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	IL6007520	A. BUILDING: _____ B. WING _____	05/27/2021

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APERION CARE PLUM GROVE	24 SOUTH PLUM GROVE ROAD PALATINE, IL 60067

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S 000	Initial Comments Annual Licensure and Certification Survey 2193383/IL133951	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)5) 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. 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) 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: 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 Regulations are not met as evidenced by: Based on interview and record review, the facility	S9999		

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S9999	Continued From page 2 failed to follow their wound care protocol, failed to provide wound care certified staff, failed to ensure that a wound did not increase in size and decline, failed to ensure that physicians were notified regarding change in wound status on 4/26/21, and failed to stage a wound correctly in order for the dietician to follow the nutritional protocol after a wound is detected. These failures resulted in one (R214) out of two residents reviewed. R214 affected by developing a coccyx pressure ulcer and required transfer to a local hospital with a diagnosis of sepsis, osteomyelitis in a stage 4 pressure ulcer and severe protein calorie malnutrition. Findings include: On 05/25/21 at 1:35 PM, R214's wound rounds and progress notes were reviewed. The initial assessment was done on 3/11/21 at 4:44 PM. Identified by V2 DON (Director of Nursing). Type: Pressure. Classification: Erythema. Source: Facility Acquired. Date Identified: 3/11/21. Performed by: V2 DON Director of Nursing. Clinical stage: Stage 1. Tissue type: Non-blanchable Erythema 100%. Exudate: None. Size (cm) centimeters: 2.00 x 2.00 x 0.00 (LxWxD). Area: 4.00 centimeters squared. Current plan and comments: V2 DON documented-Duoderm every 3 days and daily as needed. Progress notes indicate: there is no documentation of V13 Family Member being notified on 3/11/21 of R214's wound development. The 3/17/21 at 10:49 AM progress note by V20 MDS Coordinator indicates: R214 continues to refuse on repositioning. R214 continues to ask for prn (as needed) pain medications due to	S9999		

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S9999	Continued From page 3 chronic pain. POA (Power of Attorney) aware. The 3/21/21 at 11:34 AM progress note by V20 MDS Coordinator indicates: R214 takes scheduled pain medications and PRN (as needed) to control pain. She prioritizes her pain more than anything at this time. The 3/25/21 at 1:45 PM wound assessment by V2 DON indicates: clinical stage 1. Tissue type: Non-blanchable Erythema 100%. Exudate: None. Size (cm) centimeters: 2.00 x 2.00 x 0.00 (LxWxD). Area: 4.00 centimeters squared. Current plan and comments: Cleanse site with wound cleanser. Pat dry with gauze. Apply medihoney and calcium alginate and foam dressing cut to size of the wound, then apply transparent dressing. May use bordered foam dressing instead of the cut foam dressing and transparent dressing. Change every 3 days and daily as needed until healed. The 4/8/21 at 1:39 PM wound assessment by V2 DON states: clinical stage: 1. Size (cm) centimeters: 8.00 x 2.00 x 0.00 (LxWxD). Area: 16.00 centimeters squared. Tissue type: Non-blanchable Erythema 100%. Exudate: None. Current plan and comments: Same wound treatment. The 4 /15/21 at 2:38 PM wound assessment by V2 DON states: clinical stage: 1. Tissue type: Non-blanchable erythema-100%. Exudate: none. Size (cm) centimeters- 6.00 x 6.00 x 0.00 (LxWxD). Area: 36.00 centimeters squared. Current plan and comments: Same wound treatment. The 4/16/21 at 1:05 PM progress note by V2(	S9999		

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S9999	Continued From page 4 DON) indicates: R214 refused to be repositioned on her side. She also refuses incontinent product change. Coccyx wound is bigger in size. Resident may also refuse wound care. Will need order for protein supplement, wound evaluation and labs. Left message for POA (Power of Attorney). Awaiting for call back. V19 Physician also aware. The 4/20/20 at 2:02 PM progress note by V2 (DON) indicates: Spoke with R214's V13 (Family)regarding wound care/referral. V13 was aware that R214 would refuse to be turned on her side or have wound care/dressing done. R214 verbalized that she does not want the wound care evaluation at the NCH (wound care facility). V19 Physician are aware. Appointment on hold for wound evaluation as resident is refusing at this time. The 4/20/20 at 11:18 AM progress note by V20 MDS Coordinator indicates: R214 verbalized the staff reposition her more than it should and it takes time for the pain to go away when staff moves her. R214 claims that her Dilaudid is not working for her and that V19 Physician was made aware. The 4/22/21 wound assessment by V2 (DON) indicates: clinical stage: 1. Tissue type: Non-blanchable erythema-100%. Exudate: none. Size (cm) centimeters- 6.00 x 6.00 x 0.00 (LxWxD). Area: 36.00 centimeters squared. Current plan and comments: Cleanse site with wound cleanser. Pat dry with gauze. Apply skin prep to surrounding skin. Apply Santyl to the wound base and then calcium alginate cut to the size of the wound and cover with bordered dressing for dry dressing. Change dressing daily and as needed until healed.	S9999		

