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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store refrigerated resident food safely in the refrigerators on the units. This has the potential to apply to all 211 residents residing in the facility.Findings include:On 01/29/2026 at 2:59 PM, the second-floor small refrigerator (identified by V32 and V33 CNAs [Certified Nursing Assistants] as the supplement refrigerator) had no thermometer or temperature log. The supplement refrigerator contained:An opened 20 oz (Ounce) bottle of colaTwo opened cans of citrus sodaa clear plastic bag containing a bun wrapped in a paper towel with white crystal powdered substancea green apple with two brown bite marks wrapped in paper towels.A small plastic cup with vanilla pudding covered in plastic wrap without any dates or label.A 32oz (Ounce) carton of nutritional supplement without an open on or use by date.The larger refrigerator (identified by V32 and V33 as a staff and resident shared refrigerator) had no thermometer or temperature log. The refrigerator contained:A 15.4 oz cup of homestyle chicken noodle soup expired on 10/21/25.A pint of dried-up blueberriesAn unlabeled undated personal food container with rice and meat.An undated unlabeled take-out container with a noodle dish.An undated unlabeled personal container with vegetable pizza.An unlabeled undated personal container of asparagusAn unlabeled undated take-out container with bread, fettuccini [NAME] and shrimp. The container had a strong sour spoiled smell.A15.2 oz bottle of strawberry/banana no-sugar-added smoothie, expired on 1/24/25An unlabeled undated pizza sliced in a plastic zippered bag.V33 CNA. stated she was unaware of who is responsible for keeping the refrigerator clean and throwing out spoiled outdated food. The staff member that receives the food is responsible for labeling and dating the food item. V33 stated maintenance is responsible for updating the temperature log.On 01/29/2026 at 2:40 PM, V32 CNA. stated she did not know who is responsible for maintaining the refrigerator log or throwing out expired spoiled food items.On 01/30/2026 at 9:28 AM, V3 Maintenance Director stated everyone that uses the refrigerator is responsible for keeping it clean. V3 stated he did not know who was responsible for monitoring the refrigerator and the log or where they were kept once completed.On 01/30/2026 at 9:51 AM, V2 DON (Director of Nursing) the nursing staff are responsible for the refrigerators on the unit. Nursing staff are responsible for labeling and dating food items and completing the temperature log. If the thermometer is missing the nursing staff should have notified maintenance. Temperatures can't be logged without a thermometer. V2 stated she was unable to provide the requested twelve months of refrigerator temperature logs for any of the facilities unit refrigerators.On 01/30/2026 10:35 AM tested the unit refrigerators with a temperature gun. The 1st floor supplement refrigerator did have a thermometer. The temperature was 44 degrees F (Fahrenheit). The 2nd floor supplement refrigerator did not have a thermometer or temperature log was 45 degrees F. The larger refrigerator was 46 degrees F. The 3rd floor supplement refrigerator was 45 degrees F.On 01/30/2026 at 11:06 AM, V1 Administrator stated he did not have the last twelve months of temperature logs for refrigerators located on the nursing units.The facility policy Food from Family, Visitors, Community dated 2020 states food stored for residents should be labeled and dated appropriately and discarded per safe food storage guidelines. A facility may choose to utilize a specific refrigerator or area of cooler for resident food.The facility policy Food -Resident (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Pantry - Safe Storage dated 6/13/19 states to ensure that resident food items are stored in a manner that is sanitary and safe for consumption and to prevent contamination and spoilage refrigerators shall be maintained between 33 and 41 degrees. All resident foods and beverages, including alcoholic beverages shall be labeled with the resident's name and dated. If food or beverages are used for multiple residents, the date open shall be written on the container. Food items, condiments and liquids that are in the original container shall follow the expiration date on the container. Foods which are outdated or are not labeled and dated shall be discarded daily when cleaning. Employee food shall be placed in the employee refrigerator.