STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145918	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE BRIDGEPORT	**900 EAST CORPORATION BRIDGEPORT, IL 62417**

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 0686 **Level of harm -** Minimal harm or potential for 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** Based on interview and record review, the facility failed to identify and document pressure wounds, provide ordered treatments to wounds, and follow orders to prevent further deterioration of wounds for 2 of 9 residents (R1 and R2) reviewed for pressure wounds in the sample of 9. Findings Include: 1. R2's Medical Record documents an admission date of [DATE], with the following Diagnoses: [REDACTED]. R2 was discharged from a local hospital with no documentation of a Pressure Wound to the Coccyx or Distal Coccyx. R2's Progress Notes/Nurses Notes, dated 1/24/20, do not document the presence of a pressure wound on admission to this facility. R2's 72 Hour Admission Charting, dated 1/25/20 at 7:23AM, documents the following: No wounds or skin concerns. Pressure reducing device for chair. Pressure reducing device for bed. R2's Braden Evaluation, dated 1/24/20, documents a score of 17 and a note of 'at risk for Pressure Ulcer' marked. R2's 72 Hour Admission Charting, dated 1/25/20 and 11:23PM, documents the following: No wounds or skin concerns. R2's Skilled Nursing Facility Patient Transfer Form, dated 1/24/20, (from the local hospital) Impairment of Skin and Mucus Membrane is marked none. R2's Skilled Evaluation, dated 2/6/20, documents that the Skin Evaluation is 'Within Normal Limits'. On 8/18/20 at 9:00AM, V14 (Wound Clinic Nurse) stated that (R2) was seen in the Wound Clinic on 1/16/2020, and only had Wound #2. This was before the admission to the nursing facility on 1/24/20. Wound #1 had healed before (R2) was admitted to the nursing facility, and at this time there was no Wound #3. R2 was seen in the Wound Clinic on 2/6/20, 2/20/20, 3/5/20, 4/9/20, 5/7/20, and 5/14/20. R2's Wound Orders received 1/30/20 for treatment to two coccyx wounds (Wound #2 (Distal Coccyx) and Wound #3 (Coccyx)), dressings are ordered to be changed every 3 days, Off Load Weight, Wheelchair Cushion, Air Mattress, Shift Position every 15 minutes, Turn every 2 hours, Limit Head of Bed Elevation to 30 degrees in bed. R2's Wound Clinic Progress Notes, dated 1/30/20, documents R2's admission to a nursing facility on 1/24/20. The Progress Notes also documents the following: Patient is spending all of his time in bed except 40 minutes of therapy-making these areas worse. Wound #3 is an acute Stage 3 Pressure Injury Pressure Ulcer and has received a status of not Healed. No c/o (complain of) pain. Ordered: For Endoform change every 3 hours and as needed. Off Load, Keep Weight off Wound, Wheelchair Cushion, Specialty Bed Mattress for pressure reduction, Seat Lifts or Shift position in chair every 15 minutes. Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degree tilt. Limit HOB (Head of Bed) elevation to 30 egress in bed. The Wound Clinic Visit, dated 2/6/20, documents a previous wound (Wound #2, acquired 11/14/09) and a new wound acquired on 1/30/20 (Wound #3). The measurements to Wound #3 is Length 0.7 cm (centimeter), Width 0.4 cm, and Depth 0.1 cm and Classified as a Stage 3. R2's Wound Clinical Progress Note, dated 2/6/20, documents the following: Re-issue 1/30/20 orders for dressings to be changed every 3 days, Off Load Weight, Wheelchair Cushion, Air Mattress, Shift Position every 15 minutes, Turn every 2 hours, Limit Head of Bed Elevation to 30 degrees in bed. Please ensure dressings are being changed every 3 days as ordered. Patient did not have a bandage on wound at all today upon arrival to the wound center. Plan: Very concerned talked to patient again about off loading. Re-issued order to Nursing Home for dressing, patient had no dressing when he came here. R2's Wound Clinic Progress Note, dated 2/20/20, documents to follow the treatment plan and to continue to work on off loading. R2' Wound Clinic Progress Note, dated 3/5/20, documents to continue the orders and continue Endoform. Improvement of wound notes. Patient is working on off loading. On 4/9/20 Wound #3 is documented as a Stage 4, able to feel bone, and R2 complains of pain when sitting on the wound. The measurements for Wound #3 on 4/9/20 is Length 1 cm, Width .6 and Depth is 1.5 cm. R2's Wound Clinic Progress Note, dated 4/9/20. documents the following: (R2) stated, It hurts really bad when I am sitting on the wound. Stabbing pain when he sits on wounds says he was at [MEDICAL TREATMENT] despite being on waffle cushion, Pain severity is 5/10. Wound #3 has gotten worse now Stage 4 with undermining, bone is palpable. Wound #2 is healed. Wound #3 is an Acute Stage 4 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measure 1 cm Length, 0.6 cm Width, 1.5 cm Depth. Bone and Adipose are exposed. There is a moderate amount of serous drainage note which has no odor. The patient reports a wound pain level 8/10. Pain is when he is sitting on it. Can feel Bone needs to be evaluated for [DIAGNOSES REDACTED]. R2's Wound Clinic Progress Note, dated 5/7/20, documents that R2 was admitted to local hospital on 4/10 for Septic Shock. Has surgery for [REDACTED]. Has a VAC in place at the time. During the Wound Clinic Visit a Wound Vac was re-applied to Wound #3. Orders on 5/7/20 to Wound #3, Acute Stage 4 Pressure Injury, Wound VAC. Orders: Off-Loading, Wheelchair Cushion, Specialty Bed, Turn every 2, Avoid position directing position to wound site, Limit side lying to 30 degree tilt. Limit HOB elevation to 30 degree in bed. R2's Wound Clinic Progress Note, dated 5/14/20, documents: R2 was discharged home from the facility. R2's Wound Order from V 11 (Physician/Wound Specialist), dated 1/30/20, documents to Wound #2 (Distal Coccyx) and Wound #3 (Coccyx): Endoform dampened with saline to wound bed, cover with bordered form dressing, change every 3 days and as needed due to loose or soiled bandage. R2's Treatment Record for February 2020, documents 3 missed treatments to the Coccyx and 2 missed treatments to the Distal Coccyx. R2's Treatment Record for March 2020 documents 1 missed treatment to the Coccyx and 4 missed treatments to the Distal Coccyx. In April 2020 R2 was hospitalized from [DATE] through 4/22/20. R2's Treatment Administration Record for February, March, and April do not include the chart codes to document the reason for the treatment not being administered. There is no personnel presently employed at this facility that cared for R2 that can identify why the treatments were omitted. R2's Weekly Skin Observations/Skin Concerns are as follows: 1/31/20: No Concerns, 2/7/20: Skin concerns observed:Coccyx - pinpoint area top of coccyx, 2/14/20: Small Area to coccyx, 2/21/20: No Concerns, 2/28/20: WNL (Within Normal Limits), 3/6/20: Skin Intact, No concerns, 3/13/20: (Skin Concern Space is Blank), 3/20/20: Skin concerns are not new, 3/27/20: (Skin Concern Space is Blank), 4/3/20: No Concern, 4/10/20 Weekly Skin Observation is not documented, 4/29/20: (Skin Concern Space is Blank). On 8/13/20 at 12:50PM, V2 (Director of Nurses) stated that the nursing staff did not measure R2's wound for February, March, or April, but took the measurements from the wound clinic notes. V2 stated that the staff should have measured the wound themselves, documented this in the resident's records, and looked for changes either improvement or deterioration. V2 stated that there were 2 wounds. The wounds were not adequately documented and assessed. At the present time the facility is unable to find R2's wound measurements. V2 stated that the measurements were in a separate computer program and due to multiple staff changes the wound measurements cannot be located. V2 stated she did not know why R2's treatments were omitted in February and March. There is no personnel presently working at this facility that can identify why the treatments were omitted. On 8/13/20 at 1:45PM, V1 (Administrator) stated that there are no wound records for February, March, and April 2020. On 8/13/20 at 3:30PM, V1 (Administrator) stated that there is no documentation on admission of coccyx wounds or pressure wounds. There is no documentation from the discharging hospital that resident was admitted with a coccyx wound or pressure ulcers. The treatment record for February and March has administration dates that are missing. On 8/18/20 at 9:42AM, V2 (Director of Nurses) stated that R2's Wound Clinic orders received on 1/30/20 was not followed completely. There is no documentation in the nurses notes or the CNA's task that the orders for Off Load Weight, Shift Position every 15 minutes, Turn every 2 hours, Limit Head of Bed Elevation to 30 degrees in bed. On 8/18/20 at 2:50PM, V2 (Director of Nurses) stated that after R2's Braden Score of 17 was completed, interventions should have been put into place. The Braden Score indicated that R2 was at risk for pressure wounds and skin

