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APERION CARE OAK LAWN	9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453

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S 000	Initial Comments Complaint Investigation: 2199631/IL141793	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 a) 300.1210 b) 3001210 d)2)3)5) 300.1810 h) 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 decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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: 2) All treatments and procedures shall be	S9999		

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S9999	Continued From page 2 administered as ordered by the physician. 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. Section 300.1810 Resident Record Requirements h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement an individualized plan of care for pressure ulcers and the facility failed to follow physician's orders for wound care. These failures affect two of three residents (R1 and R2) reviewed for pressure	S9999		

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ulcer treatment. R1 was subsequently sent to the hospital for a wound infection.

Findings Include:

1. R1's POS (Physician Order Sheet) shows R1 has diagnosis of non-traumatic ischemic infraction of muscle, right lower leg, unspecified open wound, left lower leg, congestive heart disease, diabetes, peripheral vascular disease, anemia, acquired absence of right great toe, hyperlipidemia, muscle wasting, methicillin Resistance Staphylococcus Aureus infection, non-traumatic ischemic infraction of muscle, left lower leg.

On 1/22/22 at 12:49pm V1 (Wound Care Coordinator) stated on 12/27/21 she was on duty and when she went to conduct wound care for R1. The dressing to R1's lower left leg was dated for 12/23/21. V1 said the dressing had a brownish substance on it and the dressing was loose with the 4x4 boarder gauze was coming off (edges lifting up). When she removed the dressing R1 had maggots in the anterior leg wound. V1 said there were a lot of maggots, more that she could count. V1 said she cleaned the wound and applied a new dressing to the lower leg. She notified the V5 (Nurse Practitioner), and orders were given to send R1 to local hospital for wound evaluation and debridement. V1 said she asked V2 (Nurse) to come and look at the wound so that she could be aware of the wound status. V2 was R1's nurse at that time. V1 said V2 refused to make an observation of the wound, stating "No I'm not going to look at that". V1 said R1 often moved around in the bed, maybe the dressing came loose. V1 said R1 has scheduled orders for wound treatment and also PRN (as needed) orders for wound treatment for instances

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where the dressing may come off, get soiled, or get loose. V1 said the dressing should be change as ordered or as needed. V1 said she notified V7 (R1's POA) that R1 wound was getting worst but she did not notify V7 that R1's wound had maggots because she did not want V7 to get scared. V1 said R1 had 3 wounds to left lower extremity. She does the wound treatments Monday through Fridays if she's scheduled to work, otherwise the nurse that assigned to care for the resident supposed to complete the wound treatment for that day if it's ordered or as needed. V1 said on 12/23/21 she completed wound rounds with V4 (Wound Care Physician), and the (name brand) treatment was initiated to R1's left leg anterior wound.

On 1/22/22 at 1:29pm V2 (Nurse) said she does not document anything that she does not see for herself. V2 said she informed R1's family that R1's wound was observed with maggots. V2 said she does not remember what she mentioned to the family and does not know what she mentioned to the hospital nurse when she gave report. When asked if she looked at the wound so that she could document what she reported to the hospital nurse and R1's family V2 did not give respond.

On 1/22/22 at 2:47pm V4 (Wound Care Physician) said he was not informed that R1 was observed to have maggots in R1's wound. V4 said that is a "horrible horrible thing". V4 said R1 has orders for wound care every two days and the treatment is honey. The honey treatment may attract insects and therefore it's important that the wound dressing is intact and not loose. V4 said if R1 wound dressing became loose insect can get under the dressing and lay maggots. V4 said R1 had a MRSA infection in R1's wound but it was

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the wound treatment that attracted the insects to the wound. V4 said orders should be implemented when he writes them. If the facility is going to do treatment dressing as they desire, they should inform him. He would ask them why and inform them that the dressing should be changed every two days. V4 said the wound treatment dressing should be completed as ordered and the treatment dressing should be changed if the dressing comes loose. V4 said he saw R1 on 12/30/21 and no one mentioned anything about R1 having maggots in R1's wound.

On 1/23/22 at 3:07pm V5 (Nurse Practitioner) said she was notified by V1 on 12/27/21 regarding R1 having maggots in R1's leg wound. V5 said she was not there, and she did not see them. When V1 contact her V1 was very concerned about R1's wound. V5 said she gave orders to send R1 to local hospital for wound evaluation and debridement. V5 said she saw R1 the next day on 12/28/21. V5 said the wound physician should have been made aware of the concern of the maggots in R1's wound. It is her expectation that the orders be communicated to the hospital as given. V5 said she does not know if the hospital debrided R1's wound.

R1's progress note completed by V5 (Nurse Practitioner) shows in-part, patient is a poor historian due to cognitive/psychiatric impairment, chief complaint/reason for this visit: infected wound, AMS (altered Mental Status), Falls, HPI Relating to this Visit, being seen today per nursing request for infected wounds. Wound nurse report resident wound declining 2/2 current infection and multiple comorbidities. Nurse report presence of foreign object in wounds (maggots) upon dressing change with noted foul smelling

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S9999	Continued From page 6 drainage with greenish discharge. Nurse also report wounds recently cultured 2/2 drainage and odor, with noted results positive for pseudomonas and MRSA. Nurse report resident seen and followed by ID. Per nursing resident not at R1's baseline mentation, denies fever, chills, cough, loss of appetite or body aches. Recently treated for COVID 19 in early October 2021. Nursing report resident sustain fall earlier in the week from bed with no noted injuries or change in baseline mentation, denies hitting head at time of encounter. Per nursing PCP made aware of resident current lab results and change in baseline mentation with order to transfer to ER for further evaluation and treatment. Noted in bed alert, in NAD. Informed of plan of care. POA phoned per nursing report to inform of impending transfer for medical evaluation and treatment. Denies CP, SOB, Palpitation, Fatigue, Blurred Vision or H/A. No s/s of respiratory distress, no SOB, JVD, use of accessory muscles for breathing. Dressing intact to wounds. PMHx significant for: Schizophrenia, Dementia, Hypokalemia, HTN, CHF, Hyperlipidemia, PVD, Anemia, MRSA, COVID 19. R1's plan of care dated 10/22/21 shows in part I (R1) have pressure ulcers, pressure ulcer will show signs of healing and remain free from infection through review date. Interventions are to administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Follow facility policies/protocols for the prevention/treatment of skin breakdown. If	S9999		

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S9999	Continued From page 7 the resident refuses treatment, confer with the resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods. Inform the resident/family/caregivers of any new area of skin breakdown. Low Air Loss Mattress in use. Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size (length X width X depth), stage. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. R1's POS with start date 11/17/21 shows left lower leg anterior wound: cleanse with NSS (normal saline), apply (name brand treatment), cover with dry dressing, change daily and PRN, left lat (lateral) Leg: cleanse with NSS, pat dry, apply Santyl, and cover with dry dressing daily, one time a day for wound care, start date 11/08/21, left lower leg posterior wound: cleanse with NSS (normal saline), Pat dry, apply betadine, cover with dry dressing, change daily and PRN start date 11/17/21, and left ankle cleanse with NSS, pat dry, apply Santyl, cover with dry dressing daily, start date 11/08/21. R1's TAR (Treatment Administration record) dated for December 2021 does not show treatment documentation for left lower leg anterior wound. On 1/23/22 at 1:50pm V1 said the documentation for left lower leg is for the left lower leg anterior wound. V1 said somehow the documentation	S9999		

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S9999	Continued From page 8 may have been changed but she's certain that the documentation is for the left leg anterior wound. R1's TAR for December 2021 shows left lower leg cleanse with NSS, pat dry, apply (name brand treatment) and cover with gauze and ABD pads, wrap with kerlix daily, documentation show the first sign off for this treatment was 12/30/21. R1's wound assessment and plan dated 12/23/21 completed by V4 shows in-part R1's name, discussed care and course of treatment and obtained general consent to evaluate and treat, active/initial phase of treatment, wound location left anterior lower leg, pressure injury, healing, date of onset 10/08/21, measurement 8cm length x 5.5 cm width x 0.2 cm depth, wound bed 100% granulation, peri wound-within limits, exudate-moderate, signs and symptoms of infection-none, treatment- every 2 days medical honey gel-cleanse wound with normal saline or sterile water, apply to wound bed, cover with dry dressing and as instructed, wound slightly improving, treatment change to medical honey, follow up as scheduled, wound risk factors paranoid schizophrenia, type 2 diabetes mellitus, hypertension, acute post hemorrhagic anemia, peripheral vascular disease. R1's emergency department records dated 12/27/21 at 3:51pm shows in-part patient (R1) a/ox4 (alert and orient) to ED from Aperion care NH for c/o left lower leg wound. Patient states that NH RN (Registered Nurse) patient was sent because (R1) has maggots in (R1's) vagina. Patient also states LLE (lower left Extremity) wounds needs to be cleaned. Patient denies any other complaints at this time. Chief complaint, patient presents with wound check-LLE wounds, and medical problems re-evaluation. Past	S9999		

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medical history of paranoid schizophrenia, hypertension, hyperlipidemia, diabetes, peripheral vascular disease, wound to the left lower extremity, prolapsed uterus presenting to the ER for evaluation of lower left extremity wound. No report of fever chills, nausea, vomiting. No shortness of breath, chest pain, abdominal pain. Patient reports (R1) was told there was magnet in (R1's) sacral wound that was removed from the nurse. Patient unsure when left lower extremity wound became worst. Patient reports (R1's) doctor sent (R1) in for evaluation. Comments: left lower extremity: anterior wound with granulation tissue, distal medial wound with purulent drainage, erythema up towards the knee, warmth to the lower extremity, 1 plus pitting edema. Two pinpoint areas unstageable pressure wounds, no surrounding erythema or drainage noted.

Review of R1's emergency room records, there is no documentation that shows R1 was sent for wound debridement and wound evaluation of anterior left leg wound as ordered by V5. There is no report documented from the facility nurse that R1 was sent to the hospital for wound debridement and evaluation of the anterior left leg wound.

On 1/22/22 at 2:28p.m V3 (Manager on Duty) said wound treatment should be administered as ordered, V3 said documentation should be accurate and complete. V3 said orders should be carried out when they are received or as soon as possible that day. V3 said if it's not documented then it's not done.

2. On 1/22/22 at 11:13am R2 was observed resting on low air loss mattress. R2's skin was

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observed with assistance from V10 (Certified Nurse Assistant/CNA) and V9 (agency CNA). R2 was observed to have a dressing to the right foot dated 1/21/22. The dressing was soiled with a large brownish red stain. R2 had a dressing to the left foot dated 01/17/2022. R2 had a dressing to the sacrum, no date noted. R2 did not have a treatment dressing to the right gluteal fold wound. The wound was observed to be pink in color. R2 did not have a treatment dressing to the left hip. The wound was observed to be pink in color. R2 tracheostomy tie was observed soiled with yellow substance. The date was observed to be 1/17/22.

On 1/23/22 at 11:41am R2 was observed for wound care. V1 administered wound care with assist from V8 (wound tech) R2 had the same soiled dressing to the right lower leg dated 1/21/22. V1 removed the dressing and implemented wound care. The wound was observed to be pink in color. R2's left foot was observed to be intact. V1 said the dressing is for preventive measures and she changes that left foot every 3 days. R2's wound to the sacrum was soiled in feces. V1 removed the dressing and administered wound care to sacrum. R2's sacrum wound was large and pink in color. V1 cleansed the wound to R2's left hip, applied wound treatment and a clean dry dressing. The wound to R2's left hip was pink in color. V1 cleansed the wound to R2's right gluteal fold, applied wound treatment, and a dry dressing. The wound to R2's right gluteal fold was observed to be pink in color. R2 was observed with the same soiled yellow trach tie, date was observed to be 1/17/22.

R2's POS dated shows in-part Right Gluteal Fold: cleanse with NSS, Pat Dry, apply Santyl and

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cover with gauze and dry dressing M-W-F and PRN, one time a day every Mon, Wed, Fri for wound care AND as needed for wound care. Right Ankle: cleanse with NSS, pat dry, apply (brand name dressing), and cover with gauze, ABD, and wrap with (brand name wrap) every M-W-F and PRN, one time a day every Mon, Wed, and Fri for wound care AND as needed for wound care. Left Hip: Cleanse with NSS, Pat dry, pack with collagen and cover with gauze and dry dressing every M-W-F and PRN, one time a day every Mon, Wed, Fri for wound care AND as needed for wound care. Sacrum: Cleanse with NSS, Pat Dry, pack with collagen and cover with gauze and dry dressing every M-W-F and Prn Until Healed, one time a day every Mon, Wed, Fri for wound care AND as needed for wound care. Change Tracheostomy tie daily, every day shift and as needed.

Review of R2's December TAR, there were no documentation for wound care treatment PRN for R1's left hip, right ankle, right gluteal fold, or sacrum.

Review of R2's Medication Administration record, shows documentation for change tracheostomy tie daily, documented by V11 (Nurse).

On 1/23/21 at 2:24pm V11 (Nurse) said she changed the trach tie for R2 on 1/23/22, 1/22/22, and 1/21/22. When informed that the date on the trach tie shows 1/17/22, V11 then said the night nurse changed the trach tie and she signs off on it. Then V11 said she does not have time to change the trach tie. She only has time to suction R2 if needed because she is so busy. She has 19 residents on the Covid unit and 12 to 13 residents that are not on the Covid unit.

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S9999	Continued From page 12 On 1/23/22 at 3:00pm V12 (Director of Nursing) said the facility needs 5 nurses for the 7am to 3pm shift. V12 said there is 4 nurses on duty today and there were 4 nurses scheduled yesterday. V12 said the facility can function with 4 nurses. When V12 was informed of V11 concern of having 19 residents on the Covid unit that require constant monitoring because they can change at any moment and not being able to change the trach collar as ordered, V12 said she has seen V11 work and that V11 can get it done. V12 said the facility needs 10 CNAs for the 7:00am to 3:00pm shift. The facility has 8 but had 2 call offs. V12 said she does not know who orientated the agency CNAs on the level of care the residents need but they should ask the unit nurse if they have concerns. R2 plan of care dated 9/15/21 shows I (R2) have pressure ulcers to my right lateral ankle, left hip, right buttock, right gluteal fold r/t impaired mobility. Management of Pressure Ulcer, Prevention of Future Pressure Ulcers, Wound Will Show Signs of Improvement, Educate Resident/Representative on importance of keeping skin clean and moisturized, Evaluate skin for areas of blanching or redness, Evaluate ulcer characteristics, Keep skin clean and well lubricated, low air loss mattress, Monitor bony prominences for redness, Monitor nutritional status, Notify family of new onset finding, Notify provider if no signs of improvement on current wound regimen, offloading device, Provide skin care per facility guidelines and PRN as needed, Provide wound care per treatment order, Weekly wound assessment, including LxWxD (length x width x depth), type of tissue present, drainage, odor. S/S of infection noted or decline to wound status, call MD and all other appropriate parties.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002059	A. BUILDING: ______ B. WING ______	C 01/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 Facility policy Titled "Comprehensive Care Plans" dated 11/28/2012 with last revision date of 11/17/17 shows in-part to develop a comprehensive care plan that directs the care team and incorporate the resident's goals, preference and services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being. The facility will develop and implement a comprehensive person-centered care plan for each resident, consist with the resident rights that includes measurable objectives and timeframes to meet a resident medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. Facility policy Titled "Skin Condition Assessment and monitoring- pressure and non-pressure dated 11/28/12 with last revision date 6/8/2018 shows in part the purpose- to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented, wound assessment/measurement-number 7. Shows physician ordered treatments shall be initiated by staff on the electronic treatment administration Record after each administration. Other nursing measure not involving medications shall be documented in weekly wound assessment or nursing note. Facility policy Titled "Physician Orders-Entering and processing" dated 08/22/2017 with revision date of 01/31/2018 shows in-part purpose- to provide general guidelines when receiving, entering, and confirming physician or prescribers' orders. (A prescriber is noted as physician, nurse practitioner, and physician assistant.) Number 6 -verbal and telephone orders will be documented	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 as such in the electronic medical record. Facility Policy Titled "Pressure Ulcer Prevention" dated 11/28/2012 with revision date of 01/15/2018, shows in-part to prevent and treat pressure sores/ pressure injury. Number 1- maintain clean/ dry skin during daily hygiene measures. "A"	S9999		