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to administer and record individualized supplemental nutritional interventions for residents being treated for weight loss. This applies to 4 of 4 (R51, R8, R10, and R121) residents reviewed for nutrition in a sample of 38.The findings include:1. On 1/27/2026 at 10:10 AM, R51 was in bed and unable to recall if he had eaten breakfast. R51 was thin and frail. At 11:50 AM, V37 (Certified Nurse Assistant/CNA) said R51 skipped breakfast, and she was now going to inform the nurse.On 1/28/2026 at 9 AM, V38 (CNA) said she supervised R51 for breakfast, and he only ate his served scrambled eggs, which was approximately less than 50% of his meal.On 1/29/2026 at 8:35 AM, R51 was in bed, sleeping. R51 was fatigued and unsure if he had eaten breakfast. V32 (CNA) said R51 did not eat breakfast and had a history of refusing meals. V32 said she informed V18 (Licensed Practical Nurse/LPN). On 1/29/2026 at 8:40 AM, V18 (LPN) said R51 received an ordered nutritional supplement for his nutrition management. V18 said she administered the facility's house stock nutritional supplement and used the 5-oz (ounce) medication cup (which was approximately 148 ml/milliliters). V18 said the supplement order did not indicate the amount, and it was unclear what the serving volume should be. V18 said all the residents with orders for oral nutritional supplements did not indicate the amount that should be administered, it only indicated frequency instructions. V18 said the oral nutritional supplements were ordered by V19 (Dietitian). V18 continued to say she also administered R8, R10 and R121's nutritional supplements in the same 5-oz medication cup.R51's Nutrition Progress Note dated 9/17/2025, said R51 was assessed for significant weight loss, and was to continue with his nutritional interventions, including house stock nutritional supplement four times a day to supplement his oral intake.R51's Order Summary Report had an active order for House Nutrition Supplement four times a day 1 serving. R51's EMAR (Electronic Medication Administration Record) for January 2026 did not indicate the total amount administered and consumed of his ordered nutritional supplement.R51's care plan said he had a nutritional problem related to being underweight, a history of significant weight loss, dementia with mental health illness, and dysphagia. The interventions included Monitor intake and record.Provide supplements as ordered. 90 ml house supplements [twice daily]. 2. On 1/29/2026, R8 said he was losing weight and received a small medication cup filled with an oral nutritional supplement from the nurses. R8's Nutrition Progress Note, dated 1/15/2026, said R8 was assessed for significant weight loss, and was to continue with his nutritional supplement daily to supplement his oral intake. R8's Order Summary Report had an active order for House Nutrition Supplement in the morning one serving. R8's EMAR for January 2026 did not indicate the total amount administered and consumed of his ordered nutritional supplement.R8's care plan said he had a nutritional problem related to his recently identified significant weight loss and mental health disorders. There were no interventions regarding an oral nutritional supplement. 3. On 1/27/2026 at 12:30 PM, R10 was in the dining room for lunch. R10 was thin and frail. R10 was confused and unable to be interviewed regarding her nutrition.R10's Nutrition Progress Note, dated 1/06/2026, said she was assessed for her ongoing underweight status and recently downgraded diet, which had resulted in a diminished oral intake. The note said she was to continue with her nutritional supplement three times a day to supplement her oral intake. R10's Order Summary Report had an active order for House Nutrition Supplement three times a day one serving. R10's EMAR for January 2026 did not indicate the total amount administered and consumed of her ordered nutritional supplement.R10's care plan said she had a nutritional problem related to being underweight, a history of significant weight loss, severe mental health illnesses, and dysphagia. The interventions included Monitor intake and record.Provide and serve supplement as ordered 240 ml house supplement [twice daily]. 