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

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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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) breakdown. V2 stated that R2 should have had weekly skin checks, change and monitor dressings, check nutrition, encourage mobility as he was able, turn every 2 hours, head of bed should not be elevated greater than 30 degrees. V2 stated there is no record of these intervention being put into place or on the Care Plan. On 8/26/20 at 11:30AM, V11 (Physician/Wound Specialist) stated that R2 had several issues related to his lungs, kidney disease, and Pressure Ulcers. R2 was at increase risk for developing further Pressure Ulcers due to his lung and kidney issues. V11 stated he could not really blame the facility related to the decline of R2's Pressure Ulcers, related to the treatments being given or not being given at the facility. R2's Medical Records, dated 4/10/20, documents that R2 was sent to the emergency room related to elevated temperature and possible COVID. R2's Medical Record, dated 4/23/20, documents R2 was readmitted to facility with Wound Vac. R2's Medical Records, dated 5/14/20, documents that R2 was discharged home with Home Health. R2 was readmitted on [DATE] from a local hospital. On 7/22/20, Medical Record documents that R2 was sent to the emergency room due to a change in condition. There is no further documentation of R2. The State of Illinois Certificate of Death Worksheet, undated, gives date of death as 7/22/20 and the Cause of Death: Acute [MEDICAL CONDITION], Acute Diastolic Congestive Heart Due to [MEDICAL CONDITION], and End Stage [MEDICAL CONDITION] with Fluid Overload. R2's Care Plan, dated 2/6/20, includes the following: Assess/Record/Monitor wound healing- Report improvement and declines to the M.D. Weekly documentation to include measurement of each area of skin breakdown, width, length, depth, type of tissue and exudate. The Care Plan does not include the Wound Clinic orders, dated 1/30/20, for Off Load Weight, Wheelchair Cushion, Air Mattress, Shift Position every 15 minutes, Turn every 2 hours, or Limit Head of Bed Elevation to 30 degrees in bed. On 8/18/20 at 9:45AM, V15 (RN (Registered Nurse)/ MDS (Minimum Data Set) Coordinator) stated that the 1/30/20 and 2/6/20 Wound Clinic Orders for Off Load Weight, Wheelchair Cushion, Air Mattress, Shift Position every 15 minutes, Turn every 2 hours, Limit Head of Bed Elevation to 30 degrees in bed was not put on the Care Plan and was not put into action. The facility's Skin Condition Assessment and Monitoring- Pressure and Non-Pressure, revised 6/8/18, documents the following: Pressure and other ulcers (diabetic, arterial, venous) 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 and/or other non-pressure skin conditions are identified by licensed nurse. At the earliest sign of a pressure injury or other skin problem, 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. 6. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care. 7. Physician ordered treatments shall be initiated by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses note. 2. On 8/17/20 at 2:30 PM, V2 (Director of Nurses) stated R1 does have a wound on his right buttocks that was cultured, and he is now on [MEDICATION NAME] for 7 days. V2 stated R1's circulation is bad due the [DIAGNOSES REDACTED]. V2 also stated R1 doesn't eat very well and stated the amputations were because R1 had [MEDICAL CONDITION]. On 8/12/20 at 10:00 AM, V3 (Registered Nurse/Wound Nurse) stated R1 went out to the hospital and when he came back on 8/8/20 he was put on isolation for 14 days and they forgot to move his bed with the pressure relieving mattress into the isolation room. On 8/12/20 and on 8/17/20 at 10:00 AM, wound care was observed on R1 and his treatment was done per physician's orders [REDACTED].
