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	04/01/2026

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 - Minimal harm or potential for 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** Based on interview and record review the facility failed to provide adequate supervision to a resident with a history of falling for 1 of 3 residents (R1) reviewed for falls in the sample of 6. The findings include:The facility's Fall Report dated 10/31/25 to 3/31/26 showed R1 had un-witnessed falls on 2/1/26 at 10:15 AM, 2/10/26 at 2:20 PM, and 2/20/26 at 8:50 PM. R1's Facesheet dated 3/31/26 showed she had diagnoses to include, but not limited to unspecified fracture of right patella for closed fracture routine healing (1/15/26); diabetes; unsteadiness on feet; abnormalities of gait and mobility; fracture of right pubis (1/15/26); gastroesophageal reflux disease (GERD); chronic gout; history of falling; dementia; major depressive disorder; age related osteoporosis; osteoarthritis and hypertension. R1's facility assessment dated [DATE] showed she had severe cognitive impairment; required partial/moderate assistance with toilet hygiene and bed mobility; required substantial/max assist for shower/bathing, sit to lying, and lying to sitting; was dependent for transfers; was occasionally incontinent of urine and frequently incontinent of bowel. R1's Progress notes showed on 2/1/26 R1 was found sitting on the floor. This note showed R1 said she slid out of bed while sitting on the edge of the bed. R1 had a small abrasion to her right knee but denied pain. R1's Fall - Initial Occurrence note dated 2/10/26 showed R1 had an unwitnessed fall in her bathroom, and she was heard yelling help from the room. This note showed R1 was found sitting upright in the bathroom doorway. R1 said she didn't know what happened. R1's Social Service Note dated 2/18/26 showed R1's room was changed. (R1's new room was not near the nurses' station; it is around the corner and halfway down a long hall.) R1's Fall - Initial Occurrence note dated 2/21/26 showed R1 had an unwitnessed fall in her room on 2/20/26 at 8:50 PM. This note showed CNA reported resident was on the floor. This nurse went to R1's room and she was on her buttocks. This note showed R1 reported she was trying to get up and go to the bathroom, slipped, and ended up on the floor. This note showed R1 had an abrasion to her right knee, but no change in range of motion. This note showed R1 was assisted off the floor with a mechanical lift, placed in her wheelchair, and assisted to the bathroom. R1's Care Plan initiated 1/16/26 showed R1 had an Activities of Daily Living (ADLs) self-care deficit that may fluctuate with activity throughout the day related to a healing patella fracture with surgery. R1's Care Plan initiated 1/19/26 showed she was resistive to care and often refused to wear my (knee) brace related to dementia. R1's Fall Care Plan initiated 1/16/26 showed she was at risk for falls related to a fall at home with fracture of my patella. The interventions included place resident in high visible areas when not in bed; and anticipate and meet the resident's needs.R1's Fall Risk assessment dated [DATE] showed R1 was At Risk for Falls.On 3/31/26 at 11:34 AM, R5 said R1 had only been in her room a few days before she fell. R5 said R1 was always getting up when she wasn't supposed to. R5 said she would tell R1 not to get up on her own and to use her call light, but R1 would tell her she could do it. R5 said she would turn her call light on to get R1 help. R1 said she was sleeping that night (2/20/26) and when she turned her head she saw R1's feet on the floor, over by the entrance door and R1's side of the room. R5 said she asked R1 what happened, and she said she fell. R5 turned on the call light and they started yelling for help. R5 said R1 had some blood coming (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

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	04/01/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	through her pants, on her knee. R5 said R1 wasn't complaining about pain after she fell, in fact R1 got up by herself again the next morning. On 3/31/26 at 12:05 PM, V9 (Certified Nursing Assistant - CNA) said she was familiar with R1. V9 said R1 frequently tried to get up unassisted. V9 said we redirected R1, but she would forget, and we'd have to remind her again. V9 said they tried to keep R1 in the common areas and activities, but if she was in her room then she did checks on her every 15 minutes. On 3/31/26 at 12:50 PM, V19 (R1's POA) said R1 had fallen in the community and was admitted to the facility for short-term rehab. V19 said R1 had fallen three times since she her admission on [DATE]. V19 said R1 was moved to a new room and the room was far away from the nurses' station. V19 said R1 couldn't remember to use her call light due to dementia, and she reminded the staff of that. V19 said she was concerned R1 was that far from the nurses' station and had to yell for help. V19 said R1 was transferring back and forth to the bathroom and bed all weekend. V19 said on Tuesday (3/24/26) R1 had a follow-up appointment with the orthopedic surgeon (V10), had X-rays, V10 had R1 admitted to the hospital and she had surgery the next day for a knee fracture. On 3/31/26 at 2:04 PM, V17 (CNA) said she didn't see R1 fall. V17 said she didn't know when R1 went to her room that night. V17 said she didn't witness R1's fall and she wasn't involved with the care after. On 3/31/26 at 2:09 PM, V15 (CNA) said she knows who R1 was, but wasn't on her assignment very often. V15 said she didn't go in R1's room at