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
	IL6014617	A. BUILDING: _____ B. WING _____	C 03/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE INTERNATIONAL	4815 SOUTH WESTERN AVE CHICAGO, IL 60609

(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
S9999	Final Observations Statement of Licensure Violations: 2 of 2 Violations 300.1210b) 300.1210d)3)5) 300.1220b)3) 300.3240a) 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. 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: 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect	S9999		

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to implement appropriate interventions to prevent skin breakdown for 1 of 3 residents (R1) reviewed for pressure ulcers in a total sample of 8. This failure resulted in R1 developing a stage 4 pressure ulcer within 3 months of being admitted to the facility.

Findings Include:

The Face Sheet documents that R1 was admitted to the facility on 4/7/16 with a diagnosis of brain damage and respiratory failure with a breathing tube and feeding tube in place. R1 required maximum assist from staff with all activities of daily living. The Skin Assessment dated 4/8/16 documents that R1 had no skin breakdown on admission and the resident was placed on a pressure reducing mattress as a preventative measure.

The Nurse's Notes dated 5/15/16 documents that R1 was noted with maceration, or skin irritation related to moisture, on the left and right buttocks. The MD was notified, new orders were received and on 5/17/16 R1 was placed on a pressure re-distributing mattress.

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The Nurse's Notes dated 6/9/16 documents that the maceration to the left and right buttocks had deteriorated and was being measured as one sacral wound.

The MD Wound Notes dated 7/12/16 documents that the wound had deteriorated and was classified as a stage 4 pressure ulcer and on 7/27/16 R1 was transferred to the local hospital for evaluation and treatment.

The hospital records dated 7/27/16 documents that R1 was admitted with a stage 4 pressure ulcer to the sacrum with part of the bone exposed. The pressure ulcer had a foul odor on admission and R1 was started on antibiotic therapy. R1 also had a stage 2 pressure ulcer to the right and left ear.

R1's pressure ulcer care plan documents that the resident was on a pressure re-distributing mattress, the resident should be assisted with turning and repositioning every 2 hours and more often as needed, and the plan of care should be re-evaluated if there is no improvement noted in 3-4 weeks.

On 2/22/18 at 12:45pm V4 stated "The resident had no skin issues on admission. R1 was a trach patient and was very high risk for skin breakdown. R1 had a pressure re-distributing mattress and heel protectors in place. It started as moisture associated skin damage from incontinence and later developed into a pressure ulcer. "

On 3/2/18 at 10:45am V8 (Nurse Practitioner) stated "The resident had a brain injury, a trach and feeding tube in place, and R1 constantly

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moved around in bed. The resident could not be calmed down. It started as maceration and went on to a stage 4 pressure ulcer. R1 had no control over the movements; it was due to the brain injury. I had R1 on the maximum dose of Ativan, an anti-anxiety medication, and it just did not work. The staff tried to turn and reposition R1 but the resident would flail around and end up in another position. The wound deteriorated very quickly. It just got worse and worse so I had the resident sent out to the hospital."

On 3/2/18 at 11:15am V4 stated "All of our mattresses are pressure reducing mattresses for residents at high risk for skin breakdown. Residents with Stage 3, 4 or unstageable wounds are given a low air loss mattress. Pressure re-distributing mattresses have some of the same functions as a low air loss mattress, it redistributes the pressure. Low air loss mattresses are used for prevention and treatment of pressure ulcers where the resident is kind of floating on the air."

The Manufacturer's Recommendations for the low air loss mattresses used by the facility documents that the mattress is used to prevent and treat pressure ulcers. The facility could not provide Manufacturer's Recommendations to document the use for pressure re-distributing mattresses, the mattress being used by the resident.

(B)

300.610a)
300.1210b)5)
300.1210d)6)

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S9999	Continued From page 5 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures:	S9999		

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5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to follow their Fall Prevention Program and failed to ensure that fall interventions were

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securely in place prior to leaving the room for 1 resident (R2) reviewed for falls in a total sample of 8. This failure resulted in the R2 falling out of bed and being hospitalized with a laceration to the forehead.

Findings Include:

The Fall Risk Assessment dated 11/7/17 documents that R2 was at risk for falls due to confusion, recent falls and the resident being legally blind. The care plan was updated and appropriate interventions were put into place.

The Nurses Notes dated 1/30/18 documents that R2 was found on the floor by staff in between the resident's bed and dresser. R2 was observed with a laceration to the mid forehead and moderate bleeding.

The Incident Report documents that R2 was in bed prepared to be transferred to the chair by staff prior to the fall. When staff returned to the room to transfer, R2 was observed on the floor with a laceration on the forehead. R2 was sent to the hospital for evaluation and treatment.

The hospital records dated 1/30/18 documents that R2 presented with a laceration to the forehead where adhesive was used to close the wound.

On 2/27/18 at 12:55pm V2 (DON) stated "The CNA informed me that it was time for the resident to get up out of bed. The CNA went in and got the resident dressed. The CNA left the room and upon returning, R2 was observed on the floor. At the time of the fall the resident had bed bolsters in place. My investigation concluded that the CNA had loosened the bed bolsters while getting

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the resident dressed. The CNA did not re-tighten the bolsters before leaving the room. The resident did not move much so had the bolsters been securely in place, the resident probably would not have fallen. The CNA is no longer employed at the facility."

On 2/27/18 at 1:35pm V2 stated "The resident was to be transferred by a Hoyer lift. The CNA did not bring the equipment in the room prior to providing care for the resident. The CNA left the room to get the equipment and my investigation concluded that this was done without securing the bolsters. The CNA also should have had the equipment needed for the resident prior to entering the room. The CNA had been educated on this before the incident occurred."

The facility's Fall Prevention Program documents that "It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. Staff should use and implement professional standards of practice.

(B)