STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146001	A. BUILDING _____ B. WING _____	08/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE INTERNATIONAL	4815 SOUTH WESTERN AVE CHICAGO, IL 60609

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Complaint Survey: 1482814 / IL# 70589 No Deficiencies 1483269 / IL 71085 F314 1483339 / IL 71157 F364, F312	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to follow their Customer Service/Sensitivity Training and provide clothing protectors during meal service for 1 of 21 residents (R11) reviewed for clothing protectors during meal service in the sample of 24 residents and two resident (R25,R26) in the supplemental sample. Findings includes: R11 was admitted to the facility 4/5/12 with diagnoses that include Dementia, Depressive Disorder and anxiety. On 08/06/2014 at 1:00pm observed R11, R25, and R26 in the third floor dining room sitting at the same table wearing brown paper towels	F 241		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 tucked into the top of their shirts across their upper chest. On 08/06/2014 at 2:45pm E9, Certified Nursing Assistant (CNA) was questioned about what residents wear for clothing protectors during meals. E9 responded "Clothing protectors." E9 was then asked whether paper towels are supposed to be used for clothing protectors. E9 responded No." On 08/06/2014 at 2:50pm E8, CNA stated that she never heard of paper towels being used for clothing protectors. On 08/06/2014 at 2:55pm E7,CNA also stated that paper towels are not used as clothing protectors. On 8/7/14 at 1:00pm a policy was requested regarding resident dignity. On 8/8/14 at 10:00am E2, Director of Nursing presented Customer Service/Sensitivity Training (undated) indicates staff are trained on resident dignity which would include using appropriate clothing protectors on residents during meals.	F 241		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced	F 252		

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F 252	Continued From page 2	F 252		

by:
Based on observation, interview and record review, the facility failed to provide a personalized homelike environment for two residents (R1, R18) of 21 residents reviewed for resident room reviews in the sample of 24 residents.

Findings include:

R1 was initially admitted to the facility 9/7/12 with diagnoses that include Dementia with Behavioral Disturbance, Cerebrovascular Accident and Hypertension.

On 8/7/14 at 11:45am while observing care in R1's room it was noted that there were no personal or homelike items in R1 ' s area of the room. Walls, top of bedside table and dresser were empty of any personal items. R1's room was very stark and institutional.

Minimum Data Set (MDS)/Preferences for Customary Routine and Activities dated 7/31/14 indicates that taking care of personal belongings or things are somewhat important to R1.

R18 was initially admitted to the facility 9/6/12 with diagnoses that include Failure to Thrive, Alzheimer's Dementia and Anxiety.

On 8/7/14 at 11:15am while observing care in R18's room it was noted that there were no personal or homelike items in R18's area of the room. Walls, top of bedside table and dresser were empty of any personal items. R18's room was very stark and institutional.

Minimum Data Set (MDS)/Preferences for Customary Routine and Activities dated 6/15/14

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F 252	Continued From page 3 indicates that taking care of personal belongings or things are very important to R18. Cognition Care Plan dated 7/28/14 indicates to keep familiar objects close to R18. On 8/7/14 at 11:20am, E21, Activity Aide was asked why there were no personal items in R1 or R18's rooms. E21 responded that the family can bring in personal belongings and that activities decorates seasonally. E21 also stated that R18 has been in the facility for 2 years and has a significant other, if there are no items received from the family, we can give them some from donations. E21 went on to state that R18 had previously been a English teacher and use to have books and like to read. E21 did not state why personal items were not requested from family and was unable to indicate why donations or decorations were not provided for R1 or R18. On 8/7/14 at 2:19pm E18, Activity Director Assistant stated family may bring in decorative items for residents. When asked about residents who cannot speak for themselves, or have no family, she stated that it is important for residents to have a homelike environment and that they will look into getting them decorative items and educate the Activity Aides.	F 252		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels.	F 258		

