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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145197 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/23/2024 |
| NAME OF PROVIDER OR SUPPLIER Aperion Care Oak Lawn | | STREET ADDRESS, CITY, STATE, ZIP CODE 9401 South Ridgeland Avenue Oak Lawn, IL 60453 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34072</p> <p>Based on interviews and record reviews, the facility failed to prevent one resident who was identified as moderate risk for skin breakdown and is totally dependent on staff for all ADLs (activities of daily living), from developing three facility-acquired pressure ulcers. The facility also failed to provide the necessary care and services upon admission to promote healing of a left hip stage 2 pressure ulcer. This affected one of three residents (R1) reviewed for pressure sore. This failure resulted in R1 developing three facility-acquired pressure ulcers (unstageable wounds) including the coccyx area, right hip, and right lateral foot. R1's stage 2 wound to the left hip deteriorated to an unstageable wound.</p> <p>Findings include:</p> <p>R1's medical record notes R1 was admitted on [DATE] with diagnoses including, but not limited to, quadriplegia cervical spine, C1-4, complete, colostomy, neuromuscular dysfunction of bladder - indwelling catheter, left hip stage 2 pressure ulcer, history of osteomyelitis of pelvis, and history of pressure ulcer on buttocks. R1 transferred to hospital on 7/12/24 and did not return to the facility.</p> <p>On 9/23/24 at 11:50 AM, V4 (Wound Care Nurse) stated that V4 assesses all residents' skin on admission, re-admission, and if any skin issues arise. V4 stated that she assesses the wound, notifies physician, V5 (Wound Care Nurse Practitioner/NP), implements preventative measures such as air mattress, barrier cream, offloading - with heel boots or pillows, and notifies family. V4 stated that if the resident has wound(s), V4 does weekly skin assessments until wound(s) healed/resolved. V4 stated that if a resident's wound deteriorates, V4 will notify V5. V4 stated that when a new wound is identified, she documents wound measurements and tissue type.</p> <p>There is no documentation found in R1's medical record noting a weekly skin observation was completed on 6/30/24. There is also no documentation found in R1's weekly skin assessments that were completed noting other nursing measures not involving medications were documented in the weekly wound assessment per this facility's skin assessment and monitoring policy.</p> <p>On 9/23/24 at 1:25 PM, V5 (NP) stated that V5 ordered CRP (C-reactive protein - the liver releases this protein into the bloodstream in response to inflammation) level on 6/26/24 due to R1 developing a new wound. V5 stated that an elevated CRP level could be due to acute infection going on anywhere in the body, not just in a wound. V5 was informed R1's CRP level collected on 6/26/24 and resulted on 6/27/24 was 80.26 (normal range is 0-5). V5 was not aware of this result.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 145197 | If continuation sheet Page 1 of 3 |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 9/23/24 at 2:00 PM, V2 (Director of Nursing/DON) stated that R1 was noncompliant turning and offloading heels. V2 presented a physician/nurse practitioner acquired wounds unavoidability form, dated 7/3/24, noting R1's facility-acquired pressure ulcers to coccyx, right lateral foot, and right hip were unavoidable due to R1's noncompliance with pressure ulcer prevention program. This form was not signed or dated by V3 (Attending Physician) or V5 (Wound Care Nurse Practitioner). This form was also not part of R1's medical record prior to being informed of concern with R1's wound care treatments.</p> <p>There is no documentation found in R1's medical record, dated 5/24 - 6/19, noting R1 was noncompliant with turning or offloading heels. There is no documentation found noting R1's POA (power of attorney) was notified of R1's noncompliance. On 6/20/24, a care plan was initiated noting R1 is noncompliant/resistive to wound care treatments and turning/repositioning.</p> <p>R1's POS (physician order sheet), dated 5/24/24, notes an order for left hip wound treatment, cleanse with normal saline, pat dry, apply calcium, cover with dry dressing every Monday, Wednesday, Friday, and as needed.