Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005177	A. BUILDING: ______ B. WING ______	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE LAKESHORE	7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626

(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 Investigation 2188449/IL140268 2188539/IL140378	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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 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

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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 were not met as evidenced by:

Based on observation, interview and record review, the facility failed to perform a comprehensive skin assessment, failed to implement preventative interventions to prevent the development of a pressure ulcer, and failed to provide treatments for a facility acquired pressure ulcer. This failure resulted in R2 developing a bone infection from an open infected area in the sacrum (bottom of the spine) that required hospitalization. This failure affects 1 of 3 residents (R2) reviewed for pressure ulcers in a total sample of 7 residents.

Findings include:

R2's Face Sheet documents resident is a 78 year-old with diagnoses including but not limited to: rheumatoid arthritis without rheumatoid factor, right knee, difficulty in walking, not elsewhere classified, rheumatoid arthritis without rheumatoid factor, left knee, type 2 diabetes mellitus with unspecified complications, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, muscle weakness (generalized), atherosclerotic heart disease of native coronary artery without angina pectoris.

On 11/22/2021 at 2:05pm and 4:31pm, this surveyor attempted to contact V12 (Certified Nursing Assistant/CNA) who was the CNA on duty and assigned to R2's care on 10/04/2021 when R2's sacral wound was first identified.

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S9999	Continued From page 3 During the investigation surveyor did not receive a call back from V12. On 11/20/2021 at 2:32pm V2 (Registered Nurse) stated, "R2 was my patient that I work with regularly, but currently R2 is in the hospital. R2 was sent out because R2's wound was getting worse. R2's wound was on the sacrum. R2 was bed bound and required a lot of assistance. R2 came to the 3rd floor when the second floor was shut down in September. I do skin assessments only when the certified nursing assistant notices a problem with a resident's skin; that's when the CNA will call me and that's when I do a skin assessment. I did not do any skin assessments for R2 because the CNA did not notify me of R2 having any skin problems. R2 is bed bound so R2 gets bed baths. If the CNAs notice anything new on the skin, then they call me to come and look at it. I am required to do a weekly skin assessment on the residents. R2 was sent out November 9, 2021 to the hospital because V10 (Wound Nurse Practitioner) was worried that R2 might have osteomyelitis. On October 29, 2021 the wound looked the same; it didn't get any worse, but it wasn't getting any better. I don't assess wounds, the wound nurse deals with the wounds. On November 9, 2021, R2 was exhibiting behaviors of screaming and R2's behavior was off. On November 9, 2021 V10 (Wound Nurse Practitioner) was here doing wound rounds and said that R2's wound was getting worse. V10 sent R2 out to the hospital because V10 was suspecting that R2's wound were infected. I did not assess R2's skin because prior to the discovery of the wound, which was on October 4, 2021, nobody notified me that R2 had a skin alteration. R2's hospital admitting diagnosis was urinary tract infection (UTI) and osteomyelitis."	S9999		

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On 11/20/2021 at 4:09pm, V1 (Director of Nursing) stated, "R2 had a sacral and gluteal wound. Those wounds formed at the facility. I believe in early October the resident developed wounds. To my knowledge, R2 was turned and repositioned every two hours. Two of the smaller wounds healed, but I believe the sacral wound deteriorated. R2 was sent to the hospital on November 9, 2021, because we noticed R2's wound was not improving. R2 was admitted to the hospital with the diagnosis of osteomyelitis related to the wound and UTI. Every week I speak to V15, who is R2's doctor and medical director, and R2's doctor told me that R2 has osteomyelitis."

On 11/22/2021 at 1:28pm V1 (Director of Nursing) stated, "Skin assessments are done upon admission and wound care follows up. Skin assessments are done quarterly and upon admission. The nurses are only supposed to do skin assessments when there is a problem area identified by the CNA. The CNAs will look at the skin during a shower, and if there is a problem, the CNA will let the nurse know, and the nurse will notify the wound nurse. Nurses are required to do skin assessments upon admission and quarterly and when there is a problem area identified by the CNA. A nurse working the floor is supposed to do weekly skin assessments for the residents who are assigned for a skin assessment during that shift. I don't recall doing a skin assessment on R2. Sometimes when the nurses are busy, I will help with skin assessments. I did not do a skin assessment on R2. I signed off on R2's skin assessments for the date of October 1, 2021, but I never actually looked at R2's buttocks and sacral area. On October 1, 2021, when I signed off on the weekly skin assessment, I never looked at R2's buttocks, I just did not do it. By signing off

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on the weekly skin assessment, it means that I did a full skin inspection on R2, however, I did not assess R2's buttocks and sacral area so I failed to do a complete skin assessment for this resident."