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F 258	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure comfortable sound levels in the third floor dining room for two residents (R1, R18) of 21 residents reviewed for daily life reviews in the sample of 24 residents. Findings include: R1 was initially admitted to the facility 9/7/12 with diagnoses that include Dementia with Behavioral Disturbance, Cerebrovascular Accident and Hypertension. On 8/6/14 at 12:05 R1 was observed sitting in the third floor dining room at a table at the back of the room. R1 appeared restless with multiple continuous repositioning in his wheelchair. A sensor alarm was observed on the back of the wheelchair alarming each time R1 repositioned himself. Sitting at the same table was R27 who continually attempted to stand from her wheelchair causing her sensor alarm to alarm almost continually. R18 was initially admitted to the facility 9/6/12 with diagnoses that include Failure to Thrive, Alzheimer's Dementia and anxiety. On 8/6/14 at 12:05 R18 was observed sitting at a dining room table directly under a large flat screen television mounted on the wall. The television was on with loud volume. Lunch trays arrived and were passed by staff to residents in the dining room at 12:45pm. R1 sat under the loud television from 12:05 to 12:50pm when she received her food tray. The television remained on, at the same volume over R18's head throughout the entire lunch meal. Staff were observed having to use a loud voice to	F 258		

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F 258	Continued From page 5 talk over the television and alarms to other staff and residents in the dining room. Twenty residents were observed in the third floor dining room. R18 was observed to have a very soft, weak voice with a distressed look on her face prior to and throughout the lunch meal, at times holding her head in her hands. Both R1 dated and R18, dated 7/31/14 Minimum Data Set (MDS) Brief Interview For Mental Status (BIMS) indicates Severely Impaired Cognition and 0/15 and are unable to verbalize affect of noise on their well being. Care Plan Interventions dated 6/30/14 indicates: (R1) and (R18) Resident needs a calm, quiet setting at meal times. On 8/7/14 at 2:19pm E18, Activity Director Assistant stated that the third floor dining room television is used for current events or movies and should not be on during meals, if it is on programming and volume should be appropriate. E18 further stated that sound levels should be considered with dementia residents and could have a negative impact. No policy was presented regarding dementia residents and appropriate sound levels.	F 258		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to obtain physician's order for dialysis services; failed to obtain baseline laboratory results prior to initiating dialysis services; failed to assess and report a change in condition for 2 residents (R2, R13) in a sample of 24. The facility's Form CMS-672 shows 19 residents receiving home dialysis services.

Findings include:

1. During the initial tour of the facility on 8/5/14 at approximately 9:45am, R13 was not in his room. E2 (Director of Nursing - DON) stated that R13 is a new admission to the facility.

R13's Physician"s Order Sheet (POS) dated 8/4/14 shows R13 receives enteral feeding and receives nothing by mouth (NPO). At approximately 1:15 pm, R13 was being transported to his room, sitting in a specialized recliner chair. Facility staff stated that R13 was returning from dialysis treatment. R13 was sleeping with mouth open wide. R13's tongue was noted to be heavily coated with a dry, brown substance, lips cracked and dry. R13 was easily aroused by verbal stimuli and responded verbally when spoken to. R13's mouth remained fixed in the open position making his speech unclear. At approximately 1:50pm (35 minutes after returning from dialysis) E14 (Licensed Practical Nurse-LPN) was summoned into R13's room to assess R13's soiled sacral dressing. E14 stated she will notify E5 (Treatment Nurse). E13 and E15 proceeded to complete incontinent care for

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R13. E14 (Nurse) proceeded to leave the room without performing a post-dialyses assessment for R13. E14 stated that when residents return from dialysis they should be assessed right away for post dialysis complications. E14 went on to say that the access site should be checked for dressing integrity and signs of bleeding and residents vital signs should be checked. E14 left the room and returned with a blood pressure monitor. E14 palpated the access site and stated she feels the bruit. E14 then proceeded to check R13's blood pressure and heart rate and obtained reading of 158/71 and 91 respectively. E14 stated she will contact the staff of the home dialysis center to notify them of R13's blood pressure.

On 8/6/14 at approximately 9am, Z6 (Home Dialysis Technician) stated that R13 is scheduled for dialysis services 5 days weekly and received his first treatment on 8/5/14. Z6 went on to say that R13's baseline labs were drawn today (8/5/14) and results are not yet available. Z6 stated she did not receive a call from E14 regarding R13's post dialysis condition.

Review of R13's Physician Order Sheet (POS) dated 8/4/14 shows no order for dialysis treatment. E2 (DON) stated on 8/7/14 at approximately 9:40am, that an order for dialysis treatment should have been obtained prior to initiating treatment. E2 provided survey team with an order for dialysis treatment dated 8/6/14.

