STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145261	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Dekalb	1212 South Second Street Dekalb, IL 60115

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on interview, and record review the facility failed to notify a resident representative of an advanced stage wound for 1 of 3 residents (R1) reviewed for notification of changes in the sample of 3. The findings include: R1's face sheet printed on 3/6/25 showed diagnoses including but not limited to encephalopathy, atrial fibrillation, diabetes mellitus, malnutrition, Alzheimer disease, and chronic kidney disease. R1's facility assessment dated [DATE] showed severe cognitive impairment and total staff assistance required for hygiene, transfers, and bed mobility. The same assessment showed R1 is always incontinent of urine and bowel. R1's medical record showed an original facility admission on 1/28/25. The record showed R1 was sent to the local hospital on 2/25 and returned 2/28. R1's hospital records showed a wound consult on 2/27/25. An unstageable coccyx pressure ulcer (lower back/upper buttocks area) measuring 4.5 cm x 2 cm (centimeters) was present. The note showed the wound was present upon admission to the hospital. On 3/5/25 at 1:23 PM, V8 (R1's daughter) stated she was told R1 had an open sore on her buttocks when she was sent there by the facility. V8 said the hospital called her and said the sore was very bad and looked like it had been there while. V8 said she visits R1 almost daily and facility staff never told her of any open skin areas. On 3/6/25 at 10:37 AM, V3 (Wound Care Nurse) stated any new or worsening wound should be reported to the physician and family as soon as possible. Family needs to be kept up to date and educated on resident status, especially anything new. On 3/6/25 at 3:21 PM, V2 (Director of Nurses) stated R1's family member was not notified of the coccyx wound by the facility. The hospital notified V8 the day it was assessed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Physician-Family Notification-Change in Condition policy last revision dated 11/13/18 states: The facility will inform the resident .notify the resident's legal representative or an interested family member when there is: (B) A significant change in the resident's physical, mental, or psychosocial status (i.e. deterioration in health .).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to identify a wound prior to becoming an unstageable wound, failed to have pressure ulcer interventions in place, and failed to ensure wound treatment orders were in place for 2 of 3 residents (R1, R2) reviewed for pressure ulcers in the sample of 3. These failures resulted in R1 being at an increased risk of infection and delayed wound healing. The findings include: 1. R1's face sheet printed on 3/6/25 showed diagnoses including but not limited to encephalopathy, atrial fibrillation, diabetes mellitus, malnutrition, Alzheimer disease, and chronic kidney disease. R1's facility assessment dated [DATE] showed severe cognitive impairment and total staff assistance required for hygiene, transfers, and bed mobility. The same assessment showed R1 is always incontinent of urine and bowel. R1's pressure ulcer risk assessment dated [DATE] showed a moderate risk for pressure ulcer development. R1's medical record showed an original facility admission on 1/28/25. The record showed R1 was sent to the local hospital on 2/25 and returned 2/28. R1's hospital records showed a wound consult on 2/27/25. An unstageable coccyx pressure ulcer (lower back/upper buttocks area) measuring 4.5 cm x 2 cm (centimeters) was present. On 3/6/25 at 8:33 AM, R1 was lying in bed while V5 and V6 (CNAs-Certified Nurse Aides) performed morning cares. R1 was incontinent of urine and bowel. R1 was rolled to her side and a damp dressing was on her coccyx area. V5 removed the dressing, and an egg size open area was observed with a smaller quarter size area next to it. The aides completed peri care and alerted the nurse of the need for a new dressing. V6 stated R1 is completely dependent on staff for all daily cares. V6 stated the CNAs do skin checks during all care and on every shower day. Any skin changes should be found and reported to the nurse immediately. On 3/6/25 at 9:05 AM, V4 (Registered Nurse) provided wound care to R1's coccyx. V4 stated the nurses do weekly skin observations and the CNAs do daily checks on every shift. That way any skin changes can be found early, and treatment can get started. V4 said she was unsure how long the coccyx wound had been there, but it was sometime after she came back from the hospital. R1's progress notes were reviewed from the date of admission to current. There were no weekly skin observations done by a nurse until she returned from the hospital (no observations from 1/28 to 3/1). R1's last 30 days of CNA skin checks were reviewed. The task tab showed no skin issues observed, including every day after the unstageable pressure ulcer was found. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/6/25 at 10:37 AM, V3 (WCN-Wound Care Nurse) stated R1 is at high risk for pressure ulcers based on her low cognition, low mobility, and is bed fast most of the time. V3 said all residents are assessed weekly by the floor nurses from head to toe for any skin changes. The skin checks are documented in progress notes. The aides check resident skin during daily cares. It is important the checks are done to ensure they are found at an early stage. All skin changes need care orders and interventions put in place right away. There is the risk of infection and delayed wound healing when open areas are found at more advanced stages. V3 reviewed R1's electronic record and was unable to locate any weekly skin observations done by the floor nurses prior to her going out. V3 said he did not know why the aides' daily skin checks are still being recorded as no skin issues. V3 stated R1's unstageable coccyx wound was not found until she was sent to the hospital. R1's wound assessment done upon return to the facility and dated 3/1/25 (by V3) showed a 2 cm x 4.5 cm unstageable pressure ulcer located on the coccyx. R1's care plan was reviewed and showed no focus areas or interventions in place related to the potential for skin impairment or pressure ulcer development until she returned from the hospital. On 3/6/25 at 11:16 AM, V7 (VP of Clinical Operations) stated R1's daughter notified the facility of the coccyx wound when the hospital discovered it. That was the first time anyone realized R1 had an open area on her coccyx. V7 said R1 was seen by the corporate wound consultant sometime this week, but there is no record of any assessment or that the visit occurred. V7 stated pressure ulcer prevention interventions were in place but the care plan does not reflect that until after she came back from the hospital. On 3/6/25 at 3:21 PM, V2 (DON-Director of Nurses) stated it is important to check residents' skin and find changes early. Skin issues are easier to treat the sooner they are found. V2 said she could not say how long R1's coccyx wound had been there. The lack of weekly observations makes it impossible to know. V2 said it wasn't until R1's daughter called and alerted them to the wound after the hospital found it. V2 said it should have been found by the facility staff prior to becoming an unstageable wound. On 3/7/25 at 1:16 PM, V9 (Wound Physician Assistant) stated R1's coccyx wound absolutely should have been found earlier. There is a huge potential for delayed wound healing or to not heal at all. Wounds that are found at advanced stages could already be infected. R1 is incontinent and given the locale of her wound she is at a high risk of osteomyelitis (bone infection). The facility's Pressure Injury and Skin Condition Assessment policy revision dated 1/17/18 stated: 2. Residents identified (at risk for pressure ulcers) will have a weekly skin assessment by a licensed nurse. 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA . 6. Care givers are responsible for promptly notifying the charge nurse of skin breakdown. 2. On 3/6/25 at 8:56 AM, R2 was lying on her bed while V5 and V6 (CNAs) prepared to do a mechanical lift transfer. V5 removed R2's socks and a dressing was observed on her right heel. The dressing date and signature were both illegible and hard to read. V5 stated R2 did have a black sore on that heel but was unsure if it was still there or had healed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's wound assessment dated [DATE] showed a right heel DTI (deep tissue pressure injury) measuring 2.5 cm x 2.5 cm. The assessment showed it was identified on 2/13/25. R2's February 2025 TAR (Treatment Administration Record) was reviewed and showed an order discontinued on 2/27/25 for: Right heel-apply boarder foam dressing to DTI in the morning every Tues, Fri, Sun for prophylaxis. The TAR showed the last treatment was done on Tuesday, 2/25/25. R2's March 2025 physician orders and TAR were reviewed. There were no treatment orders related to the right heel DTI. On 3/6/25 at 10:37 AM, V3 (WCN) reviewed R2's medical record and was unable to locate any wound treatment order for the right heel. V3 said the DTI is still on her heel. V3 said orders are needed so the nurses know how to care for the wound. The orders should include how and when to treat the wound, how to clean and cover the wound. V3 stated he did not know why there were no treatment orders for her DTI. On 3/6/25 at 2:40 PM, V2 (DON) stated R2's wound treatments were discontinued by the wound doctor in February and V2 did not know if that was what was intended. V2 said staff should have followed up with the wound team before today. It needs to be clarified right away. Wounds have a higher risk of infection and delayed healing when treatments do not get done. On 3/6/25 at 3:05 PM, V3 (WCN) stated he just received the correct order for R2's heel wound. It should have continued into March with cleansing and a gauze dressing three times a week and as needed. V3 said there is nothing to show that her heel wound has been treated since 2/25/25 (9 days ago). R2's physician order showed the current wound order for the right heel DTI was just start dated on 3/6/25 (day of survey). The facility's Pressure Injury and Skin Condition Assessment policy last revision dated 1/17/18 states: 18. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration.