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	07/01/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review the facility failed to protect the residents' right to be free from physical abuse by another resident. This applies to 4 residents (R1, R2, R3 and R4) reviewed for abuse in a sample of 5. Findings include:1. On 07/01/26 at 12:03 PM, R1 stated he got into an altercation with R2. R1 stated he was attempting to pass R2 in the hallway when he accidently bumped into him. R1 stated he attempted to apologize when R2 hit him. R1 stated he then grabbed R2 by his collar and R2 bit his right thumb on the knuckle. R1 stated he got antibiotics for the bite, but his thumb still hurt. R1 stated the staff broke them up but he did not recall their names. R1's right thumb appeared slightly reddened and swollen. On 07/01/26 at 12:10 PM, R2 stated he did not recall getting into an altercation with anyone. On 07/01/26 at 12:29 PM, V3 (Registered Nurse/Assistant Director of Nursing) stated while she was providing care to another resident, she heard a commotion from the hallway. V3 stated she came out to find R1 and R2 fighting. V3 stated she and CNAs (Certified Nursing Assistants) separated R1 and R2. V3 stated she did not recall who the CNAs were. V3 stated R1 had a bite injury to his right thumb and R2 had a scratch on his ear. V3 stated she provided care for R1 and R2's injuries and obtained an order for antibiotics for R1's bite injury. On 07/01/26 at 1:03 PM, V4 (CNA) stated she was working on 06/13/2026 when R1 and R2 got into an altercation. V4 stated she heard screaming and came running to see R1 grabbing R2's collar and R2 biting R1's thumb. V4 stated R1's right thumb had teeth marks and was bleeding. V4 stated he separated R1 and R2 then returned to his unit when other staff arrived. A progress note written by V3 on 06/13/2026 at 11:26 PM for R1 documents altercation between R1 and R2 and R1's bite injury. V3's 06/13/2026 at 11:54 PM progress note for R2 documents the altercation R1 and R2 and R2's left neck and left ear abrasions. The facility's Facility Reported Incidents for R1 and R2's 6/13/2026 altercation showed .R1 then shook his finger at [R2] and [R1] then closed his teeth on [R1's] right thumb . 2. On 7/1/26 at 11:35 AM, R3 said she had an altercation with R4 when R4 came into R3's room. R3 said R4 first hit her on her back and then R3 hit R4 upside the head. R3 said she stays in her room because she doesn't want R4 hitting her. On 7/1/26 at 1:10 PM V10 (Registered Nurse/RN) said she was working on 6/13/26 when the reported altercation took place between R3 and R4. V10 said one resident scratching another resident is physical abuse. (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 - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/26 at 2:49 PM, V1 (Administrator) said V3 (Assistant Director of Nursing) called her on 6/13/26 and told her about R3 and R4's altercation. V1 said one resident scratching and/or biting another resident is physical abuse. V1 said V10 told her V12 (CNA) pulled R4 out of R3's room after the altercation occurred. On 7/1/26 at 1:20 PM, V2 (Director of Nursing/DON) said V1 notified her on 6/13/26 that R4 wheeled herself into R3's room, a CNA saw and pulled R4 out of R3's room, and R3 got upset and went after R4 in the hallway and scratched her. V2's (DON) progress note dated 6/13/26 at 8:00 PM states she was made aware by the nurse on duty that R4 had a scratch on her right cheek from another resident (R3). V13's (Social Service Director) follow-up behavior note written on 6/15/26 at 1:05 PM states he provided follow-up to resident altercation on 6/13/26. V13 states per staff, R4 wandered into R3's bedroom, which upset R3, who then swatted at R4 to get her out of her personal space, scratching R4 on the cheek. R4's Face Sheet shows the following diagnoses: Alzheimer's disease and dementia. R4's MDS (Minimum Data Set) dated 4/8/26 shows she is rarely/never understood and she has a memory problem. R4's Care Plan last revised 4/8/26 states she is at heightened risk for abuse/neglect related to Alzheimer's disease and dementia. R4 exhibits impaired cognition and communication and has a history of wandering behaviors. The Facility Reported Incidents final report sent on 6/19/26 at 2:37 PM states on 6/13/26, R4 and R3 had an altercation, and listed the event as an accident/incident. R3 was upset because she believed R4 entered her room without permission. R3 then reached out to R4 in the hallway and scratched her. R4 and R3 were assessed for injuries and it was noted R4 sustained a scratch to her right cheek. The facility's policy titled, Abuse and Retaliation Prevention and Reporting-Illinois effective 1/8/26 states, Policy: This facility affirms the right of our residents to be free from abuse.In order to do so, the facility has attempted to establish a resident-sensitive and resident-secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse.Definitions.Abuse: Abuse means any physical or mental injury.inflicted upon a resident other than by accidental means.Abuse is the willful infliction of injury.with resulting physical harm.The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse. This applies to 4 residents (R1, R2, R3, R4) reviewed for abuse investigations in a sample of 5 residents.The findings include: 1.The facility's final Facility Reported Incidents for R3 and R4's physical abuse altercation listed the event as an accident/incident rather than resident abuse. The form showed an altercation was alleged and R4 sustained a scratch on her right cheek that required first aid. The form showed Upon investigation, [R3] was upset.