STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009815	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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S 000	Initial Comments Complaint Investigation #2357647/IL164365	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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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 observation, interview and record review, the facility failed to complete weekly skin assessments, implement interventions to reduce pressure, and complete readmission assessments to identify any skin changes for 1 of 3 residents (R1) reviewed for being at risk for pressure injury in the sample of 3. This failure resulted in R1 developing pressure wounds. Findings include: 1. R1's face sheet documented an admission date of 6/15/23 and diagnoses including: chronic kidney disease, hypertension, dementia.	S9999		

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S9999	Continued From page 2	S9999		

hyperkalemia. R1's 9/15/23 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. R1's 9/15/23 MDS documented R1 required extensive two person assist with bed mobility, transfer, locomotion, dressing, and personal hygiene. R1's 7/3/23 Braden Observation documented a score of 18, indicating R1 was at risk for pressure wounds. R1's 9/15/23 Skin & Wound Evaluation documented a deep tissue injury related to pressure that was in-house acquired on the right lateral forefoot measuring 5.2 centimeters (cm) x 3.5 cm, a deep tissue injury related to pressure that was present on admission to the rear right malleolus (heel of the foot) measuring 5.6 cm x 4.7 cm, and a deep tissue injury related to pressure that was present on admission on the rear left malleolus measuring 5.64 cm x 4.21 cm. R1's Electronic Medical Record (EMR) documented R1 was transferred to the hospital on 9/10/23 and returned from the hospital on 9/14/23 at 7:40 PM. A progress note dated 9/14/23 at 7:40 PM documents that R1 returned to the facility with a new order for a daily dressing to the left heel. There was no readmission assessment documenting any skin conditions or wounds to R1's left heel.

On 9/19/23 at 10:21 AM, R1 was lying in bed watching television. R1's bilateral heels were wrapped in kerlix dated 9/19/23. R1 was not interviewable and refused to have bandages removed.

On 9/19/23 at 12:52 PM, V2 (Director of Nursing/ DON) said on 9/15/23 she went into R1's room to administer Intravenous antibiotics and while repositioning R1 noticed the wounds on R1's bilateral heels and side of the right foot. V2 said

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S9999	Continued From page 3 R1 had returned from the hospital on 9/14/23 and may have had the pressure wounds on admission but no readmission assessment was completed to document any skin conditions. V2 said all residents should have a skin assessment on admission or readmission. On 9/19/23 at 12:30 PM, V4 (Certified Nursing Assistant/ CNA) said R1 had large blisters on R1's bilateral heels 3-4 days or maybe a week prior to 9/10/23 when R1 was transferred to the hospital. V4 said she did report the blisters to the nurse but was unsure of who the nurse was or on what day she reported it. On 9/20/23 at 11:32 AM, V9 (CNA) said she noticed R1's bilateral heels to be black prior to 9/10/23 and reported it to 2 or 3 nurses but was unsure who. V9 said she was working on 9/14/23 when R1 returned to the facility from the hospital. V9 said R1's bilateral heels were black and looked really bad. V9 said she reported R1's skin changes to V8 (RN) on 9/14/23. On 9/20/23 at 11:27 AM, V8 (RN) said she did not recall R1. V8 said she did not work on R1's unit often and did not know the resident's names. V8 said she no longer was employed at the facility. On 9/20/23 at 11:38 AM, V10 (CNA) said she noticed one of R1's heels to black and "nasty looking" prior to 9/10/23. V10 said she had reported it to the nurse and thought the nurse was V6 (LPN). On 9/19/23 at 10:31 AM, V6 (LPN) said he was not aware of R1 having any pressure wounds prior to R1's 9/10/23 hospitalization. On 9/19/23 at 11:52 PM, V5 (Wound Nurse/	S9999		

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S9999	Continued From page 4 Registered Nurse/ RN) said she worked in the facility one day a week and would complete the wound documentation and take pictures of resident wounds. V5 said she had assessed R1's pressure wounds earlier in the day on 9/19/23. V5 said R1's right lateral foot pressure wound was closed and was a dark purple color measuring 5.59 cm x 3.83 cm, R1's right heel malleolus pressure wound measured 7.04 cm x 4.9 cm with 75% eschar and 25% of the wound bed being pink open tissue, and R1's left heel malleolus pressure wound measured 5.52 cm x 3.31 cm with 75% eschar and 25% of the wound bed being pink open tissue. V5 provided the pictures of R1's wounds on the wound treatment cell phone. R1's EMR documented a 9/15/23 care plan "I have a pressure ulcer r/t (related to) disease process" no previous care plan for pressure was documented. On 9/19/23 at 1:43 PM, V3 (Care Plan and MDS Coordinator/ LPN) said R1 had a Braden score of 18 indicating R1 was at risk for a pressure wound and should have had a care plan in place for being at risk for impaired skin integrity. V3 said he was unsure why R1 did not have a care plan in place prior to developing pressure wounds. V3 said he must have overlooked R1's need for a care plan for pressure to be implemented. On 9/19/23 at 12:52 PM, V2 (Director of Nursing) said any resident with a Braden score documenting a resident is at risk for a pressure wound should have a care plan with interventions to off load pressure. On 9/19/23 at 11:52 AM, V5 (Wound Nurse/ RN) said interventions for off-loading pressure would	S9999		

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S9999	Continued From page 5 be found in a resident's care plan. V5 said she would expect any resident who was at risk for pressure wounds to have a care plan with interventions such as repositioning every 2 hours, floating a resident's heels while in bed, and wedges or pillows for positioning. On 9/19/23 at 10:31 AM, V6 (Licensed Practical Nurse/ LPN) said he was unsure what interventions R1 had in place to off-load pressure. V6 said for off-loading pressure all residents should be assisted to reposition every 2 hours. R1's EMR documented R1 requiring weekly skin assessments. R1's EMR documented a Weekly Skin Observation on 6/22/23, 6/29/23, 7/6/23, 7/13/23, 8/4/23 (23 days later), 8/11/23, 8/18/23, 9/1/23 (14 days later). The last documented skin assessment completed before R1's hospital admission on 9/10/23 was dated 9/1/23. The 9/1/23 weekly skin assessment documents that R1 had a blister to the left sole, ball of the foot that is blistered and scabbed over. R1's 9/1/23 assessment further documents "no" for the question "Are any of these foot concerns new?" There is no other documentation in the progress notes or physician's orders regarding a wound, or treatment to the wound, on the left heel prior to R1's 9/1/23 assessment. On 9/19/23 at 12:52 PM, V2 (DON) said the Weekly Skin Observations were automatically generated in the EMR and was unsure why they were not completed on R1. V2 said the Weekly Skin Observations were completed to assure new skin changes would be identified, documented, and treated. On 9/20/23 at 4:37 PM V11 (Physician) said if the facility had interventions in place to off-load	S9999		

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S9999	Continued From page 6 pressure R1's pressure wounds could have been avoidable. The facility's 6/8/18 Skin Condition Assessment & Monitoring - Pressure and Non- Pressure policy documented " ... A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/ readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary. Residents identified will have a weekly skin assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure and/ or other non- pressure skin conditions are identified by a licensed nurse ... The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care ..." (B)	S9999		