

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 06/04/2026
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)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' rights to be free from verbal and physical abuse by a resident who frequently demonstrated verbal and physical abuse to others in the facility. This applies to 4 of 6 residents (R20, R37, R93, R145) reviewed for abuse in the sample of 33. A reasonable person would feel targeted, paranoid, and not safe based on R133's behaviors and physical abuse to other residents. The findings include: 1.R145's Face sheet shows that R145 has multiple psychiatric diagnoses including schizophrenia and generalized anxiety. Minimum Data Sheet (MDS) March 10, 2026, shows R145 is alert and oriented. R145's Abuse/Neglect Screening dated June 1, 2026, shows he was at risk for abuse. R145's incident report dated March 12, 2026, shows R145 had an altercation with R133. On June 1, 2026, at 11:33 AM, R145 was walking in the hallway when R133, who was in his wheelchair, came up behind R145 and suddenly struck R145 in the middle of his lower back with his left fist without provocation. R145 did not react and just kept on walking. R145 stated maybe R133 just wanted him to get out of the way. R145 continued to walk while mumbling to himself. At 4:09 PM, R145 was resting in bed, when he was informed that R133 left the unit, R145 finally spoke about R133's behavior towards him. R145 stated that R133 always bothers him. R145 also said R133 talks badly about him and struck him on his back earlier. On June 3, 2026, at 1:47 PM, V1 (Administrator) stated R133 was the instigator during the altercation with R145. While R145 was standing, R133 was yelling and waving his arms towards R145 while repeatedly approaching R145 with his wheelchair. R145 pushed R133 while he was sitting in his wheelchair to get out of his way. 2. R37's Face sheet shows that R37 has multiple diagnoses including anxiety disorder and unspecified dementia. MDS dated [DATE], shows R37 is alert and oriented. R37's Abuse/Neglect screening dated April 27, 2026, shows he was at risk for abuse. Incident reports dated March 25, 2026, April 25, 2026, and May 18, 2026, showed R37 and R133 had altercations. On June 1, 2026, at 4:13 PM, R37 was resting in bed, he was alert and oriented. R37 stated that R133 started bothering him without reason. R133 was an a**h* who ran his wheelchair over his foot and kicked him in the legs. They had altercations 3 different times, and R133 was doing it on purpose. R37 said he reported it to the social worker, but they were not doing anything about it. R37 stated that he was not the only resident that was targeted by R133, He is a bully. On June 2, 2026, at 1:18 PM, V2 (Director of Nursing/DON) stated R133 has been abusing his privileges. R133 has had multiple altercations with R37. In one of their altercations, R133 cut in line in front of R37 during smoking time. While propelling his wheelchair he bumped into R37 and kicked him to get him out of the way. R37 fell on the ground. On June 2, 2026, at 3:26 PM, V25 (Social Services Director) stated in one of R133's and R37's altercations, they were in the dining room, R133 rolled his wheelchair over R37's foot, but V25 was not sure if it was accidental or intentional. R37 and R133 continued to have altercations, so they asked R37 if he wanted to move to another unit and he gladly accepted. On June 3, 2026, at 2:07 PM, V1 (Administrator) stated R37, and R133 have had multiple altercations with one another. Every single event was instigated by R133. The first time they had an altercation was on March 25, 2026, R133 was sitting in his wheelchair and was blocking the entrance door of the dining room. When R37 (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 0600 Level of Harm - Actual harm Residents Affected - Few	wanted to enter, R133 refused to move, which blocked R37 from entering. So R37 pushed R133's wheelchair out of the way. R133 intentionally threw himself on the floor, there was no injury sustained. The next one was on April 25, 2026, both were in line for cigarettes, R133 accused R37 of looking at him, then R133 struck R37 in the leg. R37's legs were x-rayed; there was no injury noted. The third one was on May 18, 2026, R133 was backing out his wheelchair when R37 came behind the wheelchair and R133 accidentally rolled the wheel over R37's feet. R37 was sent to the hospital for further evaluation, there was no injury noted. After the third incident, R37 was moved out of the locked BHU (Behavioral Health Unit). On June 3, 2026, at 2:21 PM, V17 (Certified Nursing Assistant/CNA) stated R37 and R133 had an altercation on May 18, 2026, during lunch time. R133 believes that he was given a job by the facility owner to help staff pick up used meal trays. R133 went to the dining room to help. R133 took R35's tray from the table without consent. R35 yelled at him. R37 yelled at R133 as well for taking R35's tray. V17 (CNA) heard the commotion, and she saw R133 holding R35's tray. R37 was following R133 and was yelling at him at the same time. When V17 asked what was going on, R37 said that R133 ran his wheelchair over his foot. R37 was gesturing like he was about to hit R133. V17 immediately intervened and separated them. R133 was redirected and went back to his room. R37 was sent to the hospital via 911, for further evaluation. 