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to clean and maintain infection control practice with respiratory equipment for 4 of 4 residents (R3, R6, R7, R8) reviewed for infection control in the sample of 9. Findings include: On 8/12/20 at 8:30 AM, R3, R6, R7 and R8's [MEDICAL CONDITION]/[MEDICAL CONDITION] tubing and masks were lying on their bedside tables, without any type of barrier in place. On 8/12/20 at 10:15 AM, R3 stated he has used his Bilevel Positive Airway Pressure ([MEDICAL CONDITION]) machine every night for a long time and he ended up going into the hospital for a week and when he got back to the nursing home there were ants in the water container. R3 stated he didn't continue to use that machine, the nurses got him a new one with new tubing and mask. R3 stated the staff do not clean his [MEDICAL CONDITION] tubing, mask or filter. On 8/12/20 at 9:30 AM, V2 (Director of Nurses) stated there are 3 residents that use a Continuous Positive Airway Pressure ([MEDICAL CONDITION]), and 1 resident uses a [MEDICAL CONDITION] machine, and states she doesn't know if the nursing staff clean the tubing, masks or the units. V8 (Licensed Practical Nurse) stated there are 3 residents that use a [MEDICAL CONDITION] and 1 resident uses a [MEDICAL CONDITION] machine, and states she has never cleaned any of the machines. V5 (Licensed Practical Nurse) and V7 (Licensed Practical Nurse) both stated they have never cleaned any of the [MEDICAL CONDITION] or [MEDICAL CONDITION] tubing, water containers, or masks. V10 (Certified Nurses Aide) states she has never cleaned the units, tubing, masks, or the filters of the machines. On 8/12/20 at 9:00 AM, R3, R6, R7 and R8 all stated their [MEDICAL CONDITION]/[MEDICAL CONDITION] machines have never been cleaned by the nursing staff. The facility's undated policy, titled [MEDICAL CONDITION] Therapy documents under Cleaning and Maintenance, #4.) n.) Clean and inspect all components regularly. The mask, tubing, and headgear should last approximately 6-12 months, but the actual life of the equipment can vary greatly. The(NAME)[MEDICAL CONDITION] Respirator Series STC 1060P SN: C 3933F71 cleaning instructions; Clean the [MEDICAL CONDITION] or [MEDICAL CONDITION] tubing, nasal mask and headgear in a bathroom sink filled with warm water and a few drops of ammonia-free, mild dish detergent. Swirl all parts around for about five minutes, rinse well and let air dry during the day.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on interview and record review, the facility failed to provide a Registered Nurse for 8 hours a day, 7 days a week. This has the potential to affect all of the 65 residents living in the facility. Findings include: On 8/12/20 at 9:00AM, V1 (Administrator) stated that there is 65 residents in the facility at the present time. The Weekly Nurse Schedule for December 22 through 28, 2019, documents that there is no Registered Nurse working on 12/22/19. The Weekly Nurse Schedule for February 23 through 29, 2020 documents that there is no Registered Nurse working on 2/29/20. The Monthly Nurse Schedule for May, 2020 documents that there is no Registered Nurse working on 5/18/2020 and 5/24/2020. The Nurse Schedule for July 12 through July 25, 2020 documents that there is no Registered Nurse working on July 18, 2020. On 8/18/20 at 2:55PM, V2 (Director of Nurses) stated that the facility occasionally has issues with weekend RN coverage. The facility has recently hired two new RN's to help with weekend RN coverage.