STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145758	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Glenwood	19330 South Cottage Grove Glenwood, IL 60425

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34072 Based on interviews and record reviews, the facility failed to follow its skin care prevention policy and implement effective interventions and monitoring to prevent one resident developing three facility acquired non-pressure wounds to the right foot and ankle. This affected one of three R1 residents reviewed for non-pressure wounds in a sample of 11. This failure resulted in R1 presenting to the hospital emergency roiagnom on [DATE] with sepsis secondary to a right heel wound that was infected and with acute osteomyelitis (bone infection). Findings include: On 9/5/24 at 1:40 PM, V11 (wound care nurse) stated that the staff nurses are responsible for monitoring residents' skin for any breakdown. V11 stated that V11 noted R1 with right heel bruising on 8/19/24 and obtained order for wound cleaning and the application of skin prep. V11 stated that the blister opened on 8/24/24 and V11 obtained an order for xeroform and dry dressing daily. V11 stated that the wound on the top of R1's foot was still a blister so V11 continued applying skin prep to this wound. V11 stated that V11 placed a pillow between R1's legs, because V11 was concerned that R1's left lower leg cast was putting pressure on R1's right leg and foot. V11 stated that R1 is unable to move self in bed, dependent on staff. V11 stated that R1's legs were contracted, crossed at knees, and V11 was concerned for pressure on right leg. V11 stated that R1's right foot wounds were trauma related because nothing was wrong with R1 prior to left foot fracture on 8/7/24. V11 stated that V11 performed wound care treatments six days a week and repositioned R1 during treatments. V11 stated that V11 checked to ensure she was able to insert two fingers under R1's rim of cast at toes and positive capillary refill. On 9/6/24 at 1:20 PM, V10 NP (nurse practitioner) stated that R1's legs were very contracted. V10 stated that R1 returned from the emergency room with a post mold to left tibia/fibula fractures on 8/8/24. V10 stated that V10 visited R1 on 8/12/24 and observed bruising to R1's right foot and left knee area. V10 stated that V10 would have V11 (wound care nurse) manage residents with bruising as well as open wounds. V10 stated that fractures, contractures, and poor nutrition puts R1 at risk for skin breakdown. V10 is unable to articulate how the bruising to R1's right foot and left knee could be from trauma on 8/7/24. V10 stated that if due to trauma would have been present at the time of injury on 8/7. V10 was able to review R1's current hospital record which notes right heel wound infection with osteomyelitis. V10 stated that once a wound is present, it can deteriorate very quickly to an infection. V10 stated that the mottling and increased respirations observed by nursing on 9/1 could be due to R1's body responding to the infection. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/6/24 at 4:26 PM, V14 (family member) stated that when she was visiting with R1 on 8/31/24, V14 noted R1's right foot wounds with a foul odor. V14 stated that V14 informed the nurse on duty of the foul odor. R1's weekly skin observation, dated 8/8/24, notes R1's skin warm, dry, within normal limits. Skin turgor is fair. Swelling observed to left foot. No skin concerns noted. There were no further weekly skin observations documented between 8/9/24 and when 9/1/24 when R1 was hospitalized . The CNAs (certified nurse aides) documentation, dated 8/8/24 -9/1/24, notes 8/8, 8/9, 8/14, and 8/21, the CNAs noted discoloration. On 8/11 and 8/18, the CNAs noted redness. On 8/21, the CNA charted skin tear. There is no documentation found in R1's medical record noting the nurse assessed R1 for these skin abnormalities. V10's NP progress note, dated 8/12/24, notes R1 with a soft cast on left leg. There are surrounding bruising and discoloration to R1's left knee and right foot. R1's wound assessment, dated 8/27/24, notes R1 was identified with a facility- acquired right dorsal foot hematoma (bruise) due to trauma on 8/27/24. It is a full thickness wound with 100% intact skin. Maceration (softening and breaking down of skin resulting from prolonged exposure to moisture) noted to periwound. Wound measured 11.10cm (centimeters) x 9.6cm. On 8/29/24, V11 initiated skin prep and gauze dressing treatment. R1's wound assessment, dated 8/27/24, notes R1 with a facility acquired right heel bruise due to trauma, identified on 8/20/24. It is a full thickness wound with 100% bright pink or red tissue. Wound measured 5.5cm x 4.5cm with serous (clear) drainage. On 8/26/24, V11 initiated xeroform and gauze dressing treatment. R1's wound assessment, dated 8/27/24, notes R1 with a facility-acquired right lower leg front bruise due to trauma, identified on 8/27/24. Wound with 100% pink or red non-granulating tissue. Wound measured 18. 3cm x 3.1cm. On 8/27/24, V11 initiated application of skin prep treatment. R1's POS (physician order sheet), dated 8/20/2024, notes an order for right foot wound apply skin prep every day shift to prevent skin breakdown. There is an order, dated 8/24/24, for right ankle wound clean with wound cleaner pat dry, apply xeroform and rolled gauze every day shift for wound care. R1's TAR (treatment administration record), dated August 2024, notes R1 did not receive treatment to right ankle wound on 8/25 or 8/31. R1 also did not receive treatment to right foot blister on 8/25 or 8/31. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's hospital record, dated 9/1/24, notes R1 presented to the emergency room at 11:07 AM. Condition is serious. R1's primary admitting diagnosis is osteomyelitis right foot. R1 with necrotic (dead tissue) right heel ulceration with foul-smelling drainage and right foot blister. R1's white blood cell count was 19.2 (normal range 4-11). X-ray of R1's right foot noted heel with soft tissue gas tracking superiorly along the achilles tendon. Impression: heel ulcer with evidence of infection by a gas-forming organism. R1 with sepsis secondary to necrotic infected right heel wound. Infectious disease physician consulted and noted severe sepsis, necrotic right heel ulcer with wet gangrene, and osteomyelitis. Along the medial ankle there appears to be tissue necrosis also. It is unlikely that the limb will be salvageable given the extensive necrosis of the heel. Antibiotics alone will not take care of the infection given the tissue damage. Very foul-smelling odor noted from the right foot. Wound dressings with small bugs noted. Podiatrist consulted and noted R1's right heel ulcer with achilles tendon exposed, limb not salvageable. Right heel wound measured 14.3cm x 12.2cm x 0.4cm. This facility's skin care prevention policy, reviewed 01/2024, notes dependent residents will be assessed during care for any changes in skin condition including redness and this will be reported to the nurse. The nurse is responsible for notifying the health care provider.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34072 Based on interviews and record reviews, the facility failed to implement effective pressure relieving interventions to prevent one resident, who's lower extremities are severely contracted, at very high risk for skin breakdown, and dependent on staff for all ADLs (activities of daily living), from developing a facility acquired pressure ulcer on the left posterior distal thigh due to pressure from posterior mold splint on the left lower leg. This affected one of three residents R1 reviewed for pressure ulcers in a sample of 11. This failure resulted in R1 presenting to the hospital emergency roiagnom on [DATE] with a pressure wound to the left posterior distal thigh with hamstring tendon exposed. Findings include: On 9/5/24 at 1:40 PM, V11 (wound care nurse) stated that the staff nurses are responsible for monitoring residents' skin for any breakdown. V11 stated that R1 is unable to move self in bed, dependent on staff. V11 stated that R1's legs were contracted, crossed at knees. V11 stated that V11 checked to ensure she was able to insert two fingers under R1's rim of cast at toes and there was positive capillary refill. On 9/6/24 at 1:20 PM, V10 NP (nurse practitioner) stated that R1's legs were very contracted. V10 stated that R1 returned from the emergency room with a post mold to left tibia/fibula fractures on 8/8/24. V10 stated that V10 visited R1 on 8/12/24 and observed bruising to R1's right foot and left knee area. V10 stated that V10 would have V11 (wound care nurse) manage residents with bruising as well as open wounds. V10 stated that fractures, contractures, and poor nutrition puts R1 at risk for skin breakdown. R1's weekly skin observation, dated 8/8/24, notes R1's skin warm, dry, within normal limits. Skin turgor is fair. Swelling observed to left foot. No skin concerns noted. R1's left ankle down to the foot dark purple bruise, swollen and painful. Left elbow with dark purple bruising. The CNAs (certified nurse aides) documentation, dated 8/8/24 -9/1/24, notes 8/8, 8/9, 8/14, and 8/21, the CNAs noted discoloration. On 8/11 and 8/18, the CNAs noted redness. On 8/21, the CNA charted skin tear. There is no documentation found in R1's medical record noting the nurse assessed R1 for these skin abnormalities. R1's progress notes, dated 8/8/24 - 9/1/24, notes on three occasions, 8/27 at 1:18 AM, 8/28 at 00:17 AM, and 8/29 at 1:49 AM, documentation of positive capillary refill and two fingers can fit under the rim of the soft cast. There were no further weekly skin observations documented between 8/9/24 and when 9/1/24 when R1 was hospitalized . V10's NP progress note, dated 8/12/24, notes R1 with a soft cast on left leg. There are surrounding bruising and discoloration to R1's left knee. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	There is no documentation found in R1's medical record noting staff monitored the bruising and discoloration to R1's left knee or skin to left thigh area. R1's POS (physician order sheet), dated 8/11/2024, notes an order to monitor left lower extremity cast and surrounding areas for circulation, motion, and sensation, signs/symptoms of skin breakdown every shift, notify physician of abnormalities. R1's hospital record, dated 9/1/24, notes R1 presented to the emergency room at 11:07 AM. Condition is serious. Podiatrist consulted and noted R1's left distal thigh wound with hamstring tendon exposed related to pressure on leg from post mold splint on left lower leg. This facility's skin care prevention policy, reviewed 01/2024, notes dependent residents will be assessed during care for any changes in skin condition including redness and this will be reported to the nurse. The nurse is responsible for notifying the health care provider.