STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATI COM	(X3) DATE SURVEY COMPLETED	
	IL6005508	B. WING	B. WING		C	
AME OF DEOLUBER OF CLUBBUR				1 07/	03/2014	
AME OF PROVIDER OR SUPPLIE			STATE, ZIP CODE			
PERION CARE DECATUR		R, IL 62526	DE STREET			
(X4) ID SUMMARY S	ATEMENT OF DEFICIENCIES	T	BROVIDERIS DI AN OF CO	DDECTION	1	
REFIX (EACH DEFICIENCE	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
S9999 Final Observation	3	S9999				
Statement of Licer 300.610a) 300.610a) 300.1010b) 300.1210d)5 300.3240a) Section 300.610 Ra) The facility shall procedures govern facility. The written be formulated by a Committee consist administrator, the amedical advisory of nursing and other policies shall compart the written policies the facility and shall by this committee, and dated minutes Section 300.1010 Rg) Each resident ac examination, within within 72 hours after report shall include following: 3) Documentation of incipient or manifest known as bed sore location specified, a present. h) The facility shall of any accident, injuresident's condition safety or welfare of limited to, the present decubitus ulcers or percent or more with some state of the state of the present of the pres	esident Care Policies have written policies and ing all services provided by the policies and procedures shall Resident Care Policy ing of at least the advisory physician or the committee, and representatives ar services in the facility. The ly with the Act and this Part. a shall be followed in operating I be reviewed at least annually documented by written, signed					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

į	OTATELIE	UT OF DEFINITIONS	I	T				
		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	TE SURVEY	
	ANDFLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G:		MPLETED	
				ŀ				
					ı	С		
IL6005508		B. WING		07	/03/2014			
I	NAME OF I	PROVIDER OR SUPPLIER	OTDEET AD					
1	TO THE CT	TO FIDER OR OOF FEEL			, STATE, ZIP CODE			
l	APERIO	N CARE DECATUR	2650 NOR	TH MONR	OE STREET			
L			DECATUR	R, IL 62526				
ſ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION		
	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	HUN	(X5) COMPLETE	
l	TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPL	ROPRIATE	DATE	
L					DEFICIENCY)			
Γ	S9999	Continued From no	4	~~~~				
l	33333	Continued From page	ge 1	S9999				
ı		of care for the care	or treatment of such accident.					
		injury or change in c	condition at the time of					
		notification.	oridition at the time of					
		Number and Dave a	eneral Requirements for				and the same	
		Nursing and Person					THE STATE OF THE S	1
		a) Pursuant to subse	ection (a), general nursing				A POST	-
		care shall include, a	t a minimum, the following					
		and shall be practice						- 1
		seven-day-a-week b						-
		5) A regular program	to prevent and treat					
	pressure sores, heat rashes or other skin							ı
	breakdown shall be practiced on a 24-hour,						ı	
	seven-day-a-week basis so that a resident who						-	
enters the facility without pressure sores does not								
	PRINCIPAL AND ADDRESS OF THE PRINCIPAL AND AD	develon pressure so	res unless the individual's					1
		clinical condition don	constrates that the arms					1
		corne were unevelor	nonstrates that the pressure					١
		soles were unavoida	ble. A resident having				12000	ı
		pressure sores snail	receive treatment and					ı
		services to promote I	healing, prevent infection,					1
		and prevent new pre	ssure sores from developing.					1
		Section 300.3240 Ab	use and Neglect				700	
		a) An owner, license	e, administrator, employee or					1
		agent of a facility sha	all not abuse or neglect a					١
		resident.						١
								1
	-	These Requirements	were not met as evidenced					
	1	ру:	The mot do or de loca					
			nd record review the facility					1
	f	ailed to provide comi	ices to treat and prevent					
		receire cores by fall	ling to monitor/to-				The state of the s	
		pressure sores by fall	ling to monitor/treat a heel					
	6	abi asion and falling to	ensure prompt Physician				***************************************	ı
	Įt	reatment for worseni	ng pressure sores. The					1
	f	acility also failed to d	evelop and implement					ı
	þ	policies regarding of p	physician visits, Physician				· ·	ı
	1	Notification of Change	e in Condition, and Attending					
	F	Physician Responsibi	lities for R2 who					1
	e	experienced worsening	ng pressure sores. This					
	я	iffects one of three re	esidents reviewed for					ı
	n	ressure some (DO) :	n the sample of eight.				-	
	P	hoso foilures results	dia Do hala a di ili					I
	These failures resulted in R2 being admitted to		1				1	

