Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005177	A. BUILDING: ______ B. WING ______	C 05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE LAKESHORE	7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation 2383667/IL159413	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)2) 300.1210 d)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 accident, injury or change in condition at the time	S9999	Attachment A Statement of Licensure Violations	

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

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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:
2) All treatments and procedures shall be administered as ordered by the physician.
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 re-assess the hydration needs of a resident in a timely manner after hospitalization for Hypernatremia; failed to follow up on the abnormally high blood levels of sodium; and failed to follow the Dietician's recommendation to increase gastrostomy tube feeding water flush for a resident with hypernatremia and dehydration. These failures affected one resident (R1) who was recently hospitalized for

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Hypernatremia/Dehydration. As a result, R1 was re-hospitalized within a month of the previous hospitalization and diagnosed with Hypernatremia again and Fecal Impaction.

Findings include:

R1's face sheet and progress notes show R1 was originally admitted to the facility on 12/6/1998, and re-admitted on 9/5/22, with diagnoses which include but are not limited to: Cerebral Palsy, Gastrostomy, and Dysphagia. R1 is on NPO (Nothing by mouth) status and receives all nutrition and hydration by G-Tube. These records also show R1 was hospitalized for Hypernatremia/Dehydration due to water deficit on 3/26/23 through 3/29/23, and again on 4/29/23 through 5/7/23. R1 was re-admitted with Hypernatremia and Fecal Impaction.

R1's MDS (Minimum Data Set), dated 2/9/23 and 4/29/23, both show R1 is severely cognitively impaired, without any BIMS (Basic Interview for Mental Status) score listed.

After R1 was hospitalized for high blood levels of sodium from 3/26/23 through 3/29/23, R1's blood levels of sodium in mEq/L (milliequivalents per liter) as shown in the laboratory results reviewed were as follows:

4/6/23 -151mEq/L (Normal Range is 131-145); No record that a physician or Nurse Practitioner was notified.
4/20/23 - 150 mEq/L; No record that a physician or Nurse Practitioner was notified.
4/25/23 - 153 mEq/L; No record that a physician or Nurse Practitioner was notified.
4/28/23 - 158 mEq/L - V6(LPN) notified Nurse Practitioner (NP) the next day(4/29/23). NP

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ordered to send R1 to the hospital for Hypernatremia.

R1's Care plan, dated 5/11/22, states R1 is at risk for dehydration related to G-Tube feeding. Intervention states to evaluate the diet and refer to the Dietician. Intervention, dated 9/7/21, states R1 is dependent on Tube Feeding and water flushes and to provide Tube Feeding as ordered. Another intervention states in part to monitor for constipation or fecal impaction, diarrhea, nausea/vomiting, and dehydration.

R1's hospital records, dated 03/26/2023, written by V14 (Emergency Room - ED Physician) states in part:
Reason For Consultation: Hypernatremia
66-year-old Nursing home (NH) resident admitted for evaluation of dyspnea. Per ED notes, sent from NH due to desaturations.
Labs on admission were significant for: Na (Sodium)-162 mEq/L...

Under Assessment/Plan, V14 (Hospital ER Physician) wrote in part:
Hypernatremia-Dehydration due to water deficit ~ 5-5.7L.

R1's Hospital Records, dated 4/29/23, documents R1's admitting diagnoses includes Hypernatremia and Fecal Impaction.

On 5/7/23, V15(Hospital Physician) wrote, under "Detailed Hospitalization Summary", R1 has recurrent episodes of Hypernatremia. V15 documented there should be a bowel regimen to prevent constipation.

Page 18 of the Hospital Records: On 4/29/23, V17(Hospital Physician), under Assessment

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/Plan, documented in part: "Hypernatremia ... Free water deficit of around 4 liters, likely caused by inadequate water with tube feedings". This note also states R1's vomiting was resolved, and R1 was severely dehydrated with fecal impaction on admission. X-Ray of the abdomen, dated 5/2/23, also shows fecal impaction.

Page 58 states in part: Problem List - Emesis (Vomiting), Dark Stool, Fecal Impaction (now resolved). On admission, patient was found to have a physical impaction, (now disimpacted) and severe hypernatremia.

Page 65 states in part: Diagnosis (Nutrition): New Nutrition Diagnosis: Inadequate enteral nutrition infusion related to infusion volume not reached or schedule for infusion interrupted. Inadequate enteral nutrition volume compared to estimated requirements and evidence of dehydration.

Page 53 states in part: Under Initial Nutrition Assessment written by V27(Hospital Dietitian) on 5/1/23 at 10:03am, states in part: SNF (Skilled Nursing Facility) scans with Cyclic feeds of Glucerna 1.5 at 65 ml/hour with no referenced volume target, stop or start time.

Page 37 states in part: Under Assessment and Plan, states that R1 "was severely dehydrated with fecal impaction on admission".

For the first hospitalization, R1's progress notes, dated 3/26/23 at 11:25 AM, written by V5(LPN/Licensed Practical Nurse) states: Called hospital; The resident was admitted for hypernatremia.

For the second hospitalization, R1's progress notes, dated 4/29/23 at 3:18 PM, written by V6

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(LPN) states R1 was sent to the hospital for Hypernatremia. On 4/29/23 at 7:34 PM, V21(LPN) documented in part: Ambulance notified facility that resident was diverted to (another) hospital due to tachycardia. Resident will be admitted with diagnosis of hypernatremia.