all on 2/20/26 and she doesn't know when R1 went back to her room that night. V15 said they had to keep a close eye on R1. V15 said R1 was a high fall risk and was usually out in the common areas to keep an eye on her. V15 said when R1 was in her room, they should round on check on her frequently. On 3/31/26 at 2:33 PM, V13 (CNA) said she wasn't working R1's assignment on 2/20/26. V13 said she's on the other side of the hall and that assignment keeps her busy. V13 said she doesn't know much about R1. On 3/31/26 at 3:06 PM, V14 (CNA) said she was working when R1 fell, but she didn't witness the fall. V14 said she's not sure when R1 went in her room. V14 said R1 was confused and would often try to get up on her own. On 3/31/26 at 3:35 PM, V12 (Registered Nurse - RN) said R1 had moved from the north hall to the south hall. V12 said R1 was a risk fall. V12 said R1 was only on the south hall for 3 days before she fell. V12 said R1's room was not close to the nurses' station. V12 said the decision for room placement is up to management. V12 said he saw R1 earlier in the shift, coloring in the common area. V12 said he doesn't know what time R1 went to her room. V12 said he saw her coloring and the next time he saw R1 she was on the floor. V12 said a CNA reported R1 was on the floor. V12 said when he went to the room R1 was sitting on her butt on the floor, a few steps from her bed. V12 said R1 had some bleeding from her knee. V12 said he checked range of motion and palpated her knee. V12 said he didn't see any bruises or deformities. V12 said R1 was able to transfer later with no issues. V12 said R1 was confused and always tried to transfer herself. On 3/31/26 at 3:07 PM, V16 (CNA) said she wasn't assigned R1 on 2/20/26. V16 said she doesn't know when R1 went back to her room, she didn't witness R1's fall, and she did respond to R1's fall. On 3/31/26 at 4:20 PM, V18 (CNA) said he saw R1 coloring earlier in the shift, but he didn't know when R1 went back to her room. R1 said he went in R1's room and she was on the floor on her knees. V18 said R1 was between her bed and the entry door to her room. V18 said she had some blood on her knee. V18 said he doesn't remember when he saw her before the fall. V18 said he was not sure if R1 was a fall risk or if she tried to self-transfer. On 3/31/26 at 3:49 PM, V2 (Director of Nursing - DON) said R1 was pleasantly confused and had three falls at the facility. V2 said R1 continuously removed her knee brace, could self-propel short distances, and would try to self-transfer. V2 said there was not a room closer to the nurses' station available when they moved R1. V2 said a room closer to the nurses' station would allow the staff to keep a closer eye on her.V2 said the staff should be following the facility fall protocol and the R1's care plan. The facility's Fall Prevention Program revised 12/17/25 showed the purpose is 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. This policy showed safety interventions will be implemented for each resident identified at risk.

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	04/01/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to maintain the south shower room in a safe, sanitary, functional and comfortable condition for residents. This applies to 51 residents residing on the south wing. The findings include: The findings include:The facility census dated 3/31/26 showed 51 residents reside on the south hall. On 3/31/26 at 11:30 AM, R4 was sitting up on the edge of his bed. R4 said he takes a shower at the facility and when he first came to the facility he had to use the south shower room, but then he found out about the north shower room, and he prefers to use it. R4 said it would be nice if the shower room on this side of the building had warm water. I had to take a shower in there a few times and it was cold to luke warm water. That's no way to take a shower. R4 said we should be able to take a nice shower in warm water.On 3/31/26 at 11:41 AM, R6 said she gets showers, but she goes to the shower on the other side of the building (north) because the south shower doesn't have warm water. On 3/31/26 at 11:48 AM, V4 (Licensed Practical Nurse - LPN) entered the south shower room with the surveyor. There were black spots all over the shower room ceiling. The black growth was more concentrated near a rusted vent grate. The vent grate had peeling white paint and rust. The black spots/growth were spread across the ceiling and walls of the shower room. The was no shower stall, just a shower head in the corner of the small room. There was a musty odor to the entire room. V4 said the Certified Nursing Aides (CNAs) use the shower room for residents, but this was the first time she had been in there. The surveyor asked V4 what she thought the black spots/growths were. V4 replied, It looks like mold. V4 said there was an odor in here and it was probably from that, pointing to the mold on the ceiling and walls. On 3/31/26 at 11:55 AM, V6 (LPN) said she tries to prevent her residents from using that shower. V6 said most residents prefer using the other shower (North shower) for the reason you are here. V6 said you're hear for lack of hot water in there and the gross on the walls. V6 said it smells musty in there and there are black spots on the walls and ceiling. V6 said most of the residents refuse that shower room, but some CNAs and hospice CNAs do use that shower room (south). On 3/31/26 at 11:59 AM, V7 (Activities Aide) said that shower room had been like that since January 2026. V7 said the mold, smell, and lack of warm water have been brought to management. V7 said the residents shower in