

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER Aperion Care Wilmington		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interviews and record review, the facility failed to protect a resident's right to be free from resident-to-resident physical abuse. This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: On March 13, 2026, at 3:00 PM, R2 was walking around at his bedside and the doorway of his room. R2 said he got into a fight with his roommate (R1) in the dining room on March 12, 2026. R2 said, he got in my face, and I pushed him. R2 said when he pushed R1, R1 fell out of his wheelchair and was able to get up on his own. On March 13, 2026, at 3:15 PM, R1 was in the day room in his wheelchair. R1 said he was in the dining room on March 12, 2026, around 7:00 AM, when R2 approached him and started yelling at him, and suddenly pushed him out of his wheelchair. R1 said it happened so fast, and there was another resident in the dining room, but he did not remember the resident. R1 said there were no staff present in the dining room with them, and no staff saw what happened. R1 said he felt bad that someone attacked him at his place of residence. R1 said he asked the nurse to call the police, but the nurse refused. R1 also said he did not know the name of the nurse working on the unit on March 12, 2026. R1 said he did not sustain any injury at the time of the incident and denied having any pain. R1 had on short pants, and short sleeves on, no injury or bruising was noted on the resident. R1 said he reported the incident to V1 (Administrator) on March 12, 2026, around 11:00 AM that R2 pushed him out of his wheelchair. On March 13, 2026, at 4:11 PM, V18 (Social Services Director) said he was notified by V1 (Administrator) via text message around 6:50 AM on March 12, 2026, on his way to work that R1 had an altercation with R2. V18 said he and V1 both viewed the camera footage on March 12, 2026, in the morning. V18 said the footage showed R1 approaching R2 in the dining room and R2 yelled and pushed R1 to get away from him. V18 said part of the view where R1 was positioned was blocked off, and he did not see whether R1 fell out of his wheelchair. V18's progress notes for R1 from 10:11 AM on March 12, 2026 showed, Following breakfast services this morning, resident approached peer [R2] in [Unit] dining room, began to yell and wave his arms at peer while repeatedly approaching his wheelchair. Per peer, resident grasped him by the arm during the interaction; writer and administrator attempted to view the interaction via [Unit] dining room safety cameras, though the view was partially blocked and we were unable to verify this. Peer [R2] became agitated in response to the resident's behavior, began to argue with peers and pushed peer away from him. Both residents left the area after that. On March 14, 2026, at 10:35 AM, the video camera footage was reviewed without audio. The video showed R2 pacing in the dining room and R5 (identified by V1 while viewing the footage) walking into the dining room. R5 was seen walking towards R1 and speaking with him. R5 walked back to a table. R2 continued to pace back and forth in the dining room and within approximately one minute, R2 was seen talking to R1 in a threatening manner, with R2's upper body moving towards R1 repeatedly. Immediately after, R2 forcefully pushed R1 by reaching out with two flat hands toward R1. The camera view on R1 was partially blocked and did not show whether R1 fell out of his wheelchair. V1 said the push was forceful and that it was an abuse of R1. On March 14, 2026, at 1:08 PM, R5 was in her room, sitting on the bed. R5 was confused and could not answer questions about what happened between R1 and R2 in the dining room on March 12, 2026. On March 14, 2026, at 12:28 PM, V9 (Nurse) said that on the (continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>morning of March 12, R1 propelled his wheelchair down the hallway and said to her, he hit me, he hit me. V9 said she followed R1 to his room and asked R1 to explain what happened, and R1 repeated, he hit me. V9 said she asked R1 where he was hit, but R1 couldn't specify. V9 said she assessed R1 for injuries; there were none, and R1 denied pain. V9 said R1 did not ask her to call the police. V9 said she calmed R1 down, went to talk to R2, and saw R2 pacing in the dining room. V9 said she asked R2 what happened, and R2 told V9, He got in my face, and I pushed him out of my face. V9 said R2 gestured and held both of his hands out flat-handed to show that he pushed R1 out of his space. V9 also said she assessed R2 for injuries and found none. V9 said once a resident says they pushed another resident, it is an abuse allegation, and it has to be reported immediately, whether it's a behavior issue or not and she reported it to V1. R1's Electronic Medical Record (EMR) showed R1's diagnoses include paranoid schizophrenia