

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056820		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/19/2025	
NAME OF PROVIDER OR SUPPLIER APERION CARE LAKESHORE				STREET ADDRESS, CITY, STATE, ZIP CODE 7200 NORTH SHERIDAN ROAD , CHICAGO, Illinois, 60626			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Complaint Investigation 2588616/ 2613513						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610 a)						
	300.1210 b)						
	300.1210 c)						
	300.3210 t)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.						
	c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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S9999	Continued from page 1 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to prevent and protect residents from physical abuse. This failure affected one (R3) out of three residents reviewed for abuse. This failure resulted in R2 sustaining a closed fracture of orbital wall. Findings include: R3's admission record shows admission date on 12/31/24, with diagnoses not limited to Chronic Kidney Disease, Hypo-Osmolality and Hyponatremia, Hypokalemia, Osteoarthritis, Hypertension, Other Abnormalities of Gait and Mobility, Fracture of Other Specified Skull and Facial Bones, Left Side, Initial Encounter for Closed Fracture (added 09/14/25). R3's MDS (Minimum Data Set), dated 06/26/25, reveals R3 is cognitively intact and requires supervision or touching assistance for mobility. R3 has a care plan initiated on 01/03/25 stating he is at risk for abuse/neglect and will be cared for in a safe manner. R6's admission record shows admission date on 06/27/25, with diagnoses not limited to Psychotic Disorder with Delusions due to Unknown Physiological Condition, Unspecified Dementia with Other Behavioral Disturbance, Alcohol Dependence with Withdrawal, Bipolar Disorder, Anxiety Disorder. R6's MDS, dated 09/09/25, indicates R6's cognition is moderately impaired and R6 has adequate vision. R6's Admission/Re-Admission Observation Assessment, dated 09/08/25, documents R6 requires supervision or touch assistance with mobility and R6's Activities of Daily Living care plan indicates R6 requires supervision with mobility. R6 has a care plan in place for verbal aggression initiated on 08/12/25 which documents, "(R6) has the potential to be verbally/physically aggressive/threatening staff and others related to		S9999				

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S9999	Continued from page 2 ineffective coping skills, mental/emotional illness, and poor impulse control. R6 has a care plan for diagnosis and history of severe mental illness as manifested by delusions-paranoia." R6's electronic health records reveal R6 was hospitalized from 08/12/25 to 08/15/25 due to verbally threatening facility staff by saying, "I will beat your ass. Bit** ass nig**." R6's admitting hospital diagnosis for this hospitalization was aggressive behavior. R6 was also hospitalized from 08/26/25 to 09/01/25 due to increased agitation and odd behavior of defacing facility property with gang signs and attempting to smoke in his room. R6's admitting hospital diagnosis for this hospitalization was for acute psychosis. R6 was also hospitalized from 09/03/25 to 09/08/25. On 09/02/25, R6 was threatening to hurt staff inside and outside the facility and searching for staff with an object in his hand saying he was going to hit the staff with it. R6's hospital admitting diagnosis for this hospitalization was aggressive behavior. R6 readmitted to the facility on 09/08/25. On 09/08/25 at 11:45 AM, R3 was in the lounge sitting in a chair. R3 had black and blue marks under R3's right eye and right eye was bloodshot. R3's response to questions was garbled, with R3 mumbling in a low voice which was difficult to understand. R3 provided responded to questions with short responses. R3 stated he does not remember what happened to his eye. R3 indicates he did not fall and was not pushed. When asked if R3 remember R6, R3 said, "maybe." R3 stated R6 did not bump into him or push him. When asked if anyone punched R3, he said, "I'm not sure." On 09/18/25 at 8:20 AM, V36 (Housekeeper) stated via an interpreter, V29 (Food Service Director), on 09/09/25, V36 was cleaning a resident's room on the 4th floor when she heard a thud sound, so she went to see what was going on. V36 stated when she went to the 4-North Lounge, she saw R3 lying on his back on the floor and R6 was on top of R3. V36 stated she ran to get help. On 09/16/25 at 2:39 PM, V19 (Social Service Director) stated he was doing rounds on the 4th floor on 09/09/25 and while in the 4-North Lounge, he saw R6 walk into the dayroom aggressively. V19 remembers R3 was the only resident in the lounge at that time. V19 stated R6 was angry and walking quickly. V19 stated at that time, R3 in the process of getting up from his chair, and V19 saw R6 aggressively bump into R3 causing R3 to fall to the ground. V19 stated he asked R6 what was going on and R6 told V19, "I'm mad, man. I'm mad. I'm pissed off" and "I don't want to talk. I'm pissed off. I'm	S9999					