4. On 1/27/2026 at 12:15 PM, R121 was in the dining room for lunch. R121 was thin and frail. R121 was confused and unable to be interviewed regarding her nutrition.R121's Nutrition Progress Note, dated 10/17/2025, said she was assessed for additional nutritional support related to her new pressure injuries to promote wound healing.R121's Order (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Summary Report had an active order for House Nutrition Supplement one time a day. R121's EMAR for January 2026 did not indicate the total amount administered and consumed of her ordered nutritional supplement.R121's care plan said she had a nutritional problem related to being underweight, a history of significant weight loss, dementia, and dysphagia. The interventions included Give the resident supplement as ordered.120 ml house supplement [three times daily]. On 1/29/2026 12 PM, V2 (Director of Nursing/DON) said the facility's house stock oral nutritional supplement container that was used for all the residents, indicated a serving was 8 oz (which was approximately 236 ml). V2 said the nurses recorded the administration of the supplement in the residents' EMAR, but not the amount consumed. On 1/29/2026 at 12:05 PM, V19 (Dietitian) said R51, R8, R10, and R121 were monitored for weight loss and had standard orders for the facility's oral house stock supplement. V19 said the supplement order did not indicate the amount because at times, the available supplement product changed, but the order indicated instructions to administer a serving. V19 said the serving to be administered was based on the facility's container product instructions. V19 said nurses had to administer the ordered oral nutritional supplements to ensure the residents' nutritional interventions were being followed as ordered. V19 said it was also important that the amount consumed be recorded to ensure an accurate review of the residents' nutritional assessments.The facility's policy titled Fortified Foods, Supplements, and Snacks, dated 2020, said residents who cannot consume adequate amounts of regular foods at meals to meet their nutritional needs may be considered for oral nutritional supplements in order to increase their nutritional intake. Commercially prepared supplements and nutritional interventions may be ordered by the dietician or nursing staff and shall include specifications. Then the Registered Dietitian will then evaluate if the resident requires further nutritional interventions and if needed, will make additional recommendations. After the physician's approval, the individualized residents' care plans will be updated with their nutritional interventions and written in their MAR (Medication Administration Record). Additionally, the resident's tolerance of the supplement will be monitored, and the data will be collected in the resident's medical record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor, identify, and document side effects of medications, and failed to monitor for the therapeutic blood level of a medication.This applies to 4 of 5 (R82, R93, R182, and R51) residents reviewed for medications in a sample of 38.The findings include:1. R82 was admitted to facility on 11/13/23. Diagnoses include anxiety disorder, psychosis, schizophrenia, depression and extrapyramidal and movement disorder. R82's MDS (Minimum Data Sheet) dated 12/22/25 documents that he has intact cognitive functions.On 1/27/26 at 10:54 AM, 1/28/26 at 9:24 AM and 10/29/26 at 9:30 AM, R82 was observed drooling excessively while talking. He was observed constantly wiping his mouth and there were moisture marks on his shirt below his mouth. He said he cannot control it and feels embarrassed by his drooling.R82's POS (Physician Order Sheet) documents R82 was receiving Clozapine 50 mg, three tablets by mouth in the morning and Clozapine 50 mg, five tablets by mouth at bedtime. An order to monitor for side effects for antipsychotic medication was also documented. R82's care plan for use of psychotropic includes interventions to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift. R82's TAR (Treatment Administration Record) show that R82 did not manifest any side effects for the whole month of January 2026.On 1/29/26 at 8:30 AM, V27 (RN-Registered Nurse) said common side effects from antipsychotic medication are drowsiness, dizziness, drooling. She said if any of these symptoms are observed, she informs the Psychotropic Nurse (V11) and the psychiatrist is informed and new orders for medications like scopolamine are ordered. She said side effects from psych meds are monitored every shift and documented on TAR. On 1/29/26 at 10:15 AM, V11 said if side effects from antipsychotic medications are noted, staff should call physician right away.On 1/30/26 at 9:55 AM V2 (DON-Director of Nursing) said nurses are responsible for assessing and documenting side effects from psychotropic medication. She said nurses are also responsible