STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145877	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to isolate, monitor, and test residents with COVID-19 symptoms per the facility's policy and the CDC guidelines for two (R2, R3) residents of four residents reviewed for infection control in a total sample of six residents. This failure resulted in R2 being admitted to the hospital with [REDACTED]. Findings include: 1. R2 is an [AGE] year old with the following Diagnoses: [REDACTED]. R2 was admitted to the facility on [DATE]. A Physician Note dated [DATE] documents R2 with a temperature of 102.9 degrees Fahrenheit and currently receiving an antibiotic for a urinary tract infection [MEDICAL CONDITION]. A nursing note dated [DATE] documents R2 has been febrile all afternoon into the evening with a fever. Tylenol given twice. The doctor ordered STAT labs and a chest x-ray. A nursing note dated [DATE] documents R2's temperature 100.0 degrees Fahrenheit and Tylenol given as ordered. A nursing note dated [DATE] documents R2 is lethargic, slow to respond, and skin is ashen. R2 had a large semi-loose stool. R2 now on oxygen 2 L and a 500 ml bolus of 0.9 normal saline given wide open for low blood pressure of ,[DATE]. Blood pressure ,[DATE] after the bolus. A nursing note dated [DATE] documents R2's blood pressure ,[DATE]. The nurse practitioner ordered continuous IV fluids to be administered at 30 ml/hour. Blood pressure returned to ,[DATE] after continuous IV hydration. A nursing note dated [DATE] documents R2's blood pressure ,[DATE], lethargic, and a change in mental status. R2 sent out to the hospital for evaluation. A Nursing note dated [DATE] documents R2 returned to the facility on hospice and is COVID positive. A nursing note dated [DATE] documents CNA noticed R2 stopped breathing. A nurse went to check R2 and R2 had expired. The Care Plan for R2 dated [DATE] documents interventions as: observe for signs and symptoms of COVID-19 - document and promptly report signs and symptoms of fever, coughing, sneezing, sore throat, and respiratory issues, and follow facility protocol for COVID-19 screening and precautions. The vital signs document R2's first fever was on [DATE]. R2 remained in the same room from [DATE] until R2 expired. Low blood pressures began on [DATE]. Vital signs documented once a shift or less. R2 never resided in the COVID unit. Hospital Records document R2's [DIAGNOSES REDACTED]. R2 arrived to the hospital febrile with low blood pressure. Chest x-ray shows left lower lobe atelectasis. R2 COVID positive. Death Certificate dated [DATE] documents cause of death as novel corona (COVID-19) virus infection. 2. R3 is a [AGE] year old with the following Diagnoses: [REDACTED]. R3 was admitted to the facility on [DATE]. Progress notes for [DATE]/2020 were reviewed. An Infection Charting note dated [DATE] documents R3 is receiving antibiotics as a [MEDICATION NAME] for having a fever. A nursing note dated [DATE] documents R3's oxygen level was 72% and R3 was placed on 2L of oxygen via nasal cannula. A nursing note dated [DATE] documents R3 noted with a change in condition. R3 appears very lethargic and is groaning/moaning while moving R3's body around in bed. R3's oxygen level on 6L of oxygen is 89%. R3 sent to the hospital via 911. A nursing note later on [DATE] documents R3 admitted to the hospital with [REDACTED]. A Nursing note dated [DATE] documents R3 expired on [DATE]. The Care Plan for R3 dated [DATE] documents interventions as: observe for signs and symptoms of COVID-19 - document and promptly report signs and symptoms of fever, coughing, sneezing, sore throat, and respiratory issues, and follow facility protocol for COVID-19 screening and precautions. R3's vital signs for ,[DATE] reviewed. Vital signs were documented once daily except for temperature. Temperature checked on R3 two or three times a day due to fevers. R3's first fever noted on [DATE] at 99.7 degrees Fahrenheit. Next fever documented on [DATE] at 99.3 degrees Fahrenheit. R3 febrile again on [DATE] at 100.4 degrees Fahrenheit. R3 with a high heart rate of 101, low blood pressure of ,[DATE], and low oxygen level of 89% when sent to the hospital. Hospital Records dated [DATE] documents R3 admitted to the hospital with [REDACTED]. R3's COVID swab is positive. R3 is in mild respiratory distress. Blood pressure is ,[DATE], respirations are 36, pulse is 103, and oxygen level is 95% via nasal cannula with an overlying non-rebreather mask. The Census dated [DATE] - [DATE] documents R3 never moved