (Administrator) and V1 is aware of the whole situation. On May 26, 2026, at 12:32 PM, R1 said he and R2 had an altercation because R2 was in his business. R1 said on May 14, 2026, in the dining room, R2 made a comment about R1 mispronouncing R5's name and this led to an argument between them. R1 said he was sitting across from V5 (Restorative Aide) talking and R2 was at another table staring him down. R1 said he stood up, threw off his jacket and lunged toward R2 and R2 said, C'mon I'm not afraid of you. R1 said he was going after R2. R1 said R2 fled, and he screamed out at R2 come back you little (profane derogatory name), I'll kick your ass. R1 said he was out of line and outrageous during the incident. R1 said during the incident he went after R2 to throw a punch. On May 26, 2026, at 3:45 PM, R5 said on May 14, 2026, R1 was mispronouncing his name. R2 told R1 to stop and R1 replied he would call R5 whatever he wishes to. On May 26, 2026, at 3:40 PM, R2 said since their altercation on May 14, he still gets paranoid each time R1 comes down for smoke breaks. R6 said she was present during R1 and R2's altercation and she heard R1 threaten to kill R2. R6 said she was not interviewed by any staff or the administrator about the incident. On May 26, 2026, at 11:59 AM, V3 (Psychosocial Rehabilitation Services Director) said on May 14, 2026, R1 and R2 had an altercation in the first-floor common area, and a code yellow was called (behavior code). V4 (Psychosocial Rehabilitation Services Coordinator) said she was present during the incident and R1 was verbally aggressive to R2, saying I'm going to (profane language) kill you or kick your ass. V4 said R1 was attempting to go through staff to get to R2. On May 26, 2026, at 2:25 PM, V5 (Restorative Aide) said on May 14, 2026, he was sitting at a table with R1 in the dining area, facing and talking with R1, and R2 was sitting at another table behind him. V5 said suddenly R1 stood up and threw off his jacket then moved towards R2 who was then standing behind V5. V5 said he held R1 back from approaching R2 and R1 said to R2 I'll kill you. On May 26, 2026, at 3:01 PM, V1 (Administrator) said he interviewed V5 (Restorative Aide), V6 (Registered Nurse), V8 (Behavior Health Aide), V9 (Admissions Director), and V3 [NAME] (Psychosocial Rehabilitation Services Director) regarding the disagreement between R1 and R2 on May 14, 2026. V1 said staff reported that R1 and R2 had a disagreement, that R1 became more escalated than R2. V1 said he did not type these staff interviews. V1 said staff reported R1 and R2 were arguing over (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another resident, R2 didn't like what R1 said about R5, and they began arguing. V1 said staff did not report any swearing between the residents, just that the argument became heated. V1 said staff did not report any verbal threats were made during the incident, he did not receive any information about any attempts by R1 to swing at R2. Facility abuse investigation logs and reports from May 2026 were reviewed and did not include a report regarding an altercation between R1 and R2. On May 26, 2026, at 1:50 PM, V1 (Administrator) said he did not report the incident between R1 and R2 to the State Agency. On May 26, 2026, the facility provided their policy titled, Abuse and Retaliation Prevention and Reporting- Illinois that showed The facility affirms the right of our residents to be free from abuse. This facility is committed to protecting out residents from abuse. and mistreatment by anyone. Abuse: Abuse means any physical or mental injury. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents.regardless of an individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident. Mental Abuse includes, but is not limited to.threats of punishment.Any allegation of abuse. 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.