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
	IL6006399	A. BUILDING: ______ B. WING ______	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MORTON VILLA	190 EAST QUEENWOOD ROAD MORTON, IL 61550

(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: 2225957/IL149554	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	S9999	**Attachment A** Statement of Licensure Violations	

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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:

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 were NOT MET as evidenced by:

Based on record review and interview, the facility failed to follow policy and procedure related to pressure ulcers and implement a turning and repositioning program for a resident at risk for pressure ulcer development, for one of three residents reviewed (R1), in a sample of 13. These failures resulted in R1, who is a paraplegic, developing a necrotic unstageable pressure ulcer on the coccyx causing R1 discomfort and requiring debridement.

Findings include:

The facility policy, titled, "Pressure Ulcer Prevention (revised 1/15/18)," documents, "Purpose: To prevent and treat pressure sores/pressure injury. Guidelines: 1. Maintain

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S9999	Continued From page 2 clean/dry skin during daily hygiene measures. 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. May use lotion on dry skin. 3. Change bed linen per schedule and whenever soiled with urine, feces or other material. 4. Keep bottom sheet dry and tightly stretched and free of wrinkles. 5. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. 6. Employ active and passive range of motion exercises to improve circulation as indicated. 7. Whenever possible, encourage resident to change position at regular intervals as able to promote circulation. Wheelchair residents may be instructed to shift weight from one buttock to the other. 8. If redness does not disappear within 30 minutes, the turning schedule may be shortened to 1 hour. 9. Pressure reducing mattresses are used for all residents unless otherwise indicated. Specialty mattresses such as low air loss, alternating pressure, etc. may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple Stage 2 wounds or one or more Stage 3 or Stage 4 wounds. 10. Use pressure reducing pads in chairs to protect bony prominences for residents identified as Moderate/High/Severe risk. 11. Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction/shearing from heels, toes and malleoli as indicated. 12. Encourage resident to maintain proper nutrition and hydration, providing supplements and ordered and necessary assistance at mealtime as needed. 13. Offer snacks and fluids at regular intervals, as indicated unless contraindicated. 14. Moisture barrier may be applied by CNA (Certified Nursing Assistant) as needed to intact skin and may be kept at bedside."	S9999		

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The facility policy, titled "Skin Condition Assessment & Monitoring - Pressure and Non-Pressure (revised 6/18/18)," documents, "Purpose: To establish guidelines for assessing, monitoring and documenting the presences of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented." The policy later documents, "A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse." The policy advises staff are to, "1. Measure length vertically in relation to head to toe position. Measure width horizontally in relation to hip-to-hip. Measure depth straight down into the deepest part of the wound. *If the wound is necrotic and the base of the wound bed is not visible or tunneling, the stage cannot be measured and must be recorded as non-stageable with an undetermined depth." Lastly, the policy advises, "6. The resident's care plan will be revised as appropriate to reflect alteration of skin integrity, approaches and goals for care."

The Electronic Medical Record documents R1 was admitted to the facility on 5/17/22 after becoming a recent paraplegic. On 5/18/22, a Braden Scale for pressure ulcer risk identified R1 as at Moderate Risk for experiencing skin breakdown. A Restorative Observation assessment, dated 5/20/22, documents R1 has paralysis/paresis of both lower extremities, is incontinent of urine and is, "Totally dependent on staff for repositioning and turning in bed as necessary (specify frequency - with no frequency identified). A Minimum Data Set assessment, completed on 5/24/22, documents R1 has no

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S9999	Continued From page 4 cognitive impairment, requires the extensive assistance of two staff members for bed mobility/repositioning, has impaired functional range of motion in both upper and lower extremities, and is at risk for the development of pressure ulcers, but is without current skin impairment. R1's Plan of Care, initiated on 5/17/22, documents R1, "has potential for impairment to skin (related to as needed) opioid, incontinence and decreased mobility (related to) paraplegia" and instruct staff to avoid shearing, fold back/remove wheelchair leg rest prior to transfer, keep skin clean and dry, use lotion on dry skin, and minimize pressure over bony prominences. According to the Physician's Order Sheet, a "Skin Prevention Program" was ordered, but not until 7/18/22, which included instructions to clean the perineal area and use barrier cream after each incontinent episode. A Weekly Skin Observation, dated 7/19/22, documents R1's skin as "Skin intact, no concerns noted." A Skin Condition Report, dated 7/24/22, documents nursing staff identified on 7/23/22 a, "Red purple area with a small slit down the middle" on R1's Sacrum, and under, "Care Plan" the box next to, "No change to Care Plan" was checked. The 7/24/22 Skin Condition Report fails to document a proper wound assessment, as outlined in the "Skin Condition Assessment & Monitoring" policy, which should include measurements of the wound by the licensed nurse. The Physician's Order Sheet documents an order was obtained from the Physician, 7/24/22, to treat R1's Sacrum by cleaning it with wound cleanser, applying skin prep to the surrounding skin, apply Calcium Alginate to the wound bed and then cover with a water proof dressing daily. There is no documented evidence that R1's Plan of Care was revised to include the	S9999		

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development of a pressure ulcer/injury and new pressure relieving interventions were not implemented.

An Initial Wound Evaluation & Management Summary, dated 7/25/22, documents V18 (Wound Physician) examined R1 and identified, "Mild perianal dermatitis" and an "Unstageable (due to necrosis)" full thickness coccyx pressure wound, measuring 3 cm (centimeters) by 4 cm by an undetermined depth. R1's Initial Wound Evaluation & Management Summary documents, "Evolving pressure injury. Thin, black necrosis debrided. Patient says he is going to be discharging home. He says he went a couple weeks without the condom catheter and he was soiled with urine frequently."

On 8/02/22 at 9:22 am, R1 stated he had no skin issues when he first admitted to the facility for further rehabilitation. R1 stated, since his injury occurred, he has poor function of his arms and hands, with significant pain in hands and forearms. R1 stated he is not able to reposition himself well and needs assistance. R1 indicated if he is, "having a good day," he is able to get himself onto his right or left side independently, but he can't hold that position without pillows to support his body, because his legs spasm and he will roll to his back. R1 stated during his stay at the facility, he was never on a routine turning and repositioning schedule. R1 stated staff relied on him to reposition himself, but no one would put pillows under his side so he could hold that position and he would roll back onto his back eventually. R1 stated that on 7/15/22, R1's "bottom started hurting" and he told staff (unknown). R1 stated staff still had not implemented a routine turning and repositioning program at that time to help him offload pressure

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from his back/bottom. According to R1, around that same time, the facility ran out of the condom catheters he used at night. R1 stated he was leaking urine constantly and his skin was always wet. R1 stated, since the pressure ulcer developed, he is experiencing pain in the area and his sleep is poor because of it.

On 8/01/22 at 1:38 pm, V18 (Wound Physician) stated when he observed R1's coccyx wound on 7/25/22, the wound was, "Likely a couple of weeks old, Deep Tissue Injury that was starting to necrose, due to pressure on the area." V18 stated that R1 should have been on a repositioning program prior to the wound developing, and recommended off loading pressure from his coccyx at that time. V18 also stated, R1 told him he went two weeks without his condom catheter and was left soiled and wet for prolonged periods of time.

On 8/02/22 at 12:14 pm, V6 (Certified Nursing Assistant) stated R1 could not reposition himself, but, "He wasn't repositioned much on third shift." V6 stated she would ask R1 if he was comfortable or if he needed turned, but R1 wasn't on a scheduled/routine turning program. V6 confirmed that R1 did have a condom catheter that he used at night when he was first admitted, but later he no longer had one and she was unsure of why, so he would just void in the bed or incontinence brief.

On 8/02/22 at 12:47 pm, V8 (Certified Nursing Assistant) stated R1 could not reposition himself. V8 stated, throughout the night, they would check on him to ensure he was comfortable, but R1 was never on a repositioning schedule every two hours, as, "They (Residents) need a Physician's order for that." V8 stated they would just just

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S9999	Continued From page 7 adjust R1's pillows at night, placing them under the hip, but not fully turning him onto his side. V8 also confirmed that R1 had a condom catheter a majority of the time at night, but there were times when they didn't use one so R1 would leak urine on himself. On 8/02/22 at 1:01 pm, V7 (Certified Nursing Assistant) stated she felt R1 could roll and reposition himself and confirmed that R1 was not on a routine turning and repositioning program. On 8/02/22 at 1:18 pm, V15 (Licensed Practical Nurse) stated R1's, "Coccyx wound developed quick, but I'm not surprised because he laid in bed all day." V15 stated R1 could roll himself onto his side if using the side rail, but V15 was unsure if R1 could hold that position on his own. V15 stated R1 was not on a turning and repositioning program/schedule. On 8/02/22 at 3:12 pm, V3 (Wound/Restorative Registered Nurse) stated if nursing staff find that a resident has developed a pressure ulcer/injury, they are required to use the Skin Assessment form to describe the location, appearance and size of the wound. V3 stated nursing staff are supposed to include the wound measurement, but concluded that, "some don't know how to measure" the wounds. V3 stated the resident's plan of care is to be updated with new interventions to minimize the risk of further wounds from developing and promote wound healing. V3 stated, since R1 was identified as at Moderate Risk for pressure ulcer development at the time of his admission, he should have been on a turning and repositioning schedule of every two hours. V3 stated that R1 could turn himself using the side rail, but needed physical assistance of one staff member to push his hips	S9999		

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S9999	Continued From page 8 over and secure a side lying position with pillows. V3 stated R1 did have a condom catheter that he was to use at night. V3 was unaware of any supply issues with the condom catheter and was uncertain as to why staff would not have been utilizing it at night so he could maintain dry skin (B)	S9999		