On 8/6/14 at approximately 10:20am, R13 was in bed, eyes closed, mouth open, with heavy build-up of brown crust in entire oral cavity. There was a distinct fecal odor emitting from R13. R13 appeared lethargic and did not respond to verbal stimuli. Z4 (Wound Physician) was present and

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attempted to arouse R13 with tactile stimuli to which R13 did not respond. Z4 asked E5 (Treatment Nurse) and E14 (Unit nurse) who were present, whether this is R13's usual level of awareness or if there has been a change. Z4 went on to say if this is a change in condition, a blood glucose level should be checked. Both E5 and E14 stated that this is R13's usual status and there has been no change. Z4 went into the hallway to prepare for R13's wound assessment. Surveyor exited the room and notified Z4 that R13's present level of alertness is a decline from the previous day's observation. Z4 returned to R13's room and ordered a blood glucose test. E14 conducted the glucose test and relayed the result (248 mg/dl) to Z4. E14 then exited R13's room. E13 (CNA) was present to assist in turning of R13 for wound treatment. R13 was noted to have a large, loose bowel movement with heavily soiled sacral dressing. During incontinent care, E13 stated that R13's condition is worse than normal and stated that she had notified the nurse (E14) of her observation earlier in the day. Review of R13's nursing progress notes dated 8/6/14 shows no documentation regarding R13's change in condition and notification of R13's attending physician.

On 8/7/14 R13 was observed in the dialysis unit, appearing more alert than the previous day. Z6 (Dialysis Technician) stated that there was no communication from the floor nurse regarding R13's observed status change the previous day nor was there any communication regarding the onset of diarrhea. Z6 stated that any changes in residents' condition are to be reported to the dialysis staff. Z6 stated that the dialysis department initiates a communication form for each resident documenting pre-dialysis vital signs

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and residents post dialysis status. This documentation is not made available to the assigned floor nurse until the end of the workday.

On 8/8/14 at approximately 10:15am, E17 (Registered Dietitian) stated that she monitors high risk residents including those on gastric tube feeding and those receiving dialysis treatment. E17 went on to say that she has not yet conducted an initial assessment for R13. E17 stated she does not remember when she was notified of R13's admission to the facility and based R13's initial dietary treatment plan on faxed clinical records. E17 also stated she could not recall if there was any baseline laboratory report available to her when the dietary treatment plan was developed. E17 reviewed R13's baseline labs drawn on 8/5/14 and noted R13's blood Albumin level below normal limit. E17 stated that this is significant to protein depletion as a result of dialysis treatment and her recommendation would be to start R13 on a supplement to reverse protein depletion. R13's Medication Administration Record dated 8/4/14 shows R13's protein supplement was initiated on 8/7/14.

2. R2 was admitted to the facility on 5/29/14 with diagnoses which includes . Deep Vein Thrombosis, Congested Heart Failure, Dementia, Gastro-esophageal Reflux Disease.
During the initial tour with E2 (Director of nursing - DON) on 8/5/14 at approximately 10:15am, R2 was in her room in recliner chair sitting on mechanical lift sling. Per DON, R2 requires total staff assist for all activities of daily living and has a history of poor appetite which is being monitored. Resident ' s tongue appears dry and parched. At 12:35pm, R2 was being fed by E16

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(Restorative CNA). E16 stated that R2 only been consuming approximately 6 teaspoons of food at all meals. R2 was observed to eat only 4 spoons of the meal and drank approximately 4 ounces of water. Despite encouragement from E16, R2 refused additional food and water.
8/6/14 10:30am, up in recliner chair, eyes closed. E13 (Certified Nurses Aid - CNA) was present and stated that resident appears different today, weaker and not as alert as previous day. R2 was noted with loose bowel movement which E13 stated is a new development, and dried stool on buttocks. R2 was also noted to have early skin breakdown on the right buttocks and newly developed unstagable pressure sore on the right heel. Despite R2 receiving dietary supplement and appetite stimulating treatment, R2 experienced rapid weight loss. There is no evidence to support R2's weight being closely monitored and decline in weight being communicated to physician and dietitian in a timely manner.
Nursing notes 8/6/14 1:41pm, states R2's physician was made aware of R2's increased lethargy. Nursing notes shows inaccurate respiratory rate for R2. Respiratory rate was documented as 20 breaths per minute. Surveyor observed 40/min. Stat lab work was ordered for R2 and results showed critically high Blood Urea Nitrogen and Creatinine levels. An order was given to send R2 to the hospital at 10;25pm. R2 was not transported to the hospital until 2:10AM (8/7/14). Per nursing documentation, R2 was admitted to the hospital with a diagnosis of Acute Kidney Injury.
Z5 stated during a phone interview on 8/7/14 at approximately 11:00 am that R2 developed dehydration and became septic. Z5 stated he was not aware of R2's recent significant weight loss.