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DAT	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING	i:		COMPLETED	
						^	
		IL6005508	B. WING		i i	C	
NAME OF	DDOVIDED OD GUDDUED				1 077	03/2014	
NAIVIE OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
APERIO	N CARE DECATUR		RTH MONRO	DE STREET			
	OLD MARKET COME		R, IL 62526				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 2	S9999				
	the hospital with gar his foot.	ngrenous pressure sores on	no communicación por communica				
	Findings include:		ini di di delevazione delevazi				
	document that R2 w that date with instructhe nursing home. Report updated 6/20 admitted to the facili injury pressure ulcerheel, left alveolus ar Record documents in 4/29/2014 through 6/24/2014 at 4:30 confirmed that Z1 diresident at the nursing through 6/22/14. E2 covered for Z1 while	orders dated 4/29/14 vas admitted to the facility on ctions to see Z1 Physician at The Facility Pressure Ulcer 0/14 documents that R2 was ity with suspected deep tissuers on his left great toe, left and left knee. R2's Medical no physician visit notes from i/16/14. O PM E2 Director of Nurses d not see R2 while he was ang home from 4/29/14 explained that Z2 Physician while Z1 was out of the hat Z2 also did not see R2 at					
The second secon	E2 also stated on 6/know R2 was not see physician until 6/10/1 told her that Z1 did n on 5/23/14, 5/30/14 aworsening pressure 6/10/14 she sent a te	224/14 at 4:30pm she did not en at the facility by a 14 when E4 Wound Nurse ot respond to the faxes sent and 6/9/14 regarding R2's sores. E2 stated that on ext message to Z1 regarding the text that R2 was not his					
	great toe wound was increased in measure (cm) x 1.6 cm on 5/2/	otes document that R2's left 100% eschar and ement from 1.6 centimeters /14 to 5.0 cm x 2.8 cm on let dated 5/30/14 documents					

Illinois Department of Public Health

PRINTED: 08/21/2014 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		BENTH IOANON NOMBER.	A. BUILDIN	IG:	СОМ	COMPLETED	
		IL6005508	B. WING _	,	i	C 03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE			
APERIC	N CARE DECATUR	2650 NOF		OE STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE PROPERTY OF T	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From page	ge 3	S9999				
	a new black area ide measuring 2.8 cm x Notes dated 6/13/14	entified on R2's left heel c 2.8 cm. Wound Nurse document R2'a left heel 2 cm x 2.8 cm and remained					
	wounds were not even 6/17/14 when seen to Physician's Order Structure documents that Z4 of treatment to betading daily, and also started	6/17/14 document that R2's aluated by a physician until by Z4 Wound Doctor. The neet dated 6/16/14 hanged R2's left great toe paint and foam dressing d a treatment of betadine foam dressing daily for R2's					
	did not respond to the 5/30/14, E4 should h Director for orders. further stated that E4	PM E2 stated that when Z1 e faxes sent on 5/23/14 and ave called the Medical On 7/1/14 at 11:30 am E2 should have notified Z1 of sure areas by telephone and					
	Physician Notification "The nurse should no attending physician a which her judgement intervention. Should available the alternate contacted. If neither	or Change in Condition Overview Guidelines states of hesitate to contact the t any time for a problem in requires immediate medical the physician not be e physician should be of these physicians are Director should be notified."					
7/100	direct communication	tending Physician s that prompt notification by with the physician and not acute problems including					

Illinois Department of Public Health

PRINTED: 08/21/2014 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C IL6005508 B. WING 07/03/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2650 NORTH MONROE STREET APERION CARE DECATUR** DECATUR, IL 62526 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 The Emergency Room Documentation dated 6/22/14 documents that R2 was admitted to the hospital on that date with "multiple gangrenous ulcerations to the left foot, left great toe gangrenous and eroded....." On 6/30/14 at 8:45 am Z6 Hospital Physician confirmed that R2 was admitted to the hospital with multiple necrotic areas. Z6 stated that lack of physician care at the nursing home contributed to the worsening of R2's wounds. Z6 further stated that it appeared that the nursing home staff neglected R2's wound care. The Nurses Note date 4/29/14 documents that R2 was admitted to the facility from the hospital with an abraded area to his left heel and a bruise on his left great toe. Physician's Orders dated 5/6/14 document an order for skin prep to R2's left great toe three times daily and no orders for treatment of the left heel abrasion. The Wound Nurse Notes dated 5/2/14 documents that R2's left great toe wound measured 1.6 centimeters (cm) x 1.6 cm on that date and that the wound contained 100% necrotic hard eschar. The Wound Nurse Notes dated 5/23/14 document that the left great toe wound increased in size to 2.8 cm x 2.6 cm and remained 100%

Illinois Department of Public Health

eschar. The same Wound Nurse Notes

treatment was requested on that date.

