STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002547	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

(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 Complaint Investigation: 2395436/IL161574	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 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 300.1010 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 accident, injury or change in condition at the time of notification. 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: 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 failed to follow their policy addressing pressure injury and skin assessment. This failure affects one (R1) out of three residents reviewed for pressure injuries and resulted in a delay in	S9999		

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S9999	Continued From page 2 treatment and assessment for R1 who developed a Stage III pressure ulcer to the sacrum and deep tissue pressure injury to the left heel. Findings include: R1 is a 91-year-old female admitted to the facility 8/30/2016 for long term care. According to nursing progress notes the evening of 6/5/23, R1 was sent to the emergency room for evaluation after a fall and returned to the facility several hours later the following morning. Upon return, facility staff did not indicate any pressure injuries were present. On 8/15/23 at 1:32PM, V7 (Wound Care Coordinator) said, we determined that R1 developed a pressure injury from the hospital transfer. V7 said that they were certified in wound care and were able to accurately provide classifications to pressure wounds. V7 said, that when they assessed R1, it was determined that R1 had developed a Stage III pressure ulcer to the sacrum, and a deep tissue pressure injury to the left heel. V7 said, that the nursing staff are expected to assess all the resident's skin upon readmission to the facility so that orders and treatment could be initiated as necessary. On 8/16/23 at 10:41AM V9 Wound Care NP (Nurse Practitioner) said that wounds could develop within a couple of hours in the circumstances of pressure, moisture, and other risk factors. Stage III pressure injuries are openings in the skin that penetrate multiple layers, meaning it is more than just the top superficial portion. Because of this, Stage III pressure injuries are at greater risk of becoming infected and require immediate treatment. Depending on the location and time, without	S9999		

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S9999	Continued From page 3 proper treatment, the opening could further decline and cause additional concerns. The facility was unable to provide documentation that R1 was assessed for having any pressure injuries upon readmission from the hospital on 6/6/23. Additionally, the first documentation for pressure injuries was written by V7 on 6/13/23. In the assessment, V7 wrote that R1's representative was informed of the wound that day. Physician Order Sheet created 6/13/23, included a treatment order for the coccyx/sacrum: clean with normal saline and apply Medi honey, skin prep and cover with foam dressing. Treatment Administration Record (TAR) indicated that no treatments for the sacrum and heel were rendered to R1 from the date of transfer on 6/6/23 until 6/15/23. During a skin observation with V7 on 8/16/23 at 1:45PM V7 said, that Medi honey would be used as an antimicrobial agent applied directly to the wound. On 8/15/23 at 3:38PM, V2 Director of Nursing said, CNA's (Certified Nursing Assistants) are expected to round every two hours to check on the status of the residents. When they are providing incontinence care, they should note the skin condition of the resident and report to the nurse any unusual findings. I cannot say why the wounds for R1 were not documented at the time she returned from the hospital, or why there are no skin assessments in the electronic health record available. Looking at the TAR (Treatment Administration Record), it indicates that the treatments were not completed as the order implies. Facility Policy Titled "Pressure Injury and Skin Condition Assessment" revised 1/17/18 stated 1. "A skin condition assessment and pressure ulcer	S9999		

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S9999	Continued From page 4 risk assessment will be completed at the time of admission/readmission. 3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse. 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA (Certified Nursing Assistant). Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. (B)	S9999		