STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007413	A. BUILDING: _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DEKALB	1212 SOUTH SECOND STREET DEKALB, IL 60115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Survey 2511365/IL186601	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to identify that a resident who is at risk for developing pressure injuries and who had a pressure injury would be at a higher risk for developing a second pressure injury; and failed to implement preventative measures and adequate skin assessments for 1 of 4 residents (R1) reviewed for wounds in a sample size of 7. This failure resulted in R1 developing two pressure injuries to the back of his ears that were both identified at a stage 3 when found.

Findings include:

R1's face sheet indicated that resident admitted to the facility on 01/30/2025 with a past medical history not limited to sepsis, acute respiratory failure, pneumonitis, encephalopathy, scoliosis, dysphagia; and discharged to an acute care

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hospital on 02/18/2025.

R1's admission pressure ulcer risk assessment dated 01/30/2025 showed R1 is at moderate risk for developing pressure injuries.

R1's Minimum Data Set (MDS) Resident Assessment and Care Screening, dated 02/03/2025 documented that R1 was dependent on staff for bathing, personal hygiene, dressing, bed mobilities and transferring in/out of bed.

R1's care plan with date initiated 02/10/2024 documented: pressure ulcer to left ear related to immobility with last revision on 02/10/2025; pressure ulcer to right ear related to immobility with last revision on 02/21/2025. Interventions included but not limited to oxygen cannula will have ear protectors to alleviate pressure on the ear and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.

Order summary report with print date of 02/21/2025 showed the following orders for R1: oxygen (O2) inhalation via mask at 3 liters to maintain oxygen saturation above 90%, every shift for oxygen therapy, start date 01/30/2025; left ear pressure ulcer treatment, cleanse then apply [medical-grade honey] sheet in the evening, start date 02/04/2025; left ear pressure ulcer treatment, cleanse then apply [medical-grade honey] to affected area and cover with dressing in the evening, start date 02/18/2025; right ear pressure ulcer treatment, cleanse then apply [medical-grade honey] sheet, start date 02/21/2025.

R1's wound round assessment dated 02/03/2025

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documented stage 2 pressure ulceration to R1's left ear with measurements in centimeters (cm) of 3.00 x 2.00 x unknown (lengthxwidthxdepth).

R1's wound round assessment dated 02/04/2025 documented stage 3 pressure ulceration to R1's left ear with measurements of 3.00cm x 2.00cm x unknown. Wound assessment detail report dated 02/11/2025 documented the same assessment, indicated R1's wound was facility-acquired and that R1 was provided with "cushions to alleviate the pressure".

Review of nurse's note dated 02/04/2025 documented a fax was received back from V11 (Primary Care Physician/Medical Director) related to wound stating, "local wound care". No documentation found that indicated R1 was seen by a wound physician.

R1' s wound round assessment dated 02/17/2025 documented stage 3 pressure ulceration to R1's right ear with measurements of 1.00cm x 1.00cm x 0.20cm. Wound assessment detail report dated 02/17/2025 documented the same assessment, indicated R1's wound was facility-acquired and a "new wound assessed, new ear protectors added".

Review of repeat pressure ulcer risk assessment dated 02/11/2025 continued to show that R1 is at moderate risk for developing pressure injuries. No repeat skin risk assessment was completed after identifying the second pressure injury to the right ear on 02/17/2025. No evidence was found of ongoing assessments to affected skin areas, any effective preventative measures and/or interventions to prevent further development of pressure injuries such as turn/reposition every two hours, pressure relieving mattress, protective

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dressing to area behind ears, daily skin assessments, etc.

Review of nurse's note dated 02/18/2025 documented "new pressure ulcer noted to the right ear where the cannula sits. Protectors were already in place although they were changed for new ones. [Medical Doctor] and guardian notified. New wound care orders to include right ear entered".

On 02/20/2025 at 01:38 PM, V2 (Director of Nursing) said R1 did not admit with any skin issues or irritation to his ears upon admission but developed pressure injuries to both ears from the straps of the oxygen mask. V2 added that R1 was at moderate risk for pressure injury upon admission.

On 02/21/2025 at 11:02 AM, V8 (Wound Care Nurse) said upon admission on 01/30/25, R1 did not admit with any skin issues but he was at risk for developing a pressure injury with a "[pressure ulcer risk assessment] score was 14". V8 then said on 02/03/2025, he first identified a stage 3 pressure injury to R1's left ear that measured 3cm x 2cm (length x width), was unable to determine any depth and started a treatment for "Medi honey then cover with bordered foam". V8 said he provided wound care Monday through Friday, and the floor nurse would provide wound care on the weekends. V8 added that R1 had weekly skin assessments in place. V8 then said on 02/17/2025, he identified a stage 3 pressure ulcer to R1's right ear that measured 1cm x 1cm x 0.2 cm (length x width x depth) and started treatment for "Medi honey sheet". V8 (Wound Care Nurse) added that he didn't see an issue or believed that R1 would develop pressure injuries to his ears from the mask straps so when he

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recognized an issue to the first ear, he applied protectors to both sides of mask straps as a preventative. V8 also said that at times when he would see R1, the mask would be pulled down and the strap would fold his ear downward then indicated moving forward, interventions should be implemented due to mask movement that could cause friction.

On 02/21/2025 at 11:49 AM, V2 (Director of Nursing) said ear protectors were not applied initially to R1 because they did not suspect it was a high area of skin breakdown, but moving forward, any resident who admits in a similar condition and identified as high risk for developing pressure injuries will have ear protectors placed.

On 02/21/2025 at 1:19 PM, called the office of R1's physician V11 (Primary Care Physician/Medical Director) and was informed by receptionist that V11 was out for the week, not reachable and will not return until Monday.

On 02/21/2025 at 2:23 PM, when asked if R1's pressure injuries should have been recognized sooner than a stage 3, V2 (Director of Nursing) said staff performed weekly skin assessments and should have looked at R1's face and skin every shift, when providing care or readjusting R1's mask, and when they observed his ear folded down from the mask strap. V2 then said a resident who develops a pressure injury would be considered at higher risk for skin breakdown and if a resident is not able to adjust themselves, they also would be at increased risk for developing a pressure injury. When asked if a pressure ulcer risk assessment should have been completed for R1 after the second injury was identified, V2 (DON) said she would need to follow-up with V8

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S9999	Continued From page 6 (Wound Care Nurse) because he may have done one that could be within R1's wound documentation. (No additional pressure ulcer risk assessments were provided.) Pressure Injury and Skin Condition Assessment policy last revised 01/17/2028 reads is part: to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented ...a skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary ...each resident will be observed for skin breakdown daily during care and on the assigned bath day the CNA (certified nursing assistant) ...care givers are responsible for promptly notifying the charge nurse of skin breakdown ...at the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. (B)	S9999		