STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007280	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2318808/IL165795	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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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 develop and implement interventions to prevent pressure injuries. The facility also failed to identify two pressure wounds prior to becoming unstageable. This failure resulted in R1 developing two unstageable pressure injuries to her heels. The facility also failed to accurately implement pressure injury prevention interventions for two residents (R3,R4) with pressure injuries. This applies to 3 of 3 residents (R1, R3, R4) reviewed for pressure injuries in the sample of 6. The findings include:	S9999		

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S9999	Continued From page 2	S9999		

1. R1's Admission Record (Face Sheet) showed an original admission date of 5/26/22 with diagnoses to include dementia, Parkinson's disease (a brain disorder that causes a lack of coordination and uncontrollable movements), diabetes type two, weakness, and hypertension (High blood pressure).

R1's 7/24/23 Minimum Data Set (MDS) showed she used a wheelchair for mobility. The MDS showed she required extensive assistance of two people for bed mobility (turning from side to side and positioning herself in bed), she required extensive assistance of one person for locomotion on and off the unit (the amount of assistance she required after she was in her wheelchair), and she required extensive assistance of two people for dressing.

R1's 9/11/23 Nurses Note from 10:10 AM showed, "Upon assessment, noted resident with blister on right heel and diabetic ulcer on left heel... Resident is alert but has confusion and forgetfulness at times. Resident was complaining of tight shoes but still insisting to use it; eventually, resident developed blisters and opened up. Family is aware that she's wearing tight shoes. Resident is encouraged not to use the shoes anymore, advised family to bring a larger pair of shoes..." (The note was authored by V3 Assistant Director of Nursing/Wound Care nurse.)

R1's 9/12/23 Nurse Practitioner wound note showed, "Patient has left and right unstageable pressure ulcers identified..." The note showed the left heel had a "...medium amount of necrotic (dead) tissue within the wound bed..." The note stated the right heel had "...medium amount of necrotic (dead) tissue within the wound bed..."

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APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

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S9999	Continued From page 3 On 10/25/23 at 1:15 PM, V6 Licensed Practical Nurse stated, "...I did tell her daughter (V12 R1's daughter) that she should have slippers because her shoes were too tight. The resident still wanted to wear her shoes anyways but I told the CNAs (Certified Nursing Assistannts) not to put them on her. I'm not sure when she stopped wearing the shoes, if it was before or after the wounds developed but she did have the slippers after the pressure ulcers developed. If I want to know the pressure ulcer interventions for a resident, I go to the orders or the care plan. Those are the only places I can think of to look for them..." On 10/25/23 at 1:35 PM, V8 Certified Nursing Assistant (CNA) stated it had been some time since she provided care for R1, but she did recall R1. V8 said she required a mechanical lift to get out of bed. V8 said, "I remember she always wanted to wear her purple shoes. She also did have house slippers, she had them for a long time. I don't recall ever being told that we couldn't use her shoes." On 10/25/23 at 1:20 PM, V7 CNA stated R1 had tennis shoes that she liked to wear. V7 said she does not recall ever being told R1 should not wear her shoes. On 10/25/23 at 2:30 PM, V12 R1's Daughter said she saw her mother often, and on September 9th or 10th, 2023 (Saturday or Sunday) she saw her mother in her room. V12 said her mother was wearing her shoes and she could see her socks were bloody. V12 said she took off her mother's shoes and socks and there was no dressing in place. V12 said, "Yes, she was wearing her shoes and not her slippers...[V6] did talk to me	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

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S9999	Continued From page 4	S9999		

about her shoes and she said she needed slippers, but it was up to them (facility staff) to put them on. The CNAs would always just put on the her gym shoes and not use the slippers. No one ever said the shoes were too tight, but she had slippers, that's why I got the slippers because they were easier for the staff to put on. They never should have put the gym shoes on her with those wounds, that's just common sense. She was not able to make any decisions for herself prior to developing the wounds, I would have to make her decisions. If the staff had asked me if they could take away her shoes, I absolutely would have been okay with taking them away even if she liked to wear them. I could have gone up and talked to her (R1) about why they needed to take them (shoes) away, but no one asked me to do anything like that. Especially if they were going to hurt her. The CNAs just kept putting her in the gym shoes even though she had the slippers."

