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	06/17/2026

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. Based on interview and record review, the facility failed to protect a resident's right to be free from mental and physical abuse by a facility resident. This failure resulted in R4 experiencing psychosocial harm including flashbacks of prior abuse, sadness/crying, panic, fear of individuals walking into her room, and shame.This applies to 1 of 4 residents (R4) reviewed for abuse in a sample of 4. The findings include:Care plan, provided 6/17/26, showed R4's diagnoses included major depression, anxiety, bipolar disorder, depression, dissociative and conversion disorder, The care plan showed R4 was at risk for abuse due to a history of abuse, poor insight and judgement. The care plan showed R4 was at risk for suicidal issues and had a history of voicing suicidal thoughts and/or intentions and had a history of a suicide attempt.MDS (Minimum Data Set), dated 4/6/26, showed R4's cognition was intact.Facility Final Abuse Investigation Report, dated 6/9/26, showed, On 6/3/26 resident [R4] reported that at times while interacting with peer resident [R3] he would sometimes take hold of her hand. The report showed R4 stated R3 would sometimes grab hold of her hand and R4 would prefer being separated from him before his behavior escalated. The document showed R3 would sometimes take hold of R4's hand but only in a playful manner.On 6/17/26 at 2:45 PM with V7 (Social Services) present, R4 stated her friend saw R3 hit R4's hand and her friend encouraged her to report the incident to V7. V7 and R4 both stated they reported the allegation to V1 (Administrator) immediately. R4 demonstrated the hit she experienced by R3 as her hand resting flat on a hard surface and R3's closed fist pounding down on the top back of R4's hand. V7 stated after R3 was sent to the hospital for his behaviors, R4 began to disclose more allegations of abuse by R3 because R4 was less afraid with R3 being out of the building. V7 stated R4 reported R3 slapped R4 in the face, R3 put an umbrella up to R4's forehead and pushed the button to automatically open the umbrella hitting R4's forehead, R3 was verbally abusive to R4 (calling her multiple cuss words), R3 belittled R4, and R3 bent R4's friend's fingers backward. R4 and V7 both stated they reported the more recent allegations immediately to V1 and V2 (Administrator in Training). V7 stated she was shown the facility abuse investigation final report and stated there were bits and pieces of information that she reported that were not in the report, including R4 being hit in the face. V7 stated R4 came to her office frequently after the allegation for counseling because R4 became fearful of R3. R4 stated she cried frequently for several days after her initial allegations including when people would come into her room through the door. R4 said she was afraid it was R3 walking into her room. R4 stated she still became afraid, startled, panicked, and shocked every time the door opened to her room. R4 stated, That triggers me. V7 stated R4 frequently visited V7's office for assistance processing the shameful feelings she experienced.On 6/17/26 at 1:25 PM, V3 (Psychiatric Nurse Practitioner) stated she was told R4 alleged R3 was rough with R4 and R3 slapped R4's face and R4 became upset and scared of R3. V3 stated R4 told a female peer who told R4 to tell facility staff about the abuse. V3 stated R4 alleged the rough handling by R3 had happened for some time and was escalating with R4 becoming fearful of R3. V3 also stated R4 reported R3 could be rough during intercourse and R3 would verbally make statements toward R4 that R4 did not like.Review of R4's clinical record showed a Psychiatric Nurse Practitioner progress notes written by V3, dated 6/3/26, showed, [R4] is seen today had a stressful (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	event recently with a male peer with whom she was having a long-term relationship. She states the male is physically too aggressive and when she told him to stop, he continued. She has past trauma from prior relationship abuse. She told another peer and that peer disclosed the incident to the staff. The two are now separated and [R4] is seen in the dining area. She is tearful but feeling safe at the moment. She does not want to see or speak to this peer again. Psychiatric Nurse Practitioner notes dated 6/10/26, showed R4 was still having some intrusive thoughts and ongoing anxiety from the most recent events. Patient had a consensual relationship with another male peer at the facility which is now done. She is having residual anxiety form the separation but knows she did the right thing. R4's psychotherapy counseling notes, dated 6/8/26, showed R4 recently reported flashback of abuse by her male peer. R4 was tearful, sad, and angry at male peer whom she had a relationship with until he became abusive. Psychotherapy notes, dated 6/11/26 and 6/13/26, show R4 was experiencing labile mood and depression. The 6/11/26 note shows R4 experienced increased flashbacks of previous abuse and has been retraumatized. The 6/13/26 note shows R4 reported her flashbacks continued and were lessening slowly. Psychotherapy counseling note, dated 6/16/26, showed R4 was less tearful sad and angry at her male peer. Review of R3's clinical record showed a Psychiatric Nurse Practitioner progress note, dated 6/3/26, written by V3 showed, It is reported by a fellow peer that [R3] grabbed her forcefully and slapped her on the face. Patient is denying that this occurred did admitted to playing with her aggressively but said he was not trying to hurt her. He feels remorse and is upset when she told on him. [R3] then verbally threatened to end her life and his life. R3 was then placed on 1:1 monitoring and sent to the psychiatric hospital.Facility Abuse Prevention and Reporting - Illinois, revised 10/25/20, showed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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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. Based on interviews and record reviews the facility failed to report resident allegations of abuse.This applies to 1 of 4 residents (R4) reviewed for abuse in a sample of 4.The findings include:Care plan, provided 6/17/26, showed R4's