STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007207	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE BURBANK	5701 WEST 79TH STREET BURBANK, IL 60459

(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 2397179/IL163752	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.690 b) 300.690 c) 300.1210 b) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to prevent or determine how an injury of unknown origin occurred, and failed to report an

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injury of unknown origin to the regulatory agency. This affected one of three residents (R6) reviewed injury of unknown origin. This failure resulted in R6 sustaining an injury to the right knee receiving seven sutures at the local hospital.

Findings Include:

R6 is a 92 year old with the following diagnosis: chronic venous hypertension with ulcer of the left lower extremity, venous, insufficiency, chronic obstructive pulmonary disease, congestive heart failure, and Alzheimer's disease.

R6's Care Plan, dated 8/23/23, documents R6 has a potential for impairment of skin integrity related to fragile skin, impaired mobility, and incontinence.

The Change of Condition Evaluation, dated 8/27/23, documents R6 had a change in condition of a skin wound and this occurred in the afternoon. R6 had no changes in mental status observed. There were no other changes of condition documented besides a skin tear to the right knee.

The Hospital Records, dated 8/27/23, documents R6 was sent to the hospital when staff noted a linear laceration to the right knee. R6 does not have any pain and does not recall how this occurred. Staff denied any falls or witnesses to the injury. R6 was alert and oriented times two. The laceration to the right knee was 2.5 cm horizontally. R6 received seven sutures to the right knee during a laceration repair.

On 9/6/23 at 5:35PM, V9 (Wound Nurse Practitioner) stated the older a resident becomes the more fragile skin becomes. V9 endorsed if a

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resident has a disease related to lack of circulation then wounds can develop easier than residents who don't have circulation issues. V1 stated the facility should be monitoring residents as best as they can to prevent any wounds.

On 9/7/23 at 1:48PM, V2 (Director of Nursing/DON) stated when V14 (CNA) got R6 in bed, a skin tear was found to R6's right knee. V2 endorsed R6 was not able to say what happened. V2 reported assuming R6 bumped R6's leg, but was not able to confidentially say how the wound occurred. V1 stated the skin tear was about one to two inches long. V2 reported R6 was sent the hospital because of the skin tear and increased confusion. Per the documentation, R6 did not have any changes in mental status. V2 stated seeing a blood stain on R6's pants once R6 was in bed but was not able to see the blood stain before due to R6 having dark pants. V2 stated, "I reported it to the doctor and the Administrator. It didn't need to be reported to IDPH (Illinois Department of Public Health) because it wasn't a fall."

On 9/7/23 at 2:29PM, V14 stated V14 put R6 in the bed and started to undress R6. V14 endorsed when V14 pulled on R6's pants, a cut" was found to the top of the right knee. V14 stated when V14 asked R6 what happened, R6 couldn't say. V14 denied any falls and denied R6 hitting any part of R6's body when getting into bed.

On 9/8/23 at 12:42PM, V1 (Administrator) stated R6 was sent to the hospital after obtaining a new skin tear in the facility. When asked what an injury of unknown origin is, V1 replied, "It's an injury that can't be explained how it happened by the resident or staff." V1 endorsed a risk management investigation is completed within the

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S9999	Continued From page 4 facility but is not sent to IDPH. V1 stated, "We didn't need to send an incident report to IDPH because it was a skin tear. Skin tears do not need to be reported. You might not know how a skin tear happened so it doesn't need to be reported." V1 denied R6 being able to explain how the skin tear happened. There is no documentation the facility notified the IDPH Regional Office of the injury of unknown origin for R6. The policy titled, "Abuse, Neglect and Misappropriation of Resident Property," that has no date documents, " ...Purpose: This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of allegations of mistreatment, neglect, abuse, including injuries of unknown source, unusual occurrences and misappropriation of resident property ...Policy Interpretation and Implementation: ... 8. The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility. The Administrator and/or other officials shall notify ISDH in accordance with ISDH Guidelines." (B)	S9999		