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	02/18/2026

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. Based on interviews and record review, the facility failed to follow their policy and report an allegation of abuse. This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 3.The findings include:On February 17, 2026, at 9:43 AM, V1 (Administrator) I did do a reportable for [R1] in December (2025). He alleged to an insurance person that he was abused and stated that it was months ago, and he could not give a description of the individual. All he could say that it was a female and could not give a description or details of what exactly happened. This was investigated by (state surveying agency) with no findings. I also called the Insurance company who he reported this allegation to. The Social Service Director, a male, and his case manager, a female, spoke to him about it.R1's face sheet showed multiple diagnoses including type 2 diabetes mellitus with hyperglycemia, unspecified Dementia, unspecified severity without behavioral disturbances, psychotic disturbance, mood disturbance and anxiety, cognitive communication deficit, major depressive disorder, recurrent, moderate, alcoholic dependence with other alcohol induced disorder, alcoholic cirrhosis of liver without ascites.R1's comprehensive MDS (Minimum Data Set) dated January 9, 2026, showed that R1 was moderately impaired in cognition.On February 17, 2026, at 10:38 AM, R1 was lying in bed and answered to closed ended questions only. When asked if he has had someone physically abuse him (example: hitting, slapping) R1 stated It's been a while ago. Months ago. It was a staff member. It was a She. I think it was [first name of staff given]. I don't know why she punched me to this day. I don't think she was taking care of me. When asked if he talked to anybody about it, R1 stated I told someone around here. When asked if anyone from Administration talked to him about it R1 stated Some guy talked to me about it. I don't know if he is a staff. It wasn't a girl that talked to me about it, it was a guy. When asked if he is scared if this staff will do it again, R1 was hesitant and stated Probably. Above concerns were reported to V1 (Administrator).On February 17, 2026, at 11:14 AM, V1 was notified that R1 mentioned that a staff [identified by the first name] had abused him. V1 stated that they have a nurse (V7) and CNA/Certified nursing Assistant (V5) by that first name. V1 stated that V5 (CNA) has not even taken care of him and is working that day. V1 stated that V7 (Registered Nurse) comes in that afternoon. V1 stated that previously no names were given. V1 added that she will begin an investigation.On February 17, 2026, at 11:46 AM, V5 (CNA) stated I have worked here for almost two and a half years. I have not taken care of [R1]. I am always assigned to the [NAME] area, and he was not a resident in that unit. I heard couple of months ago that he mentioned my name from another CNA (V6). She works the night shift. She said that [R1] said that someone by the [her first name] beat him. He keeps mentioning my name and I never worked with him. Nobody (from Administration) talked to me about it. He was in the behavioral unit that time. I never worked there.On February 17, 2026, at 1:56 PM, V7 (Registered Nurse) stated I worked with R1 before when he was in [NAME] wing. He was moved to BHU (Behavioral Health Unit) and then to the (name of unit). We usually talk and he always tells me stories about his personal life, about his kids and his Pizza business (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	before. He has fragile blood sugar, so we keep a close eye on him. He never said anything about abuse. I know the protocol for abuse that we have to inform the DON (Director of Nursing), Administrator, right away when we know about it. The family also has to be notified within 24 hours.On February 17, 2026, at 11:16 PM, when asked if any resident had reported an abuse allegation to her, V6 (CNA) stated Yes, one of the residents [R1] I was giving a shower to, reported that months ago a CNA beat him up and I said who? And he said it was [identified by first name of V5 and V7]. I said I am sorry to hear that. It was about two months ago he told me this. He said that it happened 'months ago' and that he told the management about it and it was taken care of. I did not tell anybody about it. I did ask the person (V5) about it (don't recall when), and she said that it happened months ago and that it was taken care of a long time ago when they found out about it. So, I did not report it to my abuse coordinator as it was an old case. When I came to work today, I got a report that she (V5) was sent home today. I do not know if she was sent home before (during the initial allegation). On February 18, 2026, at 9:16 AM, V5 clarified that a couple of months ago, she and V6 had worked the same shift (2-10 PM) as V6 had picked up a shift. V5 stated that V6 had given R1 a shower at night. V5 stated that as she and V6 were leaving the facility after the shift, V6 told her that R1 mentioned that he was hit by someone by the name of [first name of V5]. V5 stated that she told V6 that how is this possible because she (V5) has never worked with him. V5 stated that this was the first time she heard about the allegation and that she did not take it seriously as she had never worked with him.On February 18, 2026, at 11:56, V6 clarified that she had heard about this allegation about eight months prior and that it is an old case. V6 stated that it happened when R1 was living in the [NAME] unit where V5 worked. V6 stated At that time we were told that there should be two people anytime we do care for the residents in the West. I thought this case was clear as [V5] was still working in this unit, so I did not report it. V6 stated that V5 always works in the [NAME] unit. V6 stated that R1 was moved from the [NAME] unit to the BHU unit and then to the (name of unit).On February 18, 2026, at 10:01 AM, V1 was informed about what V6 had reported. V1 stated that the name of staff [earlier stated first name] was never mentioned during allegation that R1 made to the insurance agent in December 2025 that a staff member had physically abused him. V1 stated that during facility internal investigation and to the (state surveying agency's) investigator for this allegation, R1 did not mention the name of the staff. V1 stated that V6 should have made administration aware of R1's allegation even though he mentioned that it was investigated. V1 stated that this is to confirm that investigations were carried out and to do another investigation just as it is been done now for this present allegation. V1 added that the allegation of abuse that V6 referred to occurred in the [NAME] unit and it was a different resident and V5's name was not mentioned. Facility policy titled Abuse and Retaliation Prevention and Reporting (effective date 1/8/2026) included:The 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 and misappropriation of property.The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.This will be done by [including]:Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, retaliation, and misappropriation of property.Procedures:V. Internal Reporting Requirements and Identification of Allegation:Employees are required to report any incident, allegation, or suspension of potential abuse, neglect, exploitation, retaliation, mistreatment, or (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	misappropriation of property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.