On 5/9/23 at 2:50 PM, V13 (Dietician) was interviewed regarding R1's hospitalization on 3/26/23 through 3/29/23, and the diagnoses of Hypernatremia, and what the facility did to increase R1's hydration status to prevent another hospitalization. V13 stated R1 has orders for 250 ml(milliliters) of water flush every 6 hours. V13 added, "But I'm not there and I don't know how much the nurses give." V13's attention was drawn to R1's order, dated 4/27/23 and 4/29/23,(about a month after the hospitalization of 3/26/23 and diagnosis of Hypernatremia); this order is the same feeding rate and 250 ml water flush, with no schedule and no total volume (Glucerna 1.5 65ml/hr(hour) x 15 hours). V13 responded she(V13) was not aware of the first hospitalization (3/26/23 through 3/29/23) until around April 26, (a month after). V13 added, "When I saw the hypernatremia around April 26th, I increased the water flush from 250ml QID (4 times a day) to 300ml QID (not reflected on the current POS dated 5/7/23)." Inquired from V13 why the POS (Physician Order Sheets) and Medication Administration Record (MAR) for March, April, and May 2023 do not state the total volume of formula R1 was supposed to receive, and there is no scheduled time for the G-Tube feeding for R1. V13 responded R1 should get a total volume of 900 ml for 15 hours. V13 was asked for the schedule for the 15 hours, and V13 stated the nurses will determine the schedule.

Dietician Recommendation, dated 4/26/23, under

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S9999	Continued From page 6 Progress Notes/Plan, states in part: Increase water flush to 300ml QID 2/2 hypernatremia. However, this recommendation was not followed and R1's POS dated 4/27/23 and 5/7/23 for water flush still reads "Flush Tubing with 250 ml water every 6 hours". Dietician Recommendation dated 2/18/23, 2/27/23, and 3/17/23, under Nutrition Progress Notes/Plan, states in part: Tube Feeding Glucerna 1.5 65ml/hr x 15hrs with 300ml water flush QID (4 times a day). However, R1's POS did not reflect this change. R1's Physician Order Listing Report shows R1 was getting only 250 ml water flush instead of 300 ml water flush recommended by the Dietician on the above listed dates. Current POS, dated 5/7/23, states "Flush Tubing with 250 ml water every 6 hours." On 5/10/23 at 2:32 PM, V24 (Facility's Medical Director/R1's Physician) was interviewed regarding R1's hospitalizations in March and April 2023, and the hospital diagnoses of Hypernatremia, Dehydration, and Fecal Impaction, since R1 depends on staff to get hydrated through the G-Tube. V24 stated some patients can have insensible water loss, and it could also be due to not getting enough fluids, but the tests done in the hospital will determine the cause of the dehydration/hypernatremia for the patient. V24 was also asked about how physician orders are written for G-Tube feeding for residents. V24 responded when the Dietician writes the G-Tube feeding recommendations, the physician order will be entered in the system. On 5/15/23 at 9:12 AM, V2(Director of Nursing) was asked about how the Dietician gets notified about the need for nutrition/hydration	S9999		

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S9999	Continued From page 7 re-assessment of a resident who was hospitalized for dehydration and returns to the facility, to prevent another hospitalization from the same hydration issues. V2 stated, "Usually, the Dietician will get a phone call". Inquired from V2 about who was responsible for making the phone call to notify the Dietician. V2 responded, "I will get back to you on that." V2 was also asked about why some residents on G-Tube feeding have the total volume and scheduled time of feeding specified in the physician orders, and other residents don't. V2 responded, "It depends on which nurse puts in the order." Facility's policy on "Assessment of Residents", dated 11/28/12 with latest revision date 4/18/22, states, under purpose "To gather comprehensive information as a basis for identifying president problems and needs and developing or revising an individual plan of care". Other assessment monitoring shall be initiated and recorded on facility approved forms or in conjunction with the resident's clinical condition, assessed needs, and planned interventions. These assessments are to be performed at the time of admission when the resident's past or current history indicates the need/problem is present and/or as observed or deemed necessary. Examples include but are not limited to: Upon Admission, As indicated. #b states: Dehydration Risk Assessment: To determine risk for dehydration based on clinical diagnosis, oral intake, medications and cognition. Assessment to be completed within the first 14 days in conjunction with the MDS (Minimum Data Set) process." Facility's policy on gastrostomy tube feeding and care, dated 11/28/2012 with latest revision on 8/3/20, states: To provide nutrients, fluids, and medications as per physician orders to residents	S9999		

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requiring feeding through an artificial opening into the stomach. Cyclic - prescribed amount of formula volume is given over a specific period of time that is usually less than 24 hours (8-20 hours). Continuous - prescribed formula volume is given continuously over 16 to 24 hours.

Facility's policy on Hydration Monitoring Protocol, dated 2020, states, under Guidelines, "Residents at risk for dehydration will be identified using the care assessment areas for dehydration, and fluid maintenance or other appropriate quality indicators. Determining residents at risk for dehydration is completed with collaboration between the dining services manager, registered dietitian, and nursing staff". Under Procedure, this policy states: Resident's fluid needs shall be determined according to Registered Dietitian Recommendation. #3 states: The Nutrition Assessment and all progress notes shall reflect factors that put the resident at risk for dehydration as well as interventions to reduce risk factors and ensure adequate fluid intake.

(B)