[R4] reached out to [R3] in the hallway encountering her causing a small scratch. No conclusion was included on the form to show if abuse/assault did or did not occur. On 7/1/26 at 9:45AM, V1 (Administrator) was asked for her complete investigation file of the Facility Reported Incident from 6/13/26 between R3 and R4. V1 provided the initial and final reports that were sent to the state surveying agency and was unable to provide any additional evidence such as interviews with staff witnesses or documentation or observations of R4 after the abuse. On 7/1/26 at 2:49 PM, V1 said she is the Abuse Coordinator, and she was notified of the altercation between R3 and R4 by V3 (Assistant Director of Nursing/ADON) via phone on 6/13/26. V1 said R3 and R4 were not V3's residents on that day and V3 told V1 that she did not observe their altercation but heard R3 scratched R4. V1 said R3 and R4's nurse at the time of the altercation was V10 (Registered Nurse/RN). V1 said she did not interview R3 or R4. V1 said she did not go to see R4 or observe the scratch on her cheek. V1 said she only interviewed V3 (ADON) and V10 (RN) regarding the incident and both nurses told her they did not observe the altercation. V1 said V10 told her she thought V12 (Certified Nursing Assistant/CNA) was the staff member who pulled R4 out of R3's room. V1 said she did not attempt to interview V12 because she got information from V3 and V10 (who both told her they did not witness the altercation). V1 said she did not have any documentation showing she conducted any staff interviews regarding the altercation. V1 said witness statements and interviews should be documented to complete a thorough investigation. On 7/1/26 at 1:52 PM, V10 (RN) said V1 never interviewed her regarding R3 and R4's altercation. V10 said when there is an altercation between residents, the bedside nurse should document it in a progress note. On 7/1/26 at 2:36 PM, R4's EHR/Electronic Health Record was reviewed and did not show any documentation of her scratch assessment/appearance or treatment orders or any documentation that the abuse with injury occurred. 2.On 07/01/26 at 09:45 AM, documentation for the investigation of R1 and R2's physical altercation was requested from V1 (Administrator) and V2 (Director of Nursing/DON). V2 provided the initial and final reports submitted to the state surveying agency along with the face sheets for R1 and R2. V2 stated the documents that were provided was the complete investigation. No investigation conclusion was included on the final report. On 07/01/26 at 11:27 AM, V1 (Administrator) stated when the final report had been submitted to the state surveying agency that all of her investigation, including interviews, had been completed. Documentation of the investigation was requested from V1. V1 stated she was just about to type it up. V1 stated she had handwritten her interviews for the investigation. The handwritten investigation documentation was requested from V1. V1 was unable to provide her handwritten documentation for her investigation into the altercation between R1 and R2. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/01/26 at 12:03 PM, R1 stated he discussed the incident with staff present at the time of the incident on 06/13/2026. R1 stated he did not discuss the incident with any other facility staff. On 7/01/26 at 12:10 PM, R2 was unable to recall having an altercation with anyone. On 07/01/26 at 12:29 PM, V3 (ADON) stated she had informed the Administrator of the altercation between R1 and R2. V3 stated CNAs were present at the time of the altercation, but she could not recall any of the names of the CNAs present during the abuse. On 07/01/26 at 1:03 PM, V4 (CNA) stated she was present during the altercation between R1 and R2 and no one interviewed her about it, including the Administrator. On 07/01/26 at 1:23 PM, V5 (CNA) stated he informed V3 about what he witnessed between R1 and R2 at the time of the incident, but he did not talk to the Administrator or anyone else about the incident. On 07/01/26 at 2:58 PM, V1 stated she is the abuse coordinator, and she submitted the initial and final reportable to the state surveying agency regarding the altercation between R1 and R2 on 06/13/2026. V1 stated she interviewed R1 about the incident but R2 refused to talk to her. V1 stated she also interviewed V10 (RN) and V3 (ADON). V1 stated she did not interview any CNAs because V3 (ADON) informed her no CNAs were present during the altercation between R1 and R2. V1 stated documentation of interview/witness statements is a part of the investigation, but she had none to provide. A progress note written by V3 (ADON) on 06/13/2026 at 11:26 PM for R1 showed the altercation between R1 and R2 and included the presence of CNA staff, and V3's 06/13/2026 note from 11:54 PM for R2 included the presence of CNA staff during the altercation. The facility's 1/8/2026 Abuse and Retaliation Prevention and Reporting policy showed the facility will implement .systems to promptly and aggressively investigate all reports and allegations of abuse. Under VII. Internal Investigation the policy showed 1. All incidents will be documented, whether or not abuse.mistreatment.occurred, was alleged, or suspected. 2. Any incident or allegation involving abuse.will result in an investigation. The policy continued 4. Investigation Procedures. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident, and the resident if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Regarding the final investigation report, the policy showed .The final investigation report shall contain the following.Conclusion of the investigation based on known facts.