STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146001	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care International	4815 South Western Ave Chicago, IL 60609

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 interview and record review, the facility failed to prevent and protect a resident (R1) from physical abuse for one resident from another resident (R2), with potential of aggressive behaviors including verbally threatening to hit others, for three residents reviewed for physical abuse. This failure resulted in R1 observed with redness to her cheek and saying she was hit and R1 experiencing emotional distress and feelings of being unsafe in the facility. Findings include: On 02/02/2026 at 12:54PM, R1 states she was lying in her bed at approximately 8:30PM on Friday 01/30/2026 when an unknown male (identified as R2) walked into her room. R1 states she told R2 that he had entered the wrong room. R1 states R2 then walked over and sat on the edge of her bed and began to pull her sheets down off of her. R1 states R2 then began to walk towards her and she placed the bedside table in front of her and held on to it to keep R2 away. R1 states R2 tried to pull the bedside table away from her but she held on tight and R2 then punched her in the face. R1 states R2 never said a word to her but walked past her roommate and came straight to her. R1 states one of the staff members came in and saw R2 in her room and removed him from her room. R1 states she then called V3 (R1's Family Member) and she was crying and could not even talk straight. R1 states V3 came rushing to the facility and V3 called the police. R1 states V3 talked to the police and filed a police report. R1 states the facility stated to her that they would be investigating the incident. R1 points to her left eye and surveyor observes a red bruise under her left eye measuring approximately 1/2 inch in horizontal length. R1 states at first her eye was swollen but she did not want to go to the hospital, so the nurse gave her pain medication and an ice pack for her face. R1 states she was okay before R2 did what he did to her, and she is not really sure if she feels safe in the facility. R1 states she was emotional and cried the entire day. R1 states she was informed that they sent R2 out to the hospital for psychiatric evaluation. On 02/02/2026 at 2:14PM, V3 (R1's Family Member) states on Friday 01/30/2026 at approximately 8:45PM, he received a call from R1. V3 states R1 was crying and saying, he hit me. V3 states R1 told him that R1 was in bed when an unknown male (identified as R2) came into her room and walked around her bed and then tried to pull her blanket down off of R1. V3 states R1 said R2 then walked around to the front of her bed and tried to move the bedside table to possibly get on top of R1. V3 states R2 could not remove the bedside table so then he punched R1 in the face. V3 states R1 was screaming for help in the facility and V3 called the front desk and informed someone that R1 was being attacked so that someone could go and help R1 until he arrived to the facility. V3 states he then called the police and went directly to the facility afterwards. V3 states when he arrived at the facility, he initially could not locate any of the staff members at the nurse's station. V3 states the police and the fire department arrived at the facility and he filed a police report to report the incident. V3 states R2 could have raped or killed R1, and the facility told him that R2 has dementia. V3 states that although R2 has dementia, the facility staff are responsible for (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	making sure R1 is safe, and they also should ensure that they are monitoring R2 and other residents. R1's Facesheet documents that R1 was admitted to the facility on [DATE] with diagnoses not limited to: sensorineural hearing loss, bilateral, rheumatoid arthritis, other abnormalities of gait and mobility, vitamin d deficiency. R1's MDS/Minimum Data Set, dated [DATE] documents that R1 has a BIMS/Brief Interview for Mental Status of 13/15, indicating that R1 is cognitively intact. R1's progress note dated 01/31/2026 at 1:07PM written by V4 (Wound Care Nurse/LPN) documents, writer was informed by CNA that R1 was hit in the face by another resident. Writer assessed resident. Resident in bed crying stated that another resident punched her in the face. Writer observed redness to left cheek. No open skin. Patient's face and neck were flushed. Patient called her son who came to facility. Prn pain medication given. DON, assistant administrator, and MD notified. New order for STAT facial xray. Paramedics called. R1 and family refused to be evaluated in hospital. R2's Facesheet documents that R2 was admitted to the facility on [DATE] with diagnoses not limited to: unspecified dementia, suicidal ideations, major depressive disorder, recurrent. R2's MDS dated [DATE], documents that R2 has memory problems and does not score on the BIMS/Brief Interview for Mental Status. R2's care plan documents in part, I have potential for aggressive behavior r/t dementia. Will not harm self or others. Encourage participation in activities. Observe resident's location and change in aggression level. Remove from area when resident shows increased aggression. R2's progress note dated 01/31/2026 at 1:14PM written by V4 (Wound Care Nurse/LPN) documents, writer informed by CNA that R2 hit another resident in the face. Resident was immediately separated from patient and placed on a 1:1. DON, assistant administrator and MD notified. R2 sent to ED with petition for psych evaluation. Patient transferred to hospital accompanied by 4 paramedics. R2's progress note dated 