and delusional disorder. R1's abuse care plan initiated on September 11, 2024, showed that R1 was at a heightened risk (moderate) for abuse due to psychiatric issues (paranoid schizophrenia, delusional disorder). The care plan interventions included observe resident when the company of peers. Observe resident in care area situation. Ensure safety if feeling unsafe. Report any verbalization of abuse or neglect to administrator immediately. The facility's January 8, 2026, Abuse and Retaliation Prevention and Reporting Policy showed Policy: This facility affirms the right of our residents to be free from abuse. or mistreatment. This facility therefore prohibits abuse. and mistreatment of residents. The policy further showed Definitions . Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to report an accurate allegation of abuse to the state surveying agency in a timely manner. This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: On March 13, 2026 at 3:00 PM, R2 was walking around at his bedside and the doorway of his room. R2 said he got into a fight with his roommate (R1) in the dining room on March 12, 2026. R2 said, he got in my face, and I pushed him. R2 said he pushed R1, and R1 fell out of his wheelchair and was able to get up on his own. On March 13, 2026, at 3:15 PM, R1 was in the day room in his wheelchair. R1 said he was in the dining room on March 12, 2026, around 7:00 AM, when R2 approached him and started yelling at him, and suddenly pushed him out of his wheelchair. R1 said it happened so fast, and there was another resident in the dining room, but he did not remember the resident. R1 said there were no staff present in the dining room with them, and no staff saw what happened. R1 said he felt bad that someone attacked him at his place of residence. R1 said he asked the nurse to call the police, but the nurse refused. R1 also said he did not know the name of the nurse working on the unit on March 12, 2026. R1 said he reported the incident to V1 (Administrator) on March 12, 2026, around 11:00 AM that R2 pushed him out of his wheelchair. On March 13, 2026, at 4:11 PM, V18 (Social Service Director) said he was notified by V1 (Administrator) via text message around 6:50 AM on March 12, 2026, on his way to work, that R1 had an altercation with R2. V18 said he and V1 both viewed the camera footage on March 12, 2026, in the morning. V18 said he met with R1 and R2, and he documented a behavioral progress note in R1's EMR after viewing the camera footage with V1. V18 said they saw in the camera footage that R1 was approaching R2 in the dining room and R2 yelled and pushed R1 to get away from him. V18 said part of the view where R1 was positioned was blocked off, and he did not see whether R1 fell out of his wheelchair. R1's behavioral progress note documented by V18 at 10:11 AM on March 12, 2026 showed, Following breakfast services this morning, resident approached peer [R2] in [Unit] dining room, began to yell and wave his arms at peer while repeatedly approaching his wheelchair. Per peer, resident grasped him by the arm during the interaction; writer and administrator attempted to view the interaction via [Unit] dining room safety cameras, though the view was partially blocked and we were unable to verify this. Peer [R2] became agitated in response to the resident's behavior, began to argue with peers and pushed peer away from him. Both residents left the area after that. On March 14, 2026, at 10:35 AM, V1 said V9 (Nurse) had called to notify her regarding R1 and R2's incident at approximately 6:40 AM on March 12. V1 said she also notified V18 (Social Service Director) at approximately 6:40 AM the same day, and asked V18 to find out what had happened between R1 and R2. On March 14, 2026, at 12:28 PM, V9 (Nurse) said that on March 12, R1 propelled his wheelchair down the hallway and said to her, he hit me, he hit me. V9 said she followed R1 to his room and asked R1 to explain what happened, and R1 repeated, he hit me. V9 said she asked R1 where he was hit, but R1 couldn't specify. V9 said she assessed R1 for injuries; there were none, and R1 denied pain. V9 said R1 did not ask her to call the police. V9 said she calmed R1 down, went to talk to R2, and saw R2 pacing in the dining room. V9 said she asked R2 what happened, and R2 told V9, He got in my face, and I pushed him out of my face. V9 said R2 held both of his hands out flat-handed to show that he pushed R1 out of his space. V9 also said she assessed R2 for injuries and found none. V9 said she called V1 (Administrator) at approximately 6:45 AM on March 12, 2026, to inform her that R1 alleged R2 had hit R1. V9 said she had to notify V1 the moment R2 told her he pushed R1 because it was an abuse allegation. V9 said per the facility's protocol, once a resident says they pushed another resident, it is an abuse allegation and it has to be reported immediately, whether it's a behavior