| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145740 | A. Building<br>B. Wing | 04/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aperion Care Elgin | 134 North McLean Boulevard<br>Elgin, IL 60121 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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** 48308

Based on interview and record review, the facility failed to report a suspicion of a crime to law enforcement and the survey agency in a timely manner in accordance to the facility policy.

This applies to 1 of 3 (R1) residents reviewed for incidents in sample of 5.

The findings include:

R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], and discharged from the facility on March 29, 2025. R1 had multiple diagnosis including cachexia, severe protein -calorie malnutrition, dysphagia oropharyngeal phase, unsteadiness on feet, and cognitive communication disorder, adult failure to thrive, and cognitive communication deficit.

R1's MDS (Minimum Data Set) dated March 5, 2025, showed R1 was severely cognitive impaired, and required assistance for ADLs including partial assistance with eating, substantial assistance with oral hygiene, bed mobility, and upper body dressing, and dependent on staff assistance for toileting, bathing, lower body dressing and transfer.

On March 30, 2025, at 10:13 AM, V1 (Administrator) stated there had been a firearm in a purse in the facility on March 12 or 13th, 2025. V1 explained V4 (R1's daughter) called the facility and spoke to V6 (RN) and stated she had left her purse in R1's room after her visit and did not realize it until she got home. V1 stated V6 took the purse to V5 (Social Services Director). V5 took the purse to V1's office and locked it in a drawer of the desk and locked the door to V1's office. V1 stated V4 had stated she was unable to come back to the facility that day. V1 stated he locked the purse in the basement office in the facility safe after talking to V4. V1 stated he did not contact law enforcement, nor report to IDPH (Illinois Department of Public Health) that there was a firearm in the facility, in violation of the facility sign on the door for no firearms allowed in violation of the Illinois Concealed Carry Firearms Act. V1 stated V4 came to the facility to pick up her purse the next day. V1 stated he received a text message on March 13, 2025, at 4:36 PM from V5 (Social Services Director) informing him of the purse that had a firearm inside it. V1 stated he was not in the facility at that time and returned to the facility around 7:30 PM to lock the purse inside the safe.

On March 30, 2025, at 12:11 PM, V1 provided a copy of initial report to IDPH, dated March 30, 2025, and called the local police department (incident 25-2003) after surveyor inquired if there was a report made to law enforcement or IDPH.