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S9999	Continued from page 3 pissed off." V19 stated R6 was not specifically going after R3, it is just that R3 was in the wrong place at the wrong time. V19 stated R6 was angry about something leading up to this, but he does not know what happened. V19 stated the goal is to always protect the residents to keep them safe and free from abuse. V19 stated R6 did make physical contact with R3, which is considered abuse. On 9/17/25 at 12:45 PM, V19 reenacted what he saw on 09/09/25 in the 4-North Lounge with the surveyor acting as R3 and V19 acting as R6. V19 stated it looked as if R3 was in the process of getting up from a chair when R6 made physical contact with R3. V19 acting as R6 charged head on directly toward surveyor as surveyor was attempting to get up from a chair. V19 demonstrated how the front of R6's right shoulder area made contact with R3's face. V19 stated this is what caused R3 to fall, but he not sure if R3 fell backwards or forward. V19 stated R6 was mad and there was some type of trigger that caused R6's anger, but he does not know what it was. V19 stated it was R6's anger that led to R6 willfully and aggressively hit R3 with force. On 09/16/25 at 1:20 pm, V13 (Certified Nursing Assistant) stated the incident happened in the 4-North Lounge right before lunch time on 09/09/25. V13 stated usually R3 sits in the 4-Southwest Lounge, but on that day when staff tried to get R3 to eat in the 4-Southwest Lounge, R3 wanted to go to the 4-North Lounge. V13 stated R3 was the only resident in the 4-North Lounge that she knows of, because all the other residents were in the 4-Southwest Lounge waiting for the lunch trays to arrive and be passed out. V13 stated when the incident occurred, she was sitting at the 4th floor nursing station with some of the other staff because they were waiting for the lunch trays to arrive. V13 stated this was around 12:00-12:30 PM. V13 stated one of the housekeepers was yelling "fall, fall" so they all got up and ran to the 4-North Lounge. V13 stated when she entered the 4-North Lounge, she saw R3 on the floor and could see that he was trying to get up. R6 was walking out of the 4-North Lounge, and she asked R6 what happened and R6 said to V13, "I don't know what happened, he (R3) just fell on the floor." On 09/17/25 at 11:10 AM, V2 (Director of Nursing) stated on 09/09/25, he was called to go up to the unit, and R3 and R6 were already separated by the time V2 arrived on the unit. V2 stated he first went to check on R3 who was in his room with his nurse. V2 stated R3 had an abrasion under his eye with mild swelling. V2 stated R3 appeared calm but irritated and restless. V2 stated R3's doctor was notified and gave order to		S9999				