On 11/21/2021 at 10:50am V8 (Wound Nurse) stated, "R2 is currently in the hospital. R2 has a wound on the sacrum which developed at the facility. When I started working as a wound nurse on 25th of October, R2 had the sacral wound. When I started treating R2's wounds, I heard that the wound was new, and it started at our facility. On October 25, when I first saw R2's wounds, I noticed that R2's wound was not able to be staged because there was a lot of sloth there. I was doing wound treatments for R2 daily and as needed. When the CNA was trying to reposition R2, R2 was hitting and noncompliant. When I was doing wound care, I needed assistance because R2 was a bit combative. R2's wound was bad, and as I did the treatment, the wound was not getting better. I know that we sent R2 to the hospital because the wound was not getting better, in fact R2's wound was getting worse. I know that V10 (Wound Nurse Practitioner) was worried that R2's wound was infected and V10 was worried that R2's infection might have spread to the bone. R2 was sent to the hospital on November 9, 2021 and it was confirmed in the hospital that R2 did develop osteomyelitis because of the wound."

On 11/21/2021 at 11:10am V9 (Wound Nurse) stated, "I am doing R2's wound treatment. I first learned of R2's wound on October 4, 2021, when (V13) the Assistant Director of Nursing (ADON) came to me and told me about R2's wound. V13 notified me that V13 discovered a wound on R2's sacral area. V13 (ADON) accompanied me to

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S9999	Continued From page 6 R2's room and we looked at R2's wound together. V13 was working the floor that day because a nurse who was scheduled to work the 3rd floor called off and that's how R2's wound was discovered. When I initially went to see R2's wound with V13 on October 4th, I saw R2 had a wound that was opened and it had sloth, and it was hard to stage R2's sacral wound because it was open, and it was covered with sloth so it was difficult to determine what was underneath it. Basically, what happened is that the wound was there, and nobody reported it, and nobody was treating R2's sacral wound until V13 (ADON) saw the wound and notified me. Basically, whoever was caring for R2 was covering up the wound and not letting anyone know that it was there. When I saw the wound on October 4, 2021, R2's wound was already an opened full-blown wound. Since we discovered it, the wound got bigger and we were caring for it, but it got bigger. R2 is very close to me; I really love R2, so when I learned of this wound it was heartbreaking to me. I cannot believe that someone was covering up the wound. I will say that R2's skin assessment was not done by the nursing staff during showers; that is why the wound on the sacrum developed into stage 4. The problem is that the nurses are not doing skin assessments when residents are having showers. The nurse will assess the resident's skin when the CNA will notify the nurse of a skin issue. The nurse is also required to do a skin assessment once a week. We used to have the shower sheets, now we do the shin assessments in the computer. Now they only do shower sheets when they notice a skin alteration. When I saw R2's wound on October 4, 2021, the wound on the sacrum was open and deep, so R2's wound was there for a while and nobody reported it."	S9999		

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On 11/21/2021 at 11:35am V10 (Wound Nurse Practitioner) stated, "R2 has a stage 4 sacral wound. After I did the wound debridement, the wound is now a stage 4. On November 9, 2021, R2 was sent to the hospital. I first saw R2's wound on October 5th. On October 5th, when I first saw R2's sacral wound, it was unstageable due to the amount of sloth. R2 had 3 wounds when I saw R2 on October 5th. R2 had a sacral wound unstageable, left gluteal unstageable and right gluteal stage 2. I did blood work and urine culture and I started antibiotics on October 6th. I also ordered a urinary catheter to be placed to help with wound healing. On October 12th, the left gluteal wound became a stage 3. On October 19, 2021, the sacral wound was debrided and became a stage 4. About 75% of necrotic sloth was removed from the sacral wound on October 19th. On November 2, 2021, the left and the right gluteal wounds closed, and the sacral wound was the only wound that was left opened, but it was not improving. On November 9th the sacral wound was the only open wound, and I discussed the care with V15 (R2's primary care doctor). I discussed the plan with R2's primary doctor and the plan was to place a g-tube because of nutrition issues, and we had a plan to do a bone biopsy for R2 to rule out osteomyelitis and blood work. R2 was sent out to the hospital on November 9, 2021, because R2's sacral wound looked worse, and R2 was refusing blood work and refusing everything so we sent R2 out. We could not assess the level of malnutrition if R2 was refusing blood work. We also sent R2 out because there was a possibility of an infected wound. It's hard to determine when it started but the sacral wound on October 5, 2021 was not able to be staged but it was open for a while before I first assessed it on October 5, 2021. When R2 was sent to the hospital on 11/09/2021,

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I was suspecting that R2's wound was infected, and that the infection spread to the bone."

