STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007413	A. BUILDING: _____ B. WING _____	C 09/30/2022

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APERION CARE DEKALB	1212 SOUTH SECOND STREET DEKALB, IL 60115

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S 000	Initial Comments Complaint Investigation # 2217712/IL151613	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure necessary care and services were given to a resident at risk for aspiration, failed to provide on-going assessments after a resident aspirated, and failed to notify the physician appropriately after an aspiration incident for 1 of 3 residents (R1) reviewed for care and services in the sample of 4. This failure	S9999		

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S9999	Continued From page 2 resulted in R1 being found with bacon in her mouth from the breakfast meal at 12:30 PM on 9/23/22, aspirating on that food, and not being sent to the hospital for treatment until approximately 7:30 PM. R1 remains hospitalized and receiving intravenous antibiotic treatment for aspiration pneumonia. The findings include: R1's face sheet showed he was admitted to the facility on 11/12/21 with diagnoses to include displaced intertrochanteric fracture of right femur, Type 2 Diabetes Mellitus, chronic obstructive pulmonary disease, hyperlipidemia, anxiety disorder, lack of coordination, dementia with behavioral disturbance, restless leg syndrome, gastro-esophageal reflux disease, and cognitive communication deficit. R1's facility assessment dated 7/18/22 showed she has severe cognitive deficits, requires extensive assistance with bed mobility, requires total assistance with transfers, and set up and supervision for eating. On 9/22/22 at 2:35 PM, V12 (R1's Power of Attorney) said R1 remains in the hospital on intravenous antibiotics for aspiration pneumonia. V12 said the V5 (Registered Nurse-RN) called her at 1:15 PM on 9/23/22 and told her R1 had aspirated on her lunch meal. V12 said she asked if R1 had been up in a chair for her lunch and they told "no, she was eating in bed." V12 said she had previously discussed with the facility to make sure R1 was not eating in bed because it was not safe. V12 said the problem is that R1 cannot tolerate being up in the chair for long periods of time and the staff do not want to transfer her back to bed right away so they just	S9999		

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S9999	Continued From page 3	S9999		

leave her in bed. V12 said when they called her at 1:15 PM they said R1 was stable and did not need to go to the hospital. V12 said she then spoke with V2 (Director of Nursing-DON) and told her she does not want R1 eating in her bed. V12 said it was discussed during that conversation with the DON that R1 was not to be offered her meal tray in bed. V12 said she called the facility at about 7:00 PM on 9/23/22 to check on R1 and asked the nurse if she was assisted up to the chair for supper. V12 said the nurse told her R1 was given her meal tray in bed again. V12 said she requested to talk with R1 on the phone and when R1 was given the phone she was crying and stating she did not feel well. V12 said it was then that she requested for R1 to be sent to the hospital for evaluation. V12 said R1 is not getting properly cared for and would have less of a chance of aspirating if she would have been assisted to her chair to eat. V12 said she is upset that this happened around lunch time and that it took her to call up to the facility at 7:00 PM to figure out something was wrong with her mother.

R1's nursing progress note entered by V5 (RN) on 9/23/22 at 12:30 PM showed, "At 12:30 resident was observed to be coughing by the CNA (Certified Nursing Assistant), CNA informed the writer, and immediately assessed the patient, resident aspirated with a portion of her food and coughing continuously. Patient was repositioned, and immediately given nebulization treatment, after the treatment, the coughing episode stops, and the patient's breathing improved with O2 (oxygen) saturation of 94-95% at 4LPM (liters per minute) of oxygen inhalation. DON informed. POA informed."

R1's nursing progress note entered by V5 on 9/23/22 at 1:03 PM showed, "[V12] notified in

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S9999	Continued From page 4 regards to the resident having an episode of choking, we also informed her about the management done and the current condition of the patient. We will update her if there would be any changes in the patient's condition, currently the coughing stops, difficulty breathing was lessen, oxygen saturation at 95% on 4 liter of oxygen..." R1's nursing progress note entered by V2 (DON) on 9/23/22 at 1:30 PM showed, "Call received from resident's POA in regard to resident aspirating on her lunch. POA does not want her mother sent out to ER (Emergency Room) at this time, however, she wants her mother up for all meals and no trays served in bed. POA agreeable to having a sign posted at bedside stating resident is to be out of bed for meals." R1's nursing progress note entered by V3 (RN) on 9/23/22 at 9:36 PM showed, "Received a phone call from resident's daughter and asked the writer if resident got up for her supper. Writer told the daughter that resident stayed in her bed during her meal. Daughter then asked to speak with the resident. Daughter also spoke with [Manager on Duty] and was requesting to send the resident to the hospital..." R1's nursing progress note entered by V13 (RN - Nurse Consultant) on 9/26/22 at 7:47 AM showed, "Investigated why resident was not up out of bed during meals. Staff explained that when attempted resident refused and started swearing at them and told them to get out of her room. Staff and resident have been educated recently on the importance for [R1] to be up in chair during meals. Upon return will continue to educate and reinforce compliance."	S9999		