rooms and three beds were available in the COVID unit during these days. On [DATE] at 12:38PM, V4 (Nurse) stated, I don't remember taking care of R3 the days before but I was working overnight then. I remember R3 kept yelling out for help so I went down there and took R3's vitals and R3's oxygen was low in the 80s. I called the PPHP insurance to tell them what was going on and they said to increase R3's oxygen and give R3 pain medication. I did that then came back like 30 minutes later to see if R3 was better and R3 wasn't. R3's oxygen dropped even lower after I put it up to 3 or 4 liters. R3 was grabbing my hand weak so I called them back and they said if I don't feel comfortable, send R3 to the hospital. I called 911 and R3 left. This wing has always been the COVID unit since the beginning. No, I don't think we have ever been full that I know of. We monitor residents that aren't on this unit with vital signs once a day and if they have any symptoms. If anything is new or looks like it might be COVID I call the doctor and let them know. I also tell the DON and the administrator so they can move them away from the others. I don't know if R3 was having any signs of COVID. I did have to increase R3's oxygen. I don't know if R3 had a fever. On [DATE] at 1:10PM, V1 (Administrator) stated, We monitored the residents by doing their vital signs once every shift. If anyone started showing signs or symptoms, they were moved down to the COVID unit as soon as possible. Signs and symptoms would be a fever or cough or respiratory issues. We would expect that nurse to call the DON or me to let us know. We have never been to full capacity in the COVID unit. R2 was in a private room so R2 didn't have a roommate. She was sent to the hospital and came back the next day, I think. R2 didn't have any respiratory symptoms if I remember. I know we were trying to manage R2 at the facility and kept the doctor updated on R2's status. R3 did have a roommate. I was out so I can't say what was done for R3. Maybe the facility was full at that time and that is the reason R3 wasn't moved. We had the whole building on lockdown at that time so I'm not sure R3 would have needed to be transferred. On [DATE] at 10:36AM, V6 (former Director of Nursing/DON) stated, Yes, I was acting DON and in charge of COVID at that time. When a resident started showing signs of COVID they would be moved to the COVID unit. Fever, cough, respiratory distress were some of the signs that would cause us to think they had it. On that unit they have their vital signs done every 4 hours. We monitor them more often in case there is a significant change in condition we can catch it. Everyone was getting vitals done every 4 hours then. It should be documented in PCC every time. It was the nurses' responsibility to tell me if their resident was having any signs and symptoms or changes. I couldn't watch everyone. I did the best I could. We would test a resident if the doctor told us to. Not everything was COVID related so we did a mass testing sometime in March then they decided when to test after that. If we had to send them out they got tested at the hospital too. We did a line list for tracking residents. I don't remember a COVID screening form. The nurses would tell me if someone was having a problem and the doctors ordered the test if they wanted. We did go on lockdown in March. We didn't allow any visitors in and the residents had to stay in their rooms as much as possible. We only have fall risks out at the nurse's station to watch them. When we went on lockdown everyone went on isolation too. They were contact and droplet precautions. R2 was in a private room. I don't remember R2 having any signs or symptoms of COVID. I think R2 was on hospice, but I don't remember R2 being positive. R3 had a roommate. I remember R3 went out to the hospital, but I don't remember being told anything before about R3. I don't know if R3 had a fever or what was going on