On 10/25/23 at 10:30 AM, V3 Wound Care Nurse/Assistant Director of Nursing stated, "..on 9/11 she had developed bilateral heel wounds. Prior to that the CNA's were saying her shoes were too tight, but she wanted to use the same shoes and I talked to [V12] about bringing bigger shoes. She had two pairs of shoes, but they were the same size, so I told the CNA to use the socks and not the shoes." V3 stated she believes she may have been notified of the heel wounds on the 9th or 10th of September and then assessed the wounds on 9/11/23 when she came to work. V3 stated R1 was at risk for pressure wound development, "due to her history. She is diabetic, she has Parkinson's disease, she is hypertensive (high blood pressure), she has weakness, and dementia..." V3 said, while reviewing her documentation and the images of the wounds,

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	IL6007280	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

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S9999	Continued From page 5	S9999		

the right heel wound should have been identified prior to becoming unstageable.

On 10/25/23 at 1:57 PM V3 stated, "...She should have had a pressure ulcer prevention care plan in place prior to developing pressure wounds. I do not see that she has one. They (care plans) are important, it is the backbone of their care, so we know what our plans are for the resident, and we are addressing the medical problems they have. I would agree that the care plan is an effort of us sitting down and looking at a [R1's] medical history and addressing the issues that would lead to her developing pressure." V3 was asked what she believed caused the wounds, to which she replied, "One thing to consider is her tight shoes and the CNA's have difficulty putting on her shoes. The CNA's told me about it (tight shoes) and I'm not sure when I discussed it with [V12]. I tried to find her bigger shoes. I do think the shoes were a contributing factor to her getting the heel wounds." V3 said, "When the CNA said the shoes were tight, I think I put foam in her shoes (V3 added more material inside an already tight shoe), but she kept on wearing them. She did wear the shoes until she got the wounds. She stopped when she got the blisters." V3 said she did not take away the shoes because, "She (R1) loved them. She was confused at this point. She had hallucinations...I did not discuss with [V12] taking away the shoes but we did discuss with [V12] about getting a new pair of shoes. She has the right to wear the shoes. [R1] would not have been able to make her own decisions. I think we should have asked the daughter about taking away the shoes until she (V12) could get her (R1) new shoes."

On 10/25/23 at 2:55 PM, V11 Wound Care Nurse Practitioner stated a pressure wound occurs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007280	A. BUILDING: _____ B. WING _____	C 10/26/2023

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APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

when tissue, generally over a bony prominence, is in prolonged contact with a surface for an extended period. V11 said certain areas are more prone to developing pressure wounds such as the heels and the sacrum (lower back area.) V11 said certain health conditions put a resident at higher risk such as Parkinson's, dementia, diabetes, hypertension, and weakness. V11 said, based on R1's history, she was at risk for developing pressure injuries. V11 said shoes that are too tight can cause pressure injuries. V11 said, "For residents with these comorbidities it is important to have a care plan for prevention. Once they have the care plan then they should put interventions in place to prevent the pressure injury. Interventions like repositioning and offloading of the heels. It is possible they can still develop pressure wounds even with interventions in place. It is better to try and prevent the wound before it develops. Depending on the situation it can be difficult to prevent pressure wounds, but they should still try. I would have a concern, if a resident with DM, Parkinson, dementia, and hypertension had shoes that are too tight, my recommendation would be to get them another pair of shoes and get podiatry on board to get them a different pair of shoes. They should wear slippers instead of shoes that are too tight. No one made me aware that she had shoes that were too tight, either before or after she developed the heel wounds." V11 said, "They should have been able to notice them (heel wounds) prior to them becoming unstageable."

On 10/25/23 at 11:50 AM, R1's pressure ulcer prevention care plan, prior to 9/11/23, was requested.

