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 _____	03/05/2020

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of care by not obtaining a physician order [REDACTED]. Findings include: R3 is a [AGE] year old male who has resided in the facility since (NAME)of 2018, with medical [DIAGNOSES REDACTED]. [DATE] 11:52AM, Observed R3 in the dining room, alert and oriented x3 and ambulating independently. R3 was observed eating lunch and his meal ticket read general diet with double meat. R3 stated that lunch was good. [DATE], R3 stated that he gets double meat at lunch and dinner and that is by his request. He does not feel like his diet is inappropriate, but when asked if that was ordered by the doctor, he said, No but I hope they got the order for it. Weight on admission was recorded as 168.0, last six months recorded as follows: 10/2019 -205.1, 11/2019- 201.7, 12/2019-201.6, 1/2020-204.4, 2/2020-204.4. R3 is currently on a general diet with thin fluid consistency as documented in physician order [REDACTED]. 3/4/2020 at 1:10PM, V9 (Activities Director) said that R3 gets double meat with all meals. When asked how they determine if a resident can get a special meal, she stated that residents can request an extra on special occasion like meal of the month without a doctor's order, but for a resident who gets a special diet like double portion or double meat regularly, there has to be a doctor's order which should be documented in the physician order [REDACTED]. At 1:45pm V9 said that she could not find the order and that she guesses they forgot to add it but it will have to be added now. R2 is a [AGE] year old male originally admitted to the facility on [DATE], with medical [DIAGNOSES REDACTED]. R2 was observed for the entire period of the investigation and was not noted to be agitated, or verbally aggressive towards staff or other residents but was noted with long dirty fingernails with brownish substances underneath. When asked if he would like his nails trimmed, he responded, no one helps anybody around here and when you put on your call light no one comes and you cannot get your medication on time. 3/4/2020 at 1:07PM, V8, (RN) stated, R2 has not received his morning medication because I just have not gotten to him. When asked why, V8 said that she has a lot going on and just finished giving her last morning medication 10 minutes ago. 3/4/2020 at 1:53PM V2, (DON) said that medications are supposed to be given an hour before and an hour after, the nurse did not tell me that she was still passing medication I would have helped or found another nurse who was done passing medication to help. Review of facility assessment instrument for R2 coded him as 3/3 for personal hygiene, meaning extensive assistance with two persons. A document presented by V1 (Administrator) titled Medication Administration (undated) documents that medications must be administered in accordance with physician's orders [REDACTED]. Facility document presented by V1 (Administrator), titled Nail Care (dated 11/28/2012 with a revision date of 1/25/2018) states that staff should observe condition of resident nails during each time of bathing, note cleanliness, length and uneven edges.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to answer call lights in a timely manner, assist with activities of daily living, and honor residents choices for three residents (R1, R2, and R4) reviewed for activities of daily living. Findings include: On 03/02/20 at 12:08PM R1's call light was on the floor. R1 stated the staff positions her call light near the edge of her bed and it often falls on the floor. R1 stated that she usually has to call out for help and it sometimes takes hour to an hour for the staff to respond when the call light is pressed. R1 stated that earlier this week she hadn't been changed for 24 hours. R1 stated she hadn't been changed today that she recalls. R1 stated she needs assistance with activities of daily living and she likes to get out of her room but the staff don't get her cleaned and dressed so that she can leave her room. Observed R1 lying in bed in a hospital gown and having a strong body and bowel odor. R1 stated that her pain medications aren't given right away when she requests them. R1 stated that it sometimes takes 10 hours to receive her pain medications. R1 stated that she has a urinary tract infection and asked the nurses to have her urine checked. R1 stated that a sample of her urine was taken but it was lost and never tested . R1 stated she has had pain, severe burning, and itching off and on for 6 months to a year. R1 stated that she has requested antibiotics and antifungals for her symptoms but nothing has been done. Observed R1's pillow case was soiled and clean bed linens, towel, and gown were left stacked at the foot of her bed. R1 stated that staff leaves these items on her bed in the morning so that when they need to change her and her bed linens the items will already be there. 03/03/20 at 1:30PM V6 (Registered Nurse - RN) stated that if residents report pain in specific areas or burning or itching in areas that indicate they may have a urinary tract infection she would evaluate the residents vital signs and observe for physical indications of a urinary tract infection. V6 stated that if there are signs of a urinary tract infection she will notify the doctor who will order a urine culture if indicated to confirm a urinary tract infection. V6 stated that R1's last urine culture was in May 2019. V6 stated that R1 mentioned one to two months ago that she believed she had a urinary tract infection. V6 stated that R1 reported this during the end of her shift so she reported the information to the oncoming nurse and requested that the oncoming nurse follow up with R1 and evaluate R1 based on what she reported. 03/05/20 at 11:30AM V1 (Administrator) stated R1 does not have any urine culture labs for May 2019. 03/05/20 at 1:57PM V2 (Director of Nursing - DON) stated that if a resident reports they believe they are experiencing urinary tract infection symptoms to a nurse who is ending her shift who then reported it to the oncoming nurse requesting they follow up with and evaluate the resident, the nurse who received the original report should have documented her communication with the resident and the nurse beginning the next shift. V2 stated that if R1 was non-compliant with providing a urine culture the nurse should have documented this, notified the physician and followed the physician's instructions and orders. V2 stated that the nurse should attempt to find out from the doctor what steps can be taken to address R1's symptoms although she is non-compliant with providing a urine sample. 