issue or not. On March 14, 2026, at 3:00 PM, V2 (Director of Nursing/DON) said she was notified via text message at approximately 6:36 AM on March 12, 2026, by V1 that an incident had occurred between R1 and R2. V2 said the text message read from V1 stated, allegedly [R2] pushed [R1] in the dining room because (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[R1] was yelling at him. V2 said she was not part of the investigation, but she believed the incident was investigated by V1 and V18. V2 said V1 is responsible for completing the facility's abuse investigations and reporting to (state surveying agency), and she is responsible for completing the fall investigations. V2 said she would complete the abuse investigations if V1 were not available. V2 said if she were investigating the alleged incident between R1 and R2, she would document it in the behavioral progress note and send an initial report to (state surveying agency) immediately. On March 14, 2026, at 3:31 PM, V1 and V2 viewed the unit dining room safety camera footage. After viewing the part where R2 pushed R1, V2 said, he shoved him. V2 said that it should have been reported to (state surveying agency). On March 14, 2026, at 3:34 PM, V1 said she did not send an initial abuse allegation notification to (state surveying agency) and she did not notify the police and she should have. V1 said per the facility's policy, the timeline for notifying (state surveying agency) regarding an abuse allegation, such as a resident pushing another resident, is within two hours of the time of occurrence. The Facility Reported Incidents form that V1 sent to (state surveying agency) on March 13, 2024, showed the incident occurrence as abuse and that the occurrence date was March 13, 2026, not March 12. The document description alleged, On March 13, 2026, [R1] and [R2] alleged that they both had a resident-to-resident behavior to an (state surveying agency) Surveyor. They were immediately separated and assessed for injuries, pain, and emotional distress. The facility's January 8, 2026 Abuse and Retaliation Prevention and Reporting Policy showed, Any allegation of abuse, retaliation, or any incident that results in serious bodily injury will be reported to the (state surveying agency) immediately, but not more than two hours after the 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.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to follow their policy and investigate an allegation of resident-to-resident physical abuse. This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: On March 13, 2026, at 3:00 PM, R2 was walking around at his bedside and the doorway of his room. R2 said he got into a fight with his roommate (R1) in the dining room on March 12, 2026. R2 said, he got in my face, and I pushed him. R2 said he pushed R1, and R1 fell out of his wheelchair and was able to get up on his own. On March 13, 2026, at 3:15 PM, R1 was in the day room in his wheelchair. R1 said he was in the dining room on March 12, 2026, around 7:00 AM, when R2 approached him and started yelling at him, and suddenly pushed him out of his wheelchair. R1 said it happened so fast, and there was another resident in the dining room, but he did not remember the resident. R1 said there were no staff present in the dining room with them, and no staff saw what happened. R1 said he felt bad that someone attacked him at his place of residence. R1 said he asked the nurse to call the police, but the nurse refused. R1 also said he did not know the name of the nurse working on the unit on March 12, 2026. R1 said he reported the incident to V1 (Administrator) on March 12, 2026, around 11:00 AM that R2 pushed him out of his wheelchair. On March 13, 2026, at 3:50 PM, V1 (Administrator) said she was unaware that R2 had pushed R1. On March 13, 2026, at 4:11 PM, V18 (Social Service Director) said he was notified by V1 via text message around 6:50 AM on March 12, 2026, on his way to work that R1 had an altercation with R2. V18 said he and V1 both viewed the camera footage on March 12, 2026, in the morning. V18 said he met with R1 and R2, and he documented a behavioral progress note in R1's EMR after viewing the camera footage with V1. V18 said they saw in the camera footage that R1 was approaching R2 in the dining room and R2 yelled and pushed R1 to get away from him. V18 said part of the view where R1 was positioned was blocked off, and he did not see whether R1 fell out of his wheelchair. V18 provided a copy of R1's behavioral progress note documented at 10:11 AM on March 12, 2026. The behavioral progress note showed, Following breakfast services this morning, resident approached peer [R2] in [Unit] dining room, began to yell and wave his arms at peer while repeatedly approaching his wheelchair. Per peer, resident grasped him by the arm during the interaction; writer and administrator attempted to view the interaction via [unit] dining room safety cameras, though the view was partially blocked and we were unable to verify this. Peer [R2] became agitated in response to the resident's behavior, began to argue with peers and pushed peer away from him. Both residents left the area after that. On March 14, 2026, at 10:14 AM, V1 said she now remembered going to see R1 at approximately 9:00 AM on March 12, 2026, after being notified by V9 (Nurse) that R1 was upset. V1 said she spoke with R1 in his room, and R1 told her he was upset because his roommate, R2, did not flush the toilet. V1 said that was all she knew about the incident involving R1 on March 12, 2026. V1 said she was unaware that R1 had been attacked by R2, as R1 alleged. V1 said she did not complete a grievance report for R1. V1 said she did not complete an investigation of an abuse allegation because there was only a behavioral event between R1 and R2 on March 12, 2026. V1 said she initiated an abuse investigation at approximately 4:00 PM on March 13, 2026 (during the Survey and 33 hours after the incident) after being notified by the (state surveying agency) surveyor that R1 told her he was pushed out of the wheelchair by R2. On March 14, 2026, at 10:35 AM, the video camera footage was reviewed without audio. The video showed R2 pacing in the dining room and R5 (identified by V1 while viewing the footage) walking into the dining room. R5 was seen walking towards R1 and speaking with him. R5 walked back to a table. R2 continued to pace back and forth in the dining room and within approximately one minute, R2 was seen talking to R1 in a threatening manner, with R2's upper body moving towards R1 repeatedly. Immediately after, R2 forcefully pushed R1 by reaching out with two flat hands toward R1. The camera view on R1 was partially blocked and did not show whether R1 fell out of his wheelchair. V1 said the push was forceful and that it was an abuse of R1. On March 14, 2026, at 12:28 PM, V9 (Nurse) said that on March 12, R1 propelled his wheelchair down the hallway (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and said to her, he hit me, he hit me. V9 said she followed R1 to his room and asked R1 to explain what happened, and R1 repeated, he hit me. V9 said she asked R1 where he was hit, but R1 couldn't specify. V9 said she assessed R1 for injuries; there were none, and R1 denied pain. V9 said R1 did not ask her to call the police. V9 said she calmed R1 down, went to talk to R2, and saw R2 pacing in the dining room. V9 said she asked R2 what happened, and R2 told V9, He got in my face, and I pushed him out of my face. V9 said R2 held both of his hands out flat-handed to show that he pushed R1 out of his space. V9 also said she assessed R2 for injuries and found none. V9 said she called V1 (Administrator) at approximately 6:45 AM on March 12, 2026, to inform her that R1 alleged R2 had hit R1. V9 said she had to notify V1 the moment R2 told her he pushed R1 because it was an abuse allegation. V9 said per the facility's protocol, once a resident says they pushed another resident, it is an abuse allegation and it has to be reported immediately, whether it's a behavior issue or not. On March 14, 2026, at 3:00 PM, V2 (Director of Nursing/DON) said she was notified via text message from V1 around 6:36 AM on March 12, 2026, that an incident had occurred between R1 and R2. V2 said the text message read from V1 stated, allegedly [R2] pushed [R1] in the dining room because [R1] was yelling at him. V2 said she was not part of the investigation, but she believed the incident was investigated by V1 and V18. V2 said V1 is responsible for completing the facility's abuse investigations and reporting to (state surveying agency), and she is responsible for completing the fall investigations. V2 said she would complete the abuse investigations if V1 were not available. On March 14, 2026, at 3:34 PM, V1 said V1 said she should have begun an investigation on March 12, 2026. V1 said she began investigating R1's allegation at approximately 4:00 PM on March 13, 2026. The facility's January 8, 2026, Abuse and Retaliation Prevention and Reporting Policy showed, Policy: 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. VII. Internal Investigation 1. All incidents will be documented, whether or not abuse, neglect, exploitation, retaliation, mistreatment, or misappropriation of resident property occurred, was alleged, or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, retaliation, mistreatment, or misappropriation of resident property will result in an investigation.