(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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| NAME OF PROVIDER OR SUPPLIER Aperion Care Elgin | | STREET ADDRESS, CITY, STATE, ZIP CODE 134 North McLean Boulevard Elgin, IL 60121 | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On March 30, 2025, at 1:16 PM, V4 stated she visits R1 daily but does not always remember to sign in and out of the visitor log. V4 stated she was visiting on March 13, 2025, and left in a hurry by ride share car because the driver will not wait longer than 3 minutes. V4 stated she had a concealed carry firearms license and did have a firearm in her purse when she entered the facility. V4 could not remember the time she left the facility or even the time that she arrived at the facility that day, but did state as soon as she arrived home, she called the facility and talked to a nurse to explain the purse needed to be locked away for safety.<br><br>On March 31, 2025, at 2:50 PM, V6 (RN) stated she was assigned to R1 on the evening shift of March 13, 2025, and received a call from V4 at 4:16 PM according to the caller ID on the telephone. V6 stated V4 told her she left her purse at R1's bedside and just realized it when she arrived home and immediately called the facility. V6 stated V4 said the purse needed to be locked in a safe because it contained a firearm. V6 stated she went to retrieve the purse from R1's room and brought the purse to V5 who was the manager in the facility at the time. V6 stated the purse was black, medium sized, was closed and she did not look inside the purse. V6 stated she did not think to call local law enforcement because she had a manager in the facility, and she would leave that decision to management.<br><br>On March 30, 2025, at 10:56 AM, V5 (Social Services Director) stated she was in the facility on March 13, 2025, around 4:30 PM when V6 brought her a purse. V6 told her V4 had called and informed her that there was a firearm in the purse and V5 stated she contacted V1 by text. V5 stated she did not call local law enforcement because she was not instructed to do so. V5 stated she took the purse. Locked it in a desk drawer and locked the office and made the key to the office unavailable by putting the key in the freezer of the refrigerator in V1's office and locked the door.<br><br>R1 was in the hospital during this investigation and unable to be interviewed. R2 (R1's roommate) stated she had no knowledge of a purse being left in their room and neither R1 or R2 would have been capable of picking up the purse due to immobility.<br><br>V3 (Nurse Consultant) provided a document titled Resident Rights and Responsibilities that was signed by V4 on March 4, 2025, on behalf of R1. The document showed 14. Residents are prohibited from keeping any weapons in their possession, i.e. gun, knife, razor blade, stick, etc. that may cause bodily injury.<br><br>The Illinois Concealed Carry Firearm Act, 430 ILCS 66/1 showed Concealed firearm means a loaded or unloaded handgun carried on or about a person completely or mostly concealed from the view of the public. 430 ILCS 66/65 showed Prohibited areas (a) A licensee under this act shall not knowingly carry a firearm on or into: (7) Any building, real property, and parking area under the control of a public or private hospital or hospital affiliate, mental health facility or nursing home. 430 ILCS 66/70 showed A licensee in violation (e) Except as otherwise provided, a licensee in violation of this Act shall be guilty of a class B misdemeanor.<br><br>The facility's policy titled Abuse Prevention and Reporting-Illinois, Reporting of Crimes revision October 24, 2022, showed External Reporting .Informing Local Law Enforcement. The facility shall also contact local law enforcement authorities (i.e. telephoning 911) in the following situations .When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident. and If there is a reasonable suspicion that a crime has been committed and does not involve serious bodily injury then a report to local law enforcement and Department of Public Health as soon as possible but within 24 hours of when the suspicion was formed. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308<br><br>Based on interview and record review the facility failed to investigate an incident of a suspicion of a crime in accordance with their policy.<br><br>This applies to 1 of 3 (R1) residents reviewed for incidents in the sample of 5.<br><br>The findings include:<br><br>R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], and discharged from the facility on March 29, 2025. R1 had multiple diagnosis including cachexia, severe protein -calorie malnutrition, dysphagia oropharyngeal phase, unsteadiness on feet, and cognitive communication disorder, adult failure to thrive, and cognitive communication deficit.<br><br>R1's MDS (Minimum Data Set) dated March 5, 2025, showed R1 was severely cognitive impaired, and required assistance for ADLs including partial assistance with eating, substantial assistance with oral hygiene, bed mobility, and upper body dressing, and dependent on staff assistance for toileting, bathing, lower body dressing and transfer.<br><br>On March 30, 2025, at 10:13 AM, V1 (Administrator) stated there had been a firearm in a purse in the facility on March 12 or 13th, 2025. V1 stated he did not have an investigation for the incident nor any documentation regarding the occurrence. V1 stated V4 (R1's daughter) called the facility when she realized she forgot her purse in the facility at R1's bedside. V1 stated he did not report the occurrence at the time to either law enforcement or Department of Public Health because he thought V4 had no malicious intent. V1 stated he was notified by V5 (Social Services Director) by text that V4's purse was found and V5 locked the purse in V1's desk and locked V1's office door. V1 stated he later came to the facility the same day around 7:30 PM and locked the purse in the basement of the facility in a safe and directed staff not to open the safe. V1 stated V4 came and retrieved her purse from the facility the next day.<br><br>On March 30, 2025, at 12:11, V1 provided an initial incident to IDPH (Illinois Department of Public Health) dated March 30, 2025, and contacted law enforcement on March 30, 2025, for the occurrence of March 13, 2025.<br><br>V1 stated he did not have a policy regarding what to do with a firearm discovered in the facility but followed Illinois State Police guidelines. During this investigation, V1 did not provide documentation of the State Police guidelines for firearm safety.<br><br>There was a sign on the front door of the facility that showed firearms were banned from the facility.<br><br>V1 did not provide an investigation, timeline of events, interviews held, or preventative measures taken for the occurrence of a firearm being left in a purse at R1's bedside, as requested during this investigation.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Illinois Concealed Carry Firearm Act, 430 ILCS 66/65 showed that a licensee was prohibited from knowingly entering a nursing home with a firearm on or about their person.<br><br>The facility's policy titled Abuse Prevention and Reporting-Illinois, Reporting of Crimes revision October 24, 2022, showed The facility affirms the right of our residents to be free from abuse, neglect . and mistreatment of residents .In order to do so the facility has attempted to establish a resident sensitive and resident secure environment . Internal Investigation .All incidents will be documented .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, .The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and any corrective action taken to the Department of Public Health within 5 working days of the reported incident. |