STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE OAK LAWN	9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a physician when a resident showed a significant decrease in oral intake for two days for one (R1) of three residents reviewed for change in condition in a total sample of seven residents. Findings Include: R1 is a [AGE] year old with the following Diagnosis: [REDACTED]. R1 admitted to the facility on [DATE]. The Dietary assessment dated [DATE] documents appetite and fluid intake as fair with supervision during meals. The Meal Consumption (POC documentation) reviewed for 2/24-3/10. R1's average meal consumption from 2/24-2/28 is a 3 (75% of meal consumed). No documentation on 2/29. R1's average meal consumption from 3/1-3/6 is a 2 (50% of meal consumed). No documentation on 3/7. R1's average meal consumption from 3/8 to 3/9 is a 1 (25% of meal consumed). No fluid intake documented on any date. A Nurse Note dated 3/10/20 documents R1 received in bed weak and drowsy. R1 did not eat dinner even with a family member trying to feed R1. The family requested to send R1 to the hospital at this time. The Ambulance Run Sheet dated 3/10/20 documents the ambulance was called due to R1 being lethargic. Per the nurse, R1 has not eaten in 3-5 days. The Hospital Report dated 3/10/20 documents R1 presented to the emergency department with increased confusion and decreased oral intake. The admitting [DIAGNOSES REDACTED]. Labs demonstrate hypovolemia (low fluid levels) likely due to R1's inability to tolerate oral intake. Aggressive intravenous hydration started. On 7/23/20 at 11:58AM, V3 (LPN) stated, R1 would eat 50% or more of R1's meals. R1 could eat herself when R1 first came in then a little after that we had to set up the tray and cut up R1's food. If a resident has a change from normal, I call the NP (nurse practitioner) and get a set of vitals. On 7/23/20 at 12:20PM, V4 (LPN) stated, R1 was lethargic and not eating. I don't remember exactly how much R1 would eat but I know R1 would eat like 50% or sometimes more normal days. I don't know if R1 just started not eating that day or if had been going on for a little bit of time. If a resident isn't eating you refer them to the doctor or NP after a couple days of them not eating their normal amount and you have tried everything else. On 7/23/20 at 1:10PM, V5 (CNA) stated, R1 couldn't eat by herself. A CNA would have to feed R1 meals. R1 would normally eat 50-75% of all meals that I know of. We document in POC how much each resident eats at each meal. If we notice a change in eating, I tell the nurse. On 7/23/20 at 1:20PM, V6 (Dietary Manager) stated, If there is a change with how much a resident is eating, nursing lets me know and calls the doctor. If a resident eats less than 50% for 2 consecutive meals then they doctor should be notified. On 7/24/20 at 2:50PM, V1 (Administrator) stated, In the POC documentation for resident intake, a 4 means they ate 100% of the meal. A 3 means 75%. A 2 means 50%, and a 1 means 25%. On 7/24/20 at 3:00PM, V9 (Primary Physician) stated, If R1 wasn't eating for a couple days then nursing should notify the nurse practitioner or me. They can also try interventions before we have to send out to the hospital. The policy titled, Physician-Family Notification- Change in Condition, dated 11/13/18 documents the facility will inform the resident; consult with the resident's physician or authorized designee (i.e. Nurse Practitioner); and if known, notify the resident's legal representative or interest family member when there is: .(C) A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); a need to alter treatment 'significantly' means a need to stop a form of treatment because of consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure or therapy that has not been used on that resident before).
F 0686 **Level of harm** - 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 treat an open lesion on a resident's sacral region for four days for one (R1) of three residents reviewed for wound care in a total sample of seven residents. This failure of resulted in the delay of treating for four days of an open lesion progressing to a stage III pressure ulcer Findings Include: R1 is a [AGE] year old with the following Diagnosis: [REDACTED]. R1 admitted to the facility on [DATE]. The Minimum Data Set ((MDS) dated [DATE] Section H documents R1 is frequently incontinent of urine and always incontinent of stool. Section M of the MDS dated [DATE] documents R1 is at risk for pressure ulcers with no interventions to prevent pressure ulcers in place. The Skilled Evaluation on 3/5/20 documents R1 has an open lesion to the sacral area. No documentation of any other staff notified about the new wound. The Skilled Evaluation on 3/6/20 documents R1 has a skin tear to the sacral area. No documentation of any other staff notified about the wound. The Skilled Evaluation on 3/9/20 documents no wounds noted on R1. The Wound Assessment Report dated 3/9/20 documents R1 has a sacral wound identified on 3/9/20 that is a stage 3 with measurements of 5 cm x 7.5 cm x 0.1 cm. A Nurse Note dated 3/10/20 documents R1 with an open area to the sacral region. The area was cleaned and dressed. On 7/23/20 at 11:58AM, V6 (LPN) stated, I don't remember R1 having any wounds. We do weekly skin assessments on the residents. I would let the DON and wound care know if I found one. On 7/23/20 at 1:35PM, V7 (Wound Care Coordinator) stated, R1 developed a pressure ulcer on the sacrum that was noted on the 9th. The wound was assessed to be a stage 3 pressure ulcer and the resident was placed on a low air loss mattress that same day. On 7/23/20 at 2:00PM, V7 stated, I saw her on 