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F 309	Continued From page 11 Facility's Change in Condition Physician Notification Overview Guidelines dated 1/1/2014 states "All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record. Medical care problems are communicated to the attending physician in a timely, concise, and thorough manner."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide timely incontinent care and oral hygiene for 2 of 9 residents (R2, R13) reviewed for incontinence care in a sample of 24. Findings Include: 1. During the initial tour of the facility with E2 (Director of Nursing) on 8/5/14 at approximately 10:15am, R2 was in her room in recliner chair sitting on mechanical lift sling. Per don, requires total staff assist for all activities of daily living. R2 was observed to remain in the chair until 2pm. There was no toileting performed for R2 during this observation. On 8/6/14 10:30am, E13 (Certified Nurses Aid) stated that her shift ended at 3pm on the previous day and she transferred	F 312		

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resident back to bed at end of shift (approximately 2:30pm).
8/6/14 10:30am, R2 was again up in recliner chair, eyes closed. E13 was present and stated R2 was up in chair since the beginning of shift (6am). According to E13, R2 had not been toileted. Surveyor request transfer to bed for incontinent care. R2 was noted with loose bowel movement and dried stool on buttocks.
R2's Minimum Data Set dated 7/4/14 shows R2 is totally dependent on staff for all activities of daily living, including toileting.
2. R13's Physician"s Order Sheet (POS) dated 8/4/14 shows R13 receives enteral feeding and received nothing by mouth (NPO). At approximately 1:15 am, R13 was being transported to his room, sitting in a specialized recliner chair. Facility staff stated that R13 was returning from dialysis treatment. R13 was sleeping with mouth open wide. R13's tongue was noted to be heavily coated with a dry, brown substance, lips cracked and dry. E13 and E15 transferred R13 to bed with use of mechanical lift.

On 8/6/14 at approximately 10:20am, R13 was in bed, eyes closed, mouth open, with heavy build-up of brown crust in entire oral cavity. There was a distinct fecal odor emitting from R13. R13 appeared lethargic and did not respond to verbal stimuli. E13 (Certified Nursing Assistant) was present to assist in turning of R13 for wound treatment. R13 was noted to have a large, loose bowel movement with heavily soiled sacral dressing.

Facility's Oral Hygiene Policy dated 1/1/2014 states oral hygiene is an "essential part of morning and evening care. Some residents may require oral care hygiene after each meal due to

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APERION CARE INTERNATIONAL	4815 SOUTH WESTERN AVE CHICAGO, IL 60609

(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) COMPLETION DATE
F 312	Continued From page 13 inability to rinse out food debris."	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement pressure prevention and management services according to it's policy and procedures for 2 of 9 residents (R2, R13) reviewed for pressure sores in a sample of 24. Findings include: During the initial tour of the facility with E2 (Director of Nursing - DON) on 8/5/14 at approximately 10:15am, R2 was in her room sitting in a recliner chair sitting on mechanical lift sling. Per E2, R2 requires total staff assist for all activities of daily living and has history of poor appetite which is being monitored. At 12 noon R2 was observed still sitting in recliner chair in same position. At approximately 12:35pm, R2 was still sitting in the chair, being fed by E16 (Restorative Certified nursing Assistant - CNA). R2 remained in the chair after the meal. At 2pm R2 was observed still in recliner chair. Over this 4 hour observation R2 was not repositioned nor toileted.	F 314		