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to investigate an incident of verbal and mental abuse. This failure applies to 2 of 6 residents (R1 and R2) reviewed for abuse in the sample of 8.The findings include:R1's EMR (Electronic Medical Record) shows R1 is a [AGE] year-old male with diagnoses that included a single episode of major depressive disorder, alcohol dependence in remission, insomnia, and peripheral vascular disease who was admitted to the facility August 1, 2025.R1's current care plan-initiated September 12, 2025, shows he has a history of verbal aggression and poor impulse control.R2's EMR shows R2 is a [AGE] year-old male with diagnoses that included anxiety disorder and problems related to social environment who was admitted to the facility March 28, 2024.On May 26, 2026, at 2:25 PM, V5 (Restorative Aide) said on May 14, 2026, he was sitting at a table with R1 in the dining area, facing and talking with R1. R2 was sitting at another table behind him when V5 said suddenly R1 stood up and threw off his jacket and moved towards R2 who was then standing behind him. V5 said he held R1 back from approaching R2 and R1 threatened to kill R2. On May 26, 2026, at 11:59 AM, V3 (Psychosocial Rehabilitation Services Director) said on May 14, 2026, R1 and R2 had an altercation in the first-floor common area. V3 said he responded to a code yellow (behavior code) that was called over the speaker system for an incident happening on the first floor. V3 when he arrived the staff had separated the residents. V3 went to R1's room where R1 was saying, someone needs to beat him up, he needs to learn. V4 (Psychosocial Rehabilitation Services Coordinator) was present during interview with V3 and said she was present during the incident between R1 and R2. V4 said R1 was verbally aggressive to R2, saying I'm going to (profane language) kill you or kick your ass. V3 said V5 and V7 (Restorative Aides) had to physically block R1 from attacking R2. R1 was attempting to push past staff.On May 26, 2026, at 11:10 AM, R2 said there was altercation between him and R1 on May 14, 2026, at approximately 8:00 AM, in the dining room. R2 said R1 was teasing R5. He was making fun of his name by mispronouncing it. R2 said he could see that R5 was getting upset, so R2 asked R1 to stop it and pronounce his name correctly. A few minutes later, another resident, R6, jumped into the conversation and told R2 he heard R1 say he was going to get out of his chair and fight him. R2 said his response to R6 was that he would like to see R1 try it. R1 heard the comment and became angry and told R2 to bring it on you (profane derogatory name). R1 stood up and headed towards R2 to attack him. R2 said R1's words were verbally abusive and R1 was threatening to kill him. R2 said he was shaking and moving away when R1 attempted to attack him. R2 said R1 had threatened residents before, and he has seen R1 yelling and threatening other residents. R2 said he becomes nervous when R1 comes around during smoke breaks and he would be uncomfortable with R1 moving back to the floor he is located on.On May 26, 2026, at 12:32 PM, R1 said he and R2 had an altercation because R2 was up in his business. R1 said on May 14, 2026, in the dining room, R2 made a comment about R1 mispronouncing R5's name and this led to an argument between them. R1 said he was sitting across from V5 (Restorative Aide) talking and R2 was at another table staring him down. R1 said he stood up, threw off his jacket and lunged toward R2 and R2 said, C'mon I'm not afraid of you. R1 said he was going after R2. R1 said R2 fled, and he screamed out at R2 come back you little (profane derogatory name), I'll kick your ass. R1 said during the incident he went after R2 to throw a punch.On May 26, 2026, at 3:40 PM, R6 said she was present during R1 and R2's altercation and she heard R1 threaten to kill R2. The facility provided their abuse investigation logs for May 2026 and there was no investigation including R1 and R2's altercation from May 14, 2026.On May 26, 2026, at 3:01 PM, V1 (Administrator) said the staff reported that R1 and R2 had a disagreement and that R1 became more escalated than R2. V1 said he did not type up interviews. V1 said the staff reported to him that R1 and R2 were arguing over another resident and R2 did not like what R1 said about R5 and they began arguing. V1 said the staff did not report swearing between the residents, just that the argument became heated. On May 26, 2026, the facility (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided their policy titled, Abuse and Retaliation Prevention and Reporting- Illinois that showed The facility affirms the right of our residents to be free from abuse.This will be done by: implementing systems to promptly and aggressively investigate all reports and allegations of abuse.VII. Internal investigation 1. All incidents will be documents, whether or not abuse.2. Any incident or allegation involving abuse. will result in a proper investigation.