On 10/25/23 at 3:50 PM V1 Administrator stated, R1's Care Plan Focus area skin integrity was

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	IL6007280	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

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S9999	Continued From page 7 R1's pressure ulcer prevention care plan. R1's care plan (Provided by the facility following the request on 10/25/23) showed "I have a potential for impairment to skin integrity r/t (related to) aging/disease process, decreased mobility, incontinence" The care plan was initiated 6/13/22. The following list of interventions is all inclusive and were initiated on 6/13/22: "Avoid scratching and keep hand and body parts from excessive moisture. Keep fingernails short. Keep skin clean and dry. Use Lotion on dry skin. Protective skin barrier cream as ordered. Provide diet as ordered and monitor nutritional status and dietary needs." (The care plan does not discuss shoes, air mattress, or offloading of heels.) R1's Orders showed an order to "Use Pillows to off load bilateral (both) heels." The order stopped on 7/21/23. The next order to off load heels was not until the wounds were found on 9/11/23. R1's September 2023 Treatment Administration Record showed no heel offloading or air mattress interventions. The facility's Comprehensive Care Plan policy showed, the purpose is "To develop a comprehensive care plan that directs and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." The policy showed, "The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including	S9999		

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	IL6007280	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 8 the right to refuse treatment..." The facility Pressure Ulcer Prevention policy (Revised 1/15/18) showed, the purpose is "To prevent and treat pressure sores/pressure injury.... Inspect the skin several times daily during bathing, hygiene, and repositioning measures...Turn dependent resident approximately every two hours or as needed and position resident with pillow or pads protecting bony prominences as indicated..." 2. R3's Admission Record (Face Sheet) showed an original admission date of 5/26/23 with diagnoses to include: myasthenia gravis (Muscle weakness), dementia, heart failure, and blood clots in her legs. R3's 8/17/23 Significant Change Minimum Data Set (MDS) showed she had severe cognitive impairment. The MDS also showed she required extensive assistance of two people for bed mobility and transfers. R3's 10/17/23 Progress Note (Wound Note by V11 Nurse Practitioner/Wound Care) showed she has unstageable pressure ulcer to the right and left heel. R3's Order Summary Sheet showed an order to "Ensure low air loss mattress functioning properly" to be done every shift. The order was active as of 10/25/23 and was started on 10/16/23. R3's October 2023 Treatment Administration Record showed, beginning the night of 10/16/23, an order to Ensure low air loss mattress functioning properly. The order was documented	S9999		

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	IL6007280	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

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S9999	Continued From page 9 as being done three times a day; 10/21/23 through 10/25/23. On 10/20/23 at 11:54 AM, R3 was in bed, her low air loss mattress was on and set to 400 pounds. On 10/24/23 at 2:25 PM, R3 was asleep in bed, her low air loss mattress was on and set to 400 pounds. On 10/25/23 at 9:35 AM, R3 was in her reclining high back chair and her low air loss mattress was set to 400 pounds. R3's air mattress had a digital read out with push buttons to adjust the pressure. R3's electronic charting showed her weight on 10/4/23 was 156.3 pounds. (A difference of 243.7 pounds between her measured weight and the low air loss mattress.) On 10/25/23 at 1:15 PM, V6 Licensed Practical Nurse (LPN) stated she was the nurse for R3's hallway. V6 stated she does not check or adjust air mattress pressure. V6 said she believes the pressure is set when the air mattress is delivered. On 10/25/23 at 1:20 PM, V7 Certified Nursing Assistant (CNA) stated she does not adjust or check air mattress pressures. On 10/25/23 at 10:30 AM, V3 Assistant Director of Nursing/Wound Care Nurse stated, the low air loss mattresses are used for residents at risk of developing pressure injury and for those residents with pressure injuries. V3 stated, the air mattress helps to "distribute the pressure" across the residents entire body instead of localized areas of the body. V3 said the air mattresses do have settings and one of those settings is a weight setting. V3 said the setting	S9999		

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APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

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S9999	Continued From page 10	S9999		

should be set as close as possible to the resident's actual weight. V3 said a pressure too high will make the mattress too firm and not work as intended. V3 did not know why R4's air mattress was set incorrectly. V3 said she checks all air mattresses in the facility once a week. V3 said all residents with an air mattress should have an order and a corresponding treatment intervention to be done once a shift. V3 said the purpose of the intervention is for nursing staff to verify the air mattress is functioning properly and it is set to the resident's weight.