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure residents have a safe, functional, sanitary, and comfortable restroom environment. This applies to 18 of 18 residents (R3, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24) reviewed for restroom environment in sample of 24. The findings include: On March 12, 2026, at 1:32 PM, V3 (Environmental Manager) said that some residents have shared restrooms, while others have private rooms. She said each housekeeper has assigned residents' restrooms and bedrooms to clean daily. V3 said the day shift housekeepers clean the residents' bedrooms and bathrooms, including the toilets, sinks, soap, and paper towel dispensers daily. V3 said the housekeepers clean the residents' dining rooms after mealtimes, three times a day. On March 12, 2026, at 1:44 PM, the shared bedroom restroom for R3, R20, R21, R22, R23, and R24 was inspected in the presence of V3. There were toilet papers on the restroom floor, and the floor also had scattered black, stained footprints. There was a blue cloth bed pad with large brown stains at the front of the toilet base on the floor. V3 said the cloth bed pad was probably placed to soak the leakage from the base of the toilet. There was a black-and-white plunger on the floor next to the toilet. V3 said the plunger looks filthy and dirty. V3 said the toilet had been leaking, and it was brought up in the facility's team meeting. On March 12, 2026, at 1:48 PM, the shared bedroom restroom for R8, R9, R10, R11, R12, and R13 was inspected in the presence of V3. The bathroom's sink had large areas of stale brown stains and toothpaste build-up. The floor had several scattered black stains. V3 said the floor needs to be swept and mopped. The toilet seat was chipped in scattered areas, and the porcelain inside the toilet bowl had large areas of black buildup. A plunger was placed on the floor next to the toilet. V3 said the staff used the plungers to unclog the toilet, and they are not clean or hygienic. On March 12, 2026, at 2:30 PM, R9 said the housekeeping staff comes to clean the bathroom every three days. R9 said the black build-up stains in the toilet have been there ever since she could remember, and she said, I hate it, and that the chipped toilet is not hygienic, considering that she shares the restroom with five other residents. R9 said the toilet gets clogged at least once a day, and the residents always let the staff know each time it gets clogged. V3 said she knew about the toilet leakage because it had been brought up in the facility's team meeting a couple of times. V3 said she had previously notified V6 (Maintenance Director). On March 12, 2026, at 2:44 PM, R10 said the housekeeping staff comes to clean the bathroom maybe once a week. R10 said the black buildup stains in the toilet have always been there since she has been there, ever since she can remember, and she does not like toilets being dirty or the toilet seat being chipped. V10 said the facility staff is aware of the toilet seat being chipped. On March 13, 2026, at 2:30 PM, R8 said that the facility staff comes to clean the bathroom three times a week, but the bathroom is always dirty. R8 said she does not like using dirty restrooms, and she sometimes goes to the bathroom in the shower down the hall because her restroom would be dirty. On March 12, 2026, at 1:54 PM, the shared bedroom restroom for R14, R15, R16, R17, R18, and R19 was inspected in the presence of V3. There was a blue cloth bed pad with large brown stains at the front of the toilet base on the floor. There was also a large area on the restroom floor with black stains and peeling tiles beneath the cloth bed pad. On March 12, 2026, at 1:56 PM, R14 said the tiled toilet floor had black stains for a long time and that he had told the facility staff. V14 said the bed pad cloth is always there to cover up the unpleasant sight of the floor. On March 12, 2026, at 1:58 PM, R16 said the restroom floor had been with black stains for a very long time, and he had told the staff at the facility. On March 12, 2026, at 2:00 PM, R18 said the toilet sometimes leaks, and he is sure someone at the facility knows because it has been happening for a long time. On March 12, 2026, at 2:42 PM, V6 (Maintenance) said the black-stained tile on the shared restroom floor for R14, R15, R16, R17, R18, and R19 was from moisture, such as urine. V6 said he notified me about two months ago that the restroom floor tiles next to the toilet needed to be replaced, and it is still on his work-to-do list. V6 (continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>said the toilet seat for R8, R9, R10, R11, R12, and R13 needed to be replaced, and he was unaware. V6 also said the black buildup in the toilet was dirty and needed cleaning. On March 14, 2026, at 3:00 PM, V2 (Director of Nursing) said he had heard concerns about some residents' toilets getting clogged. V2 said the plungers are unsanitary and should not be left in residents' restrooms. The facility's undated Housekeeping Cleaning Schedule policy showed, Purpose: To establish a schedule which ensures the building and equipment is maintained in a clean and sanitary manner. All items may be cleaned more frequently, if necessary. 1. Daily: a. Toilet, lavatory .</p>		