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 _____	08/04/2022

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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 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	**Attachment A** **Statement of Licensure Violations**	

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 _____	08/04/2022

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
S9999	Continued From page 1 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 observation, interview and record review the facility failed to identify areas of pressure, assess areas of pressure and implement interventions for pressure prevention. These failures resulted in deterioration of the pressure area for R22. These failures resulted in R43's pressure deteriorating into an unstageable pressure injury. These failures resulted in R178 developing a deep tissue injury. This applies to 3 of 8 residents (R22, R43, R178) in the sample of 19 reviewed for pressure. The findings include: 1. The facility face sheet for R22 shows diagnosis to include dementia, hypertension, schizoaffective	S9999		

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 _____	08/04/2022

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
S9999	Continued From page 2 disorder. R22's facility assessment dated 2/22/2022 shows R22 has severe cognitive impairment and requires extensive assistance of 2 for bed mobility and is always incontinent of urine. The facility wound report printed on 8/3/2022 shows R22 had a stage 4 pressure injury to her coccyx on 3/23/2022. The initial wound report dated 3/23/2022 by the facility shows a stage 4 facility acquired pressure injury measuring 1.8 x 1.5 x .6 centimeters with no tunneling. The wound report for R22 on 7/26/2022 shows the coccyx pressure injury is measuring 2.3 x 1.5 x .30 centimeters with tunneling of 4 centimeters present. The facility skin checks dated 4/5/2022 to 5/22/2022 shows no mention of a pressure injury to R22's coccyx. Starting 6/22/2022 the weekly skin observation sheets show a pressure injury to R22's coccyx. On 8/03/22 at 3:25 PM, V3 Assistant Director of Nursing (ADON) and wound nurse said R22 was admitted to hospice in February and the hospice nurse said they were doing the weekly skin assessments. V3 said the hospice staff did not let the facility know she had a pressure wound to her coccyx. On 8/04/22 at 8:30 AM, V7 Hospice Registered Nurse (RN) said the pressure injury was first observed to R22's coccyx on 3/1/22. V7 said an order for wound care was obtained from the doctor and written in the facility's records for the facility nurses to do. V7 said when new orders are written at the facility, the facility nurses are always informed of changes.	S9999		

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 _____	08/04/2022

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
S9999	Continued From page 3 8/04/22 at 9:00 AM, V8 Hospice Certified Nursing Assistant (CNA) said she cares for R22 2-3 times a week and she first noticed a black looking area to R22's coccyx the beginning of March. V8 said she informed the hospice staff as well as the facility staff. The hospice caring for R22 was notified and sent this surveyor copies of their wound assessments for the month of March 2022. The records were not available at the facility. The hospice first wound assessment shows on 3/1/2022 a 1x1 centimeter unstageable pressure injury with hard black/brown scab to R22's coccyx. The hospice wound assessment dated 3/16/2022 for R22 shows the wound is now a stage 3 pressure injury and R22 is grimacing and moaning while wound care is provided. The facility Physician Order Sheet for R22 shows a new order for wound care to the coccyx. The treatment Administration record for the Month of March for R22 shows a treatment in place for the wound to the coccyx and was being completed by the facility staff. The facility care plan for R22 shows new interventions were not put into place until 3/24/2022 (24 days after initially being found by the hospice staff). On 8/04/22 at 10:15 AM, V2 Director of Nursing (DON) said the nursing staff should be assessing the wound weekly for sure and doing measurements even though hospice is involved. If the treatment was started by hospice, we should still be assessing the wound. The facility should have had better communication with hospice and obtained the records from them and put interventions in place sooner.	S9999		

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 _____	08/04/2022

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
S9999	Continued From page 4	S9999		

The facility policy with a revision date of 1/17/2018 for pressure injury and skin condition assessment shows to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. Pressure and other ulcers will be assessed and measured at least every 7 days by a licensed nurse and documented in the resident's clinical record.

2. R43's Admission Record, provided by the facility on 8/4/22, showed diagnoses including cerebral infarction (stroke), cognitive communication deficit, hemiplegia and hemiparesis (muscle weakness or the inability to move on one side of the body that can affect the arms, legs and facial muscles) following cerebral infarction, dementia and peripheral vascular disease. R43's Physician's Orders showed monitor DTI (deep tissue injury) to tip of right great toe. The orders showed cleanse right great toe with wound cleanser, paint area with betadine and leave open to air daily.

R43' Wound Assessment Details Report dated 6/27/22 showed, on that date, a facility-acquired, unstageable pressure injury was identified on R43's right big toe measuring 1.10 cm (centimeter) x 1.20 cm. R43's Braden assessment (a tool used to determine a resident's risk for pressure injury) dated 11/5/21 showed R43 was a high risk for the development of pressure injuries. The facility assessment dated 6/24/22 showed R43 had moderately impaired cognitive skills and required extensive assist of two staff members for bed mobility. R43's Pressure Ulcer care plan, initiated on 1/5/22, with a revision date of 1/7/22, showed at