The facilities Pressure Ulcer Prevention policy (Revision 1/15/18) showed, "...Specialty mattresses such as low air loss, alternating pressure may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple Stage 2 wounds or one or more Stage 3 or Stage 4 wounds..."

3. R4's Admission Record (Face Sheet) showed an original admission date of 8/26/23 with diagnoses to include: dementia, diabetes, and chronic obstructive pulmonary disorder (COPD).

R4's 9/29/23 Quarterly Minimum Data Set (MDS) showed he required extensive assistance of two people for bed mobility.

R4's 10/17/23 Progress Note (Wound Note by V11 Nurse Practitioner/Wound Care) showed he had a 13 centimeter by 8 centimeter wound to his lower back that had 11 centimeters of tunneling.

R4's Order Summary Sheet showed an order to "Ensure low air loss mattress functioning properly" to be done every shift. The order was

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APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

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S9999	Continued From page 11 active as of 10/25/23 and was started on 10/16/23. R4's October 2023 Treatment Administration Record (TAR) showed, beginning the night of 10/16/23, an order to Ensure low air loss mattress functioning properly. The TAR showed this intervention was documented as being done three times a day; 10/21/23 through 10/25/23. On 10/20/23 at 12:30 PM, R4 was in bed, his low air loss mattress was on and set to 300 pounds. On 10/24/23 at 2:30 PM, R4 was in bed, his low air loss mattress was on and set to 300 pounds. The adjustment for R4's air mattress weight setting was a dial type with a range of weights. On 10/25/23 at 9:50 AM, V3 Assistant Director of Nursing/Wound care nurse provided wound care for R4. At the completion of R4's wound care, V3 doffed her personal protective equipment and exited the room. R4's air mattress was set to 320 pounds. R4's electronic charting showed his weight on 10/4/23 was 179.0 pounds. (A difference of more than 120 pounds between his measured weight and the low air loss mattress weight setting.) On 10/25/23 at 1:15 PM, V6 Licensed Practical Nurse (LPN) stated she was the nurse for R4's hallway. V6 stated she does not check or adjust air mattress pressure. V6 said she believes the pressure is set when the air mattress is delivered. On 10/25/23 at 1:20 PM, V7 Certified Nursing Assistant (CNA) stated she does not adjust or check air mattress pressures.	S9999		

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	IL6007280	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE HIGHWOOD	50 PLEASANT AVENUE HIGHWOOD, IL 60040

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S9999	Continued From page 12 On 10/25/23 at 10:30 AM, V3 Assistant Director of Nursing/Wound Care Nurse stated, the low air loss mattresses are used for residents at risk of developing pressure injury and for those residents with pressure injuries. V3 stated, the air mattress helps to "distribute the pressure" across the residents entire body instead of localized areas of the body. V3 said the air mattresses do have settings and one of those settings is a weight setting. V3 said the setting should be set as close as possible to the resident's actual weight. V3 said a pressure too high will make the mattress too firm and not work as intended. V3 did not know why R4's air mattress was set incorrectly. V3 said she checks all air mattresses in the facility once a week. V3 said all residents with an air mattress should have an order and a corresponding treatment intervention to be done once a shift. V3 said the purpose of the intervention is for nursing staff to verify the air mattress is functioning properly and it is set to the resident's weight. The facilities Pressure Ulcer Prevention policy (Revision 1/15/18) showed, "...Specialty mattresses such as low air loss, alternating pressure may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple Stage 2 wounds or one or more Stage 3 or Stage 4 wounds..." B	S9999		