3/9. When I am notified about a wound, I normally see them that day unless they find it over the weekend then I see them first on Monday. I see a resident for just about every type of wound when I am notified. I know R1 had a skin tear or something on R1's thigh then they found that wound on R1's sacrum and I treated it the day I was told about it. Yes, R1 is high risk for pressure ulcers. We are notified through a risk management form the nurse fills out. I never had a notification any sooner than March 9th for R1's wound. If it was there sooner and they were documenting on it then I wasn't notified about it. The policy titled, Skin Condition Assessment & Monitoring- Pressure and Non-Pressure, dated 6/8/18 documents, Caregivers are responsible for promptly notifying the charge nurse of skin breakdown. At the earliest skin of a pressure injury or other skin problem, the resident, legal representative, and attending physician will the notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor a resident's oral intake for meals and hydration to maintain proper health for one (R1) resident of three resdients reviewed for nutrition and hydration in a total sample of seven residents. Findings Include: R1 is a [AGE] year old with the following Diagnosis: [REDACTED]. R1 admitted to the facility on [DATE]. A Nurse note dated 3/10/20 documents R1 in bed leaning to the left with tremor noted. Vital signs stable and the doctor ordered STAT labs. A Nurse Note dated 3/10/20 documents R1 received in bed weak and drowsy. R1 did not eat dinner even with a family member trying to feed R1. Labs drawn at 5PM. The nurse called the lab multiple times to check on the lab results but were not available until 8PM. The family requested to send R1 to the hospital at this time. On 7/23/20 at 11:58AM, V3 (LPN) stated, R1 would eat 50% or more of her meals. She could eat herself when she first came in then a little after that we had to set up the tray and cut up R1's food. I don't remember R1 having any weight loss. I fill

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) up water pitchers for all residents at the beginning of my shift and then in the afternoon an aide goes around to fill up again. I remind all residents to drink water when I am in their room. I never had R1 ask me for water that I remember. On 7/23/20 at 12:20PM, V4 (LPN) stated, I don't remember exactly how much R1 would eat but I know R1 would eat like 50% or sometimes more normal days. I don't know if R1 just started not eating that day or if had been going on for a little bit of time. When R1 would ask for water, R1 would sometimes drink it or sometimes just set it on the table. I never noticed any signs of dehydration with R1. We monitor dehydration through signs and symptoms like dry mucous membranes, skin turgor is slow, output, and vital signs. If a resident isn't eating you refer them to the doctor or NP after a couple days of them not eating their normal amount and you have tried everything else. On 7/23/20 at 1:10PM, V5 (CNA) stated, R1 couldn't eat by herself. A CNA would have to feed her meals. R1 would normally eat 50-75% of all R1's meals that I know of. We document in POC how much each resident eats at each meal and how much they drink. R1 would drink fine. R1 could tell you when R1 was thirsty and R1 would drink water when we brought it. I would prompt R1 to take sips with meals and in between the meals when I was in R1's room. If we notice a change in eating, I tell the nurse. On 7/24/20 at 3:00PM, V9 (primary Physician) stated, I know R1 would need to be cued to eat and drink per nursing. R1 needed to be cued due to R1's dementia. R1's BUN (blood urea nitrogen) did increase from 25 to 45 along with a sodium increase so that would lead me to think R1 was dehydrated because R1 wasn't able to keep up orally. I don't know if they let the nurse practitioner know R1 had been eating less. If R1 wasn't eating for a couple days then nursing should notify the nurse practitioner or me. They can also try interventions before we have to send out to the hospital. We would try supplement shakes, talking with a dietician, and more frequent checks on the resident. There isn't a set guideline or protocol of when to call me but I expect them to use their clinical judgment on when to notify me. When you have a wound like that you also lose a lot of fluid through it so R1 would not have been able to keep up orally with what R1 was losing. The Skilled Evaluation Progress notes from 3/1/20-3/9/20 document R1 taking food and hydration orally with no noted issues. The Meal Consumption reviewed for 2/24-3/10. R1's average meal consumption from 2/24-2/28 is a 3 (75% of meal consumed). No documentation on 2/29. R1's average meal consumption from 3/1-3/6 is a 2 (50% of meal consumed). No documentation on 3/7. R1's average meal consumption from 3/8 to 3/9 is a 1 (25% of meal consumed). No fluid intake documented on any date. The Laboratory Reports dated 2/25/20 documents R1's sodium level 139 mEq/L (normal range is 131-145mEq/L) and the blood urea nitrogen level 25 mg/dl (normal range is 5 to 28 mg/dl). The Laboratory Report dated 3/10/20 documents R1's sodium level of 154 mEq/L and the blood urea nitrogen level is 45 mg/dl. The Ambulance Run Sheet dated 3/10/20 documents the ambulance was called due to R1 being lethargic. Per the nurse, R1 has not eaten in 3-5 days. The Hospital Report dated 3/10/20 documents R1 presented to the emergency department with increased confusion and decreased oral intake. The admitting [DIAGNOSES REDACTED]. Labs demonstrate hypovolemia (low fluid levels) likely due to R1's inability to tolerate oral intake. Aggressive intravenous hydration started.