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F 314	Continued From page 14 On 8/6/14 10:30am, E13 (CNA) stated that her shift ended at 3pm on the previous day and she transferred resident back to bed at end of shift (approximately 2:30pm). On 8/6/14 at approximately 10:30am, R2 was up in recliner chair, eyes closed. E13 (CNA) was present and stated that R2 was sitting in the chair since the beginning of shift (6am). R2 was not repositioned nor toileted since that time. Surveyor request R2 to be transferred to bed for toileting. R2 was noted with loose bowel movement and dried stool on buttocks. E13 stated that R2's bowel was not loose prior to this observation. During toileting of R2, an area of redness was noted on R2's right lower buttocks. Additionally, there was a brownish exudate noted of R2's socks on the right heel and same drainage noted on the bed sheet. E13 removed R2's sock to reveal an area of black discolored area on R2's right heel. E2 (Director of Nursing) was notified by surveyor of this observation at approximately 10:45am. At approximately 12:30pm, Z4 (Wound physician) was asked to evaluate R2's right heel. Z4 assessed the wound as a neuropathic ulcer which developed because R2 has limited sensation to pressure in the lower extremities. The wound measures 4.1 centimeters (cm) x 4.9 cm. Z4 initiated an order for wound treatment. Nurses notes dated 8/6/14 describes the wound as 'avoidable.' There was a new order for heel lift boot and off-loading. E5 (Treatment Nurse) was present during wound assessment and did not address the area of redness on R2's buttocks with Z4. E5 assessed the redness which was noted to be non-blanchable, and stated that it was a result of irritation from loose bowel. There is no documentation to support Z4 having been notified of this impaired skin integrity. E5 applied barrier cream to the area.	F 314		

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F 314	Continued From page 15 R2's Braden scale assessment dated 7/19/14 shows R2 at high risk for developing pressure sores. Facility's Pressure Ulcer Prevention policy dated 1/1/2014 states "Turn dependent residents approximately every two hours and position resident with pillow or pads protecting bony prominences." During 2 of 2 days observation, there were no timely repositioning nor pressure prevention measures to R2's lower extremities. 2. During the initial tour of the facility on 8/5/14 at approximately 9:45am, R13 was not in his room. E2 (Director of Nursing) stated that R13 is a new admission to the facility. There was a pressure relieving mattress on the bed and E2 stated she thinks R13 has a pressure sore. Review of the Facility's Pressure Sore report dated 8/5/14 shows R13 not listed on the report. At approximately 1:15 am, R13 was being transported to his room, sitting in a specialized recliner chair. Facility staff stated that R13 was returning from dialysis treatment. R13 was transferred to bed with use of a mechanical lift. The transfer was performed by E13 (Certified nurses Aid - CNA) and E16 (Restorative CNA). After the transfer E13 and E16 placed R13's call light within reach and adjusted his bed covers and prepared to leave R13's room. At surveyor's request E13 and E15 checked R13 for incontinence. R13 was noted to be incontinent of feces with his sacral dressing heavily soiled with feces and of poor integrity. On 8/6/14 at approximately 10:20am, R13 was in bed. There was a distinct fecal odor emitting from R13. E13 (CNA) was present to assist in turning of R13 for wound treatment. R13 was noted to have a large, loose bowel movement with heavily soiled sacral dressing.	F 314		

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F 314	Continued From page 16 During wound treatment observation with Z4 (Wound Physician) and E5 (Treatment Nurse)on 8/6/14 at approximately 10:20am, R13 was assessed with an unstagable wound to the sacrum/coccyx. Wound measures 8.4 centimeters (cm) x 5.0 cm x 0.1 cm. There was mild to moderate yellow drainage noted. Z4 ordered a collagen dressing to the wound. The Physician's Order Sheet (POS) dated 8/4/14 shows no treatment order for this wound prior to 8/6/14. Review of R13's admission skin assessment documentation by E5 dated 8/4/14 shows the location of the wound with no assessment. There was no baseline measurements obtained upon admission.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to timely assess weight management needs and monitor and manage weight loss for 1 of 10 residents (R2) reviewed for weight loss in a sample of 24.	F 325		