to make the Psychotropic nurse aware so he can inform the psychiatrist and have a recommendation for treatment, or if the resident is already on a medication for side effects, maybe the medication can be adjusted.Facility's Policy on Psychotropic Medication- Gradual Dosage Reduction dated 11/28/12 and revised on 2/1/18 documents the following: Monitoring: Staff will monitor residents for side effects, withdrawal symptoms and/or changes in behavior and report to physician and/or psychiatrist. Documentation of observed side effects by nursing staff will occur as indicated in the nurse's Notes and/or on the EMAR.2. R93 was admitted to facility on 4/19/23. Diagnoses include dementia, depressive disorder, severe intellectual disabilities and schizoaffective disorder, bipolar type. R93's MDS dated [DATE] documents he has short- and long-term memory problem. And he needs extensive assist of one person with grooming related to dementia.On 1/27/26 at 9:55 AM, R93 was observed pacing the hallways of the unit. He was repeatedly saying he was going to the gas station and asking everybody what he needs to buy. He was observed excessively drooling and his shirt had moisture marks under his mouth by his collar. On 1/28/26 at 9:30 AM and 1/29/26 at 9:20 AM, R93 was standing close to the nurse's station and was drooling excessively.R93's POS documents he receives Clozapine 50 mg, 1 tablet at bedtime for schizoaffective disorder and Olanzapine 20 mg, give half tablet by mouth two times a day for schizoaffective disorder, bipolar type. An order for Benztropine Mesylate 0.5 mg, give 1 tablet by mouth twice a day to prevent drug-induced extrapyramidal symptoms was ordered and started on 10/25/2023. An order to monitor for side effects for antipsychotic medication was also documented. R93's care plan for use of psychotropic includes interventions to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift. R93's TAR show that R93 did not manifest any side effects for the whole month of January 2026.3. R182 was admitted to facility on 11/25/23. Diagnoses include depressive disorder, anxiety disorder, extrapyramidal and movement disorder, schizophrenia and schizoaffective disorder. R182's MDS dated [DATE] (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documents he has intact cognitive functions.On 1/27/26 at 10:59 AM, R182 was standing by his doorway. He was observed with excessive drooling and was constantly wiping his mouth while talking. He said he is embarrassed by his excessive drooling and stated his appearance matters to him.R182's POS documents he receives Clozapine 100 mg, one tablet by mouth every morning for schizophrenia and Clozapine 100 mg, two tablets by mouth at bedtime for schizophrenia. An order for Benztropine Mesylate 1 mg, by mouth two times daily related to extrapyramidal and movement disorder was ordered and started on 1/14/2022. An order to monitor for side effects for antipsychotic medication was also documented. R182's care plan for use of psychotropic includes interventions to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift. R182's TAR show that R182 did not manifest any side effects for the whole month of January 2026. 4. On 1/29/2026 at 8:25 AM, R51 was in bed. R51 was weak and frail, unable to be interviewed regarding his seizure disorder and treatment. At 8:40 AM, V18 (Licensed Practical Nurse/LPN) said R51 had a seizure disorder with a history of convulsions. V18 said R51 was receiving Dilantin (antiseizure) oral medication for management of his disorder. V18 reviewed R51's EMR (Electronic Medical Record) and said his last Dilantin medication blood level was done on 11/20/2025. V18 said the level was 4, which was too low because the normal reference range is between 10 and 20. V18 continued to say that R51's physician gave an order on 11/21/2025 to increase his Dilantin dosage and repeat a blood level check in two weeks. V18 said R51 did not get his medication drug blood level checked as ordered. V18 said lab orders should be followed as instructed to ensure residents receiving antiseizure medications are monitored appropriately with the goal to prevent seizures. V18 said checking blood levels for antiseizure medication is needed to determine proper medication dosage and ensure residents had therapeutic levels.R51's laboratory report dated 11/20/2025 showed his Dilantin level was 4.0 L and the reference range was 10.0-20.0. The report also showed a written physician's order to increase the medication dosage and repeat the medication level in two weeks. R51's EMR showed that as of 