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
	IL6002547	A. BUILDING: ______ B. WING ______	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DOLTON	14325 SOUTH BLACKSTONE DOLTON, IL 60419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2294843/IL148204	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3 300.1010h) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

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 of notification.

These Requirements were NOT MET as evidenced by:

Based on interview and record review the facility failed to notify the physician for five hours after a resident (R1) had an episode of vomiting which caused a decline in respiratory status, failed to appropriately assess a resident's (R1) respiratory status after an episode of vomiting, for one of three residents reviewed for improper nursing care in a total sample of three. This failure

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S9999	Continued From page 2 resulted in R1 aspirating the vomit; R1 experiencing increased secretions, increased respiratory rate, decreased oxygen levels; and R1 needing to be admitted to the intensive care unit and placed on a ventilator. Findings Include: R1 is an 81 year old with the following diagnosis: respiratory failure, tracheostomy status, and gastrostomy status. R1 admitted to the facility on 06/06/22 and discharged on 06/18/22. A Nursing note dated 6/18/22 at 6:41 AM documents R1 had a large amount of emesis and the feeding was put on hold. Trach care was provided and R1 was suctioned. Thick white secretions were suctioned. Vital signs are documented as stable but no values are noted. A Nursing note dated 6/18/22 at 3:05 PM documents trach care was provided to R1 at around 10:30 AM. Vital signs are stable but no values are documented. R1's family requested R1 be sent to the hospital due to the amount of mucus. 911 was called. The doctor and the DON when were made aware. The SBAR Communication Form dated 6/18/22 documents R1 has no changes in respiratory status observed and vital signs are within normal limits. The Ambulance Run Sheet dated 6/18/22 documents the paramedics were dispatched for low oxygen saturation. Upon arrival, R1 was showing shallow breathing at 50 to 60 times for a minute with no muscle tone. Oxygen saturation was 83% on 5 L via trach mask and there was audible gurgling from the trach with a stick/yellow	S9999		

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S9999	Continued From page 3 mucus in the oxygen supply tubing. R1 was suctioned immediately with approximately 50 through 75 mL of mucus removed. The oxygen was increased to 15 L per minute and the oxygen saturation increase to 98%. Additional suctioning continues to show improvement in mucus change from yellow to clear. Reassessment shows R1 to still be tachypneic with an additional drop in oxygen saturation to 88% The decision to divert to the closest facility was made at that time and respirations were given via bag valve mask to trach. On scene, the nurse never came to the room and when asked when the last time R1 was checked on, the nurse reported R1 was "fine." The Hospital Records dated 6/18/22 document R1 presented from the nursing home by ambulance for evaluation of respiratory distress. R1 is trach dependent and the paramedics reported being called due to difficulty breathing. The paramedics did suction R1 and had a large return of yellow sputum. Oxygen saturation did improve but R1 needed to be bagged through trach upon arrival. R1 was placed on mechanical ventilation. R1 is with decreased air movement in the lungs. R1 has bilateral infiltrates in the lungs on the chest x-ray. R1 did have a hemorrhagic stroke in 04/2022 where a tracheostomy and gastrostomy tube were placed. R1 was able to be weaned off the ventilator prior to coming in today. R1 was brought in for respiratory failure in significant mucus production. Given the respiratory distress and despite significant suctioning, R1 had to be placed back on the ventilator. R1 had a normal white blood cell count but it was significant for bandemia (too many white blood cells being released into the blood stream indicating an infection or inflammatory process) with elevated lactic acid and procalcitonin indicating an infectious process. R1	S9999		

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was transferred to the intensive care unit. R1's admitting diagnosis is documented as acute hypoxic respiratory failure secondary to pneumonia.

On 07/09/22 at 1:25PM, V2 (Nurse) stated, "V4 (Nurse) said the family was concerned that R1 was having trouble breathing. They said they wanted R1 to be sent to the hospital. It didn't look to me like she was struggling to breathe. Signs of that would be increased respiratory rate, shallow breathing, or lower oxygen level. I believe when we checked her level (oxygen saturation) it was in the 90s. I can't remember exactly what it was but I don't think it was low. I know R1 was suctioned once that I know of. The family refuse for R1 to be suctioned anymore. R1 was on a concentrator. I don't remember how much oxygen R1 was getting but we did not turn it up. R1 was not on a ventilator. The family was concerned that R1 had aspirated on R1's vomit and wanted R1 to be evaluated. We called the doctor and he told us to send R1 out. We called 911 then. I know the nurse (V4) told me V4 got a phone call after that from EMS saying that the oxygen level dropped so they had to reroute R1 to a closer hospital. No, they did not say why it dropped to. If you think someone aspirated then you should stop the feeding, suction them as much as you can, and just keep an eye on them to make sure they are still breathing OK."

On 07/09/22 at 1:37PM, V3 (DON) stated, "I was told that the family requested to transfer R1 because they thought R1 was in distress. The nurse (V4) told me that V4 suctioned R1 but R1's family still wanted R1 to be sent out for an evaluation. I was not made aware that R1 was in any distress while R1 was here. I know that R1 ended up having to be put back on a ventilator in

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the ICU when R1 went to the hospital. They did not say why. That's the only update we received. I was not told that R1 had any vomiting. A resident with a trach that vomits you need to suction what you can, keep the head of the bed elevated, and monitor them for any changes from their baseline with the respiratory status. I was only told that the family wanted R1 to leave. I was never told R1 was in distress or that R1 vomited. Staff should notify me and the doctor if there are any changes."

