| 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 | 09/17/2025 |

| 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 (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to prevent the verbal/mental abuse of a resident. This applies to 1 of 3 (R1) reviewed for abuse in a sample of 17. The findings include:On 9/15/25 at 12:30 PM, R1 stated V4 (CNA- Certified Nursing Assistant) and V5 (CNA) were harassing him at the facility. R1 alleged V4 called him Honey Bunn7 and came into his room uninvited in a threatening manner making threatening comments such as her father purchased her a gun and telling R1 he had not better be talking about V4. R1 stated one day V4 was standing in the hall and pointed to R1 and began a hoola dance. R1 stated he reported the harassment to V1 (Administrator) and V1 prohibited V4 and V5 from working near the unit on which R1 was residing. R1 stated on 9/13/25, R1 left his room to warm up food and saw V4 and V5 at the nursing stating in his hall. R1 stated he told his nurse that V4 and V5 were not to be near his hall and to call V1 to confirm they needed to leave. R1 stated he began recording the episode on his phone. At 12:32 PM R1 played the video he recorded on the phone which showed R1 continuously telling the nurse on his hall that the two staff were not supposed to be present in the back of the building near his hall, that V1 gave the two staff a stern warning, that they would not receive any more warnings, and to call V1 and confirm the information. The video showed as R1 repeatedly told the nurse the staff were not to be on his unit, V4 and V5 remained near R1 and eventually the floor nurse began to move the staff toward the front of the building. The video showed the floor nurse on the phone walking behind V4 and V5 and the staff were walking toward the front of the building. At 6 minutes and 6 seconds of the recording s the staff walked away from R1, a female voice off camera stated, That's what he is. A little bitch! R1 immediately replied, Oh I'm a little bitch, huh? Thank you! R1 stated he previously showed V1 the video and V1 was going to address the behavior with the staff. Facility Email, dated 9/14/25, shows R1 told V1 on 9/13/25 V4 was on his wing in spite of V1 telling V4 that she was only work in another part of the building. The email shows R1 brought his concern to the attention of the nurse on duty. The email shows R1 recorded the interactions and V4 stated to R1, You are just a little bitch. On 9/15/25, V4 denied calling R1 any names and stated R1 was harassing V4 for some time including following her around the building and calling her a bitch and racial slurs. V4 stated on 9/13/25, she arrived at the facility and went to the back to look for her assignment. V4 stated she did not call R1 a bitch but that she was on the phone with her dad and told her dad R1 called V4 a bitch. V4 stated R1 then followed V4 and V5 to the front of the building and continued to harass them. On 9/15/25 at 11:33 PM, V5 stated she did not hear V4 swear at R1. V5 stated she was taking her break and performing charting at the back nursing station when she saw R1. V5 stated V4 was also at the back nursing station putting her personal belongings down. V5 stated she did not say anything to R1 and R1 did not say anything to V4 or V5. On 9/15/25 at 10:00 AM, V1 (Administrator) stated he received an email from R1 alleging V4 and V5 were present in the back of the building near R1 and V4 swore at R1. V1 stated V4 and V5 were previously instructed to remain in the front of the building because of conflicts between R1 and V4 and V5. On 9/15/25 at 1:39 PM, V6 (Registered Nurse) stated she was on duty 9/13/25 when R1 came out of his room and told her V4 and V5 should not be working on his unit. V6 stated I needed to speak with administration which she did and administration told V6 the staff needed to move to the front of the building. V6 stated V4 and V5 moved away from the unit in 5 to 10 minutes of R1 initially stating they should not be on his unit. When asked if V6 felt the staff were lingering at the nursing station after they were told they should not be there, V6 stated, Yeah, a little bit but not that much. On 9/15/25, V7 (CAN) stated on 9/13/25 R1 was telling the nurse in the hall that V4 and V5 could not be in the back of the building, and they were warned not to be in the back. V6 stated the nurse told the staff they needed to go to the front hall nursing station and there was much talking back and forth and one of the nurses was trying to calm it down. V7 stated V4 and V5 stayed at the back hall nursing station 10-20 minutes before they went to the front of the building. Nursing note written by V6 (Registered Nurse) and effective 9/13/25, showed The nurse was passing the medication; the resident come to the nurse and was complaining about staff CNA. He wants the CNA out of the unit. The CNA and the resident were arguing each other. Facility email, dated 9/7/25, shows R1 expressed concern to V1 that V4 walked into his room in a threatening way without his permission. Facility email, dated 9/5/25, shows R1 expressed concern to V1 that V4 entered his room in a threatening way, allegedly called R1 Honey bunny, and R1 requested that V4 not be anywhere near him in the future. Facility email by V8 (Human Resources), dated 9/16/25, shows the facility outcome of investigation proves that R1 violated the facility's abuse policy. The email shows the |