

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/02/2019
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NAME OF PROVIDER OR SUPPLIER APERION CARE CAPITOL	STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST CARPENTER SPRINGFIELD, IL 62702
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violation: 1 of 1 Violation:</p> <p>300.610a) 300.1210b) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		
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Attachment A
Statement of Licensure Violations

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/23/19
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S9999	<p>Continued From page 1</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Based on observation, interview, and record review the facility failed to ensure a turning and repositioning program was initiated, a Moisture Associated Skin Damage (MASD) wound did not deteriorate into a pressure wound, and failed to ensure a wound was cleansed prior to applying a dressing for one of three residents (R2) reviewed for pressure ulcers in a sample of 22. These failures resulted in R2 developing a MASD wound which then deteriorated into two pressure wounds with necrotic tissue requiring surgical debridement.</p> <p>Findings include:</p> <p>A Pressure Ulcer Prevention policy dated 11/28/12 gives its stated purpose as, "To prevent and treat pressure sore/pressure injury. Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated."</p> <p>R2's Minimum Data Set (MDS) dated 4/11/19 documents that R2 is totally dependent on two people for bed mobility, transfers, and requires extensive assistance of two people for toileting.</p> <p>R2's pressure ulcer risk assessment dated 3/28/19 documents that R2 has slightly limited sensory perception, is occasionally moist, and chairfast which contributes to R2 being assessed as at risk for the development of pressure ulcers.</p> <p>R2's Wound Physician's (V11) note dated 4/2/19 documents that R2 developed two moisture associated skin damage wounds, one to the right and the left lower medial buttocks. This same note documents that R2's right buttock wound</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>measured 1.5cm (centimeters) long x 1cm wide without measurable depth and R2's left buttock wound measured 4.5cm long x 3cm wide x 0.2cm deep.</p> <p>V11's wound progress note dated 4/9/19 documents that R2's right buttock wound had deteriorated from the previous assessment resulting in thick adherent devitalized necrotic tissue covering 100% (percent) of the wound bed. This note also documents R2's right buttock wound was larger than on 4/2/19 measuring 7cm long x 5 cm wide which required surgical debridement. This same note documented that R2's left buttock wound had also deteriorated resulting in thick adherent devitalized necrotic tissue covering 100% of the wound bed. This note further documents that R2's left buttock wound was larger than it had been on 4/2/19 measuring 5cm long x 3cm which required surgical debridement.</p> <p>R2's care plan intervention dated 2/27/19 states, "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 repositioning." This same care plan does not document R2 is on an every two hour turning and reposition program or address R2's extensive and total dependence for mobility.</p> <p>On 4/29/19 at 11:15a.m. V3 (Day Shift Manager) verified that R2's buttocks wounds had worsened. V3 stated that V11 originally classified R2's buttocks wounds as MASD but V3 stated that she thinks R2's wounds look more like pressure ulcers. V3 stated that R2 has taken a decline in his activities of daily living abilities and requires</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>extensive to total assistance with care. V3 stated that R2 was not on an every two hour turning and repositioning program prior to developing his buttocks wounds and R2 continues to not be on a turning and reposition program because, "That just sets us up for failure."</p> <p>On 4/29/19 at 2:25p.m. R2 was laying in bed. R2 had been incontinent of stool and was being provided incontinence care by V15 (Certified Nurse Aide/CNA) and V16 (CNA). R2's right and left buttocks dressing was loose and soiled with fecal material. V16 removed the soiled dressing and proceeded to cleanse around the lower edge of R2's wounds with the same wash cloth V16 used to cleanse the fecal material from R2's buttocks. Once R2's incontinence care was complete, V15 rolled R2 onto his back so R2 was laying on his open wound. V15 and V16 left R2's room to notify V5 (Registered Nurse) that R2 needed a new dressing to R2's right and left buttocks. At approximately 3:00p.m. V15 and V5 entered R2's room to apply R2's buttocks dressing. V15 assisted R2 to roll to the right side while V5 prepared the dressing supplies. Without cleansing R2's wound, V5 applied a medicated ointment and dressing then covered the wound with an adhesive dressing. V5 stated that she did not cleanse R2's buttocks wounds prior to applying a clean dressing because R2's wounds had just been cleansed during incontinence care by V15 and V16.</p> <p>On 4/30/19 at 3:05p.m. V11 stated that when R2's right and left buttocks wounds first developed around 4/2/19, V11 diagnosed those wounds as MASD. V11 stated that R2's right and left buttocks wounds deteriorated as a result of pressure injury. V11 also verified following that deterioration, R2's wounds enlarged and required</p>	S9999		
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