On 07/09/22 at 4:18PM, V4 stated, "I just came on that morning and the other nurse (V5) told me that R1 had just vomited. R1 never vomited for me so I didn't actually clean R1 up or suction R1 then. R1 was doing fine for me but there was a little bit of mucus on R1's chest when R1's family came to visit and they called in more family and after that they just started demanding R1 be sent out. I did suction R1 one time and it was thick and white. It wasn't a lot. I can't say how much but I only need to suction R1 one time and it was clear. This was only my second time taking care of R1 so I wasn't really familiar with R1 but from what the family was saying it wasn't like R1 to have that much mucus. R1 did not seem to be in any respiratory distress. R1 did have a little bit of gurgling right before I suctioned R1 but after that it was fine. I didn't listen to her with a stethoscope. I just was listening to see if R1 needed to be suctioned more. I called the doctor when the family kept requesting that R1 go out and V6 (Primary Physician) told me just send R1 out. No I did not call V6 before. I didn't think I needed to because R1 was fine. I don't know if the nurse before me called the doctor to tell him that R1 vomited. I know we called 911 because the family wanted R1 out of there as fast as possible. They came and picked R1 up and they

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S9999	Continued From page 6 did call me to tell me that they had to take R1 to the closest hospital because R1 had desatted when R1 was in route to the hospital the family wanted R1 to go to." On 07/11/22 at 3:256PM, V6 (Primary Physician), stated, "It is difficult for trach patients to aspirate because that is what the trach is there for but it's not 100% guarantee. Residents with a G-tube feeding and a trach still can aspirate. If a resident like that does vomit, they should check the respiratory status to make sure they are breathing on and monitor the pulse ox. Just look out for any changes. If there does seem to be a change or they aren't doing well then 911 should be called. They may need further intervention at the hospital that we cannot provide here. They should also be suctioned. You want to try to get out as much as you can before it does go down into their lungs. If the family ever complains that something is not right with the resident then I send them out immediately if I am not there. I listen to what the families telling me because they usually can tell me more about what is going on. If the aspiration is massive you will be able to see that on a chest x-ray immediately. For a smaller aspiration it could take days to develop infiltrates in the lungs. The most important thing to monitor is the resident's clinical status. I want to be notified when a resident does aspirate. They call me at 2 AM for a skin tear so something like this I would want to be notified about that could change the resident's condition. If they don't notify me about the vomit, then they should immediately notify me once they see any changes in condition. You would watch for increase respirations, a decrease in oxygen saturations or a need for more oxygen than they are normally getting, increased secretions that need to be suction more frequently, if it appears they are struggling to	S9999		

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breathe, and a fever."

On 07/11/22 at 9:46PM, V5 (Nurse) stated, "I was giving R1 morning medications right around shift change. The next nurse (V4) walked into the room and saw that I was cleaning up R1's vomit. R1 vomited just as I was giving R1 medication through her G-tube. I held the feeding and sat R1 up more. I suctioned everything out that I could and both me and the nurse coming on did the trach care. That is supposed to be done once a shift. I can't say how much the vomit was but I would say it's a decent amount. R1 did not seem to be struggling to breathe at all after we suctioned R1. I wasn't there that long so I can't tell you what happened after that but for the couple minutes I was in the room and we cleaned R1 up she did not seem like she was in any respiratory distress then. No I did not call the doctor. I was working with the morning nurse to clean R1 up so I assumed the morning nurse would have called him. If a resident starts showing signs of a change of condition then you call the doctor right away. If the vital signs are off or if there's something new that wasn't happening before then you call them to notify them to get orders and see what you need to do."

The vital signs for 06/2022 were reviewed. There is only a temperature documented on 6/18/22 which was normal at 97.1°F. No other vital signs are documented on 6/18/22. The average documented respiratory rate for R1 is 18 through 20 breaths per minute. All other vital signs are documented within normal range.

The Admission Respiratory Therapy note dated 6/6/22 documents R1 was admitted from the hospital. R1 has vital signs and oxygen saturation within normal limits. R1 suctioned once within

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S9999	Continued From page 8 yellow secretions. Respiratory therapy will work with patient to begin decannulation process in the future. The Care Plan dated 6/6/22 documents R1 requires tube feedings related to dysphasia. The following are documented interventions: listen to lung sounds each shift and document/monitor/report any signs or symptoms of aspiration, shortness of breath, and abnormal breath/lungs sounds. The Care Plan dated 6/14/22 documents R1 has a tracheostomy related to impaired breathing mechanics. The following are documented interventions. Monitor/document respiratory rate, depth and quality and suction as necessary. The Minimum Data Set dated 6/13/22 documents R1 does not display any shortness of breath or difficulty breathing during this assessment. The Respiratory Infection Screener dated 6/17/22 at 10:42 PM documents the oxygen saturation is 98%. R1 does not display any difficulty breathing and breath sounds are clear. R1 does not have a cough and mucus production has not been increased. The Physician Order Sheet dated 7/9/22 documents trach to be suctioned as needed for retained secretions. The policy titled, "Physician - Family Notification - Change in Condition," dated 11/13/18 documents, "Purpose: To ensure that medical care problems are communicated to be attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner. Guidelines: The facility will inform the resident; consult with the residence physician or authorized	S9999		

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S9999	Continued From page 9 designee such as nurse practitioner; and if known, notify the residence legal representative or an interested family member when there is: (A) An accident involving the resident which results in injury and has a potential for requiring physician intervention; (B) A significant change in the residents 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		