STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007207	A. BUILDING _____ B. WING _____	C 10/25/2023

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APERION CARE BURBANK	5701 WEST 79TH STREET BURBANK, IL 60459

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S 000	Initial Comments Annual Health Survey Complaint Investigation 2398004/IL164809	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)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. Restorative	S9999	Attachment A Statement of Licensure Violations	

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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 requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement interventions in preventing the reopening of a healed pressure ulcer and worsening of an existing pressure ulcer for two (R18 and R29) of four residents in the sample of 27 reviewed for skin breakdown. This deficiency resulted in R18's healed pressure ulcer on the sacrum reopening and being identified as a facility acquired, Stage 3 wound.

Findings include:

1. R18 is a 67-year-old, male, admitted in the facility on 07/24/23. with diagnosis of Multiple Sclerosis. According to Skin Wound Report. dated 07/24/23, he was admitted with Stage 2 pressure injury on the sacrum, measuring 1cm

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S9999	Continued From page 2 (centimeter) x 1cm x 0.1cm. R18's Care plan on pressure ulcer to sacrum related to immobility, dated 08/23/23, documented: Interventions: Avoid positioning the resident on sacrum; Encourage and assist with turning and repositioning at regular intervals as allowed and tolerated every shift and when requested for comfort; Facility follow policies/protocols for the prevention/treatment of skin breakdown. R18's NP (Nurse Practitioner) wound notes recorded the following: 08/30/23 - Integumentary: Wound status is healed. The wound is currently classified as a Category/Stage II wound with etiology of pressure ulcer and is located on the sacrum. The wound measures 0cm length x 0cm width x 0cm depth. 09/20/23 - Integumentary: Wound status is open. The date acquired was 09/20/23. The wound is currently classified as a Category/Stage III wound with etiology of pressure ulcer and is located on the sacrum. The wound measures 7cm length x 8cm width x 0.2cm depth. There is a small amount of serosanguineous drainage noted. There is large granulation within the wound bed. There is a small amount of necrotic tissue within the wound bed including adherent slough. The periwound skin appearance exhibited: scarring, maceration. R18's Wound Assessment Details Report, dated 10/18/23, documented: Sacral wound/Stage 3 pressure ulcer, date identified 09/20/23, facility acquired. Measurements: 3cm x 4cm x 0.10cm. On 10/22/23 at 10:00 AM, R18 was observed lying on his back, in bed, with head of bed slightly elevated, watching TV (television). R18 was	S9999		

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asked if he has an active wound. R18 stated, "I have a pressure ulcer in the lower back." At 12:10 PM, wound care was observed on R18. R18 has an indwelling urinary catheter and wears an incontinence brief. It was observed the brief was dry, but with scant amount of serosanguineous drainage. V4 (Registered Nurse, RN) stated during wound care, "The discharge was coming from his sacral wound. Treatment is clean with soap and water and apply (ointment) and zinc, leave it open to air." It was noted R18's wound is open, with pinkish to reddish wound bed.

It was also observed 10:00 AM to 12:10 PM, R18 was lying on his back in bed, watching TV.

On 10/23/23, random observation every 15 to 30 minutes interval was conducted from 10:10 AM to 12:48 PM, which showed R18 was not repositioned, nor was his sacral wound offloaded. From 10:10 AM to 11:00 AM, R18 was observed in bed, lying on his back in a semi-sitting position. From 11:15 AM to 12:10 PM, he was observed in bed, lying on his back, with head of bed elevated to a 90 degree-angle. From 12:35 PM to 12:48 PM, he was lying on his back again in a semi-sitting position. At 1:50 PM, he was again observed lying on his back, in bed. R18 was asked if he is turned or repositioned while in bed. R18 stated, "No, I am not turned. When I'm asleep, I sleep on my side. But when I am awake, no, they don't turn me."