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F 325	Continued From page 17 Findings include: During the initial tour of the facility with E2 (Director of Nursing) on 8/5/14 at approximately 10:15am, R2 was in her room in recliner chair. E2 stated that R2 requires total staff assist for all activities of daily living and is monitored for poor appetite. R2 receives a pureed diet and requires 1:1 assist with meals. Resident ' s tongue appears dry and parched and was receiving Oxygen via nasal canula at 2 liters per minute. At 12:35pm, R2 was being fed by E16 (Restorative CNA). E16 stated that R2 usually eats 6 teaspoons or less of food at all meals and this has been going on for a while. During this observation R2 ate 4 spoons of food and drank approximately 4 ounces of water. Review of R2's food intake documentation for the period of 8/1/14 through 8/6/14 confirms that R2 eats less than 25% of meals. There was no documentation of liquids intake. Physician's Order Sheet (POS) dated 6/27/14 shows an order for Remeron 15 mg daily to increase appetite; Megace 400 milligrams daily ordered on 6/28/14; house supplement daily, ordered on 7/9/14. Review of R2's weight history shows that upon admission (5/29/14) R2 weighed 198.2 pounds. Subsequent documented weight dated 6/19/14 shows a weight of 196 pounds. R2 was next weighed on 7/2/14 at 184.6 pounds. This signifies a 5.8% weight loss in 3 weeks. This significant weight loss was not addressed by nursing staff nor reported immediately to the Dietitian. E17's (Registered Dietitian) notes dated 7/22/14 addresses R2's significant weight loss with recommendations to increase Remeron to 30 milligrams daily; increase house supplement to three times daily; Megace increased to 400 milligrams twice daily. On 8/6/14, at surveyor's request, R2 was weighed	F 325		

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F 325	Continued From page 18	F 325		

and weight observed at 163.8 pounds. This signifies an additional weight loss of 11% in one month.
8/6/14 10:30am R2 was up in recliner chair, eyes closed. E13 (Certified Nurses Aid - CNA) was present and stated that resident appears different today, not as alert as previous day and sleeping for longer periods. R2 was receiving Oxygen therapy and respirations noted to be 40 respirations per minute. E13 stated she reported R2's condition change to E14 (Nurse) earlier in the morning. During incontinent care observation for R2 on 8/6/14 at 10:30am, R2 was noted with a non-blanchable area of redness to the left lower buttocks and a new pressure ulcer on the right heel. R2 was also noted to have developed loose stools which E13 stated was a new occurrence.
E14's (Nurse) notes dated 8/6/14, 1:41pm states Z5 (Attending physician) was made aware of R2's increased lethargy. E14 documented R2's respirations as 20 breaths per minute. The notes goes on to say that order for labs obtained and R2 started on supplements to help wound healing and R2 noted with loose stools.
Subsequent nurses notes documents a Blood Urea Nitrogen (BUN) result of 87 and Creatinine level of 41. Z5 order to send R2 to hospital at 10:25pm (8/6/14); R2 was not transferred to the hospital until 2:10am (8/7/14). Per nursing notes, R2 was admitted to the hospital for "acute kidney injury."
Z5 stated during a phone interview on 8/7/14 at approximately 11:00 am that R2 is a very sick resident who developed dehydration and became septic. Z5 stated he was not aware of R2's recent significant weight loss.

On 8/8/14 at approximately 10:45 am, E17 stated that she has not conducted an assessment of R2

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F 325	Continued From page 19 and all dietary recommendations were made based of R2's clinical findings faxed to her. E17 stated she's at the facility approximately 7 days each month. E17 stated she was not made aware of this continued weight loss and if she were she would have referred R2 for evaluation by speech therapy, monitor weekly weights and possibly a 3 day calorie count.	F 325		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure food temperatures were at at palatable levels. This failure has the potential to affect 31 residents residing on the third floor receiving regular meal trays of three floors reviewed. Findings include: On 8/6/14 at 12:50pm temperatures were taken from the last regular tray served on the third floor lunch meal cart. Temperatures were as follows: Meat ball 96 degrees. Mash potatoes 104 degrees. Peas and carrots 86 degrees. All above items were taste tested and found to be	F 364		

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F 364	Continued From page 20 marginally warm affecting palatability of food items. At that time E12, Dietary Manager stated the food temperatures did seem "too low" and it could affect the flavor of the food. Facility Policy Safe Food Handling and Preparation dated 2009 indicates: 6. Food will be held at proper temperatures. Hot food minimum of 135 degrees.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure proper chemical sanitization solutions were within appropriate concentration levels for the kitchen sanitization buckets, three compartment sink and dishmachine and failed to properly air dry pans and trays prior to stacking. This failure has the potential to affect all 155 residents in the facility. Findings include:	F 371		

