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 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE OAK LAWN	9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453

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S 000	Initial Comments Complaint Investigation: 2497539/IL178201	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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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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.

This REQUIREMENT is not met as evidenced by:

Based on interviews and record reviews, the facility failed to prevent one resident who was identified as moderate risk for skin breakdown and is totally dependent on staff for all ADLs (activities of daily living), from developing three facility-acquired pressure ulcers. The facility also failed to provide the necessary care and services upon admission to promote healing of a left hip stage 2 pressure ulcer. This affected one of three residents (R1) reviewed for pressure sore. This failure resulted in R1 developing three facility-acquired pressure ulcers (unstageable wounds) including the coccyx area, right hip, and right lateral foot. R1's stage 2 wound to the left hip deteriorated to an unstageable wound.

Findings include:

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R1's medical record notes R1 was admitted on 5/24/24 with diagnoses including, but not limited to, quadriplegia cervical spine, C1-4, complete, colostomy, neuromuscular dysfunction of bladder - indwelling catheter, left hip stage 2 pressure ulcer, history of osteomyelitis of pelvis, and history of pressure ulcer on buttocks. R1 transferred to hospital on 7/12/24 and did not return to the facility.

On 9/23/24 at 11:50 AM, V4 (Wound Care Nurse) stated that V4 assesses all residents' skin on admission, re-admission, and if any skin issues arise. V4 stated that she assesses the wound, notifies physician, V5 (Wound Care Nurse Practitioner/NP), implements preventative measures such as air mattress, barrier cream, offloading - with heel boots or pillows, and notifies family. V4 stated that if the resident has wound(s), V4 does weekly skin assessments until wound(s) healed/resolved. V4 stated that if a resident's wound deteriorates, V4 will notify V5. V4 stated that when a new wound is identified, she documents wound measurements and tissue type.

There is no documentation found in R1's medical record noting a weekly skin observation was completed on 6/30/24. There is also no documentation found in R1's weekly skin assessments that were completed noting other nursing measures not involving medications were documented in the weekly wound assessment per this facility's skin assessment and monitoring policy.

On 9/23/24 at 1:25 PM, V5 (NP) stated that V5 ordered CRP (C-reactive protein - the liver releases this protein into the bloodstream in response to inflammation) level on 6/26/24 due to

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R1 developing a new wound. V5 stated that an elevated CRP level could be due to acute infection going on anywhere in the body, not just in a wound. V5 was informed R1's CRP level collected on 6/26/24 and resulted on 6/27/24 was 80.26 (normal range is 0-5). V5 was not aware of this result.

On 9/23/24 at 2:00 PM, V2 (Director of Nursing/DON) stated that R1 was noncompliant turning and offloading heels. V2 presented a physician/nurse practitioner acquired wounds unavoidibility form, dated 7/3/24, noting R1's facility-acquired pressure ulcers to coccyx, right lateral foot, and right hip were unavoidable due to R1's noncompliance with pressure ulcer prevention program. This form was not signed or dated by V3 (Attending Physician) or V5 (Wound Care Nurse Practitioner). This form was also not part of R1's medical record prior to being informed of concern with R1's wound care treatments.

There is no documentation found in R1's medical record, dated 5/24 - 6/19, noting R1 was noncompliant with turning or offloading heels. There is no documentation found noting R1's POA (power of attorney) was notified of R1's noncompliance. On 6/20/24, a care plan was initiated noting R1 is noncompliant/resistive to wound care treatments and turning/repositioning.

R1's POS (physician order sheet), dated 5/24/24, notes an order for left hip wound treatment, cleanse with normal saline, pat dry, apply calcium, cover with dry dressing every Monday, Wednesday, Friday, and as needed.

There is no physician order for wound care

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treatments for R1's right lateral foot wound, that was identified on 6/26/24, or R1's right hip wound, that was identified on 7/3/24, in R1's medical record until 7/11/24.