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S9999	Continued from page 4 transfer him to the hospital. V2 stated when he saw R6 he was alert, agitated, irritable. V2 stated R6 said he bumped into R3. V2 stated he does not remember if R6 said it was intentional. V2 stated we think it was an accident because R6 was agitated and aggressively walking and bumped into R3. V2 stated he does not know why R6 was agitated and R6 could be unpredictable and demonstrate aggressive behaviors abruptly; they just happen, there is not necessarily a trigger. On 09/17/25 at 3:33 PM, V1 (Administrator) stated he is the Abuse Coordinator for the facility. V1 stated the goal is to keep the resident's safe and free from abuse. V1 stated it is the resident's rights to be free from abuse while they are residing in the facility and that all residents are at risk for abuse, and it is everyone's responsibility to prevent abuse. V1 stated on 09/09/25, R6 walked into the room aggressively and quickly made contact with R3. V1 stated R3 fell straight backwards. V1 stated maybe when R3 fell, he made contact with the floor and that is how R3 injured his eye. V1 stated R3 was sent to the hospital and diagnosed with a fractured eye socket. V1 stated this injury was caused by contact with R6 and he does not know what R6's state of mind was when he made contact with R3. V1 stated it was an observed fall and R6 bumped into him, it was not willful intent, so therefore it was not abuse. V1 stated he does not think R6 had intent to harm R3; R6 happened to aggressively bump into R3 and that caused the injury to R3. V1 stated there is no video footage of the incident because the facility cameras have not been working for a while. V1 stated the facility did an immediate discharge for R6 because of the other incidences he was involved in and because R6 he made contact with a resident. V1 stated he did not want to take a chance R6 could do something like that again. On 09/18/25 at 10:52 AM, V34 (Nurse Practitioner) stated R3 sustained a fall due to an unintentional interaction with another resident and this fall is what caused R3's injury. V34 stated R3 was sent out to the hospital and was diagnosed with an orbital wall fracture of the right eye. V34 stated R3's eye area would have had to come in contact with something to cause the injury, but no one knows what that was because no one witnessed the fall. R3's Nurse's Note titled Fall-Initial Occurrence, dated 09/09/25, documented, "resident had a witnessed fall on 09/09/25 12:30 PM in the 4-North Lounge. Resident was watching television in 4-North Lounge, then another resident who was agitated and walking fast toward the 4-North Lounge bumped into this resident resulting him	S9999					

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S9999	Continued from page 5 losing his balance and fell on the floor. Witnessed fall, observed to have struck head. An abrasion under the eyes. Send to hospital for further evaluation per doctor's order." R3's hospital records, dated 09/09/25, documented, "some concern from nursing staff, as well as myself, with lack of description of mechanism of injury. Nursing facility (name of facility) was called twice but was uncertain as to why patient had blood from his nose. After workup patient with orbital fractures and significant periorbital ecchymosis and periorbital swelling. As a mandated reporter, filed report through the Illinois Department of Public Health, for possible elder abuse." R3's Emergency Department Physical Exam comments documents ecchymosis to inferior aspect of right eye. Raccoon sign on the left eye. Blood from right nare. Contusion and ecchymosis overlying left forehead. R3's hospital records, dated 09/09/25, Quantitative Computed Tomography (CT) completed 09/09/25 impression right medial orbital and likely inferior orbital wall fractures. R6's Petition for Involuntary/Judicial Admission, dated 09/09/25, documents, "resident presents with increased agitation and responding to internal stimuli resulting in psychomotor whereby resident was walking very fast towards 4-North Dining Room and bumped into other resident. Also, resident was verbally confrontational with staff, placed on 1:1 monitoring; unable to be redirected, refused a PRN (as needed), may pose as a threat to himself and others." R6's Nursing Progress Note, dated 09/10/25, documents resident is admitted to hospital with diagnosis: aggression. Facility's final incident report submitted to Illinois Department of Health on 09/16/25 listed R3 as the victim and R6 as the perpetrator. Incident category listed as Resident Abuse. Facility final incident report documents in part, based on the investigation that included interviews with staff and residents R6 was agitated and was walking swiftly into the 4-Floor Lounge when he accidentally bumped into R3, resulting with R3 losing his balance and falling to the floor. Facility provided document titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities dated 11/2018 which documents your rights to safety: you must not be abused, neglected, or exploited by anyone financially,		S9999				

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S9999	Continued from page 6 physically, verbally, mentally or sexually. Facility provided policy titled Abuse Prevention and Reporting – Illinois reviewed 04/13/22 which documents the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. (B)	S9999					