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
	IL6009815	A. BUILDING: ______ B. WING ______	R-C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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S 000	Initial Comments First Complaint Certification Revisit to Survey date 9/20/23, Complaint #2357647/IL164365	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	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.

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 were not met as evidenced by:

Based on observation, interview and record review, the facility failed to identify and immediately implement treatment for a new pressure injury, ensure wound care treatment was completed and documented as ordered, and complete wound care aseptically. This applies to 2 of 4 (R1 and R5) residents reviewed for being at risk for pressure injuries. This failure resulted in not identifying and implementing orders to treat a new sacral wound and causing the wound to the left ischial tuberosity to worsen.

Findings include:

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S9999	Continued From page 2 1. R5's face sheet documented an admission date of 4/4/23 with diagnoses including: acute and chronic respiratory failure, cerebral infarction, flaccid hemiplegia affecting left dominant side, non-ST elevation (NSTEMI) myocardial infarction. R5's care plan printed 10/17/23 documented "...I am non-compliant/ resistive to care at times with: Care Intervention, Prevention Precautions: off loading, laying in bed between meals..." and "...I have pressure ulcer (related to) impaired mobility and bowel and bladder incontinence..." R5's pressure ulcer care documented interventions including "...Encourage and assist with turning and repositioning at regular intervals every shift as allowed/ tolerated and when indicated/ requested for comfort..." and "...monitor/ document/ report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size (length x width x depth), stage..." and "...the resident needs (Specify: monitoring/ reminding/ assistance) to turn/reposition at least every 2 hours, more often as needed or requested..." R5's July 10, 2023 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, indicating R5 was moderately cognitively impaired. R5's MDS section G documented R5 required extensive assistance of two staff for bed mobility, transfer, and toilet use. R5's MDS section H documented R5 was always incontinent of bowel and bladder. R5's 10/13/23 Braden Observation documented a score 13, indicating R5 was at moderate risk for pressure injuries. R5's 10/6/23 Wound Care Telemedicine Initial Evaluation documented an unstageable (due to necrosis) of the left buttock full thickness and	S9999		

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stage 2 pressure wound of the left ischium partial thickness. R5's October 2023 Treatment Administration Record (TAR) documented a 10/7/23 physician order "...cleanse stage 2 pressure ulcer on left outer gluteus with normal saline, pat dry, then apply Medihoney and border foam dressing daily and prn (as needed) if soiled or dislodged every day shift..." and a 10/7/23 physician order "... Lt. (left) ischial tuberosity: Cleans with NS (Normal Saline) and pat dry. Apply Medihoney and dry dressing daily and PRN until resolved. One time a day..." R5's October 2023 TAR documented no treatment was administered to the left outer gluteus or the left ischial tuberosity on October 9, 10, 14, and 16, 2023.

On 10/17/23 at 11:11 AM, V3 (Wound Registered Nurse/ RN) was performing R5's wound care. V3 said while she was prepping R5 for the wound care observation she found a Deep Tissue Injury (DTI) with an open area measuring 4.50 centimeters (cm) x 10.50 cm x 0.10 cm on R5's sacrum. R5's sacral wound was discolored a dark red with the wound bed to be red in color. V3 said she had called R5's Primary Care Physician (PCP) for wound care orders and had received an order to cover the DTI with a foam dressing and follow up with Wound Care Provider. V3 cleaned R5's sacral wound with normal saline and covered it with a foam dressing.

R5's October POS (Physician's Order Sheet) documented an order with a start date of 10/18/23 "...Sacrum: Cleanse with NS (Normal Saline) et (and) pat dry. Apply foam over area daily et PRN (as needed) every day shift..." Prior to 10/18/23, there was no order in place on the TAR or POS for the wound to the sacrum.

