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
	IL6008783	A. BUILDING: ____ B. WING ____	C 02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE SPRING VALLEY	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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 Facility Reported Incident of February 1, 2022/IL143511	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2) 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. 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	

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care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

These requirements were not met as evidenced by:

Based on interview, and record review, the facility failed to routinely assess a pressure wound and failed to follow physician's orders for the treatment of pressure wounds, for one of three residents (R1) reviewed for pressure ulcers, in the sample of 3. These failures resulted in the disruption of surgical skin grafts, resulting in a delay of healing to R1's wounds.

FINDINGS INCLUDE:

The facility policy, Skin Condition Assessment and Monitoring- Pressure and Non-Pressure, dated (revised) 6/8/2018 directs staff, "To establish guidelines for assessing, monitoring and documenting the presents of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Pressure and other ulcers will be assessed and measured at least weekly by licensed nurses and documented in the resident's clinical record. A skin condition assessment and

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pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. A wound assessment will be initiated and documented in the resident's chart when pressure and/or other skin conditions are identified by the licensed nurse. Adherent or semipermeable membranous dressings used for debriding or healing purposes will be removed at least weekly or more often in accordance to physician's orders. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care."

R1's (hospital) History and Physical, date 1/28/22 documents, "(R1) was admitted for gangrene of the bilateral feet (heels) with osteomyelitis. Start IV (Intravascular) antibiotics. Podiatry was consulted. (R1) has received debridement and surgical intervention. Discharge Diagnoses: Gas Gangrene of Feet (heels); Cellulitis of Lower Extremity; Type 2 Diabetes; Open Wound of Left Foot; Open Wound of Right Foot, Abscess of Right Foot; Abscess of Left Foot; Acute Osteomyelitis of Right Foot; Acute Osteomyelitis of Left Foot.

R1's Physician Order Sheet, dated 1/31/22 documents that R1 was admitted to the facility on 1/31/22 with the following physician orders: Wound Vac (Vacuum-Assisted Wound Closure) at 125 mmHg (millimeters of mercury) to bilateral heels; Change Wound Vac every day shift, every three days; Non-weight bearing.

R1's Admission Minimum Data Set Assessment documents, "Section C: Cognitive Patterns-15:15 (Cognitively Intact).

R1's Admission Care Plan includes the following Focus Areas: (R1) is non weigh bearing due to

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S9999	Continued From page 3 bilateral heel wounds. R1's Admission Observation Assessment, dated 1/31/22 at 11:35 A.M. documents, "Section D: Skin Integrity (interruption of skin integrity) to Right heel and Left heel." No description or details (assessment) are given. The facility report: Resident Abuse Investigation Form, dated 2/1/2022 documents, "(R1) is alert and oriented, with a BIMS (Brief Interview for Mental Status of 15. (Range 1-15). (R1) was interviewed and states that at approximately 4:20 A.M. her bedroom door opened, and two CNAs (V4 and V5) said they were taking (R1) to the bathroom. (R1) states she told (V4 and V5) that she was not supposed to put any weight on her feet. (R1) states the two CNAs (V4 and V5) put yellow socks on her and assisted her to the bathroom. When (R1) sat down on the toilet she noticed blood on the floor. V3/Registered Nurse sent her to the hospital for treatment." R1's Skin Condition report, dated 2/1/22 and signed by V3/Registered Nurse documents, "Right heel skin graft dehiscence. Assessed (R1's) right heel. Bleeding present. Dressing changed. Physician and (V2) Director of Nurses notified. Sent to ER (Emergency Room) for further evaluation." R1's Emergency room report, dated 2/1/22 documents, " (R1) is a 63-year-old female with a past medical history of hyperlipidemia, diabetes, osteomyelitis presenting to the emergency department via EMS (Emergency Medical Services) from (facility) due to wound issues. (R1) on January 28, 2022, was seen at (local hospital) and had bilateral heels operated on with skin grafts. (R1) was getting treated for osteomyelitis.	S9999		