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F 371	Continued From page 21 Federal Form 670 indicates resident census as 155 on 8/5/14. On 8/5/14 at 9:45am during initial kitchen tour a bucket of sanitizing solution near the coffee service station was tested by E11, Dietary Manager for proper solution level. E11 used a quaternary test strip and held the strip in the solution bucket for approximately six seconds, then removed the test strip. The test strip remained the original color when removed from the sanitizing bucket indicating zero ppm (parts per million). At that time E11 stated that E12, Dietary Aide filled the bucket up from the three compartment sink and then diluted the bucket with water and further stating "(E12) shouldn't have diluted the solution." On 8/5/14 at 10:00am E11 was asked if the three compartment sink was in use and answered "yes." At that time E11 placed a test strip into the sanitizing compartment, waiting approximately five seconds and removed the strip. The test strip did not change color indicating 0 ppm. At that time E11 stated that the solution had also been diluted in the three compartment sink. Neither E11 or E12 could not explain the procedure to obtain the proper sanitizing solution in the three compartment sink. On 8/6/14 at 9:50am E12 was actively running dishes through the dishmachine and was asked to test the sanitizing solution in the dishmachine. At that time E12 took a white test strip from the container and placed it on a fork and ran it from the beginning of the dishmachine. The test strip ran through the dishmachine, exited and remained the same color indicating 0 ppm.	F 371		

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F 371	Continued From page 22 At that time E11 stated "The test strip is supposed to be placed in solution at the end of the wash and the strip is supposed to turn purple. If it's still white there's not enough solution. It should be between 100 and 200 ppm." E11 further stated that E12 had not tested the solution prior to starting the breakfast dishes and that E12 should have tested the solution on the first tray run through the dishmachine and that E12 would have to re-wash all the dishes due to the lack of sanitizing solution in the machine. E11 also stated that they don't have a step by step procedure for sanitization testing posted but they should have. On 8/5/14 at 9:55am a large stack of medium and large metal rectangular baking pans were nested together and were were noted to be wet with moisture between pans. At that time E12 stated they should not be wet. On 8/6/14 at 11:50am meal trays being used for lunch meals were noted to be visibly wet as they were being unstacked and used in the tray line. At that time E11 stated trays were not supposed to be wet when stacked. Facility Policy and Procedure: Why is proper dishwashing important? dated 2009 indicates: Proper dishwashing is an important part of a good sanitation program. When chemicals are used to sanitize, test strips must be available to check proper concentration (e.g. Chlorine 50-200ppm). Facility Policy and Procedure/Dish Machine Sanitation Instructions dated 8/6/14 indicates: Run a rack with dishes through the dish machine. At the end of the cycle obtain a chlorine test strip. Place the test strip on top of the dish in the rack for 1 second.	F 371		

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F 371	Continued From page 23 Check and compare the strip with the color chart located on the vial. Test strip should read between 50ppm-200ppm for the sanitizer to be operating properly. If the reading color is not between 50-200ppm notify supervisor and maintenance immediately. Facility Policy/ Manual Ware Washing dated 2009 indicates: Air dry all items on a drain board. Proper dishwashing is an important part of a good sanitization program. Correct dishwashing involves five steps: 1. Scraping 2. Washing 3. Rinsing 4. Sanitizing 5. Air Drying	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 24 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to properly sanitize the glucometer for two residents (R31, R32) in the supplemental sample reviewed during medication pass. The facility also failed to provide documentation showing that established criteria is being followed for the use of antibiotics for 3 residents (R26, R29, R30) in the supplemental sample. Findings include: 1. On 08/05/14 at approximately 5:00pm during medication administration, E19 (Licensed Practical Nurse - LPN), proceeded to R31 ' s room and performed a blood glucose check. After the procedure was done E19 removed her	F 441		