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 _____	08/04/2022

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
S9999	Continued From page 5 that time she had a pressure ulcer to her right lateral ankle, right lateral heel, and gluteal (area located below the pelvic girdle that extends into the upper leg) related to immobility. The care plan was not updated to show the pressure area to R43's right great toe. The care plan showed interventions in place were to follow facility's policies/protocols for the prevention/treatment of skin breakdown and to off load pressure from R43's bilateral heels. R43's potential for skin impairment care plan initiated on 1/5/22, showed interventions in place were to assess and record changes in skin status and to minimize pressure over bony prominences. R43's Progress Note dated 6/25/22 showed a 1 centimeter pressure area was identified on R43's right big toe. The note showed it seemed to be caused by a constrictive sock worn consistently by R43. The Progress Note dated 6/27/22 at 10:00 AM, showed "Resident was found to have a 1 cm dark spot on right great toe post shower. Resident has been wearing compression type stockings, noted this has put increased pressure on (the) tip of (her) toes. Stockings left off post shower. Will monitor DTI (deep tissue injury)." The progress note dated 6/27/22 at 1:21 PM, showed V3 (Assistant Director of Nursing) assessed the pressure injury to R43's right great toe. V3 noted a deep maroon area to R43's right great toe measuring 1.10 cm x 1.20 cm. On 8/3/22 at 1:06 PM, V3 (Assistant Director of Nursing) went into R43's room with this surveyor to look at the pressure area on R43's right great toe. R43 had a dark scab on the tip of her right great toe. V3 said R43 had recently had a pressure area to her right heel that has healed. At 1:32 PM, V3 said she would expect staff to identify areas of pressure prior to them becoming	S9999		

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 _____	08/04/2022

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
S9999	Continued From page 6	S9999		

unstageable. V3 said the facility was using agency nurses at the time. V3 said a lot of things did not get done and it was hard to keep track of things. V3 said now the facility has more nurses hired and are training them.

On 8/3/22 at 2:03 PM, and again at 3:15 PM, R43 was lying in bed with nothing under her heels. R43's heels were directly flat on the bed.

On 8/04/22 at 12:05 PM, V2 (Director of Nursing-DON) said R43 needs staff assist for dressing. Staff should perform skin checks and look for any changes off of R43's baseline. V2 said staff should report any changes to the nurse on duty, so they can assess the area. V2 said the facility may have been able to identify any subtle skin changes and put something in place before it got to that point with R43's great toe. V2 said staff should follow the interventions in place and offload R43's heels to prevent a reoccurrence of pressure areas.

R43's Wound Assessment Details Report dated 8/1/22, showed R43 recently had a deep tissue injury to her right heel, that was identified on 7/22/22. A Wound Assessment Details report dated 3/31/22 showed R43 had previously had an unstageable pressure injury to her right heel that was identified on 10/15/21. A Wound Assessment Details Report dated 3/4/22 showed R43 had a previous deep tissue injury to her right lateral heel that had been present on admission.

The facility's policy and procedure titled Pressure Injury and Skin Condition Assessment, with a revision date of 1/17/18, showed the purpose of the policy was to establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries

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 _____	08/04/2022

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
S9999	Continued From page 7 and other ulcers and assuring interventions are implemented. The policy showed "1. 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. 2. Residents identified 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. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment...6. Care givers are responsible for promptly notifying the charge nurse of skin breakdown...17. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care." 3. On 8/2/22 at 1:00 PM, R178 was lying in bed. R178 was not wearing any heel protectors and his heels were not being floated. On 8/2/22 at 1:31 PM, R178 was observed on the floor, face down on a fall matt. R178 was not wearing a sock on his left foot. R178 had a purplish-black, egg size area to his left heel. On 8/3/22 at 1:38 PM, V3 (WCN-Wound Care Nurse) stated she was not following or treating R178 for any skin issues. V3 said she was unaware of any skin problems with R178. V3 said R178's heels should be offloaded when he is in bed to prevent any break down. On 8/3/22 at 4:19 PM, R178's was lying in bed and his heels were directly on the mattress. R178's heels were observed with V3 present. V3 stated she did not know anything about the dark area on his left heel. V3 said, "That is new to me.	S9999		

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 _____	08/04/2022

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
S9999	Continued From page 8 I was not aware of this until now." V3 said that looks like a pressure issue to me. It could be a DTI (deep tissue injury). His heels should be offloaded to take off the pressure. V3 said the aides should be inspecting resident skin daily during all cares. Any changes should be reported to the nurse right away. V3 said the nurses also do weekly skin assessments and should be inspecting the skin from head to toe. V3 said this should have been reported immediately. It is important to treat pressure ulcers right away to prevent worsening of the issue. R178's progress note dated 7/28/2022 (last weekly skin assessment) showed no skin concerns and "FOOT OBSERVATIONS/CARE: No foot concerns noted." R178's wound round documentation dated 8/2/22 at 12:40 PM by V3 (WCN) showed no wound or skin concerns. R178's wound round documentation dated 8/3/22 at 5:36 PM (after the observation with surveyor) by V3 (WCN) showed a facility-acquired left heel deep tissue pressure injury. The measurements were 6.00 cm long by 5.00 cm wide by 0.01 cm deep. On 8/4/22 at 9:40 AM, V2 (Director of Nurses) stated skin checks should be done daily by the aides with all ADLs (activities of daily living) and cares. Any changes should be reported immediately. Resident's skin is checked weekly by the floor nurses too and special attention is needed for high pressure areas like the backside and heels. It is important to catch changes right away to stop rapid deterioration. It is important to start interventions right away to prevent further breakdown. Staff should be finding skin changes	S9999		

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 _____	08/04/2022

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
S9999	Continued From page 9 before reaching a DTI level. Finding pressure problems at an advanced level takes it longer to heal. The facility Pressure Injury and Skin Condition Assessment policy revision dated 1/17/18 states: "4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. 6. Care givers are responsible for promptly notifying the charge nurse of skin breakdown." (B)	S9999		