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R5's Wound Assessment Details Report dated 10/17/23 documents a sacral ulceration identified on 10/17/23 measuring length 4.50 cm, width 10.50 cm, depth 0.10 cm, deep maroon 50% and pink or red non-granulation 50%, with scant serous exudate. R5's Wound Assessment Details Report dated 10/12/23 of the Right ischial tuberosity included a picture of R5's sacrum. The area to the sacrum appears reddened and there are 2 small open areas to the sacrum along with the open area to the right ischial tuberosity. There are no measurements or description of the areas to the sacrum on the Wound Assessment Detail Report.

R5's Skin and Wound Evaluation dated 10/3/23 documents that R5 has a new stage 2, in-house acquired pressure wound to the left ischial tuberosity measuring 2.2 cm in length, 0.9 cm in width, and "not applicable" for depth. R5's Wound Assessment Details Report dated 10/17/23 documents that R5 has a stage 2 pressure wound to the left ischial tuberosity that was identified on 9/25/23. The wound measurements are documented as 3.5 cm in length, 1.7 cm in width, and 0.1 cm in depth. There were no other Skin and Wound Evaluations or Wound Assessment Detail Reports for the wound to the left ischial tuberosity from 10/3/23 to 10/17/23.

On 10/18/23 at 10:44 AM, V8 (Licensed Practical Nurse/ LPN) said she had completed wound care for R5 on 10/16/23. V8 said R5's sacral wound was present on 10/16/23 and was being dressed for a foam dressing. V8 said R5's sacral wound had been present and being dressed with a foam dressing for protection for "about a week." V8 said R5's sacral DTI was not open on 10/16/23 when she completed R5's treatments. V8 said she did not know why there was not a dressing

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order in R5's POS. V8 said when a change in skin condition is found, V2 (Director of Nursing/DON) or V3 (Assistant Director of Nursing/ADON) should be notified so they can document the area and take pictures. V8 said she thought V2 or V3 was aware of R5's sacral wound because it had a dressing on it. When V8 was asked how nurses knew about any resident skin changes and dressings, V8 said that was given in verbal report at shift change and wound treatments would be on the Treatment Administration Record (TAR).

On 10/17/23 at 2:32 PM, V9 (Doctor of Nursing Practice/ DNP) said she was a medical provider for R5. V9 said she expected when any staff found a change in a resident's skin, a medical provider would be notified for treatment orders. V9 said she expected facility staff to follow physician orders as given.

On 10/17/23 at 1:39 PM, V7 (Certified Nursing Assistant/CNA) said she was caring for R5 on 10/17/23 from 6:00 AM through 6:00 PM. V7 said she had completed perineal care on R5 twice the morning of 10/17/23 prior to V3 completing R5's wound care and had seen R5's sacral DTI was covered with a dressing. V7 said any changes in skin condition should be reported the nurse immediately. V7 said if a resident's wound was covered with a dressing, she would not report anything to the nurse because the nurse was the person who would have put the dressing on the wound. V7 said CNA's did not have access to any wound charting and was not sure how a CNA would know if a new wound was documented. V7 said the only type of documentation CNA's completed about wounds was the shower sheets. V3 said when a resident gets a shower, the nurse is to perform a skin check and document any wounds. V7 said R5 was able to reposition

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himself in bed and did not need staff to assist with repositioning every 2 hours.

On 10/18/23 at 12:20 PM, V5 (RN) said R5 required assistance with repositioning every 2 hours due to R5's flaccid hemiplegia.

On 10/17/23 at 1:10 PM, V2 (ADON) said staff were to report any resident skin changes to V1 (DON) or V2 so pictures and measurements could be taken.

On 10/17/23 at 1:31 PM, V5 (RN) said the floor nursing staff did not have access to wound rounds in a resident's Electronic Medical Record (EMR). V5 said wound rounds in a resident's EMR is where resident wound pictures and measurements were documented. V5 said she was not sure how floor nursing staff wound know if V1 (DON) or V2 (ADON) were aware of new resident skin changes.

On 10/18/23 at 11:46 AM, V1 (DON) said the facility had changed software systems documenting resident wounds. V1 said the software system did not communicate with the resident's EMR and nursing staff did not have access to the new software program.