1/29/2026, R51's lab order from 11/20/2025 was not completed. R51's care plan said he required the use of an anticonvulsant medication because he was at risk for seizures related to convulsions. The interventions included Monitor lab values for therapeutic levels of anticonvulsant medications and report to MD.On 1/29/2026 at 9:40 AM, V2 (Director of Nursing/DON) said she expected nurses to follow lab orders for medication drug levels as ordered by the physician to ensure residents at risk for seizures be safely monitored.The facility's policy titled Physician Orders- Entering and Processing, dated 1/31/2018, said the facility followed general guidelines when receiving, entering, and confirming physician orders. Orders would be confirmed by the nurse to ensure the order instructions were followed. All orders will be documented in the Electronic Medical Record.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to have thermometers, keep temperature logs, remove expired items, and maintain resident refrigerators. This applies to 5 of 5 residents (R66, R118, R119, R168, R207) reviewed for refrigerators in a sample of 38.The findings include:1.On 1/27/26 at 11:05 AM, R119's refrigerator did not have a thermometer inside. R119 was not in her room. R119's roommate stated the staff was supposed to bring a thermometer, but they never did.2.On 1/27/26 at 11:19 AM, R207's refrigerator did not have a thermometer inside. Inside, there was a package of chicken salad and container of apple sauce. R207 said she's never seen a thermometer inside her fridge.3.On 1/27/26 at 11:22 AM, R168's refrigerator had ice built up in her freezer and the door's hinge was broken, causing difficulty in opening and closing it. R168 stated it has been like that for some time. She told staff, but nobody came to fix it.4.On 1/27/26 at 11:41 AM, R118's refrigerator had no thermometer inside. Inside, there was a 1/2 pint of 2% milk with a best by date of 1/26/2026. There were two 1/2 pint fat free milk with a best by date of 1/21/26. There was one 1/2 pint of fat free milk with a best by date of 1/26/26. She stated she never had a thermometer in her fridge. 5.On 1/27/26 at 11:44 AM, R66 was not in his room. The fridge was heavily stained and dirty on the inside.There were no temperature logs for the above residents' refrigerators inside their room, and the facility was unable to provide any temperature logs.On 1/28/2026 at 9:21 AM, V2 (DON-Director of Nursing) stated, There are supposed to be thermometers in resident refrigerators. Usually, the Social Workers are supposed to check in with the residents regarding the refrigerator. Housekeeping should clean the refrigerators.On 1/28/26 at 3:51 PM, V3 (Maintenance/Environmental Services Director) stated residents should have a thermometer in their refrigerators. He stated Social Services gives the residents a temperature log sheet where they can record their own temperatures for their refrigerators. If the fridges freeze, then maintenance would go and defrost them. He stated all staff are supposed to remove expired items from resident refrigerators. Staff, including managers, nurses, and CNA's (Certified Nursing Assistants), and/or housekeeping are responsible for cleaning the refrigerators.Facility's policy titled Refrigerators in Resident Rooms (2020) shows: 2. Each refrigerator shall have a temperature log with daily entry. Each refrigerator will have an inside thermometer. 3. The housekeeper will enter the temperature once daily. 6. All food will be monitored when daily temperature check is performed. Any food item past its use by date will be discarded by staff or resident. The resident and/or the resident's responsible party will be educated on food safety and leftover food to be discarded after three days. 8. The housekeeping department will clean and sanitize the refrigerators at least once a month or as required. 9. Housekeeping supervisor will conduct at least monthly quality assurance audit of refrigerators to monitor adherence to procedures.