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S9999	Continued From page 5 The 4/22/21 at 4:03 PM progress note by V2 (DON) indicates: Tele visit with wound care physician for wound evaluation. New order obtained for treatment. R214 agreed to outpatient wound clinic evaluation. Awaiting for insurance pre authorization to be approved in order to schedule for outpatient wound evaluation. Nurse practitioner was aware. Notified and updated POA (Power of Attorney). The 4/26/21 at 6:04 AM progress note by V22 (LPN) indicates: R214's wound has worsened despite applying treatment. Tunneling noted, along with brown leakage and foul odor. R214 complains of pain during dressing changes, administered Dilaudid and ibuprofen. R214 states, "I want to go to hospital." Notified V2 (DON). The 4/26/21 at 2:31 PM progress note by V2 (DON) indicates: Called wound center to set up appointment. Preauthorization is already clear. R214 has agreed to go to wound clinic for her wound to be evaluated. The 4/27/21 at 4:24 PM, progress note by V2 (DON) indicates: Spoke with V13 (Family) regarding R214's wound and overall condition. The 4/27/21 at 4:25 PM progress note by V1 (Administrator) indicates: Spoke with V13 (Family) regarding R214's recent refusals to eat, gave general update. R214'S Wound rounds were reviewed. The last assessment was on 4/27/21 at 4:58 PM which indicates: Wound to coccyx site, date identified: 3/11/21, type: pressure, classification: ulceration, source:	S9999		

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S9999	Continued From page 6 facility acquired, tissue type: slough white and fibrinous 80%, exudate: moderate amount; purulent, length: 6.80, width: 6.80, depth: 0, area: 46.24 cm squared. Clinical stage: Unstageable. Performed by V2 (DON). Current plan and comments state: Wound measurement is bigger in size. Old dressing with odor. Moderate amount of serous drainage noted. Notified wound MD about wound condition. Notified V19 (Physician) with order to send resident out to a local hospital On review of R214's care plan it indicates: I have a pressure injury on my coccyx 3/11/21. Wound is not healing well. R214 prefers not to turn side to side and has stated she values her comfort over her health 4/16/21. Interventions: Assess/record changes in skin status weekly and as needed, avoid shearing, use lift sheet for reposition, educate resident/family/caregivers of causative factors and measures to prevent skin injury, encourage good nutrition and hydration in order to promote healthier skin, encourage turn and reposition and explain the importance of turning side to side 4/16/21. Keep skin clean and dry. Lab work albumin level 4/16/21. Minimize pressure over boney prominences. Monitor skin injury to coccyx area, healing status, any signs and symptoms of infection and inform wound nurse and medical doctor of any significant changes 3/11/21. Registered dietician to re-evaluate needs for healing process of the wound 3/11/21. Registered dietician and medical doctor to review medications and follow recommendations accordingly 4/16/21.	S9999		

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S9999	Continued From page 7 Report pertinent changes in skin status to physician. Skin assessment every day and wound nurse to check wound every week 3/11/21. R214 needs pressure relieving/reducing mattress to protect the skin while in bed. Treatment as ordered. Measure all open areas as needed and record. Monitor signs, symptoms of infection during dressing change. Notify medical doctor of non-healing wounds, or of wound deterioration. Observe for pain during treatment. Pain management as ordered. Notify medical doctor as needed. At 12:30 PM, reviewed R214'a physician orders which indicate: House supplement 2.0 three times a day for supplement 90ml (mililiters). Order date: 6/8/20. March of 2021- Dilaudid 2mg (milligrams) give 1 tablet by mouth every 4 hours as needed for chronic pain. 4/21/21 Dilaudid 4mg (milligrams) give 1 tablet by mouth every 6 hours as needed for chronic pain for 14 days. Ibuprofen 200mg (milligrams) give 2 tablets by mouth every 6 hours as needed for shoulder pain. Multiple Vitamins-Minerals tablet give 1 tablet by mouth one time a day for supplement. Order date: 6/8/20. R214's MAR (Medication Administration Record) indicates an increase in her pain with use of Dilaudid and Ibuprofen during March and April of 2021. On 5/26/21 at 1:20 PM, V13 (Family) was interviewed regarding R214. V13 stated, "The staff did tell me that R214 had another bedsore. I	S9999		