3. R93's Face sheet shows that R93 has multiple psychiatric including anxiety disorder, brief psychotic disorder, and schizophrenia. R93's MDS dated [DATE], shows he is alert and oriented. R93's Abuse/Neglect screening dated May 6, 2026, shows he was at high risk for abuse. The facility's incident report dated January 23, 2026, shows that R133 and R93 had a resident-to-resident altercation. They were immediately separated and assessed for injury. No injury noted upon head-to-toe assessments. On June 1, 2026, at 4:37 PM, R93 was resting in bed. R93 said he and R133 had an altercation before but that was in the past. On June 3, 2026, at 1:58 PM, V1 (Administrator) stated R133's and R93's altercation happened when R133 blocked the doorway of the dining room, which prevented R93 from entering the dining room. R93 moved R133's wheelchair out of the way, and R133 threw himself on the floor, pretending that he was pushed by R93. 4. R20's Face sheet shows that R20 has multiple diagnoses including anxiety disorder, and Alzheimer's disease. MDS dated [DATE], shows R20 is alert and oriented. Abuse/Neglect Screening dated April 16, 2026, showed R20 is at risk for abuse. On June 1, 2026, at 4:30 PM, R20 was in bed, he was alert and oriented. R20 stated that a few months ago (he was unable to recall exact date of when it happened) R133 called him insulting names and even ran his wheelchair over his right foot. According to R20, R133 was constantly bothering him, and he (R20) reported it to the staff. R20 also said he was not afraid of R133, but he was just irritated towards him because he used to constantly harass him. R133's face sheet shows R133 is [AGE] years old with multiple medical diagnoses including delusional disorders, and paranoid schizophrenia. Minimum Data Set (MDS) dated [DATE], shows R133 is cognitively impaired. R133's Abuse/Neglect Screening dated March 25, 2026, showed R133 is at high risk for abuse. This same screening showed R133 exhibits poor space boundaries and provoking/antagonizing behavior with peers. R133 has history of false accusations related to psychosis. The facility's resident to resident altercations/incident report from January to June 2026, showed R133 had multiple altercations with different residents. R133's Behavior/Progress Notes from January 2026 to present showed multiple antagonistic and delusional behaviors towards peers, entering other residents' rooms without permission, exhibiting poor boundaries, and argumentative behaviors towards staff and peers. R133's care plan with revision date of May 21, 2026, showed, R133 has a behavior problem. R133 makes grandiose/persecutory complaints about staff, peers, and other unknown individuals to staff and others (e.g. State Regulatory Agency, and Ombudsman office) related to persistent delusional ideation. R133 often denies or minimizes these reports later when follow-up is provided. The incident reports made by R133, are often vague in nature and are made by R133 hours or days after the incident allegedly occurred. R133 tends to call 911 to make inaccurate reports. R133 also regularly exhibits antagonistic, verbally and physically aggressive behavior toward staff and peers related to (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	delusional thoughts, poor impulse control, delusional disorders, and paranoid schizophrenia. R133 would approach peers and make taunting sounds while they are talking, make inflammatory comments (e.g. that the resident is having sexual relations with his/her family members, that they are demons, R133 was in a Chinese prison etc.) and will respond to staff redirection with yelling/hitting doors. R133 tends to threaten staff related to paranoia. On June 2, 2026, at 2:15 PM V1(Administrator) stated R133 frequently gets involved in verbal and/or physical altercations. R133 is very delusional sometimes he is a priest, a rabbi, or a [NAME]. R133 says random things, believes that staff and other residents make anti-semitic statements towards him. R133 also states that the other residents were following him and giving him the evil eye. R133 verbalized that the medication is ungodly and antisemitic, and he didn't want to take any Chinese pills. The staff are doing 15 minutes check on him; room changes have been necessary in the past to separate him from the people whom he thinks were giving him an evil eye. R133 is non-compliant with medications, and he takes medications selectively. R133 will pick and choose whichever medication he wants to take depending upon his mood and who is giving him the medications. On June 2, 2026, at 1:50 PM, V2 (Director of Nursing) stated they try to redirect all their residents when displaying behaviors. They have to be careful with R133. They redirect him, but the problem with R133 is that he does not take redirections very well, he constantly calls the police and the state for everything. R133 was non-compliant with medications which was a big problem in curbing his behavior and the facility cannot force him to take medications. R133 does not allow doctors or nurse practitioners to interview or examine him. R133 has made false claims against nurses, CNAs, and other residents. R133's mindset is I'm not