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to honor a resident's wishes to have food warmed in a microwave at their preferred time.This applies to 1 resident (R37) reviewed for accommodation of needs.On 01/27/2026 at 12:43 PM, R37 stated there use to be a microwave available for residents' use, but it was taken away. The only microwave available is at the nursing station and is not accessible to the residents. R37 stated if residents want any food reheated, they must request the facility staff do it for them, but the time for reheating food is limited. If he wants any food reheated after 9:30 PM, staff will not heat his food. On 01/28/2026 at 4:10 PM, V8 RN (Registered Nurse) stated residents are not allowed behind the nursing station to use the microwave. Staff will reheat food for residents, but only during the posted specified times (8:30 AM to 9:30 AM, and 8:45 PM to 9:15 PM). V8 stated it's to prevent the residents from interrupting staff while they are working and because the residents need to go to sleep at night. V8 stated if there isn't a cut off time, the residents will stay up all night heating up food.On 01/29/2026 at 2:06 PM, V30 Behavioral Aide stated she is not allowed to reheat residents' food outside the posted time frames.On 01/29/2026 at 2:12 PM, V31 Behavioral Aide stated there are time restrictions for reheating residents' food. V31 stated the times for heating up resident food are posted, and staff stick to those times.On 01/29/2026 at 2:40 PM, V32 CNA (Certified Nursing Assistant) stated staff will reheat resident food items only during the specified times and not after bedtime.The facility's documented microwave use hours are 8:30 AM to 9:30 AM, and 8:45 PM to 9:15 PM.On 01/29/2026 at 12:33 PM, V1 Administrator stated there are set times for residents to reheat food items so staff aren't reheating food all day. V1 stated there is no facility policy specifying times that food may be reheated.

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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.

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 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.

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

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review, the facility failed to provide physical therapy that was ordered by the physician.This applies to 1 of 1 resident (R151) reviewed for rehab services in a sample of 38. Findings Include:R151's diagnosis list includes Parkinsonism, idiopathic progressive neuropathy, recurrent major depressive disorder, and drug-induced subacute dyskinesia.R151's current care plan includes limited range of motion in bilateral upper and lower extremities related to pain and limited mobility; interventions include to demonstrate exercises and have resident return-demonstrate the exercises.On 01/27/2026 at 11:02 AM, R151 stated for two years he's had numbness and tingling in both legs and his fingers. R151 stated his Neurologist wrote orders for him to have PT (Physical Therapy) that was never set up for him. R151 stated he provides his after-visit summary from his doctor's office visit to the floor nurse on duty and to V29, Scheduler.On 01/28/2026 at 2:59 PM, V8, RN (Registered Nurse), stated R151 had not recently received any physical therapy services.On 01/28/2026 at 3:10 PM, V29, Scheduler, stated she arranges residents' follow up appointments and referrals. V29 stated R151 has been followed by the in-house PT department. V29 stated the referral was given to V25, Physical Therapist.On 01/28/2026 at 3:22 PM, V25, Physical Therapy Director, stated the PT department was not seeing R151 and had not seen him since 2022. R151's last PT evaluation was 8/8/22, and he received eight sessions before being discharged from PT. On 01/28/2026 at 3:38 PM, V2, DON (Director of Nursing), stated when a resident returns from a community physician's office visit with PT referral, V25 is notified during the morning meeting. V2 stated if the floor nurse provides her with the referral, she will notify V25 directly. V2 stated she did not know how the order therapy order was overlooked.R151's community Neurologist after-visit summary, dated 4/23/25, included a referral for Physical Therapy to evaluate and treat for the diagnosis of sensory ataxia.The facility had no documentation of R151 receiving the physician-ordered Physical Therapy services. The facility policy Therapy - Specialized Rehabilitative Services Guidelines dated 7/16/24 states, the facility shall provide specialized and supportive rehabilitative services either directly or through arrangements with services provider. Services shall be provided in accordance with the assessment results, the written comprehensive plan of care in accordance with physician's orders. Specialized rehabilitative service may include but not limited to physical therapy, speech / language audiology, speech pathology, respiratory therapy, occupational therapy. Such services are utilized to restore, maintain or improve the resident's optimal level of functioning, self-care, independence, and quality of life.