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F 441	Continued From page 25 gloves, disposed of them in waste bag, returned the glucometer to the medication cart then proceeded to wipe the glucometer off with alcohol wipes. At that time E19 was questioned about the procedure for glucometer cleaning and responded " I know I was supposed to clean the glucometer with bleach wipes but they ' re in the nurses station and I didn ' t want to walk there. " 2. On 08/05/14 at approximately 5:15pm during medication administration, E15(Licensed Practical Nurse - LPN) removed the glucometer from medication cart, took the sanitizing wipe from container and covered the glucometer. E15 then proceeded to R32 ' s room to perform blood glucose check. E15 then performed the glucose test on R32 without using gloves. At that time E15 stated that he was nervous and should have worn gloves during the glucose test. E15 returned glucometer to the medication cart and covered it with the same sanitizing wipe used previously to sanitize the glucometer. Facility Policy on Maintaining the Blood Glucose Meter #3 procedure dated 11/2013 states, "To clean and disinfect the meter, use pre-moistened wipe/towel of 1 ml or 5-6% sodium hypochlorite solution (household bleach) and 9 ml water to achieve a 1:10 dilution final concentration of 0.5-0.6% sodium hypochlorite." On 8/07/14, 11:30 AM, E2, DON (Director of Nursing) presented the infection control policy. Also, the infection control log was reviewed. The infection control log did not provide	F 441		

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F 441	Continued From page 26	F 441		

documentation indicating the appropriateness and the effectiveness of the use of antibiotics for residents.

R26 was listed on the for redness of left eye, culture site, "non applicable." R26 was prescribed Cipro eye drops. Review of the nurse's note for 3/20/14, 3:10 PM said R26 was noted during lunch time rubbing the left eye. Upon assessment redness and puffy left eye lid was noted. R26 denied pain and no drainage was noted. The physician was notified per telephone and ordered Ciprofloxacin eye drops, 0.3%, 2 drops to left eye twice daily for 5 days.

The infection verification form stated the condition was conjunctivitis, and the criteria for diagnosis and treatment said at least one of the following must include:

1. Pus from one or both eyes, present for at least 24 hours.

2. Conjunctival redness with or without itching or pain, present for at least 24 hours.

R29 was listed on the infection control log for eye infection and urinary tract infection and antibiotic treatment was prescribed for both conditions. There was no verification form documenting criteria was met for the appropriateness of use of antibiotics for this resident.

R30 was listed for urine infection and was prescribed Bactrim DS from 3/28/14 - 3/31/14. The urine culture final report, dated 3/28/14 showed no growth while the urinalysis showed 500 mg/dl of sugar and 100 mg / dl of protein. The antibiotic treatment was documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146001	A. BUILDING _____ B. WING _____	08/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE INTERNATIONAL	4815 SOUTH WESTERN AVE CHICAGO, IL 60609

(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) COMPLETION DATE
F 441	Continued From page 27 prophylactic. Review of the nurse's progress note, on 3/29/14 11:40 AM stated, "Resident receiving Bacterium DDS one tablet every 12 hours for 7 days related to UTI (Urinary Tract Infection). Resident remains asymptomatic as evidenced by no complaint of itching, no rashes noted, resident afebrile." When E2, DON and Infection Control Nurse was questioned about the criteria for antibiotic use, E2 stated, that she has been in the position since June (approximately 3 months). E2 also also said she is working on a tracking system to monitor the use of antibiotics.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide repairs and maintain the appropriate water temperatures in the shower rooms on all 3 floors. Findings Include: On 8/6/14 at 10:40am during the environmental tour on the 3rd floor with E20 (Maintenance Director), the water temperature of the tub in the south shower room was 95 degrees Fahrenheit (F) and the shower stall had missing tile with jagged edges exposed. In the east shower room there was a leaking pipe in the shower stall and the water temperature was 80 degrees F. The	F 465		

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F 465	Continued From page 28 water temperature of the tub in the east shower room was 76 degrees F. At 10:45am E22 (Certified Nursing Assistant) stated "We use this tub for the residents everyday." At 11:00am in the south shower room on the 2nd floor, there was a broken shower head in the shower stall. The tub in the east shower room was not functioning properly and only produced a small stream of water. At 11:30am in the shower room on the 1st floor, the shower head was missing in the shower stall and the water ran through the connecting hose. The water temperature of the tub was 96 degrees F. On 8/7/14 at 10:00am E1 (Administrator) stated "We don't have a policy on water temperatures, we go by the state regulations, between 98-110 degrees. The boiler was turned up so the temperatures are good now."	F 465		