leaving, they are. R133 has the potential to demonstrate harm towards others. V2 said we have tried to send him out to the hospital for psychiatric evaluation and treatment; however, when the EMTs (Emergency Medical Technicians) would come to take him, he would adamantly refuse to go. The EMTs would tell our staff that they cannot force someone to go to the hospital. R133 would fight with the EMTs, and so they would just leave him here. R133 is always the instigator. If he is having issues with a resident, we move that resident away as a means to stop the altercation, but once the resident is removed from that situation, R133 will pick another resident to target. R133 intimidates people. They had a meeting with his physician, and the physician suggested that the best thing they could do would be to send R133 to a group home or an assisted living facility, but no one would accept him because of his behavior. Once in a great while he will pick a nurse that he likes, and he might take his medications but that's a rarity. The state guardian was notified of his behavior, however, the state guardian said, if R133 was happy here, she does not see any reason to move him. V2 added, R133 has been abusing his privileges. On June 2, 2026, 1:37 PM, V42 (Social Service) stated R133's behavior was mostly related to his psychosis, he has a lot of delusional beliefs. R133 antagonized peers, he would go up to them and accused them of having sex with their mothers. Most of the staff who work in this unit were aware of R133's behavior. Facility has care plans and assessments for his behaviors. They attempted to do a lot of counseling, but he does not respond to most staff. Interventions they had in place to prevent some of these altercations were to pay him a little extra attention, keep a closer eye on him, especially during meals and smoke times, frequent monitoring, and the presence of staff inside the unit. Ideally there should be someone within line of sight of the residents. R133 has been non-compliant with medications. R133 only took Salt tablets and Tylenol in the past years that he has been here. R133 refused to meet with psychiatric nurse practitioner nor the psychiatrist. On June 2, 2026, at 3:26 PM, V25 (Social Services Director) stated R133 has been on increased monitoring, which means heightened awareness of the staff whenever R133 was out of the room and in proximity with other residents especially when he is in milieu. This was a way to provide redirections when R133 begins to exhibit antagonistic behavior and for safety of the other residents. They also attempted to counsel R133. R133 has been very resistant to all the treatment plans, including medications, and appointments with a psychiatrist. They offered counselling and anger management groups, but he consistently refuses. They had regular care plan meetings which he refused to attend to. R133 was (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	sent to psychiatric hospital before, and they just send him back because he refused to cooperate with treatment plan. They attempted to manage R133 the best way they could, but he is a very difficult person. They have tried significant referrals to other facilities, but they were not successful. On June 2, 2026, at 12:51 PM, V43 (Housekeeping) stated R133 likes to instigate fights with other residents and new staff. R133 likes to be called [NAME] and if not called like that, he gets upset. R133 has been wandering and entering other residents' rooms without permission. Other residents had been complaining about him. V43 had personally heard residents screaming at R133 to get out of their rooms and V43 informed the social services about it. This was an everyday occurrence with R133. There are certain residents that he will try to intimidate or yell at. V43 also said, R133 would scream out loud at certain residents, R133 would say He likes to have sex with his mother! R33 would do that to R20 and R145. R145 does not bother anyone, he just mumbles to himself. R133 gets into altercation with regards to the meal trays, he would enter bedrooms and grab people's tray without consent which upsets other residents. On June 3, 2026, at 2:21 PM, V17 (CNA) stated R133 picks and chooses different people to bully, he likes to bully R20, R145, R93, and R163. R93 doesn't like to wear a belt, and his pants would slip down which bothers R133, and R163 who was cognitively impaired and talks constantly to herself also bothers R133. R133 bullied selective people. The residents are not afraid of R133 they just felt irritated towards him due to his behavior. The staff who work in BHU, including the administration, were all aware of R133's antagonistic, aggressive, and bullying behavior towards specific residents. V1, V25, and V42 all identified that R133 was non-compliant with treatment plan, and they stated that one of their interventions was to increase the monitoring of this resident. On June 1, 2026, at 11:33 AM, when R133 struck R145, there were no staff present in the hallway. They attempted to send R133 to the hospital after he struck R145, but R133 refused and the EMT paramedics left. However, facility called an ambulance again and the second set of EMT staff were firmer towards R133, so they were able to bring R133 to the hospital.		