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	IL6006100	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WESLEY	1415 WEST FOSTER AVENUE CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigation 2483907/IL173319	S 000		
S9999	Final Observations Statement of Licensure Violations: 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 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	S9999		

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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 requirements are not met as evidenced by:

Based on interviews and record review, the facility failed to provide for pressure redistribution to prevent a resident's (R1) pressure injuries from developing out of 3 residents reviewed for pressure ulcers. This failure resulted in R1 developing avoidable bilateral buttock pressure injuries identified as facility acquired stage three pressure ulcer (left buttock) and unstageable pressure ulcer (right buttock).

Findings include:

R1's Face sheet documents that R1 is an 80 year-old male who has diagnoses is not limited to: Parkinson's disease without dyskinesia, dementia, chronic obstructive pulmonary disease, need for assistance with personal care, weakness.

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R1's admission Minimum Data Set (MDS) section M dated 01/29/2024 documents R1 is at risk for pressure ulcers and documents R1 does not have any pressure ulcers.

R1's admission Minimum Data Set (MDS) section GG dated 01/29/2024 documents R1 needs extensive assistance for eating and bed mobility, and R1 is dependent on oral hygiene, toileting hygiene, shower, dressing, and transfers.

R1's MDS/Minimum Data Set Section C dated 04/26/2024 shows R1 has a BIMS/Brief Interview for Mental Status score of 99, indicating that R1 was unable to complete the interview due to severe cognitive impairment.

R1's Minimum Data Set (MDS) section M dated 04/26/2024 shows R1 has one stage 2 pressure ulcer and one unstageable pressure ulcer.

R1's Minimum Data Set (MDS) section GG dated 04/26/2024 documents R1 needs extensive assistance for eating and bed mobility, and R1 is dependent on oral hygiene, toileting hygiene, shower, dressing, and transfers.

R1's discharge Minimum Data Set (MDS) section GG dated 05/14/2024 documents R1 needs extensive assistance for eating and bed mobility, and R1 is dependent on oral hygiene, toileting hygiene, shower, dressing, and transfers.

R1's discharge Minimum Data Set (MDS) section M dated 05/14/2024 shows R1 has one stage 3 pressure ulcer and one unstageable pressure ulcer.

R1's doctor's progress note, 04/16/2024 4:35 PM, documents in part: buttocks are healed. left heel

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is better. 0.8 X 1.2 X 0.1 CM

R1's weekly skin observation note, 04/17/2024 1:31 PM, documents in part: skin concerns observed: Right buttock - Resolved, Left heel - DTI (deep tissue injury), measures: 0.8 x 1.2 cm. Skin concerns observed are not new.

R1's skin note, 04/21/2024 at 07:26 AM, documents in part: R1 was seen, and skin was examined. Measurements were taken, for the left buttock, 4.0 x 2.0 x 0.1 cm, for the right buttock it measures, 5.0 x 3.0 x 0.1 cm. The resident is currently using a LAL mattress and is currently on treatment for a DTI on his left heel. Staff were reminded regarding incontinence care and turning of residents. Also, referred to the Dietician for dietary management of the wound.

R1's doctor's progress note, 04/23/2024 5:25 pm, documents in part: r. (right) buttocks has a black eschar. 5 x 3 x. 0.l (left) heel is larger. 2.5 x 3 cm.

On 6/18/24 at 3:24 PM V4 (Registered Nurse/Treatment nurse) states that he began working as the treatment nurse in March 2024. V4 states that when there is documentation that a wound is healed, V4 states that it means it is already resolved, and V4 states it means the resident is discharged from wound care rounds. V4 states it is up to the doctor or NP (nurse practitioner) to determine appearance of a healed wound, but V4 states that for him, it means the skin is already intact. Surveyor questioned V4 what was the significance of R1's bilateral buttocks healed and four days later R1's bilateral buttocks noted with the following measurements (left buttock, 4.0 x 2.0 x 0.1 cm, and right buttock, 5.0 x 3.0 x 0.1 cm) per V4's documentation? V4 states that for four days, there was a bit of

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change, and V4 states that maybe the resident didn't receive wound care, V4 states maybe R1 was not turned as scheduled, maybe the resident's skin was not checked. V4 states maybe R1 was not eating enough nutrition, V4 states maybe if R1 stayed too long in bed. V4 states R1 was already being followed by wound care team and the prior wound care nurse. V4 states that he continued to follow R1 during the course, V4 states that wound care team were more focused on his sacrum wound and V4 states R1 would stay in the wheelchair per R1's wife request, so V4 states it was quite difficult to manage the wound.

