STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145758	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 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 observation, interview, and record review, the facility failed to follow wound care interventions for two residents (R2 and R3) reviewed for wound care. Findings include: On 8/10/20 at 12:00pm, R3 lay on his back with both heels wrapped in a dressing and laying on a pillow. R3 states they are usually laying on the pillow. V15 (Certified Nursing Assistant, CNA) repositioned R3 in bed but did not move heels or feet which remained laying on the pillow. At 2:00pm, R3's legs remained in same position, heels laying on the pillow. At 8/10/20 at 1:40pm, R2's legs are both contracted and touch at knees or mid-shin. V6 and V7 (Certified Nursing Assistant, CNA's) positioned R2 on her left side. Right leg lays over left at knees/boney prominence. R2 has 2 small reddened areas on outside of right foot noted as soon as she was turned to the other side. V6 and V7 stated that R2's legs are stiff and contracted and she pulls her legs back up to her chest like this. V6 and V7 put a sheet over R2 and left the room without placing a pillow or separating the two areas where her legs rub. R2's heels and feet lay directly on the bed. On 8/11/20 at 8:41am, wound care observed with V13 (Wound care nurse) who stated R3's heels should be elevated and off loaded at all times to prevent pressure ulcer on the left heel and worsening of the right heel wound. If his heels are laying on a pillow, that is not good, that is still pressure. He does not move his legs on his own. R3's left heel wound recently healed. I wrap it with gauze to protect it. The heels should be floating off the bed. On 8/11/20 at 9:50am, V16 (CNA) stated that R2 needs total assistance from 2 staff to reposition and turn. We try to put a pillow between her legs if we can to prevent a pressure sore because she keeps her legs real tight together. She cannot move her legs on her own. There is nothing special with her feet as far as wound intervention. On 8/11/20 at 9:55am, R2's feet lay directly on the bed when entered the room. V13 (Wound Care nurse) stated her right outer foot had a few sores that just recently healed (red areas seen on skin). Part of the wound care intervention is to offload her heels and feet and to put a towel or pillow in between her legs to avoid pressure sores. On 8/11/20 at 10:14am, V13 stated that R2 and R3 have wound care interventions which include off load heels to prevent pressure ulcers or worsening of wounds. Part of the wound care intervention that I include for R2 is to put a towel or pillow in between legs to avoid a pressure area. On 8/11/20 at 11:00am, V3 (Director of Nursing, DON) stated that CNA's review the kardex (patient information card) in order to know what care the resident needs. 8/11/20 at 1:52pm, V13 stated that I noticed yesterday afternoon when I was doing my rounds that R2 did not have a towel or pillow in between her bony prominences in between her contracted legs. I spoke to staff and informed them and explained this is to relieve pressure areas. There are times that the wound interventions are not in place and I re-educate the CNA's when I see that. R2's [DIAGNOSES REDACTED]. R2's kardex notes to off load heels. R2's skin assessment note dated 8/10/20 notes she is at high risk for skin breakdown. R2 requires total care and current plan includes both heels offloaded while in bed. R2's preventative intervention worksheet, last amended by V13 on 6/16/20 notes use pressure redistribution surface in bed if additional risk factors are present. (over bony prominences). R2's care plan dated 3/18/20 notes R2 had a pressure sore to the right lateral (side of foot) with intervention listed to off load heels in bed. R3'S [DIAGNOSES REDACTED]. R3's care plan notes he had a deep tissue injury (pressure) on left heel that resolved on 7/6/20. Wound care interventions to assure proper protective devices are in place. R3's kardex notes to off load heels in bed.

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