there and it's gross. On 3/31/26 at 12:00 PM, V9 (CNA) said we try not to use the south shower room, but sometimes it's necessary. V9 said the residents complain about the south shower. V9 said there are black spots all over the place in there, it smells musty all the time, and the water doesn't get very warm. V9 said the south shower room has been an ongoing issue. V9 said management has been notified and it doesn't seem like they are listening. On 3/31/26 at 12:05 PM, V9 (CNA) said she doesn't give showers in the south shower room because there is mold in there. There are black spots all over and it smells like mold in there. Everyone knows it, but I don't think anything is being done about it. The water also takes a long time to warm up.On 3/31/26 at 12:13 PM, V3 (Maintenance Director) entered the shower room with the surveyor. V3 turned on the shower head in the corner of the room. The surveyor pointed to the black spots/growths all over the ceiling (especially near the rusted vent grate) and the walls. The surveyor asked what that was. V3 replied, I think it's mildew from the water running and no ventilation. The surveyor asked if it could be mold. V3 replied, I'm not really sure the difference between mold and mildew. V3 said the exhaust fan was broken and it wasn't reported by the staff. V3 said he didn't find out until there was a grievance filed by a doctor's office. V3 said he came to the shower room to check. V3 said the exhaust fan wasn't working, so there was no ventilation. V3 said he had no idea how long the exhaust fan was broken. V3 said the warm, damp room with no ventilation caused the black spots to show up and the vent grate to rust. V3 said the smell is from the mildew. V3 said he fixed the fan last week or the week before but hadn't had a chance to fix the rest yet. At 12:19 PM (with the shower running for 6 minutes), V3 checked the running water in the shower. The water temperature was 89.2 degrees Fahrenheit (F). V3 said the (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	04/01/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water does get warmer, but it takes a while. The surveyor asked V3 if he would want to take a shower in that water. V3 replied, Hell no, I wouldn't want to take a shower in that. I wish I could make it warmer, but I can't. At 12:23 PM (with water running for 10 minutes), V3 checked the water temperature, and it reached 94 degrees. V3 stated, It shouldn't take this long. I wonder if there is an issue with the valve in this shower. V3 exited the shower room and checked the water temperature of the running sink in the room across the hall. The water temperature was 109 degrees F. V3 went back to the shower room and stated, Theory would say the water in the shower should be the same. I have the water turned all the way on hot. At 12:25 PM, V3 tested the water temperature, and it was 87.9 degrees F. V3 said he could feel the water get warmer and cooler when he held his hand under the water. V3 said I probably need to check the valves. On 3/31/26 at 3:49 PM, V2 (Director of Nursing - DON) said she was not aware of concerns with the south shower room having mold/mildew or water temperature issues. V2 said she goes in the shower room but doesn't look at the walls or the ceiling. V2 said she would not expect there to be mold/mildew in the shower room and it could put residents at risk for health concerns. V2 said if there were concerns with mold then corporate would make sure it was taken care of. V2 said if she was taking a shower she would want the water to be warm. V2 said all residents are encouraged to take showers and not bed baths. V2 said the shower on south hall hadn't been remodeled for many years, but the north shower was remodeled more recently and was nicer. On 3/31/26 at 4:08 PM, V1 (Administrator) said the facility did receive a grievance from doctor in the community. V1 said she didn't speak with the doctor directly but was called by her corporate office. V1 said a Grievance Form was completed, but she was told there was a black substance in the building. The surveyor asked V1 if she had been in the shower room. V1 said she had. V1 said she saw the black spots on the ceiling and walls of the shower room and the rusted vent. V1 said parts and paint were ordered. The surveyor asked if the black spots were mold. V1 replied, I was thinking more mildew.' V1 said the shower room should not look like that. The surveyor asked what the water temperature should be. V1 replied, the water temperatures should be no greater than 110 degrees F. The surveyor asked if she would want to take a shower in 89-degree F water. V1 said that doesn't sound like a very warm shower. V1 said she would expect the shower to be clean, functional, and warm for the residents. On 4/1/26 at 10:45 AM, V1 said the facility did not have a General Maintenance Policy or a Mold policy. The facility Grievance Form dated 3/20/26 showed a community physician had a concern of no hot water and mold noted in the facility. This form showed this was partially substantiated. This form showed, Hot is subjective to the individual. Our water temperatures are maintained at 120 degrees F or higher for infection control, and thermostatically mixed via a thermostatic mixing valve to achieve between 100-110 degrees F output temperatures at fixtures to prevent scalding. Several fixtures tested between 104-110 degrees F. Mold that was located due to a ventilation issue in the shower room is being remediated. This form was signed by V1 (Administrator) on 3/23/26. The surveyor requested policies for General Plant Maintenance and Mold, but none were received.