Illinois Department of Public Health

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
i			A. BUILDING:		COMPLETED	
IL6012173		B. WING		C 10/14/2021		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
APERION	N CARE WESTCHEST	ER .	ITH WOLF I ESTER, IL			
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S 000	Initial Comments		S 000			
	Complaint 2197164	/IL138658				
S9999	Final Observations		S9999			
	Statement of Licens	ure Violatioins:				
	300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1220b)3) 300.3240a)			e		
	Section 300.610 Res	sident Care Policies				
	procedures governin facility. The written p be formulated by a F Committee consistin administrator, the admedical advisory cor of nursing and other policies shall comply The written policies state facility and shall the state of the state	g of at least the visory physician or the nmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed	7 T	46°		
i ş		neral Requirements for		5		
1	with the participation resident's guardian o applicable, must deve	esident Care Plan. A facility, of the resident and the r representative, as elop and implement a plan for each resident that		Attachment A Statement of Licensure Violations		

DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING IL6012173 10/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2901 SOUTH WOLF ROAD **APERION CARE WESTCHESTER** WESTCHESTER, IL 60154 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 1 S9999 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders. and personal care and nursing needs. Personnel, representing other services such as nursing,

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activities, dietary, and such other modalities as

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: ____ IL6012173 B. WING 10/14/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2901 SOUTH WOLF ROAD APERION CARE WESTCHESTER WESTCHESTER, IL 60154 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced Based on interview and records review. the facility failed to follow care plan interventions to elevate head of the bed 30-45 degrees to prevent complications in one resident (R1) of 3 reviewed with a feeding tube. This failure resulted in R1 being transferred to the Emergency Room for treatment of acute respiratory failure with hypoxia and aspiration pneumonitis. Findings include: R1 is 91 years old with diagnoses including Cerebral Infarction, Dysphagia, Dementia. Osteoarthritis, Alzheimer's Disease, Right heel pressure ulcer stage 4, Contractures on multiple extremities, Adult Failure to Thrive, and Attention to Gastrostomy. According to the 9/1/20 Order Summary report R1 receives tube feeding formula for 22 hours.

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On 10/5/21 at 10:44AM V3, Certified Nursing Assistant (CNA), said R1 is on a feeding tube and must have the head of bed elevated to prevent

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S 9 999	Continued From page 3		S9999				
	she saw R1 around stated the feeding that and R1 was left in the said R1 was not contain time. V6 said "// into R1's room by wassigned to R1, but R1 needed help." noted R1 was laying stated when she encyellow/white, foamy R1's mouth. V6 state R1 to the hospital. Weeping R1's head	gistered Nurse (RN), stated 15:00PM on 9/28/2021. V6 ube was flushed with water, he upright position, in bed. V6 ughing or congested during At 6:00 or 6:30PM, was called 15, CNA. V15 was not she was walking by and saw V6 said V15 told V6, she gflat and was aspirating. V6 stered R1's room, she saw ifrothy secretions coming from ted the doctor told her to send V6 said the purpose of of bed elevated is to prevent she did not find out how or led.	73				
	CNA, said V16, CN 9/28/21. V8 stated a should be sitting up elevated because the On 10/5/21 at 1:15F stated V6 called an aspirating and V6 rehead of the bed up.	PM,via phone interview, V8, A, was assigned to R1 on any person on a feeding tube or have the head of bed ney can choke or aspirate. PM V2, Director of Nursing, d notified V2 that R1 was exported she had raised the V2 stated after a feeding has would be necessary to leave					
:	the head of bed ele	vated because the resident ual feeding and need time to					
:	said the care plan for should include: elev 60 minutes after a for for patients. V13 said	PM V13, Care Plan Nurse, or residents with feeding tubes rate the head of bed for 30 to eeding to prevent aspiration id anyone with a feeding tube on. V13 stated it should be a)20	

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something irritating the lungs and is not an

secretions to be produced.

infection. V18 said Pneumonitis causes increased

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pneumonitis.

receiving tube feeding. Noted tachypneic and coughing. Suctioned with thick liquid consistent with tube feed removed and her breathing became labored. Hospital Course: Aspiration

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