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
	IL6003628	A. BUILDING: ______ B. WING ______	C 01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 Investigation of facility Reported Incident 10/17/22/IL153902 Complaint Investigations: 2299213/IL153463	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 1/2 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regualtions were not met as evidenced by:

Based on interviews and records reviewed the facility failed to ensure that one resident (R5) of 4 residents reviewed was free from abuse from a CNA in a total sample of 21. This failure resulted in R5 being screamed at and threatened to be hit with a cane by a CNA and R5 feeling afraid and unsafe at the facility.

Findings include:

The facility's final Incident reported dated 10/17/2022 documents the following: R5 stated on Monday 10/17/2022 that a C.N.A. on the night shift the night before threatened to hit him with a cane. He described her as a young lady with a nice physique who was African American with blonde curly hair. No one with that description worked on that day. R14 was the roommate of R5 and is alert and oriented. R14 states that he does not know why, but a C.N.A came in the room and waved the cane at R5 and said she was going to hit him with it. Report also documents 2 staff members being interviewed: V29 (nurse) and V22 (CNA)

Review of R5's face sheet documents a 67 year old male with history of the following diagnoses: Encounter for Surgical aftercare following surgery

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on the digestive system, Encounter for attention to colostomy, Type 2 Diabetes Mellitus Without complications, Obesity, hypertension, Benign Prostatic Hyperplasia, personal history of Transient Ischemic Attack and Cerebral Infarction Without Residual Deficits, Colostomy status, long term (current) use of anticoagulants.

R5's Minimum Data Sheet (MDS) dated 10/4/2022 section C documents R5's mental status was intact as noted in the Brief Interview for Mental Status (BIMS) score of 14 out of 15. R5's Admission observation dated 9/28/2022 documents R5 Alert and oriented to person, place, time and situation. On 10/3/2022 V34 (FNP) document R5 to be alert and oriented.

On 12/29/22 at 12:55 PM V1 (Administrator) states that she is the abuse coordinator. V1 states that on 10/17/2022 R5 asked to see her and family called and said go see him because he had a concern. V1 states that R5 said the CNA threatened to hit him with a cane the previous night. V1 states, R5 said it was an African American with light curly hair. V1 states we had no one with that description. V1 states then someone told her that V22 (CNA) wears a light colored wig. V1 states on the video she saw she could see the room and did not see a CNA go into his room. V1 states that on 10/15/2022 she saw that V22 was on the unit and saw her wearing light colored hair on 10/15/2022. V1 states she never saw V22 go into R5's room. Surveyor asked for clock-ins for V22 for that week. V22's time clock in report documents she did not work on 10/15/2022. After pointing that out to V1 that V22 did not work 10/15/2022, V1 states she doesn't remember the day she saw V22 in the light colored wig on video and she no longer has the video. V1 states V22 was

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suspended pending investigation. We had figured out it was V22 that R5 was talking about. V1 states R5's Roommate, R14 added info that helped her figure it out. V1 states "something wasn't sitting right with her" about the allegation and R14 had corroborated it, so they suspended V22 on 10/20/22 pending the investigation. Incident reported on 10/17/22 documents that she was suspended on 10/20/22. V1 states she interviewed V22 on the 20th and suspended her on the same day. Then when surveyor states that V22 worked the night shift on 10/20/22 then V1 stated it was probably the 21st that we suspended her. V1 states V22 agreed she was assigned to R5 then we let V22 go.

On 1/3/2023 at 10:33 AM V1 states that R5 said young lady who threatened him had blonde hair. V1 states she looked at the video from 10/16/2022 from 11pm to 7 am at the nurse's station only for who fit that description. V1 states, she did not look at who was going in and out of R5's room for that time period. V1 states she does not know if V22 went into R5's room because she did not look on the video by his room. V1 states several people working that unit that evening and she interviewed V29 (nurse) and the V22 (CNA) only. Video lasts only one week. V1 states she found video of V22, fitting the description that R5 gave on a different day, but she does not know what day that was. V1 states, when they figured out that it was V22 R5 was talking about they told V22 she was no longer employed. V1 states R5 had never had any allegations about any staff or residents before.