The Wound Nurse Notes dated 5/30/14

document that Z1 physician was updated on the status of R2's left great toe wound, and a new

document that the left great toe wound increased in size to 3.0 cm x 3.0 cm and remained 100% eschar on that date. The same Wound Nurse

PRINTED: 08/21/2014 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
			A. BUILDING	3:	CON	MPLETED
		IL6005508	B. WING		07	C /03/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
APERIO	N CARE DECATUR	2650 NOF	RTH MONRO	DE STREET		
/			R, IL 62526			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
	Notes document "tr	eatment change to betadine edical doctor, nurse awaiting				
	5/16/14, and 5/23/14 information concern The Fax dated 5/30/ Wound Nurse faxed new black area are measured 2.8 cm x	s dated 5/2/14, 5/9/14, 4 contain no assessment ing R2's left heel abrasion. /14 documents that E4 I Z1 information regarding a a on R2's heel which 2.8 cm, and requested an treatment to the area.				
	the following "left gre	Notes dated 6/6/14 document eat toe measures 3.0 cm x rLeft heel measures 2.8 eschar."				
-	The Wound Nurse N documents the follow 2.8 cm 100% eschar 100% eschar."	lotes dated 6/13/14 ving "left great toe 5.0 cm x left heel 3.2 cm x 2.8 cm				
	that she was not awa area on his left heel facility. E4 further standing the area if stated that when R2's increased in size she by fax on 5/23/14 and to those faxes. E4 standing to her notificat that time to refax the fax from Z1 to the fadocuments that R2 "I continued that on 6/1 nurse and obtained a					

Illinois Department of Public Health

STATE FORM

6899

KGYV11

If continuation sheet 6 of 8

PRINTED: 08/21/2014 FORM APPROVED

APERION CARE DECATUR

2650 NORTH MONROE STREET

APERION CARE DECATUR 2650 NORTH MONROE STREET DECATUR, IL 62526							
(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			
THE PROPERTY SALES AND	Continued From page 6 6/16/14 documents that Z4 Wound Doctor saw R2 on that date and changed R2's left great toe treatment to betadine paint and foam dressing daily. Z4 also started a treatment of betadine paint and foam dressing daily for R2's left heel. On 6/24/14 at 4:30 PM E2 Director of Nurses could not provide documentation that R2's left heel wound was monitored from admittion on 4/29/14 until 5/30/14. At that time E2 stated that when Z1 did not respond to the faxes sent on 5/23/14 and 5/30/14, E4 should have called the Medical Director for orders. On 7/1/14 at 11:30 am E2 further stated that E4 should have notified Z1 of R2's worsening pressure areas by telephone and not by fax. On 6/30/14 at 10:25 AM E2 stated the facility does not have a policy regarding the frequency of physician visits. On 7/1/14 at 11:30 AM E2 stated she did not know that physician visits were required every 30 days for the first 90 days for newly admitted residents.	S9999					
; ; ; ;	The undated policy Change in Condition Physician Notification Overview Guidelines states "The nurse should not hesitate to contact the attending physician at any time for a problem in which her judgement requires immediate medical intervention. Should the physician not be available the alternate physician should be contacted. If neither of these physicians are available the Medical Director should be notified." The undated policy Attending Physician Responsibilities states that prompt notification by direct communication with the physician and not by fax is required for acute problems including pressure sores. The undated policy Attending Physician and not by fax is required for acute problems including pressure sores.						

Illinois Department of Public Health

STATE FORM

6899

KGYV11

and the control of th

If continuation sheet 7 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005508	B. WING			C 03/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		00/2014
APERIO	N CARE DECATUR	2650 NOF		OE STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	ge 7	S9999			
	6/22/14 documents hospital on that date ulcerations to the lef gangrenous and ero On 6/30/14 at 8:45 a confirmed that R2 w with multiple necrotic physician care at the the worsening of R2' that it appeared that	ded" Im Z6 Hospital Physician as admitted to the hospital c areas. Z6 stated that lack of nursing home contributed to s wounds. Z6 further stated the nursing home staff				
	neglected R2's wour	id care.				
	(B)					
The state of the s						
77-700-2-8						
V Sandan - Apply (Halles) and have a					***	The second secon
WOOV After TO SHEET HERE						
TOOLS IN THE PROPERTY OF THE P						
201- D					TOTOMORE MENTAL	

Ilinois Department of Public Health STATE FORM

6899

KGYV11