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S9999	Continued From page 5 R1's acute care hospital documentation dated 9/23/22 showed, "... The patient was noted to have a coughing fit for 10 minutes while eating dinner. She was thought to have aspirated. The patient's family requested that she be sent to the emergency department for further evaluation... The patient was not answering questions well and just said that she did not feel well... CT found evidence of aspiration pneumonia and bronchiolitis. The patient appeared to have encephalopathy making administration of oral antibiotics difficult. The patient received (intravenous antibiotics) ..." On 9/29/22 at 12:49 PM, V5 RN said when asked about R1 on 9/23/22, "That day a CNA was in her room. As far as I know the CNA was feeding her. There were times she needed to be fed and times she fed herself. Most of the time she fed herself. The CNA approached me and said [R1] was continuously coughing. I immediately repositioned her and removed food from her mouth. There was bacon in her mouth. (This event occurred at approximately 12:30 PM, the menu for 9/23/22 showed bacon was served at breakfast.) When I went in, she was in bed at a 45 degree angle, I turned her on her side and patted her on the back to help her get it out. After that I gave her a nebulizer treatment and her oxygen level increased. I let the DON (V2) know and let the POA know what happened. The POA said during feeding time [R1] should be up to a chair. I talked about sending her to the hospital with the DON but then the DON and the POA discussed her going to the hospital. I did not send her to the hospital because she was stabilized at that time. My shift ended at 3:00 PM so I let the oncoming shift know [R1] was at risk for aspiration now. I did not call the physician, I updated him through fax."	S9999		

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S9999	Continued From page 6 On 9/29/22 at 11:28 AM, V3 RN said, "[R1] had an aspiration episode per the day shift nurse. I checked on her. She was the same as she had been before. The dinner time came and after dinner her daughter called the facility and requested to talk with her mom. [V12] said she heard something in her mom's voice and requested I send her to the hospital. She was not coughing then. I contacted the hospital for transport..." The facility's fax communication sheet initiated by V5 with R1's physician dated 9/23/22 and faxed at 2:35 PM showed, "Just to inform that the resident has episode of aspiration this afternoon while taking her lunch around 12:30 PM. Nebulization (breathing treatment) done, coughing with difficulty of breathing stabilized. Recent oxygen saturation at 95% on 3/lpm of oxygen..." The facility's fax communication sheet dated 9/23/22 and transmitted at 8:50 PM showed, "This is to inform you that the resident above (R1) has been sent to the hospital as per daughter's request. She has aspirated this day during lunch and family wants her to be sent to the hospital to make sure she is okay." On 9/30/22 at 12:29 PM, V11 CNA said, "I only served her breakfast because I had been assigned room trays that morning. She was really sleepy. She was right across the hall from the nurse's station so I could see her pretty well because the door was open. I had her up at a 90 degree angle. She did not want to wake up. I had to try and wake her up to get her to eat. She ate very little. She was in bed for breakfast..."	S9999		

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On 9/29/22 at 1:28 PM, V10 CNA said, "[R1] is not normally my resident and I don't normally go in her room. I went in her room (9/23/22) and she was coughing. It looked like something was wrong. I told [V5]. I had went in to pick up the room trays and it looked like she was sleeping. She had not even touched her lunch tray. When I woke her up, she started coughing but it was different than her cough before. I told the nurse right away because I knew her, and she looked terrible. She had her eyes shut and was not "coughing" but was doing like a short, half cough like you are trying to get something up. There was a CNA that said she had taken bacon out of her mouth at breakfast. She said she picked up her breakfast tray and she pulled bacon out of her mouth... I stopped in before I left at 7:00 PM and asked how she was doing, and she said the right side of her head hurt. She said, 'I don't know what happened but my head hurts.'"

On 9/29/22 at 1:50 PM, V7 CNA said, "[R1] usually does not eat everything. She does sometimes choke. She eats by herself. We keep an eye on her while she eats... We watch her the entire time if we are on room trays. She will start coughing while she is eating, and it sounds like mucus in her system. She wants to get up so we get her up and before she can even get her meal, she wants to lay back down, so we have to lay her back in bed because that is what she wants. We thought it would be okay for her to be in the bed while she eats. Before she never choked so bad that we had to intervene. We could go in if she calls or chokes. We would go in there."

On 9/29/22 at 2:05 PM, V6 CNA said, "I only assist her if she is very sleepy and looks like she needs help. I usually do keep an eye on her when she is in the bed because I'm scared something

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is going to happen. She feeds herself most days... We would sometimes try and get her up but very rare, always see her in the bed. I feel like the only time she wakes up is to eat. It started a few months ago where she just became a lot sleepier. She will wake up if you tell her that her breakfast is here. If I walk by and she hasn't eaten I'll help her, for instance, if we are 30 minutes into the mealtime and she is not waking up to eat, I'll help her. She is pretty good at chewing and swallowing as long as you go at a good pace and give her drinks as well..."

On 9/29/22 at 3:22 PM, V14 (Nurse Practitioner) said, "We would expect the staff to call us and alert us of something like an aspiration incident. I was not notified of this incident at all. I would be concerned for aspiration pneumonia. It would be to the emergency room she would go because the nursing home is not able to make things happen quick enough like a hospital can. Timeliness of notification is important. She is able bodied to feed herself. They put the tray in front of her, but she might not be sitting up properly, and she is unable to reposition herself. She is often times lying in bed and she isn't adjusted in a proper way. I've seen it before when I'm there."

On 9/29/22 at 11:15 AM, V2 (DON) said, "I'm sure you are here about [R1]. She had a coughing episode at lunch. The daughter was informed and didn't want to send her out to the hospital. Then she stayed in bed for supper. There was no incident that occurred during supper, but the daughter called and found out she had stayed in bed again to eat and requested her to be sent to the hospital." At 3:06 PM, V2 said, "I think [V5] said he called the physician to let him know right after the incident. I would expect them to contact the physician for any new orders... I would say

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S9999	Continued From page 9 they would need to call and get the information to the physician; faxes should be used for something more of an FYI (for your information), not something you need immediate attention to. I did do in servicing on contacting the physician via phone for something like this after this happened." The facility's policy and procedure with revision date of 11/13/18 title Physician-Family Notification of Change in Condition showed, "Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner... The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner... (A) An accident involving the resident which results in injury and has the potential for requiring physical intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) ..." (A)	S9999		