On 12/28/2022 at 12:27 PM R14 states R14 that he remembers the situation with R5 and a CNA in October. R14 states the facility fired the CNA. R14 states that R5 was sitting up at the side of

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S9999	Continued From page 4 the bed and he had a colostomy bag. R14 states the CNA came into the room and she never said anything about emptying the bag or what she wanted to do. R14 states she just told R5 to lay down and R5 said no that he did not have to lay down. The CNA was then screaming "lay down, lay down!" she said "if you don't I will hit you with this cane." V14 states, he saw her shadow and heard the commotion and he got up. R14 states the CNA was screaming "lay down, lay down right now or I'll hit you with this cane", and she had the cane holding it up like she was going to hit him. R14 states he told the administrator what happened when she came and asked him about it. R14 states, "I felt like it was wrong." R14 states R5 wasn't in the best of health, and R14 states he felt like the CNA was taking advantage of R5. R14 states he had back surgery but he got up to see what was going on. R14 states R5 was mad. The CNA had his cane in her hand and holding it up above his head like she was going to strike him. After that happened the CNA went to work on A&B for about a week and then I didn't see her again. The incident happened about midnight. I had my T.V on and the CNA was saying "Lay down, I said lay down right now, If you don't lay down I'm going to hit you with this cane." R14 states, "I thought she was going to hit him (R5) for real. On 12/28/2022 at 2:53 Pm V30 (family of R5) states that when she went to the facility on 10/17/2022, they said they had started the investigation. V30 states V1 told her they would review the camera's because they didn't find anyone that fit the description R5 gave. V30 states that R5's roommate explained to them that the CNA wears different wigs and had a had a short wig that night. V30 states a few days later, V1 called and said "I have good news, we found	S9999		

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out who the CNA was and we terminated her on the spot."

V30 put R5 on the phone and R5 assessed to be alert to person, place, event, and states in the middle of the night I was sitting on the side of the bed and the CNA came in and wanted me to lay back. R5 states the CNA didn't say why she wanted me to lay down. R5 states, "she wanted me to lay down like a kid. She made it sound like I was a child." R5 states he told the CNA," You can't make me get in the bed. I'll get in the bed when I'm ready." R5 states, she took his cane and said I am going to hit you with this cane if you don't lay down. R5 states, "I said please don't hit me." I felt like she was wrong. I was afraid. I was scared. I put my hands up so she wouldn't hit me in the head. The facility said no one fit the description with short hair. R5 states, "I didn't feel safe after that, because I couldn't believe they would do that to me. I don't think they would fire her for nothing." R5 states he did not want to hit her, but was feeling like he would have to protect himself if she hit him.

Review of staffing schedule and assignment sheet for 10/16/2022 documents V22 working the night of 10/16/2022 and was assigned to R5. Review of R5's clock in sheet document she worked the 3rd overnight shift (11PM to 7:30 AM) on 10/16/2022, 10/17, 2022, 10/18/2022, 10/19/2022 and 10/20/2022. Review of staffing schedule also documents V29 (nurse D wing), V35 (CNA), V36 (CNA), and V37 (CNA) working on C and D wings on 10/16/2022

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On 12/30/22 at 6:22 AM V29 (Nurse) states he has never heard of any situation with a resident and staff threatening with cane. V29 states he does not remember R5 and no one has

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S9999	Continued From page 6 interviewed him regarding R5. On 1/2/2023 at 11:45 PM V37 (CNA) states she doesn't remember R5. V37 states no staff has interviewed her regarding any situation or allegation of abuse with R5. The facility's Abuse Prevention and Reporting policy dated 10/24/2022 documents the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. (B) 2/2 300.610a) 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	S9999		

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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.

Section 300.1210 General Requirements for Nursing and Personal Care
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 were not met as evidenced by:

Based on interview and record reviews, the facility failed to follow their practice and perform weekly skin assessments for one resident R6, out of 4 residents reviewed for pressure ulcer prevention in a sample of 21. This failure resulted in R6 developing an unstageable pressure ulcer to his coccyx, a deep tissue pressure injury to the left buttock and a left medial upper thigh full thickness wound. The facility also failed to properly assess one resident's (R8) wounds and order wound care treatments for 5 days after R8 was admitted with 3 wounds. This failure led to

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the worsening of R8's sacral wound.

Findings Include:

1. R6 is a 59 year old admitted on 06/02/2022 with a diagnosis not limited to major depressive disorder, unspecified hemiplegia and hemiparesis, essential (primary) hypertension, and multiple sclerosis. R6's admission skin assessment indicates that R6's skin was intact. MDS section G indicates that R6 needs extensive assistance, and is total dependence with activities of daily living.

R6's Wound Assessment dated 10/27/2022 documents 3 new wounds identified on 10/27/2022:
1) Coccyx- unstageable, size 7.5 x2.5 x unknown, and 70% slough
2) Left buttock- deep tissue pressure injury. 6.00 x 5.00 x unknown, deep marron 60%
3) Left medial upper thigh- full thickness

On 12/30/22 at 2:24 PM V8 (MDS) states she looked for all assessments for R6 and was only able to find one assessment and handed surveyor an admission assessment dated 6/3/20222. Surveyor Reviewed R6's electronic records for wound assessments and there were no skin/wound assessments documented.

Review of R6's Braden observation dated 6/2/2022 documents R6 as a moderate risk for development of pressure ulcers.