On 10/17/23 at 1:10 PM, R5's 10/9/23 Weekly Skin Observation documented R5's skin was intact and no concerns were noted. R5's Wound Report documented R5 to have a left gluteus ulceration identified 9/23/23, left ischial tuberosity ulceration identified 9/25/23, and a right ischial tuberosity ulceration identified 10/12/23. V2 (ADON) was asked why R5's 10/9/23 Weekly Skin Observation documented R5's skin was intact, and no concerns were noted when R5 had ulcerations identified prior to 10/9/23 and V2 said

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she was unsure. V2 said she expected nursing staff to accurately document any resident wounds on the Weekly Skin Observations.

On 10/18/23 at 11:46 AM, R5's 10/9/23 Weekly Skin Observation was marked "incorrect documentation." V1 said R5's 10/9/23 Weekly Skin Observation was marked out because it was not accurate and was supposed to be documented on another resident. R5's EMR documented there was not a Weekly Skin Observation from 10/3/23 until 10/17/23.

On 10/17/23 at 1:10 PM, V2 (ADON) said she expected staff to perform a Weekly Skin Observation on every resident. V2 said Weekly Skin Observations are automatically generated in every resident's EMR and are flagged in red for nursing staff to be alerted they need completed.

On 10/17/23 at 2:32 PM, V9 (DNP) said she expected every resident to have accurate Weekly Skin Observations completed.

On 10/18/23 at 10:29 AM, V11 (Wound Nurse Practitioner) said she was not familiar with R5's sacral DTI. V11 said the treatment she would expect to see for an open DTI would depend on several factors. V11 said it is possible she would expect to see Dakin solution to inhibit bacterial growth, or santyl or medihoney to cause to the wound to progress and slough.

The facility's revised 6/8/18 Skin Condition Assessment & Monitoring - Pressure and Non-Pressure policy documented " ... Pressure and other ulcers ... will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record ... Residents identified will have a weekly skin

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assessment by a licensed nurse ... A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse ... At the earliest sign of a pressure injury or other skin problems, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes ... Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration ..."

2. R1's face sheet documented an admission date of 6/15/23 with diagnoses including: chronic kidney disease stage 4, hypertension, type 2 diabetes, dementia. R1's MDS documented a BIMS score of 6, indicating severe cognitive impairment. R1's October 2023 TAR documented a 10/11/23 physician order "...LT (left) heel: Cleanse Right heel with NS or wound cleaner et pat dry. Apply medihoney, calcium alginate et secure with kerlix wrap daily et PRN until resolved every day shift..." and a 10/5/23 physician order "...Cleanse right heel with NS, apply xeroform, kling wrap and secure. Every day and night for wounds to bilateral heels...

On 10/18/23 at 10:44 AM, V8 (LPN) was observed performing wound care for R1's left and right heels. V8 donned gloves without performing hand hygiene then cut the dressing off of the left heel with medical scissors and removed R1's dressing and cleaned R1's wound with normal saline. V8 changed her gloves without performing hand hygiene and used her gloved finger to dip into the medicine cup of medihoney and applied the medihoney to R1's wound with her gloved finger. V8 changed her gloves without performing

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hand hygiene and applied calcium alginate to R1's wound. V8 changed her gloves without performing hand hygiene and wrapped R1's left heel with kling and secured. V8 then performed hand hygiene and donned gloves. V8 used the same medical scissors without sanitizing them to cut off R1's right heel dressing. V8 changed her gloves without performing hand hygiene and cleaned R1's right heel wound with normal saline. V8 changed her gloves without performing hand hygiene and used the medical scissors (used to cut off the left and right heel dressings) to cut the xeroform without sanitizing the scissors. V8 placed the xeroform on R1's right heel wound. V8 changed her gloves without performing hand hygiene and wrapped R1's right heel with kling and secured.

The facilities Skin Condition Assessment & Monitoring policy (revision date 6/8/18) documents "... Conduct hand hygiene in accordance with facility standard/ universal precautions..."

B