On 11/22/2021 at 10:43am V13 (ADON) stated, "On October 4, 2021, I was working on the floor that day; a nurse called off and I filled in. R2 said that R2's bottom hurts. On October 4, 2021 at 2:30pm, as R2 reported that R2's butt hurts, we turned R2 over and I looked at R2's buttocks. I saw an open area on R2's sacrum, and it looked like it needed attention immediately. The wound looked like it was circular, and it was on R2's sacrum. R2's wound appeared to have sloth and I was not able to stage it. R2 is bed bound and R2 was getting care that day by V12 (CNA), but the CNA did not report to me R2 had a wound. R2 reported pain at the buttocks area, and that is how I discovered R2's sacral wound. V12 (CNA) did not tell me anything about the wound all day. When I asked V12 (CNA), who was working that day with R2, if V12 has seen this wound, V12 said 'yes'. V12 stated, 'I saw the wound and applied some barrier cream on the wound.' I asked V12 if the regular nurse that works the 3rd floor knew about this wound. I (V13) don't remember what V12 said. Nothing was done to address R2's wounds and when I first saw R2's sacral wound, it was completely open and not covered by a dressing. On October 4, 2021 at 2:33pm I (V13) asked V9 (Wound Nurse) to come and look at R2's wounds immediately, because R2's wound looked like it needed immediate attention. When V9 (wound nurse) came to assess R2's wounds, V9 stated that R2's wounds look horrible and that the wounds don't look good. R2's wounds could have been avoided. If the CNA or the nurses would have reported R2's wounds sooner, when they first developed, R2 wound not have developed a stage 4 wound and it would not have gotten infected. If the staff

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S9999	Continued From page 9 reported R2's wounds sooner, than R2 would not have developed such a huge wound. The policy in this facility is that when a resident is receiving a shower or a bed bath, the nurse should go in there and assess the resident's skin. So, with every bed bath or a shower, the nurse should be assessing the resident's skin. The nurses are required to do a general skin observation once per week called a UDA (User-Defined Assessment). The UDA assessment that nurses do is a skin assessment that is supposed to be done once a week. The nurses are consistently supposed to do resident skin assessment. It is obvious that the nurses who were caring for R2 were not assessing R2's skin. The facility policy is that nurses are supposed to assess the resident's skin with every bed bath or shower, but clearly that is not being done and that is why R2's wound was not discovered earlier. The problem is that the nurses are not doing the skin assessments as they are required to. Every resident receives two showers a week, so the nurses are supposed to assess resident's skin with the showers and once a week as part of the UDA assessment." On 11/22/2021 at 12:11pm, V11 (Administrator) stated, "The policy here at the facility is that with showers the CNAs are supposed to report any kind of skin breakdown to the nurse. The nurses are required to assess the resident's skin weekly. When a resident is showered, the nurse is required to do a skin assessment only if the resident reports an issue. The nurse is required to do a weekly skin assessment. There was a situation where the wound nurse practitioner sent out R2 to rule out osteomyelitis. The wound nurse practitioner was worried that R2's wound was already infected, which it was, and the infection spread to the bone."	S9999		

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On 11/22/2021 at 4:04pm, V15 (medical director/R2's doctor) stated, "R2 has osteomyelitis. It was confirmed at the hospital that R2 does osteomyelitis which happened because of the wound. I learned of R2's wound when R2 was admitted to the hospital while I was on vacation. The wound could have been avoided if the staff addressed and treated the wound sooner. R2's sacral wound would not have developed into a stage 4. It is difficult to assess wounds when you first look at them because you don't know what's happening underneath the skin, but if the facility assessed and treated the wound sooner, R2 would not have developed osteomyelitis. R2 does have osteomyelitis, R2 does have an infection in the bone; it was confirmed during R2's hospitalization."

General Skin Observation (dated 10/01/2021 at 10:01am) authored by V1 (Director of Nursing) documents that R2's weekly skin observation was completed, skin is warm, dry, and within normal limits.

Shower & Tub Bath Policy (dated 01/31/2018) states that C.N.A must call for a nurse to report and reddened areas, skin discoloration or breakdown.

Complete Bed Bath Policy (dated 01/31/2018) states that C.N.A must call for a nurse to report and reddened areas, skin discoloration or breakdown.

Progress Note (dated 10/05/2021 at 11:00am) authored by V10 (Wound Care Nurse Practitioner) documents R2 was examined for follow up w lab review shows hypokalemia, and for sacral and buttock wounds. Followed by wound care team inhouse with recommendation

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S9999	Continued From page 11 for {urinary} catheter. On PO antibiotics to promote wound healing. Progress Note (dated 11/09/2021 at 11:59am) documents R2's sacral wound is worsening and there is a concern for osteomyelitis, but pt. is non-compliant with lab testing, severe decreased appetite. Pt might need to go to hospital for evaluation. Wound Consultation Note (dated 10/05/2021) documents R2's wound measurements: Sacral wound 2.2Lx2Wx0.3D; left gluteal 3Lx5Wx0.3D; Right gluteal 4Lx7Wx0.1D. Emergency room CT of Abdomen and Pelvis (dated 11/09/2021) documents R2 has a large left sided sacral decubitus pubis ulcer extends to the underlying bone with apparent destruction of the distal coccyx. Findings are concerning for osteomyelitis. Emergency room report MDM/ED course (dated 11/09/2021) documents R2 is a 78 year old from nursing home with hypotension and tachycardia without fever. Found to have osteomyelitis of the sacrum as well as possible bilateral lower lobe pneumonia. (A)	S9999		