

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054817		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/31/2026	
NAME OF PROVIDER OR SUPPLIER APERION CARE WEST CHICAGO				STREET ADDRESS, CITY, STATE, ZIP CODE 201 WEST NORTH AVENUE , WEST CHICAGO, Illinois, 60185			
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S0000	Initial Comments Annual Health Survey Complaint Investigation 2671230 / 2729768		S0000			02/04/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)3) 300.3210t) 300.3240b) 300.3240c) 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		S9999			02/04/2026	

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 personal care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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. Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from resident-to-resident physical abuse, and failed to identify abuse, investigate an incident of resident-to-resident abuse, implement interventions to prevent further recurrence, and report the incident. These failures resulted in a resident experiencing severe shoulder pain with a possible fracture, and subsequent psychosocial harm.		S9999				

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S9999	Continued from page 2 This applies to 1 of 2 residents (R131) reviewed for abuse in a sample of 38. The findings include: R131's Electronic Medical Record (EMR) indicated that progress notes, dated 1/18/2026, documents at approximately 10:15 PM, R131 was suddenly attacked by another male resident (R200) without provocation when R200 attempted to place his arm around R131's neck. V9 (RN) documented that he and another resident (R37) intervened and were able to separate the two residents, and that R200 stated, "I'm not on for the 3rd floor (secure unit)," adding, "I'm here for murder," which was also heard by R131. On 1/20/2026 at 6:11 AM, V12 (LPN) documented that R131 reported 8/10 left shoulder pain, for which PRN Acetaminophen-Codeine was administered; assessment revealed stinging pain with upward shoulder movement. R131's Minimum Data Set (MDS) dated 1/21/2026 reflects that his cognition was intact. R200's Orders-Administration Note by V9, dated 1/18/2026 at 11:33 PM, states R200 was "agitated, impulsive, and aggressive toward another male resident." 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. On 1/27/2026 at 10:37 AM, R131 was observed sitting in		S9999				

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S9999	Continued from page 3 bed, holding his left shoulder and wincing in pain. R131 reported a history of chronic cervical and back pain from a decades-old accident but stated his left shoulder pain was new and began after the incident on 1/18/2026. R131 described his pain as severe, rating it as 8 to 10 out of 10 on the pain scale (with 10 being the worst pain he had ever experienced). R131 said he was holding a cup and standing in front of the ice machine when R200 suddenly charged at him, grabbed him, placed both arms around his upper torso, and put him in a headlock. R131 reported being caught off guard and unable to defend himself. He stated the pain in his left shoulder had not been relieved by his current pain medications and he had been requesting an X-ray and to be sent to the hospital to assess the injury. On 1/27/2026 at 10:48 AM, R145 (R131's Roommate) confirmed the events of the night of R131's attack. R145 said R37, another resident in their hallway, was the first to intervene to separate R200 from R131. R145 reported the incident was unprovoked and noted R131 appeared to be in significant pain and distress following the event. The staffing assignment sheet for 1/18/2026 indicated V8 (RN-Registered Nurse) was assigned as R200's nurse. V9 (RN) was assigned as R131's nurse, and V10 (CNA-Certified Nursing Assistant) was the CNA assigned to the unit that evening. On 1/28/2026 at 11:42 AM, V8 (RN) said on the evening shift of 1/18/2026, she heard screaming and observed R200 physically holding R131's neck area. V8 stated R200 had to be moved to the facility's secure unit due to his aggressive, unprovoked behavior towards R131. V8 classified the incident as physical abuse. On 1/28/2026 at 1:48 PM, V10 (CNA) said she saw R200 approach R131 and attack him. V10 stated R131 was screaming as R200 aggressively put his arms around R131's upper torso and shoulder area. V10 described the altercation as physical abuse. An X-ray was ordered, and the result was reported to facility on 1/28/2026. The result showed an acute or subacute glenoid fracture of the left shoulder. On 1/28/2026 at 10:48 AM, V13 (ADON-Assistant Director of Nursing) documented radiology results showing linear bone density inferior to the glenoid consistent with an		S9999				

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S9999	Continued from page 4 inferior glenoid fracture fragment, prompting a physician order to send R131 to the hospital. V1 (Administrator) and V2 (DON-Director of Nursing) stated R131 returned to the facility without hospital paperwork and were unable to provide R131's hospital discharge paperwork prior to the end of the survey. On 1/29/2026 at 12:05 PM, R131 reported continued pain, rating it 8 out of 10 (severe), increasing to 10 out of 10 with sideward shoulder extension. R131 described the pain as "unbearable." On 1/29/2026 at 12:27 PM, V36 (RN) assessed R131 and confirmed compromised ROM (Range of Motion) to his left shoulder and severe pain. On 1/29/2026 at 12:45 PM, R131 stated since the incident on 1/18/2026, he had been feeling "on edge," anxious, and preoccupied with what had happened. R131 reported he remained deeply disturbed by R200's statement of "I'm here for murder", which he had heard R200 say during the altercation. R131 stated R200's remark plays over and over in his mind and causes fear and distress. R131 state he was afraid of encountering R200 again and he was now hesitant to use common areas of the facility, including the ice machine and hallway where the abuse occurred. During the interview, R131 was observed pacing back and forth in his room, appearing restless and visibly tense when recounting the event. He stated his pain and fear made it difficult for him to sleep, he had been waking frequently at night, and he felt more depressed and withdrawn than usual. R131 reported he no longer felt safe in the facility and expressed concern a similar incident could happen again. On 1/29/2026 at 10:46 AM, an interview was conducted with V14 (In-house NP – Nurse Practitioner), and on 1/30/2026 at 9:37 AM, an interview was conducted with V34 (Psychiatric NP). Both stated pain is a subjective experience, meaning it is based on the resident's personal perception and report rather than solely on observable or objective findings. They emphasized regardless of a resident's mental or psychiatric status, if a resident reports pain, it must be taken seriously, appropriately assessed, and treated as real pain. V34 further explained that the symptoms reported to her regarding R131 following the 1/18/2026 altercation — including heightened anxiety, hypervigilance, disrupted sleep, and worsening mood — were not consistent with his baseline presentation. V34 explained that these symptoms are characteristic of an "acute traumatic response" to a threatening event,		S9999				

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S9999	Continued from page 5 particularly when the resident continues to experience ongoing physical pain and fear of recurrence. V34 stated such a response can manifest as rumination about the incident, avoidance of common areas, sleep disturbance, emotional withdrawal, and increased distress, and may warrant additional psychiatric support, monitoring, or interventions. V34 further emphasized psychological distress, like pain, is a subjective experience, and clinicians must take a resident's report of distress seriously rather than discount it based solely on objective findings. 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. The facility's policy titled "Abuse and Retaliation Prevention and Reporting" (effective 1/8/2026) states, "The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.... The policy defined "abuse" as "the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish to a resident." The policy also showed "Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. 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		S9999				

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S9999	Continued from page 6 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..." (A)		S9999				