On 10/23/23 at 12:56 PM, V7 (Wound Care Nurse) stated, "He is verbal; does not like to be in the wheelchair. He was admitted with Stage 2 pressure ulcer on the sacrum on 07/24/23, healed on 08/30/23. No hospitalizations since admission. It reopened on 09/20/23 as Stage 3, measuring 7cm x 8cm x 0.2cm. It reopened

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S9999	Continued From page 4 because he is noncompliant with repositioning." On 10/23/23 at 1:39 PM, V6 (Certified Nurse Assistant, CNA) stated, "He cannot turn himself, but he is willing to be turned. He is compliant with turning, awake and asleep. We do turning and repositioning every two hours." V4, Registered Nurse/RN was also asked regarding R18 and repositioning. V4 mentioned, "We do side turning every two hours. He is able and compliant." On 10/23/23 at 4:23 PM, V9, Wound Nurse Practitioner stated, "His sacral wound was healed on 08/30/23. It reopened to Stage 3 on 9/20/23. I don't have anything documented for the opening. Scar tissues are very fragile for reopening. After a wound is healed, it is prone to reopen. To prevent sacral pressure ulcer from developing and worsening, in general - turning and repositioning per protocol, in general about 2-3 hours; nutrition; use of low air loss mattress. I expect staff for early identification of skin issues and implementation of preventative measures like use of low air loss mattress, following up of nutritional status, offloading, turning and repositioning." R18's NP Wound Notes, dated 10/25/23, recorded: Wound status is open. The wound is currently classified as a Category/Stage III wound with etiology of pressure ulcer and is located on the sacrum. The wound measures 6cm length x 9cm width x 0.1cm depth. There is a small amount of serosanguineous drainage noted. There is medium red, pink granulation within the wound bed. The periwound skin appearance exhibited: scarring, maceration, ecchymosis. 2. R29 is a 78 year old male, admitted in the	S9999		

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S9999	Continued From page 5 facility on 07/13/23 with diagnoses of Hemiplegia, Unspecified Affecting Left Nondominant Side; Nontraumatic Acute Subdural Hemorrhage; Malignant Neoplasm of Prostate; Cerebral Infarction, Unspecified and Aphasia Following Cerebral Infarction. According to MDS (Minimum Data Set), dated 7/20/23, Section M, R29 was admitted with a Stage 3 pressure ulcer. R29's care plan, dated 09/06/23, regarding pressure ulcer on sacral buttocks documented: Interventions: Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent positioning; Follow facility policies/protocols for the prevention/treatment of skin breakdown; Minimize pressure over bony prominences R29's Skin Wound Report, dated 07/13/23, recorded: Stage 3 pressure injury on the sacrum, measurements of 1cm x 1cm x 0.1cm. R29's NP (Nurse Practitioner) notes documented the following: 07/26/23 - Integumentary: The wound is currently classified as a Category/Stage III wound with etiology of pressure ulcer and is located on the sacrum. The wound measures 2.5cm length x 2.5cm width x 0.1cm depth. 08/02/23 - Integumentary: The wound is currently classified as Unstageable/Unclassified wound with etiology of pressure ulcer and is located on the sacrum. The wound measures 4cm length x 4.5cm width. There is large pink granulation within the wound bed. There is a small amount of necrotic tissue within the wound bed including	S9999		

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eschar and adherent slough.
08/09/23 - Integumentary: The wound is currently classified as Unstageable/Unclassified wound with etiology of pressure ulcer and is located on the sacrum. The wound measures 5cm length x 5cm width. There is a large amount of necrotic tissue within the wound bed including adherent slough. The periwound skin appearance exhibited: scarring, maceration.

On 10/23/23 at 12:56 PM, V7, Wound Care Nurse, stated, "He is nonverbal; he is alert; he has a sacral ulcer, admitted with 07/19/23 his sacral wound increased in size to 2.5, he had multiple comorbidities, he had a history of head trauma. He had sepsis and infections; been in and out of the hospital. He also had prostate cancer."

There were no recorded hospitalizations on R29 from 07/13/23 to 08/09/23 per census report.

On 10/24/23 at 12:34 PM, V4 stated, "He is turned every two hours. We put him in the reclining chair during daytime and stays there for about five to six hours."

On 10/25/23 at 8:19 AM, V9, Wound Care Nurse Practittioner, was asked regarding length of time should a resident with sacral pressure ulcer can sit in the wheelchair or reclining chair. V9 stated, "Residents who have pressure ulcers on the sacrum can be up and be put in wheelchair or reclining chair in two to four hours. Putting pressure on the sacrum will not allow blood flow. Blood flow facilitates wound healing."

Facility's policy titled "Skin Condition Assessment and Monitoring - Pressure and Non Pressure"

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S9999	Continued From page 7 dated 6-8-18 stated in part but not limited to the following: 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. (B)	S9999		