R1's TARs (treatment administration records), dated May, June, and July 2024, does not have any documentation that R1's left hip dressing was changed on 5/27, 5/29, 5/31, 6/3, 6/7, 6/12, 6/14, and 6/17. There is no documentation found in R1's medical record noting R1 refused any wound care treatments. V4 documented R1 refused treatment on 6/5 after V4 provided wound care treatment and R1 tolerated it well.

R1's functional ability assessment, dated 5/27/24, notes R1 is dependent for all ADLs.

R1's pre-admission hospital record, dated 5/24/24, noted R1's upper extremities and lower extremities are flaccid. R1 has sensation to upper extremities but no sensation to lower extremities.

R1's coccyx facility-acquired pressure ulcer was identified on 6/19/24. On 7/10/24, this wound measured 1.5cm (centimeters) x 0.5cm x 0.2cm, wound 100% pink or red non-granulating tissue, peri wound macerated (a softening and breaking down of skin resulting from prolonged exposure to moisture). On 6/19/24, R1's initial wound assessment noted wound measured 1.2cm x 0.3cm 0.2cm, 100% pink or red non-granulating tissue. This wound deteriorated as evidenced by increase in size.

R1's right hip unstageable pressure ulcer, facility-acquired, was identified on 7/3/24. On 7/10/24, this wound measured 3cm x 1.8cm, wound 50% pale pink non-granulating tissue and

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50% slough (yellow) loosely adherent tissue, peri wound macerated. On 7/3/24, R1's initial wound assessment noted wound measured 3.5cm x 2cm, 50% pale pink non-granulating tissue and 50% slough. This wound was unchanged.

R1's right lateral foot unstageable pressure ulcer, facility-acquired, was identified on 6/26/24. On 7/10/24, this wound measured 8cm x 5cm, wound 50% pink or red non-granulating tissue and 50% necrotic (dead) soft adherent tissue, peri wound normal. On 6/26/24, R1's initial assessment noted wound measured 8cm x 6cm x 0.2cm. This wound was classified as a partial thickness wound due to abrasion. This wound deteriorated as evidenced by development of necrotic tissue.

R1's left hip stage 2 pressure ulcer, present on admission on 5/24/24 deteriorated to an unstageable wound. On 7/10/24, this wound measured 6cm x 4cm, 60% pale pink non-granulating tissue and 40% necrotic soft adherent tissue, peri wound macerated. On 5/24/24, R1's initial wound assessment noted wound measured 0.8cm x 0.5cm x 0.1cm, 50% pale pink or red tissue and 50% pale pink non-granulating tissue. This wound deteriorated as evidenced by its increase in size and development of necrotic tissue.

On 9/23/24 at 1:25 PM this surveyor requested V4 provide all of V4's (Wound Care Nurse) wound assessments for R1. V1 (Administrator) presented wound assessment details report for R1's left hip wound for 5/24/24 only; coccyx wound for 6/19/24, 6/28, 7/3, and 7/10; and right lateral foot and right hip wounds for 7/3/24 only.

On 9/23/24 at 2:00 PM, this surveyor requested V2 (DON) provide all of V5's (Wound Care NP)

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wound care assessments for R1. V2 presented visit reports for 5/29/24, 6/19, 6/26, 7/3, and 7/10. V5's notes were not found in R1's medical record. There are no visit notes provided for 6/5 and 6/12.

This facility's skin condition assessment and monitoring, pressure and non-pressure wounds, policy, revised 6/8/2018, notes pressure ulcers will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record. 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 skin conditions are identified by licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA (certified nurse aide). Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. The initial observation of the ulcer will be described in the nursing progress notes. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. These changes include, but are not limited to, new onset of purulent drainage, new onset of odor, significant increase in wound measurements, and onset of new ulcers. Physician ordered treatments shall be initiated by the staff on the TAR (treatment administration record) after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nursing progress notes.

"B"