On 6/18/2024 at 2:10 PM V5 (Director of Nursing/DON) states that in general wound preventative measures include turn and reposition as needed. V5 states that all residents are on weekly skin observations and V5 states that the overnight nurse is responsible to conduct these skin assessments. V5 states since this building just got acquired, V5 states that staff began the weekly observations in April 2024.

On 6/18/2024 at 3:57 PM, V6 (Doctor of Medicine/Wound Clinician) states that he remembers R1. V6 states that it is hard to say if R1's wounds could have been preventative, V6 states it can be a contribution of nutrition and V6 worries that both wounds had deteriorated. V6 states more is going on with nutrition, diet, and V6 is not sure what the dietitian had for him. V6 states pressure can contribute to it. Surveyor informed V6 R1 is dependent on care. V6 states that both the heel and buttocks deteriorating can be due to pressure, nutrition, turn and reposition, and V6 states then the nurses must do more turning. V6 states that he agrees the wounds could have been prevented from opening to that

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measurement and appearance within four days. V6 states that his next note on April 30th, 2024, indicates the heel is larger and left buttock wound, and right buttock wound is the same measurement as previously.

On 6/21/2024 at 1:13 PM V7 (Certified Nursing Assistant/CNA) states that R1 was a very sweet man to take care of. V7 states that R1 was total care. V7 states that when R1 would be able to be up in the wheelchair, R1 was able to feed himself. V7 states that when R1 was up in his wheelchair, R1's ability to feed self was way more successful than in bed. V7 stated "for example, in the morning, because we didn't get him up until mid-morning, for lunch he was a feeder for only 10% of the time. For breakfast he was a feeder, like 90%. We would still sit with him and encourage him and open items up. We were still with him." V7 states that for the last week to a month R1 was in the facility, R1 wasn't eating as well. V7 states that she is the wound care assistant and was able to see his wounds once a week during wound care rounds. V7 states it was one moment of him sitting too long and it could have opened again. V7 states that R1 could not be sitting up in his wheelchair no longer than 3 hours. V7 states if R1 got up at 11am, V7 states R1 had to be back in bed by 1pm. V7 states staff would give report to each other, CNAs to CNAs. V7 states some people would say they had the hardest time with R1, and I just couldn't get him to turn over. V7 states these statements were from the newer CNAs.

On 6/21/2024 at 3:00 PM V8 (Director Regional Dietitian Consultant) states that V8 conducted an assessment for R1 on May 8th, 2024, and on March 8th, 2024. V8 states that another dietitian conducted R1's assessment in April 2024. V8

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states that R1 had a weight loss. V8 states there was intake improvement in May. V8 states that March intake was fair. V8 states that they base it on the nursing assistants' documentation and what they charted for residents' intake. V8 states if the CNAs charted that the resident ate ten times good and three times poor then it is fair intake. V8 states it depends on the individualized dietitian's clinical judgment.

R1's wound assessment detail report dated 5/14/2024 documents in part, right buttock active, type- pressure ulceration, source- facility acquired, unstageable.

R1's wound assessment detail report dated 5/14/2024 documents in part, left buttock active, type- pressure ulceration, source- facility acquired, stage three.

R1's care plan dated 1/24/2024 documents in part: the resident will be free from injury through the review date.

R1's physician order set documents in part: House Nutrition Supplement three times a day for nutrition support give 120ml TID (three times a day), Nutritional Treat one time a day - one cup of Yogurt (Family supplied), protein Sugar Free supplement one time a day 30 ml, nutritional shake two times a day supplement.

R1's weight log documents the following: 01/23/2024 - 196.6 lbs (pounds), 1/28/2024- 195 lbs, 2/06/2024- 196 lbs, 03/01/2024- 196.3 lbs, 4/11/2024- 176.2 lbs, 04/30/2024- 176.2 lbs, 05/04/2024- 169.2 lbs. R1's weight documents R1's weight remained the same during the period R1's bilateral buttocks healed and R1's bilateral buttock wounds were noted.

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S9999	Continued From page 7 The facility's Policy, titled Skin Condition Assessment & Monitoring- Pressure and Non-Pressure dated 6-8-18, documents in part, the resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care. The facility's Policy, titled Pressure Ulcer Prevention dated 1/15/2018, documents in part, to prevent and treat pressure sores/pressure injury, turn dependent resident approximately every two hours or as needed, wheelchair residents may be instructed to shift weight from one buttock to the other. (B)	S9999		