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 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) with R3. I honestly don't remember why they weren't moved to the COVID unit. Like I said, I did the best I could but I don't remember being told anything about COVID for either of them. On [DATE] at 3:53PM, V5 (R3's Primary Physician) stated, I don't remember being called about any symptoms R3 was having or a chest x-ray. I could have been called; I just don't remember. Everything was changing so early in the beginning so I can't tell you about protocols or testing or anything because the standards now are so different. They would have to refer to what their management was telling them. If R3 were showing signs of COVID, R3 should have been monitored more frequently if that is what the guidelines reported. This way they could have monitored for a deterioration in condition. I can't say if a test should have been ordered for her or not because I can't remember the specific situation. Moving R3 to a private room immediately would have decreased her chances of spreading it to others. The policy titled, Infection Control - Interim Policy Addressing Healthcare Crisis related to Human [MEDICAL CONDITION], dated [DATE] documents Outcome Surveillance: Infection Preventionist will track all residents with fever and/or respiratory symptoms and utilize the laboratory testing algorithm to determine if these individuals should be considered a person under investigation. Any trends or patterns will be evaluated and addressed as deemed appropriate. Residents with known or suspected COVID-19 should be cared for in a single person room OR cohorted with another positive COVID-19 patient (this does not include PUI) with the door closed. The resident should have a dedicated (not shared) bathroom. The resident that is a PUI or confirmed positive will be assessed at least every 4 hours; This assessment should include but is not limited to: full set of V/S - B/P, pulse, temperature, respirations, and oxygen saturation %; respiratory assessment - lung sounds, presence or absence of cough, sputum production, shortness of breath; Physician or Nurse Practitioner should be notified immediately of any change in condition; dedicated or disposable noncritical resident-care equipment. The CDC guidelines advise Resident with new-onset suspected or confirmed COVID-19: Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing - Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission; If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to isolate and test residents with COVID-19 symptoms per the facility's policy and the CDC guidelines for two (R2, R3) of four residents reviewed for infection control in a total sample of six residents. Findings include: 1. R2 is an [AGE] year old with the following Diagnoses: [REDACTED]. R2 was admitted to the facility on [DATE]. A Physician Note dated [DATE] documents R2 with a temperature of 102.9 degrees Fahrenheit and currently receiving an antibiotic for a urinary tract infection [MEDICAL CONDITION]. A nursing note dated [DATE] documents R2 has been febrile all afternoon into the evening with a fever. Tylenol given twice. The doctor ordered STAT labs and a chest x-ray. 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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) much as possible. We only have fall risks out at the nurse's station to watch them. When we went on lockdown everyone went on isolation too. They were contact and droplet precautions. R2 was in a private room. I don't remember R2 having any signs or symptoms of COVID. I think R2 was on hospice, but I don't remember R2 being positive. R3 had a roommate. I remember R3 went out to the hospital, but I don't remember being told anything before about R3. I don't know if R3 had a fever or what was going on with R3. I honestly don't remember why they weren't moved to the COVID unit. Like I said, I did the best I could but I don't remember being told anything about COVID for either of them. On [DATE] at 3:53PM, V5 (R3's Primary Physician) stated, Moving R3 to a private room immediately would have decreased her chances of spreading it to others. The policy titled, Infection Control - Interim Policy Addressing Healthcare Crisis related to Human [MEDICAL CONDITION], dated [DATE] documents Outcome Surveillance: Infection Preventionist will track all residents with fever and/or respiratory symptoms and utilize the laboratory testing algorithm to determine if these individuals should be considered a person under investigation. Any trends or patterns will be evaluated and addressed as deemed appropriate. Residents with known or suspected COVID-19 should be cared for in a single person room OR cohorted with another positive COVID-19 patient (this does not include PUI) with the door closed. The resident should have a dedicated (not shared) bathroom. The CDC guidelines advise Resident with new-onset suspected or confirmed COVID-19: Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing - Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission; If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.