</p> <p>There is no physician order for wound care treatments for R1's right lateral foot wound, that was identified on 6/26/24, or R1's right hip wound, that was identified on 7/3/24, in R1's medical record until 7/11/24.</p> <p>R1's TARs (treatment administration records), dated May, June, and July 2024, does not have any documentation that R1's left hip dressing was changed on 5/27, 5/29, 5/31, 6/3, 6/7, 6/12, 6/14, and 6/17. There is no documentation found in R1's medical record noting R1 refused any wound care treatments. V4 documented R1 refused treatment on 6/5 after V4 provided wound care treatment and R1 tolerated it well.</p> <p>R1's functional ability assessment, dated 5/27/24, notes R1 is dependent for all ADLs.</p> <p>R1's pre-admission hospital record, dated 5/24/24, noted R1's upper extremities and lower extremities are flaccid. R1 has sensation to upper extremities but no sensation to lower extremities.</p> <p>R1's coccyx facility-acquired pressure ulcer was identified on 6/19/24. On 7/10/24, this wound measured 1.5cm (centimeters) x 0.5cm x 0.2cm, wound 100% pink or red non-granulating tissue, peri wound macerated (a softening and breaking down of skin resulting from prolonged exposure to moisture). On 6/19/24, R1's initial wound assessment noted wound measured 1.2cm x 0.3cm x 0.2cm, 100% pink or red non-granulating tissue. This wound deteriorated as evidenced by increase in size.</p> <p>R1's right hip unstageable pressure ulcer, facility-acquired, was identified on 7/3/24. On 7/10/24, this wound measured 3cm x 1.8cm, wound 50% pale pink non-granulating tissue and 50% slough (yellow) loosely adherent tissue, peri wound macerated. On 7/3/24, R1's initial wound assessment noted wound measured 3.5cm x 2cm, 50% pale pink non-granulating tissue and 50% slough. This wound was unchanged.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>R1's right lateral foot unstageable pressure ulcer, facility-acquired, was identified on 6/26/24. On 7/10/24, this wound measured 8cm x 5cm, wound 50% pink or red non-granulating tissue and 50% necrotic (dead) soft adherent tissue, peri wound normal. On 6/26/24, R1's initial assessment noted wound measured 8cm x 6cm x 0.2cm. This wound was classified as a partial thickness wound due to abrasion. This wound deteriorated as evidenced by development of necrotic tissue.</p> <p>R1's left hip stage 2 pressure ulcer, present on admission on 5/24/24 deteriorated to an unstageable wound. On 7/10/24, this wound measured 6cm x 4cm, 60% pale pink non-granulating tissue and 40% necrotic soft adherent tissue, peri wound macerated. On 5/24/24, R1's initial wound assessment noted wound measured 0.8cm x 0.5cm x 0.1cm, 50% pale pink or red tissue and 50% pale pink non-granulating tissue. This wound deteriorated as evidenced by its increase in size and development of necrotic tissue.</p> <p>On 9/23/24 at 1:25 PM this surveyor requested V4 provide all of V4's (Wound Care Nurse) wound assessments for R1. V1 (Administrator) presented wound assessment details report for R1's left hip wound for 5/24/24 only; coccyx wound for 6/19/24, 6/28, 7/3, and 7/10; and right lateral foot and right hip wounds for 7/3/24 only.</p> <p>On 9/23/24 at 2:00 PM, this surveyor requested V2 (DON) provide all of V5's (Wound Care NP) wound care assessments for R1. V2 presented visit reports for 5/29/24, 6/19, 6/26, 7/3, and 7/10. V5's notes were not found in R1's medical record. There are no visit notes provided for 6/5 and 6/12.</p> <p>This facility's skin condition assessment and monitoring, pressure and non-pressure wounds, policy, revised 6/8/2018, notes pressure 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 assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure skin conditions are identified by licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA (certified nurse aide). Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. The initial observation of the ulcer will be described in the nursing progress notes. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. These changes include, but are not limited to, new onset of purulent drainage, new onset of odor, significant increase in wound measurements, and onset of new ulcers. Physician ordered treatments shall be initiated by the staff on the TAR (treatment administration record) after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nursing progress notes.</p> | | |