03/05/20 at 2:27PM V2 (Director of Nursing - DON) stated that if a resident reports they are experiencing symptoms of a urinary tract infection a nurse should evaluate the resident, notify their physician of what the resident has reported and any signs or symptoms observed and follow the doctor's orders of care for that resident. V2 stated that when R1 expressed concerns of having a urinary tract infection to V6 (Registered Nurse) when changing shifts, V6 should have documented this information. V2 stated that the nurse who V6 reported to about R1 expressing concerns of having a urinary tract infection should have evaluated the resident, notified the resident's physician and followed the doctor's orders. V2 stated that V6 and the nurse she reported R1's complaints of urinary tract infection symptoms to should have documented these events. V2 stated the physician order's effective May 07, 2019 to have R1's urine sampled and tested should have been followed and if R1 was non-compliant with providing a urine sample the nursing staff should have reported that to R1's physician and documented it. V2 confirmed there was no history of documentation in R1's progress notes of her being

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) non-compliant with providing a urine sample. V2 stated that the nurses should have documented any incidents of R1 being non-compliant with obtaining urine culture labs. Grievance form dated 1/12/20 documents a concern with a resident not being washed up and left wet for the 2nd Sunday in a row. Grievance form dated 1/14/20 documents a concern with a resident being left wet multiple times in the morning hours. Grievance form dated 1/30/20 documents a concern with a resident being denied emptying of his urinal by a nurse and certified nursing assistant. Grievance form dated 0[DATE] documents a concern with a resident being left soiled, not cleaned in a timely manner, and call light response time being too long. 03/04/20 at 2:35PM observed R4's call light wrapped around the bead rail on the floor and inaccessible to him. R4 stated that he has to wait 15-20 minutes for an answer to his call light if they answer at all. R4 stated that the staff get upset with him for using the call light because he soiled his diaper. R4 stated that the facility does not have enough staff. R4 stated that the staff won't usually allow him to stay in bed if he wishes and they make him get up. Observed R4 did not have a flat sheet covering his mattress. R4 stated the staff get him out of bed in the morning to put sheets on his bed but they often don't do it. R4 stated he was glad the surveyor noticed he didn't have a sheet on his mattress. R4's current care plan documents he has frequent incontinence of bowel/bladder, has activities of daily living self-care performance deficit, and has potential for complications related to incontinence of bowel/bladder. R2 is a [AGE] year old male originally admitted to the facility on [DATE], with medical [DIAGNOSES REDACTED]. R2 was observed multiple times throughout the course of this survey (3/2 - 3/5/2020) with long dirty fingernails with brownish substances underneath. When asked if he would like his nails trimmed, he responded that no one helps anybody around here and when you put on your call light no one comes and you cannot get your medication on time. Review of facility assessment instrument coded R2 as 2/2 for eating, meaning limited assistance with one person and coded him as 3/3 for personal hygiene, meaning extensive assistance with two persons. Facility document presented by V1 (Administrator), titled Nail Care (dated 11/28/2012 with a revision date of 1/25/2018) states that staff should observe condition of resident nails during each time of bathing, note cleanliness, length and uneven edges.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have adequate staffing to meet the daily care needs of residents observed throughout the course of this survey. This has the potential to affect all 117 residents currently in the facility. 03/02/20 3:15PM V13 (Certified Nursing Assistant - CNA) stated that today only five CNA's showed up to work so today was not a good day. V13 stated the CNA's will have 24 residents a piece. 03/03/20 at 10:36AM observed R4 sleeping during activities. R4 reported to the surveyor that he was sleepy because his roommate kept him up all night with noise. R4 stated he asked his nurse could he stay in bed but she denied it advising that he needed to be out of his room and in the dining room. R4 asked the surveyor if she could get someone to take him back to his bed so he can rest. 03/03/20 at 10:48AM V18 (Registered Nurse - RN) stated to the surveyor that she wanted R4 to stay in the dining room because she was concerned he may choke if he lies in his bed while having lunch. V18 stated that staff is short and there wasn't enough staff for R4 to be assisted with eating in his room. 03/04/20 at 2:35PM observed R4's call light wrapped around the bed rail on the floor and inaccessible to him. R4 stated that he has to wait 15-20 minutes for an answer to his call light if they answer at all. R4 stated that the staff get upset with him for using the call light because he soiled his diaper. R4 stated that the facility does not have enough staff. R4 stated that the staff won't usually allow him to stay in bed if he wishes and they make him get up. Observed R4 did not have a flat sheet covering his mattress. R4 stated the staff get him out of bed in the morning to put sheets on his bed but they often don't do it. R4 stated he was glad the surveyor noticed he didn't have a sheet on his mattress. R4's current care plan documents he has frequent incontinence of bowel/bladder, has activities of daily living self-care performance deficit, and has potential for complications related to incontinence of bowel/bladder. R2 is a [AGE] year old male originally admitted to the facility on [DATE], with medical [DIAGNOSES REDACTED]. R2 was observed multiple times throughout the course of this survey (3/2 - 3/5/2020) with long dirty fingernails with brownish substances underneath. 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