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	12/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review the facility failed to provide ordered wound care for 2 of 3 residents (R2 and R3) reviewed for nursing care/wound care in the sample of 13. The findings include: 1. R3's admission Record showed diagnoses to include but not limited to dementia, diabetes type 2, heart failure, and an antibiotic resistant organism infection. R3's 12/10/25 Wound Assessment Details Report showed he had an open venous stasis (poor venous circulation) ulcer to his left lower leg front measuring 7.5 centimeters (cm) by 2.0 cm by 0.1 cm deep. The wound assessment showed a second wound/skin tear to his right lower leg measuring 2.0 cm by 1.5 cm by 0.0 cm deep. R3's November 2025 Treatment Administration Record (TAR) showed an order for daily wound treatments to his left and right legs. The treatments consisted of cleansing, ointments, oil emulsion dressings, and gauze wraps. The order was started on 10/16/25. The TAR showed treatments were not documented as having been done on 11/3/25, 11/16/25, 11/20/25, 11/25/25, and 11/28/25. R3's December 2025 TAR showed the same ordered treatment for his right and left legs as the November 2025 TAR. The December 2025 TAR showed no documentation for these treatments on 12/11/25, 12/12/25, and 12/16/25. R3's December 2025 progress notes showed no documented treatments for these days and showed no explanation for the missing treatments. On 12/19/25 at 11:10 AM, V2 Director of Nursing stated wound care should be documented on the TAR when it is done. V2 stated if the resident refuses, he or she should educate and make another attempt, then document the refusal. V2 stated if the wound care is not documented on the TAR there is no proof the wound care was completed. V2 stated wound care is important for wound healing, infection prevention, and provides an opportunity to assess the wound. 2. R2's 12/10/25 Wound Assessment Details Report showed a skin tear to his left foot measuring 1.0 centimeters (cm) by 1.0 cm by 0.0 cm deep. The left foot wound was identified on 11/3/25. The wound report showed a second skin tear to his left knee measuring 0.8 cm by 0.5 cm by 0.0 cm. The left knee was identified on 12/3/25. R2's December 2025 Treatment Administration Record (TAR) showed an order for Monday, Wednesday, and Friday wound care. The treatments including normal saline cleansing, oil emulsion dressing, and a bordered dressing. The TAR showed not documented treatments on 12/12/25 and 12/15/25. The TAR showed an identical treatment and schedule for his left knee. The TAR showed the left knee treatments were not documented as being done on 12/12/25 and 12/15/25. On 12/19/25 at 12:49 PM, R2 stated Sometimes they are too busy to get to my wound treatments. On 12/19/25 a policy for wound care treatment was requested and was not provided.

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

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	12/24/2025

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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	12/24/2025

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to provide ordered medications and failed to administer the correct medication. This applies to 2 of 5 (R5 & R1) reviewed for medications in the sample of 13.The findings include: 1. R5's admission Record showed diagnoses to include but not limited to stroke, heart failure, atrial fibrillation (rapid and irregular heartbeat). R5's December 2025 Medication Administration Record (MAR) showed her 12/18/25 diltiazem for her congestive heart failure 240 milligrams (mg) extended release medication was documented as not given. R5's MAR also showed her 12/18/25 duloxetine 30 mg for her depression was documented as not given. On 12/18/25 at 9:20 AM, V4 stated R5 was out of her duloxetine and diltiazem. V4 stated the medication refills were rejected by the pharmacy for an unknown reason. V4 said the diltiazem was rejected on 12/15/25 and the duloxetine was rejected on 12/17/25. V4 stated it is the policy that the nurses notify the Director of Nursing if medications are rejected. On 12/19/25 at 9:30 AM, R5's December 2025 MAR showed her 12/19/25 duloxetine and diltiazem had been documented as given. On 12/19/25 at 10:35 AM, V12 RN stated she had given R5 her last available dose of diltiazem and duloxetine from R5's medication cards. (The residents' prescription medications come in a foil-backed punch cards.) V12 was asked to provide R5's completed duloxetine and diltiazem cards. V12 was then made aware that V4 was not able to pass these medications the day prior due to the medications being unavailable. V12 then stated she borrowed these medications from other residents. V12 showed R11's medication card for duloxetine 30 mg stating she used this card. V12 then showed R12's diltiazem 60 mg tablets (not extended release) and stated she gave R5 this medication. On 12/19/25 at 10:45 AM, V12 stated she gave R5 three tablets of R12's 60 mg diltiazem. V12 then changed and said two tablets were given, then four tablets, then stated no, I gave two tablets. On 12/19/25 at 10:50 AM, V12 then approached this surveyor in the conference room and stated, At first I gave her two (tablets of Cardizem) then saw she was on 240 (mg dose) and then I gave her two more. On 12/19/25 at 10:55 AM, V12 approached this surveyor in the conference room and stated she only gave one tablet of R12's diltiazem to R5. R12's December 2025 MAR showed an order for diltiazem 60 mg (not extended release) to be given three times a day. On 12/19/25 at 11:10 AM, V2 Director of Nursing stated, They cannot take the meds from the other residents, it violates the 5 right of medications. They could give the wrong dose and then the other resident, depending on their insurance, they may not be able to get their medication filled when they need it. On 12/19/25 at 12:23 PM V2 stated, [Diltiazem] is a cardiac medication, and it is used to treat high blood pressure. It comes with parameters of when it can be given and if it needs to be held. Extended release and the regular diltiazem treat the same issues, but they cannot be interchanged. The nurses should not be making judgement calls when it comes to medications dosages. The facility's policy Medication Administration General Guidelines showed, Five Rights- Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 rights is recommended. The policy showed, If a medication with a current active order cannot be located in the medication cart/drawer, other areas of the medication cart.the pharmacy is contacted or the medication is removed from the emergency kit. The policy continued, Medications supplied for one resident are never administered to another resident. 2. R1's Face Sheet showed diagnoses to include but not limited to dysuria (difficult and/or painful urination), urinary tract infections, and kidney cancer. R1's Order Summary Report (Physician Order Sheet/POS; provided 12/19/25 at 12:55 PM) showed an active order for Mirabegron 50 milligrams daily for incontinence. R1's December 2025 Medication Administration Record (MAR, printed 12/19/25 at 1:00 PM) showed R1's mirabegron was documented as 9 Other/See Progress Notes on 12/3/25, 12/6/25, 12/7/25, 12/8/25, 12/9/25, 12/11/25, 12/14/25, 12/15/25, and 12/17/25. On 12/19/25 the medication was documented as Hold/See Progress Notes. On 12/18/25 at 8:51 AM, V3 Registered Nurse stated R1's mirabegron was not available, and she was not able to administer it. (At this time R1's MAR showed the Mirabegron was documented as given.) On 12/18/25 at 2:07 PM, V3 stated she has not looked to see if R1's mirabegron was available in the facilities emergency supply. On 12/18/25 at 2:20 PM, R1 was alert and oriented to person, place, time, and condition. R1 stated she was uncertain if she was on a medication for her bladder; however, R1 stated she has an overactive bladder and needed to use the bathroom frequently. R1 stated she would expect the staff to notify her if she is out of a medication. R1 stated she had not been notified of missing medications. On 12/23/25 at 1:10 PM, V2 Director of Nursing stated she expects staff to notify her if the pharmacy rejects filling a medication, so she can correct the reason for the rejection. V2 stated, lately, if a resident's medication is