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	02/23/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify law enforcement and the state surveying agency of the attempted diversion of narcotic medications. This applies to 2 of 2 residents (R7 and R8) reviewed for control of narcotic medications.The findings include: On 02/13/26 at 11:15 AM, V3 (Registered Nurse/RN) stated on 08/09/25 he left two bingo cards of Norco, one for R7 and one for R8 on top of the cabinet in the medication room. V3 stated he took a break and when he returned from break, the medications were not where he placed them. V3 stated only him and V4 (RN) had keys to the medication room. V3 stated he searched the medication room and found both of the bingo cards inside of V4's unzipped shoulder bag. V3 stated he contacted V2 (Director of Nursing/DON) and informed her of the situation. V3 stated V2 and V1 (Administrator) immediately came to the unit. On 02/14/26 at 1:44 PM, V2 stated on 08/09/25, she received a call from V3. V3 stated he had placed two narcotic medications (Norco) on the counter in the medication room that were due to be wasted. V2 stated V3 took his break, and when he returned, the medications were not where he put them. V2 stated V4 had two bingo cards with Norco for two separate residents in her personal bag. V2 stated the bingo cards were visible and wrapped with the narcotic sheets still attached to them. V2 stated she removed the medications from V4's personal bag. V2 stated V4 admitted that she put the narcotics in her bag. V2 stated V4 stated she was addicted to drugs and just had gotten out of rehab one or two months prior. On 02/23/26 at 3:18 PM, V1 stated the narcotic medications found in V4's personal bag belonged to R7 and R8. V1 stated the police were not called due to the narcotic medications not leaving the facility, the medication count was accurate, and no residents missed any medications. V1 stated the police would only be called if there was a discrepancy with the drug count or the resident not being able to get their medications. V1 stated V4 was not reported to state licensing agency or the state surveying agency for the same reason. R7 was admitted to the facility on [DATE] with multiple diagnoses which included major depressive disorder, bipolar, anxiety, osteoarthritis, cervicalgia, and left-hand contracture per R7's Face Sheet. R7's Order Sheets for 07/01/25 through 08/30/25 showed a discontinued order for Norco Tablet 10-325 mg, give one tablet every 12 hours as needed for pain, start date 07/11/25. The same orders showed another discontinued order for Norco Tablet 10-325 mg, give one tablet every 8 hours as needed for pain, start date 08/09/25. R8 was admitted to the facility on [DATE] with multiple diagnoses which included acquired absence of right leg below knee, cognitive communication deficit, end stage renal disease, anxiety disorder, gout, and diabetes per R8's Face Sheet. R8's Order Sheets for August 2025 showed an order for Norco Tablet 5-325 mg (milligrams) give one tablet by mouth every 12 hours as needed for severe pain (7-10 on pain scale), for 5 days. The same orders showed the medication was ordered and started on 08/01/25 and ended on 08/06/25. The facility's Discrepancies, Loss, and/or Diversion of Medications Policy, revised 08/2020, showed, All discrepancies, suspected loss, and/or diversion of medications, irrespective of drug type or class, are (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	immediately investigated and a report filed. Procedures: Immediately upon discovery or suspicion of a discrepancy, suspected loss of diversion, the Administrator, Director of Nursing (DON), and consultant pharmacist are notified and an investigation conducted. The DON leads the investigation. 5. Appropriate agencies required by state regulation will be notified. Robbery: Immediately following the robbery: Notify the police

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to securely store controlled substances in the medication room. This applies to 2 of 2 residents (R7 and R8) reviewed for medication storage.The findings include:On 02/13/26 at 11:15 AM, V3 (Registered Nurse/RN) stated on 08/09/25 he left two bingo cards of Norco, one for R7 and one for R8 on top of the cabinet in the medication room. V3 stated he took a break and when he returned from break, the medications were not where he placed them. V3 stated only him and V4 (RN) had keys to the medication room. V3 stated he searched the medication room and found both of the bingo cards inside of V4's unzipped shoulder bag. V3 stated he contacted V2 (Director of Nursing/DON) and informed her of the situation. V3 stated V2 and V1 (Administrator) immediately came to the unit. On 02/14/26 at 1:44 PM, V2 stated on 08/09/25, she received a call from V3. V3 stated he had placed two narcotic medications (Norco) on the counter in the medication room that were due to be wasted. V2 stated V3 took his break, and when he returned, the medications were not where he put them. V2 stated V4 had two bingo cards with Norco for two separate residents in her personal bag. V2 stated the bingo cards were visible and wrapped with the narcotic sheets still attached to them. V2 stated she removed the medications from V4's personal bag. V2 stated when narcotic medications are in the medication room, they should be double locked. On 02/23/26 at 3:18 PM, V1 stated the narcotic medications found in V4's personal bag belonged to R7 and R8. On 02/23/26 at 3:41 PM, V12 (Assistant Director of Nursing) stated narcotic medications stored in the medication room should have been double locked and not stored on the cabinet. V12 stated the medications should have been placed back in the narcotic drawer in the medication cart, and locked. R7 was admitted to the facility on [DATE] with multiple diagnoses which included major depressive disorder, bipolar, anxiety, osteoarthritis, cervicalgia, and left-hand contracture per R7's Face Sheet. R7's Order Sheets for 07/01/25 through 08/30/25 showed a discontinued order for Norco Tablet 10-325 mg, give one tablet every 12 hours as needed for pain, start date 07/11/25. The same orders showed another discontinued order for Norco Tablet 10-325 mg, give one tablet every 8 hours as needed for pain, start date 08/09/25. R8 was admitted to the facility on [DATE] with multiple diagnoses which included acquired absence of right leg below knee, cognitive communication deficit, end stage renal disease, anxiety disorder, gout, and diabetes per R8's Face Sheet. R8's Order Sheets for August 2025 showed an order for Norco Tablet 5-325 mg (milligrams) give one tablet by mouth every 12 hours as needed for sever pain (7-10 on pain scale), for 5 days. The same orders showed the medication was ordered and started on 08/01/25 and ended on 08/06/25. The facility's Storage of Medications Policy showed Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.