STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145316	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Wilmington	555 West Kahler Wilmington, IL 60481

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of sexual abuse to the state surveying agency and the police within required timeframes. This applies to 1 of 3 residents (R1) reviewed for abuse allegations.The findings include:On 10/9/25 at 4:00 PM, R1 stated that on 9/28/25, V3 (Nurse) was applying cream to her buttocks during wound care and then V3 applied the cream to her vaginal area and labia. R1 said that she felt that it felt sexual and that the nurse was violating her. R1 said that she reported the incident to V10 (Psychiatric Rehabilitation Service Coordinator/PRSC) on 10/2/25.On 10/10/25 at 1:14 PM, V10 (PRSC) stated that on 10/2/25, R1 told her that V3 (Nurse) had provided wound care to R1. V10 stated R1 told her that V3 applied a cream on and around her wound and then to R1's genital area, where it should not have been put on. V10 said R1 told her that V3 then touched her genital areas. V10 said that R1 told her that it made her feel bad and that she had to clean the area to clean the fingerprints off. V10 said she immediately reported the incident to her supervisor, V11 (Social Service Director), and then V11 went with V10 to V1's (Administrator) office to report the incident to V1. On 10/10/25 at 1:31 PM, V11 verified he went with V10 to V1's office on 10/2/25 and was present when V10 reported R1's alleged abuse to V1.R1 was admitted to the facility on [DATE] with diagnoses of major depressive disorder, bipolar disorder, anxiety disorder, and suicidal ideations. R1's 8/15/25 MDS (Minimum Data Set) shows that R1's cognition is intact. On 10/9/25 at 3:40 PM, V2 (Director of Nursing/DON) said that R1 alleged sexual abuse because she felt that V3 touched her inappropriately during wound care. V2 said that she was informed by V1 of the incident on 10/5/25 (three days after originally reported) and she interviewed R1 on 10/6/25. V2 said that she received a document from V10 dated 10/2/2025 stating that R1 was allegedly sexually abused, but V2 said she could not recall when she received the document. V2 said that the facility is to report allegations of abuse to the state surveying agency within 2 hours of it being reported and the facility did not do that. V2 said that the facility notified the state surveying agency on 10/9/25 and the incident was reported to the facility staff on 10/2/25. V2 said that the facility should have reported it to the state surveying agency on 10/2/25.On 10/15/25 at 12:53 PM, V1 (Administrator) confirmed R1's allegation of sexual abuse was reported to V10 (PRSC) on 10/2/25, and the facility reported it to the state surveying agency on 10/9/25. V1 stated the allegation was reported to the police on 10/9/25 as well.The facility's Abuse Prevention and Reporting policy (revised 10/24/2022) showed Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. The policy continued Initial Reporting of Allegations: When an allegation of abuse. has occurred, the resident's representative and the Department of Public Health 's regional office shall be informed.Public Health shall be informed that an occurrence of potential abuse. has been reported and is being investigated. The policy further showed Informing Local Law Enforcement. The facility shall also contact local law enforcement authorities. in the following situations:. Sexual abuse of a resident by a staff member, another resident, or visitor. When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their abuse policy by failing to timely investigate an allegation of abuse and suspend the alleged perpetrator. This applies to 1 resident (R1) reviewed for abuse allegations in a sample of 3.The findings include:On 10/9/25 at 4:00 PM, R1 stated that on 9/28/25, V3 (Nurse) was applying cream to her buttocks during wound care and then V3 applied the cream to her vaginal area and labia. R1 said that she felt that it felt sexual and that the nurse was violating her. R1 said that she reported the incident to V10 (Psychiatric Rehabilitation Service Coordinator/PRSC) on 10/2/25.R1 is a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of major depressive disorder, bipolar disorder, anxiety disorder, and suicidal ideations. R1's 8/15/25 MDS (Minimum Data Set) shows that R1's cognition is intact.On 10/10/25 at 1:14 PM, V10 (PRSC) stated that on 10/2/25, R1 told her that V3 (Nurse) had provided wound care to R1. V10 stated R1 told her that V3 applied a cream on and around her wound and then to R1's genital area, where it should not have been put on. V10 said R1 told her that V3 then touched her genital areas. V10 said that R1 told her that it made her feel bad and that she had to clean the area to clean the fingerprints off. V10 said she immediately reported the incident to her supervisor, V11 (Social Service Director), and then V11 went with V10 to V1's (Administrator) office to report the incident to V1. On 10/10/25 at 1:31 PM, V11 verified he went with V10 to V1's office on 10/2/25 and was present when V10 reported R1's alleged abuse to V1.On 10/9/25 at 3:40 PM, V2 (Director of Nursing/DON) said that R1 alleged sexual abuse because she felt that V3 touched her inappropriately during wound care. V2 said that she was informed by V1 of the incident on 10/5/25 (three days after originally reported) and she interviewed R1 on 10/6/25. V2 said that she received a document from V10 dated 10/2/2025 stating that R1 was allegedly sexually abused, but V2 said she could not recall when she received the document. V2 said that V3 (Nurse) remained working until 10/10/25 when V3 was suspended pending the investigation (eight days after the initial allegation). V2 said that the facility is to report allegations of abuse to the state surveying agency within 2 hours of it being reported and the facility did not do that. V2 said that the facility notified the state surveying agency on 10/9/25 and the incident was reported to the facility staff on 10/2/25. V2 said that the facility should have reported it to the state surveying agency on 10/2/25.On 10/15/25 at 12:53 PM, V1 (Administrator) said R1's allegation of sexual abuse was reported to V10 on 10/2/25, and the facility reported it to the state surveying agency on 10/9/25. V1 said that V3 was not suspended on 10/2/25 as per the facility's policy and was not suspended until 10/10/25. V1 said based on the facility's policy, the person alleged to have abused a resident is to be suspended for the safety of all residents.Under Protection of Residents in the facility's Abuse Prevention and Reporting policy (rev. 10/24/2022), it showed .Employees of this facility who have been accused of abuse .will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed The Internal Investigation portion of the policy showed .Any incident or allegation involving abuse .will result in an investigation .