On 10/07/2022, skin assessment documentation indicated wound observation on right knee (front), and sacrum.
Review of R6's progress notes by the previous director of nursing documents the following:

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S9999	Continued From page 9 Resident observed with 3 new skin issues: unstageable wound to coccyx, DTI to left buttock, and skin tear/shearing to left inner thigh. 2. Review of R8's face sheet documents a 75 year old male with diagnoses including the following: Complete traumatic amputation at level between left hip and knee, sepsis, malignant neoplasm, diabetes mellitus, pressure ulcer of sacral region unstageable, and end stage renal disease. R8's Discharge wound care recommendations from the hospital dated 11/2/222 documents wound treatments for a Left Knee Amputation site, a Sacral Wound, and a Right Foot Wound. Review of R8's Braden observation dated 11/2/2022 documents R8 as at risk for development of pressure ulcers. Review of R8's admission skin integrity assessment is absent of any wounds and documents R8 to have potential for impairment to skin integrity. The admission skin assessment also documents R8 has a pressure ulcer, but does not specify a location of any wound or pressure ulcer or any measurements. Review of R8's wound assessment dated 11/7/2022 documents a pressure ulceration that documents an unstageable sacral wound measuring 6.50 x 9.00 x unknown with 80% slough and no tunneling. The only other wound assessment is dated 11/15/2022, the day R8 was discharged and it documents the sacral wound with the same measurements and 100% slough and tunneling present. Review of R8's Physician orders documents he did not have any wound care orders for 5 days from admission 11/2/2022 through 11/6/2022.	S9999		

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The first wound care orders are dated 11/7/2022.

Review of R6's care plan does not document his new 3 wounds or any new interventions.

On 01/03/2023 at 10:15 am, V14 (Nurse) said that R6 had a wound on his sacrum and coccyx. V14 said that she started taking care of R6's wound after the wound care nurse left. V14 said that the facility wound care doctor does not see VA residents in the facility. V14 said R6 was never assigned to her because R6 resides on D-Wing, and she works on C-Wing. V14 said that weekly assessments are done when it pops up on the medication administration record or the treatment administration record. V14 said that weekly assessments are supposed to be done on all the residents and it could pop up to be done on different shifts.

On 12/30/2022 at 1:03 pm, V32 (Previous Wound Nurse) said that she recalled taking care of R6. She said that R6 is 1 - 2 assist but she does not recall seeing any wounds. V32 said that if she notices any wounds on the residents, she tells the nurse and also document in the POC.

On 12/30/2022 at 2:00 PM V18 (Nurse) said that she remembered that R6 had wounds but she cannot recall the location of the wounds. V18 said that R6 is not ambulatory, can only turn with assistance, and as such, is at high risk for developing a wound. V18 said that when she notices a wound on residents, she cleans the wound, covers it and notify the doctor for orders. V18 said that the wound care nurse is responsible for all wound care. V18 said that the nurses perform baseline skin assessment upon admission and on a weekly basis to ensure that the resident's skin integrity is intact or notify the

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doctor to initiate treatment for any skin breakdown in a timely manner.

On 1/3/2023 at 09:58 AM, V18 said that she took care of R6 every day she worked. V18 said that the nurse does the skin assessment if it shows up on the medication administration record (MAR) or the treatment administration record (TAR). V18 said that she does not recall performing a skin assessment on R6, but if she did, it would be charted.

On 1/3/2023 at 2:30 PM V2 (ADON) states upon admission all residents should have a skin assessment. V2 states, the admitting nurse documents the wounds and refers the resident to the wound care nurse. The nurse will then notify the doctor of wounds. V2 states, you want to document whatever skin condition is there on admission to have a baseline of where they are and that is standard practice. V2 states nursing staff should do skin assessments weekly. V2 states that nursing staff should be documenting skin or wounds on a skin assessment form or some nurses put it in the progress notes. V2 states, nurses should be documenting skin assessments weekly in the weekly skin assessment tool in the electronic medical record. Wound care team does the measurements of wounds. V2 states that within 72 hours the wound care team should see wounds and measure and assess the wounds. V2 states, orders for wound care should come with admission and immediately be put into the system. V2 states, she can't see any reason to wait 5 days to get wound care orders on a person with wounds and/or unstageable wounds. V2 states, If there are empty spaces on the Treatment Administration record (TAR) and it is not initialed, then it is not done. V2 states, the

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S9999	Continued From page 12 C.N.A.'s should be doing skin checks and documenting it when providing care to a resident. The facility's Pressure Injury and Skin Condition Assessment dated 1/17/18 documents the following: 2) Residents identified will have a weekly skin assessment by a licensed nurse. 4) Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. 10) Pressure injuries and other ulcers will be measured at least weekly and recorded in centimeters in the resident clinical record. (B)	S9999		