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S9999	Continued From page 8 asked V2 (DON) why it was taking so long to heal. They did not tell me R214 was refusing treatments or dressing changes. I did not speak with V2 about R214 not eating. I spoke with V2 (DON) on April 27th around 6pm. She said they were sending R214 to the hospital, I did not speak with V1 (Administrator). I was not updated on her condition. I spoke with R214 and she was asking to go to the hospital, but they didn't send her until the next day." On 5/25/21 at 1:37 PM, V1 Administrator was inquired if he contacted R214's family regarding her condition. V1 stated, "Yes I did on April 27th. I called her daughter. I called the number we have on file." On 5/26/21 at 2:11 PM, V2 (Director of Nursing) inquired of R214's wound care treatment. Inquired if V2 (DON) was wound care certified? V2 (DON) stated, "I am not." Inquired if any nursing staff providing wound care treatment for R214 was wound care certified? V2 (DON) stated, "No." Inquired when R214 developed the wound and the staging of a wound. V2 (DON) stated, " R214's wound developed on March 11th of this year to my knowledge. I know how to stage a wound. The 3/25/21 assessment there is some skin opening, the wound should be a stage 2. I do the assessment on an iphone and I take pictures of the wound. I can't change the stage on there, but I could have put the correct stage of the wound in the comments." Inquired if R214's POA Power of Attorney was notified of the wound development. V2 (DON) stated, "V13 Family was notified and it was documented what the plan and interventions in the progress notes. V13 was well aware of the wound."	S9999		

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S9999	Continued From page 9 Inquired when the wound care physician was consulted regarding R214's wound. V2 (DON) stated, " We were trying to get R214 to the wound clinic but had some issues with the insurance. V19 Physician, the primary was aware of the status of the wound and the appointment. V19 was giving the orders for the wound. The wound care physician said they were not allowed to come in the building so they did a telehealth visit. The telehealth visit was on April 22nd." Inquired what nutritional interventions were ordered for R214 regarding the development of the wound. V2 (DON) stated, "There was a house supplement and multivitamins ordered. R214 was requesting more and more pain medications. She was on Dilaudid." On 5/26/21 at 2:30 PM, R214's wound treatment administration record and nutrition notes were reviewed. R214's nutrition progress note by V23 (Dietitian) indicates: 3/23/21: R214 refusing to be weighed. Noted with stage 1 coccyx wound. Multivitamin/Multimineral. House stock 2.0 90 ml (mililiters) three times a day. Continue current POC (plan of care). No Recommendations. 4/26/21 nutrition progress not by V23 Dietitian which indicates: R214 last seen by V23 4/8. Skin stage 1 coccyx wound stable per 4/22 skin report. Continue current POC (plan of care). No Recommendations. V2 (DON) Director of Nursing did not stage the wound correctly resulting in V23 (Dietitian) not following the nutritional protocol after a wound is detected. The nutritional notes reflect R214 wound as stage 1 status on every assessment	S9999		

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S9999	Continued From page 10 versus the worsening condition. On 05/27/21 at 08:32 AM, V19 Physician was interviewed regarding R214's wound care. V19 inquired when she was notified R214's wound worsened. V19 stated, "The initial orders were from me. The middle of April the wound care specialists were giving some input. The wound started to get worse toward the end of April. She was not eating or drinking much; she started declining. It would have been V2 (DON) or the floor nurse who notified me." V19 inquired why there were no wound care certified staff providing care to R214's wound? V19 Physician stated, " We utilized the facility staff on site. They are capable of following the wound care orders. I don't know why we don't have wound certified staff, it would have been good." V19 inquired why R214 was not sent to the hospital with increasing pain and change in her wound condition. V19 Physician stated, "The condition had to be significant enough, she was stable at the time. We managed with pain medication changes. We had to adjust her meds, we tapered them then had to increase them. She was being cared for her COPD (Chronic Obstructive Pulmonary Disease) and discussed hospice care with her POA (Power of Attorney) but she was not receptive. She was declining slowly." On 05/27/21 at 12:32 PM, V24 (Regional Dietitian) interviewed regarding R214's nutritional assessments related to the wound stage. V24 was inquired what would have been implemented if she was aware of R214's wound progressively worsening. V24 stated V23 Dietitian is on vacation and she will conduct the interview. V24 stated, "We do read the wound assessments,	S9999		

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S9999	Continued From page 11 what V23 wrote in her assessment is what she saw at the time. A stage one wound is like a diaper rash. We typically do a protein module to provide more protein for wound healing. V2 (DON) should have sent a new referral when she downgraded the wound to un-stageable. We have an on-call dietician she could have sent it to. The information on the 4/26/21 assessment was not accurate from the wound assessment which stated it was a stage 1." The revised 6/8/18 Skin Condition Assessment & Monitoring Pressure and Non-Pressure Policy states: Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Wound Assessment/Measurement: 2. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. Physician and responsible party notification will be documented in the clinical record. These changes include but are not limited to: a. new onset of purulent drainage, b. new onset of odor, d. increased pain related to wound, e. significant increase in wound measurements. The revised 1/15/18 Pressure Ulcer Prevention Policy states: Purpose: To prevent and treat pressure sores/pressure injury. Guidelines: 12. encourage resident to maintain proper nutrition and hydration, providing supplements as ordered and necessary assistance at mealtime as needed. (B)	S9999		

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