01/31/2026 at 8:20PM documents Writer called hospital; spoke with RN; R2 is being admitted with diagnosis of AMS/altered mental status. On 02/02/2026 at 3:42PM, V4 (Wound Care Nurse/LPN) states she was the nurse on duty assigned to care for R1 and R2 on Friday 01/30/2026. V4 states at approximately 8:30PM, she was located in another resident's room admitting a new resident when V5 (Certified Nursing Assistant/CNA) informed her that an incident had occurred between R1 and R2. V4 states she then went inside of R1's room to talk to R1 to ask what happened. V4 states she assessed R1 and R1 was upset at that moment. V4 states R1 informed her that R2 hit her in the face. V4 states R1's face was not swollen but flushed red and R1 was sitting on the bed. V4 states at this time R2 was not located inside of R1's room. V4 states she was trying to calm R1 down and tell her that R2 has been removed for R1's safety. V4 states she informed administration of what had occurred. V4 states R1 had already called V3 (R1's family member) and V3 arrived at the facility pretty quickly. V4 states she also went to assess R2 and ask what happened. V4 states R2 told her that he did not remember going into R2's room. V4 states 911 was called, and she informed R2 that he would be going out to the hospital for evaluation. V4 states R2 was placed on 1:1 monitoring and one of the CNA staff members monitored R2 until the paramedics arrived. V4 states R2 has a diagnosis of dementia and residents with dementia are monitored by the general standards of every two hours. V4 states R2's room was located right next door to R1's room so R2 must have just walked right into R1's room. During observation on 02/02/2026, surveyor observes that R1's room is located next door to R2's room and both rooms are located directly across from the nurses' station. On 02/02/2026 at 4:00PM, V5 (Certified Nursing Assistant/CNA) states she was assigned to care for R1 and R2 on Friday 01/30/2026. V5 states she was located in the shower room providing care for another resident when she heard a resident say help. V5 states when she exited the shower room, she saw another CNA (identified as V6/CNA) going inside of R1's room. V5 states she also went to R1's room and she saw R2 standing in R1's room on the side of R1's bed and she saw R1 holding her (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	face. V5 states she saw that R1's face was flushed red. V5 states she asked R2 what happened and R2 did not say one word to her. V5 states herself and V6 removed R2 out of R1's room and placed him at the nurse's station. V5 states R2 was placed on 1:1 monitoring and she monitored R2 until the ambulance came because staff did not want R2 to hit anyone another resident. V5 states ten minutes before the incident, she checked on R2 and saw that R2 was asleep in bed with the lights and TV/television off. V5 states R2 has never done anything like this before. V5 states R2 talks whenever he wants to and will usually tell you that he is about to hit you. V5 states R1 and R2's rooms are right next to one another and R2 can easily access R1's room. V5 states there was no reason why R2 was inside of R1's room and R2 should not have been in R1's room. On 02/02/2026 at 4:19PM, V1 (Administrator) states he has been the abuse coordinator for the past 3 years. V1 states he was informed that on Friday 01/30/2026, R2 went into R1's room, there was an altercation, and R2 was sent out to the hospital for psychiatric evaluation. V1 states a police report number was provided to him as #JK133146. On 02/03/2026 at 1:47PM, V1 informs surveyor that the facility does not have a supervision/monitoring policy. On 02/02/2026 at 5:10PM, V6 (CNA) states at approximately 8:00PM, she was providing care to another resident when she heard R2 yell out for help. V6 states she walked into R1's room and saw R2 standing in R1's room located at the foot of R1's bed. V6 states R1 was very hysterical, and she heard R1 say get him out. V6 states she removed R2 from R1's room. V6 states she went to inform the nurse and manager, who then went inside of R1's room to check on her. V6 states she took R2 to the nurse's station and V5 (CNA) monitored R2 until 911 arrived. V6 states when the ambulance arrived R1 did not go to the hospital. V6 states she provided R1 with an ice pack and finished caring for her assigned residents. V6 states she could not really see R1's face because R1 was covering her face with her hands. V6 states she had never seen this behavior from R2 before, but she knows that R2 has dementia. V6 states although R2 can get up and walk, he ambulates via a wheelchair. V6 states R2's usual behavior is that R2 will be inside of the dining room being monitored by staff or inside of his room. V6 states usually every 15 minutes, staff monitor the residents who are diagnosed with dementia. V6 states residents who are not diagnosed with dementia, staff monitors them every two hours. Facility reported incident dated 01/30/2026 documents the facility reported an incident involving R1 and R2 to the state agency. Facility policy dated 01/08/2026 titled, Abuse and Retaliation Prevention and Reporting documents in part, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.this will be done by: stablishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. This facility is committed to protecting our residents from abuse, neglect, exploitation, retaliation, misappropriation of property and mistreatment by anyone, including but not limited to facility staff, other residents. Supervisors will monitor the ability of the staff to meet the needs of residents, including ensuring that assigned staff have knowledge of individual resident care needs.