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 03/07/2025

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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S 000	Initial Comments Complaint Investigation 2511704/IL187352	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 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	S9999		

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resident to meet the total nursing and personal 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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 meet as evidenced by:

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.

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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 1/31/25 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 2/11/25 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.

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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.

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

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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.

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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.

R2's wound assessment dated 2/27/25 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".

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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

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S9999	Continued From page 7 states: "18. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration". (B)	S9999		