STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145523	A. BUILDING _____ B. WING _____	C 01/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE AMBOY	**15 WEST WASSON ROAD AMBOY, IL 61310**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation #1610211 / IL82695	F 000		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to complete and document daily skin assessments, identify new open areas, complete risk assessments, develop and implement specific pressure ulcer prevention interventions, and provide treatment as ordered. This applies to 1 of 3 residents reviewed for pressure ulcers in a sample of 3. (R3) The findings include: On 1/14/16 at 9:20 AM, R3 was seated in a chair with both legs elevated on a foot stool. R3's feet were externally rotated and her ankle was resting on the foot stool. On 1/15/16 at 9:50 AM, R3 was transferred to the toilet by E6 and E8. (Certified Nursing Assistants) E8 performed perineal cleansing after R3 had a bowel movement and R3 cried out in pain each time E8 wiped the area. E5 (Director of Nursing) replaced R3's dressing to her right buttock. An	F 314		2/2/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/02/2016

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 314	Continued From page 1 irregular shaped open area was observed just above R3's anus. E2 and E5 (Wound Nurse) stated this was a new area and it had not been reported. E5 (Wound Nurse) removed a gauze dressing from R3's buttocks and an adhesive dressing from R3's right outer ankle. E5 measured the area and it was 1.0 cm (centimeters) circular wound, with a dry yellow center. The wound started weeping when E5 touched it. E5 said that R3 was seen by the wound doctor on January 12, 2016 and the wound was healed. E5 said the adhesive dressing was being used to reduce pressure to R3's ankle, and they had some heel protectors available. On 1/14/16 at 12:00 PM E6 (CNA) stated they look over the residents skin whenever they provide care. They perform a complete skin check when they give the residents a shower. Any new skin breakdown is reported to the nurse. R3's Electronic Medical record for 11/26/15 documents and open area on the outer right ankle with measurements of 0.8 cm x 1.0 cm x < 0.1 cm depth with creamy, white drainage. (First wound assessment) The first documented treatment order was not until December 4, 2015. (8 days later) No documentation of a daily skin check was found in R3's medical record. R3's most current Braden risk assessment date was March 19, 2015 (10 months ago) R3's Minimum Data Set (MDS) Assessment of March 23, 2015 shows R3 is at risk for pressure ulcer and has no current pressure ulcer, or pressure ulcer history. R3's care plan for pressure area dated December 28, 2015 (1month after development) shows no specific prevention interventions for R3's pressure ulcer development. The facility Policy (undated) for skin care	F 314		

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F 314	Continued From page 2 documents to positon the body with pillows, foam wedges etc to prevent pressure on boney prominences. The same document shows to apply heal protector when up and keep heels elevated.	F 314		