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	03/19/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on interview and record review the facility failed to safely reposition a resident in bed for one of three residents (R1) reviewed for safety/supervision in the sample of three. This failure resulted in R1 rolling out of bed onto the floor and experiencing increased pain and a humeral fracture. This past noncompliance occurred from March 11, 2025- March 17, 2025. The findings include: R1's Face Sheet dated March 19, 2025, shows she was admitted to the facility on [DATE], with diagnoses including hemiplegia, dysphagia, aphasia, unsteadiness on feet, contracture left knee, low back pain, adjustment disorder with anxiety, depression, and heart failure. R1's Care Plan initiated December 8, 2022, shows R1 had an ADL self care performance deficit related to a stroke with left side effected. R1 was at risk for falls. R1's MDS (Minimum Data Set) dated March 4, 2025, shows, R1 had an impairment to one side of her upper and lower extremities. R1 was dependent on staff for toileting hygiene. R1 required substantial/maximal assistance from staff for rolling left and right. R1's Fall-Initial Occurrence Note dated March 11, 2025, shows, Resident had a witnessed fall March 11, 2025, 3:15 AM. CNA (Certified Nursing Assistant) called this writer and saw that the CNA was holding the resident on the floor on a sitting position. CNA said that she was changing the resident when her legs went out of the bed and fell . R1's Nurses Note dated March 11, 2025, shows R1 complained of left arm pain. The doctor was notified and gave an order for an X-Ray. R1's X-Ray report dated March 11, 2025, shows, Transverse fracture lucency in the surgical neck of the humerus with minor displacement. Generalized extremity edema. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On March 19, 2024, at 8:47 AM, V2 DON (Director of Nursing) said R1 was admitted to hospice services on March 1, 2025. V2 said R1 had a history of a stroke and could not use her left arm or left leg. V2 said that R1 was a two person assist for bed mobility. V2 said when residents have had a stroke and are on a low air loss mattress should always use two staff members for assistance. V2 said V5 CNA (Certified Nursing Assistant) was the CNA that was caring for R1 when R1 fell out of bed. V2 said V5 rolled R1 onto her right side, which was away from the CNA. R1's weak side was up when R1's legs slid off of the bed. V2 said R1 slid off of the side where no staff was present. V2 said R1 would not have been able to grab the side rail because R1 couldn't use her left arm. V2 said R1's family and hospice decided not to send R1 to the hospital. V2 said R1 was a thin resident that had a decreasing appetite. V2 said R1 was complaining of left arm pain at lunch time so the doctor ordered an Xray and that's when they found out R1 had a fracture to her left arm. V2 said that R1's morphine pain medication was increased after her fall due to the increase in R1's pain. V2 said as long as R1 was still, she did not have any pain. V2 said staff were in-serviced on if residents have a low air loss mattress, then to use two staff members to assist with care. V2 said if two staff members were present during R1's fall out of bed, then the fall could have possibly been prevented. On March 19, 2025, at 2:04 PM, V6 RN (Registered Nurse) said he was called into R1's room. V6 said he saw R1 kneeling next to her bed on the floor with V5 holding R1 up. V6 said R1 had an abrasion to her left knee that was bleeding, so he put a dressing on that. V6 said he gave R1 morphine for her pain after the fall. V6 said V5 told him that R1 fell out of the bed while V5 was trying to change R1. V6 said he did not know that R1 required two staff assistance for cares. V6 said he has been in-serviced on using two staff members while changing dependent residents. A message was left for V5 CNA on March 19, 2025. On March 19, 2025, at 11:00 AM, V3 CNA said she took care of R1 a lot prior to her fall. V3 said two staff members were always used to reposition R1 because she was a difficult resident to care for. V3 said R1 was always a nervous person and always fearful she was going to get hurt. V3 said R1 was not able to reposition herself. R1's MAR (Medication Administration Record) shows she had an order for morphine sulfate 20 MG/ML give 0.5 ML by mouth every four hours as needed for pain/air hunger prior to her fall. There was an order entered after R1's fall and fracture for morphine every two hours for pain. R1 was rating her pain 5-8 on a 0-10 pain scale after her fall occurred. R1 complained of pain one time prior to her fall in March. The facility's Fall Prevention Program revised November 21, 2017, shows, To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Prior to the survey date of March 19, 2025, the facility had taken the following actions to correct the noncompliance: -Resident was assessed for injuries -Resident care plan updated and fall assessments updated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Nursing staff have been re-educated on proper bed mobility and care of residents that require extensive assistance -A QA tool has been implemented to monitor compliance with proper assistance with ADL (Activities of Daily Living) care. DON (Director of Nursing) or designee will conduct daily audits of five residents a week. -Reviewed current bed mobility and transfer needs to ensure they are accurate and updated if needed. -Reviewed current residents fall risk score for accuracy and updated if needed. -Resident has been assessed for pain and has a pain management plan in place. -Facility has reviewed agency usage and communication of resident needs to agency staff.