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S9999	Continued From page 4 (R1) had incision and drainage and a procedure done by (V6/Doctor of Podiatry Medicine). According to (R1) she was awoken at 4 AM this morning and was trying to go to the restroom. (R1) is not supposed to be weight bearing. According to (R1) she was forced to put weight onto her right foot. Upon putting weight onto the right foot (R1) felt tearing of the staples. (R1) had bleeding. Wounds were dressed and (R1) was brought to the emergency department. Right heel examined and heel graft present with staples. At heel and distal area patient has dehiscence from staples with oozing of blood. More at the heel, versus distal. Wound was visualized by myself and undressed. Images were taken. (V6/DPM) was contacted from the emergency department and images and videos were reviewed via secure medium. (V6/DPM) recommended that the patient should do well with continued negative pressure wound therapy and dressed the wound with an adaptive base layer and compression. (Facility) recommendations are (R1) should be 100% non-weigh bearing for 1-week, bedside commode only. Two-person lift. In the emergency department wound has been redressed. (R1) will be discharged back to the (facility) with instructions of non-weight bearing once again." R1's Electronic Medical Record, date 1/31/22 (Admission) does not document that a Wound Assessment was initiated or documented on, despite R1 being admitted to the facility with open pressure wounds to the bilateral feet. Nor does R1's Medical Record include any Weekly Wound Assessment from 1/31/22 through 2/15/22. On 2/15/22 at 8:15 A.M., R1 stated, "I was at (local hospital) after a long bout with Covid. I had been on bed rest and both of my heels developed wounds. I was admitted (to the facility) on 1/31/22	S9999		

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S9999	Continued From page 5 with a doctor's order for no weigh bearing because of my recent skin graft surgery. On 2/1/22, before breakfast, 2 CNAs (V4 and V5/Certified Nursing Assistants) entered my room and without asking me, put yellow socks on my feet and set me on the side of the bed. I kept telling I was not supposed to bear weight on my feet, but they (V4 and V5/CNAs) stood me up and walked me to the bathroom. As soon as I put weight on my heels, I felt the staples in my right heel tear and saw blood saturate the bandages and on the floor. They (V4 and V5/CNAs) got the nurse. They sent me to the local ER (Emergency Room), where they took pictures of the injury, dressed my heel and sent me back to the facility. I just want to go home now." On 2/15/22 at 10:45 A.M., V2/Director of Nurses (DON) stated, "(R1) was admitted to our facility on 1/31/22 from (a local hospital). (R1) was admitted as no weight bearing on admission (1/31/22). That information was placed on R1's CNA Kardex. I expect staff to consult a resident's Kardex for ambulation status and new information status, prior to ambulating a resident for the first time." V2/DON also stated, "It is the facility policy to assess all wounds upon admission and weekly thereafter." At that time, V2/DON verified no wound assessments were performed on R1's bilateral heels wounds on admission or weekly thereafter, as required. On 2/16/22 at 8:33 A.M., V3/Registered Nurse (RN) stated, "(R1) was no weight bearing on her bilateral heels, due to recent skin grafts (on admission). The previous nurse passed along that information in Report. Around midnight or 1:00 A.M. (on 2/1/22), (V5/CNA) asked me what (R1's) weight bearing status was and I told (V5/CNA) that (R1) was no weight bearing.	S9999		

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S9999	Continued From page 6 Around 5:00 A.M., I was summoned to (R1's) room due to (R1) bleeding from the right foot. (R1) was lying in bed and there was active bleeding from her right heel. When I asked what happened, both CNAs (V4 and V5) stated they had ambulated (R1) to the bathroom and back. I undressed only the right heel and noted the bottom of the wound had dehisced and the area was bleeding, profusely. I applied a dressing to staunch the blood, called (R1's) physician and the (V2/Director of Nurses) and requested (R1) be sent to the ER for an evaluation." On 2/16/22 at 10:59 A.M., V4/Certified Nursing Assistant (CNA) stated, "I was told in Report that (R1) was not ambulatory due to wounds on her bilateral heels. I guess I didn't think about it later when me and (V5/CNA) went into (R1's) room around 5:00 AM (on 2/1/22), to take her to the bathroom. I don't recall if (R1) said she wasn't supposed to be on her feet. Once (R1) ambulated to bathroom, we (V4 and V5/CNAs) noticed bright red blood from (R1's) right heel and alerted the nurse (V3/RN)." On 2/16/22 at 10:21 A.M., V6/DPM (Doctor of Podiatry Medicine) stated, "I am the physician that has been following (R1), since performing bilateral skin grafts on her heels. (R1) developed the bilateral wounds and presented to the hospital after developing gas gangrene, back in December of 2021. The disruption of the skin grafts, due to weight from ambulation, would cause a delay in healing of (R1's) wounds." (A)	S9999		