diagnoses included major depression, anxiety, bipolar disorder, depression, dissociative and conversion disorder. The care plan showed R4 was at risk for abuse due to a history of abuse, poor insight and judgement. The care plan showed R4 was at risk for suicidal issues and had a history of voicing suicidal thoughts and/or intentions and had a history of a suicide attempt.MDS (Minimum Data Set), dated 4/6/26, showed R4's cognition was intact.On 6/17/26 at 2:45 PM with V7 (Social Services) present, R4 and V7 both stated between 6/3/26 and 6/8/26, they reported allegations R3 hit R4's hand, slapped R4's face, opened an umbrella toward R4's forehead hitting R4, was verbally abusive to R4, and bent R4's friend's fingers backward to V1 (Administrator) and V2 (Administrator in Training). V7 stated R4 demonstrated to V1 how R3 hit R4's hand to V1 and V2 at the time of the report. V7 stated she was shown the facility abuse investigation final report and stated there were bits and pieces of information that she reported that were not included in the report, including R4 being hit in the face. On 6/17/26 at 1:25 PM, V3 (Psychiatric Nurse Practitioner) stated she was told R4 alleged R3 was rough with R4 and R3 slapped R4's face and R4 became upset and scared of R3. V3 stated R4 told a female peer who told R4 to tell facility staff about the abuse. V3 stated R4 alleged the rough handling by R3 had happened for some time and was escalating with R4 becoming fearful of R3. V3 also stated R4 reported R3 could be rough during intercourse and R3 would verbally make statements toward R4 that R4 did not like. Psychiatric nursing notes, dated 6/8/26, showed R4 was tearful, sad and angry at male peer whom she had a relationship with until he became abusive. Facility Final Abuse Investigation Report, dated 6/9/26, showed, On 6/3/26 resident [R4] reported that at times while interacting with peer resident [R3] he would sometimes take hold of her hand. The report showed R4 stated R3 would sometimes grab hold of her hand and R4 would prefer being separated from him before his behavior escalated. The document showed R3 would sometimes take hold of R4's hand but only in a playful manner. On 6/17/26 at 3:29 PM, V1 stated there were no other facility abuse investigation reports for R3 and R4 other than the initial report submitted to the regional office on 6/3/26 and final report submitted to the regional office on 6/9/26.On 6/17/26 at 2:00 PM, V1 (Administrator) stated he and V2 (Administrator in Training) interviewed R4. V1 said he was not aware of R4's allegation that she was slapped or was hit by R3 or his umbrella. V1 stated R4 told V1 that R3 would grab her hand and put her hand flat on a table, but V1 stated R4 did not mention R3 hitting her on her hand. V1 stated, I must have missed it.As of 6/17/26, the facility failed to show documentation they reported R4's allegations that R4 was slapped by R3, was hit by R3's umbrella, was called derogatory names by R3, and R3 hit R4's hand. Facility Abuse Prevention and Reporting - Illinois, revised 10/25/20, showed, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

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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 interviews and record reviews the facility failed to investigate resident allegations of abuse.This applies to 1 of 4 residents (R4) reviewed for abuse in a sample of 4.The findings include:Care plan, provided 6/17/26, showed R4's diagnoses included major depression, anxiety, bipolar disorder, depression, dissociative and conversion disorder. The care plan showed R4 was at risk for abuse due to a history of abuse, poor insight and judgement. The care plan showed R4 was at risk for suicidal issues and had a history of voicing suicidal thoughts and/or intentions and had a history of a suicide attempt.MDS (Minimum Data Set), dated 4/6/26, showed R4's cognition was intact.On 6/17/26 at 2:45 PM with V7 (Social Services) present, R4 and V7 both stated between 6/3/26 and 6/8/26, they reported the following allegations to V1 (Administrator) and V2 (Administrator in Training): R3 hit R4's hand, slapped R4's face, opened an umbrella toward R4's forehead hitting R4, R3 was verbally abusive to R4, and R3 bent R4's friends fingers backward. V7 stated R4 demonstrated to V1 how R3 hit R4's hand to V1 and V2 at the time of the report. V7 stated she was shown the facility abuse investigation final report and stated there were bits and pieces of information that she reported that were not included in the report, including R4 being hit in the face. On 6/17/26 at 1:25 PM, V3 (Psychiatric Nurse Practitioner) stated she was told R4 alleged R3 was rough with R4 and R3 slapped R4's face and R4 became upset and scared of R3. V3 stated R4 told a female peer who told R4 to tell facility staff about the abuse. V3 stated R4 alleged the rough handling by R3 had happened for some time and was escalating with R4 becoming fearful of R3. V3 also stated R4 reported that R3 could be rough during intercourse and R3 would verbally make statements toward R4 that R4 did not like.Facility Final Abuse Investigation Report, dated 6/9/26, showed, On 6/3/26 resident [R4] reported that at times while interacting with peer resident [R3] he would sometimes take hold of her hand. The report showed R4 stated R3 would sometimes grab hold of her hand and R4 would prefer being separated from him before his behavior escalated. The document showed R3 would sometimes take hold of R4's hand but only in a playful manner. On 6/17/26 at 3:29 PM, V1 stated there were no other facility abuse investigation reports for R3 and R4 other than the initial report submitted to the regional office on 6/3/26 and final report submitted to the regional office on 6/9/26.On 6/17/26 at 2:00 PM, V1 (Administrator) stated he and V2 (Administrator in Training) interviewed R4 and V1 was not aware of R4's allegation that she was slapped or was hit by R3 or his umbrella. V1 stated, I must have missed it.As of 6/17/26, the facility failed to show documentation they investigated R4's allegations that R4 was slapped by R3, was hit by R3's umbrella, was called derogatory names by R3, and R3 hit R4's hand.Facility Abuse Prevention and Reporting - Illinois, revised 10/25/20, showed, Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.