DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146010	A. BUILDING _______ B. WING _______	C 09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTIAC HEALTHCARE AND REHAB	**300 WEST LOWELL PONTIAC, IL 61764**

(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 Complaint #1665310/IL88534-F323 Complaint #1665328/IL88554-F157, F309, F315	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; 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 need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to notify the physician and family of R2's significant change in health condition (hematuria due to self removal of the indwelling catheter and abdominal pain) for one of three residents (R2) reviewed for indwelling catheter care in a sample of fourteen.

Findings include:

The facility policy "Physician Notification Of Residents Change of Condition" dated 3/15/1998 documents "The residents attending physician will be notified of changes that occur in the residents condition by Licensed Personnel. Physicians notification is to include,but not limited to the following: b.) significant change, ...d.) any accident or incident with or without injury. i.e. falls, skin tears, bruises ect., ... and k.) abnormal complaints of pain. It is the charge nurses responsibility to notify the physician of any changes in a resident's condition. It is the responsibility of all staff members to notify the charge nurse and/or Director of Nursing (DON) of noted changes in a residents condition. It is the responsibility of the DON/designee, through monitoring of the 24 hour report to ensure that physicians have been notified of condition changes."

R2's Progress Note dated 9/3/2016 at 11:32AM, documents "(R2) got up to go to the bathroom and pulled out (R2's) indwelling catheter. Re-inserted without any issues. Urine is blood tinged with a few clots noted." The next documented Progress note was 9/4/2016 at

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3:23PM documenting "(R2) is alert and oriented. (R2) requires assistance with transfers. Urine has a large amount of blood in it. Catheter pulled out by accident by (R2) at the end of the shift. Second shift nurse re-inserted the new one." (R2's) progress notes document hematuria again on 9/7/2016 at 4:43PM and 9/8/2016 at 9:21PM. R2's medical record has no documentation that Z6, (R2's family) or the physician were notified of the catheter being pulled out by the resident on 9/3/2016 or 9/4/2016 or the hematuria on 9/7 or 9/8.

On 9/14/2016 at 2:45PM, E6 (Nurse) stated "I inserted a 16 french indwelling catheter with a 10cc (cubic centimeter) balloon on 9/3/2016. (R2) got up to go to the bathroom and forgot the indwelling catheter bag was attached to the bed, self removing the catheter with the balloon intact. I did not document the size of indwelling catheter I inserted in the progress notes, just that I re-inserted the indwelling catheter. The facility does not have any indwelling catheter anchors so none was utilized for (R2). On 9/3/2016 (R2) self removed the catheter on the night shift about 4:30AM. The night nurse did not document (R2's) self removal, call the doctor or the family. On 9/4/2016 (R2) again self removed the indwelling catheter with the balloon intact. The evening shift nurse (E8) reinserted the indwelling catheter at that time. The indwelling catheter change is to be documented on the Treatment Sheet, I did not document the re-insertion there either. I replaced the catheter with the size that (R2) had before removal. There are no indwelling catheter orders on the Physicians Order Sheet for size or daily catheter care. I should have called the physician for orders as well as notified the physician of the catheter self removal and hematuria."

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On 9/14/2016 at 3:15PM, E2 (Director of Nursing) stated "The physician and family should both be notified if a resident pulls out a indwelling catheter. The physician is to give the orders for the size catheter and daily catheter care." E2 verified no orders were available in R2's medical record for catheter care or re-insertion size.

On 9/16/2016 at 9:15AM, E11,Certified Nurses Aide (CNA) stated "I was (R2's) CNA on 9/7, 9/8 and 9/9/2016. (R2) complained of abdominal pain all three days. I told the nurse each day. I don't remember who it was I told. I did indwelling catheter care for (R2) all three days also. (R2) would say "my bladder hurts." (R2) would tell that to anyone who would listen."

On 9/13/2016 at 11:15AM, E13 (Nurse) stated "(R2) complained of abdominal pain for a couple of days before (R2) was transferred to the hospital. (R2) said "my bowels need to move." I was told by (E12) CNA that (R2) had a bowel movement on 9/10/2016. I did not do an abdominal assessment or notify the physician of the complaint of abdominal pain until 9/11/2016, the day (R2) was transferred to the hospital."

R2's progress notes dated 9/9/2016 document "(R2) complained to family about not having a bowel movement, will assess after lunch." No documented bowel assessment or description of the abdomen or physician notification was documented in (R2's) medical record for 9/9/2016. On 9/10/2016 the dietary manager (E15) documented "(R2) states went yesterday and had no discomfort at the time. Visited again in the afternoon and (R2) stated went today." There was no nursing documentation in R2's

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F 157	Continued From page 4 medical record for 9/10/2016. The next documented progress note for (R2) is on 9/11/2016 at 5:55PM documenting increased confusion, blood in urine, and abdominal distention. On 9/15/2016 at 1:00PM, Z4 (R2's Physician) stated "I was not notified that (R2) self removed the indwelling catheter twice, was having hematuria or that (R2) complained of any abdominal pain prior to 9/11/2016... when after assessing (R2) I immediately sent (R2) to the hospital due to shortness of breath with respirations of 40, severe abdominal pain and distension... I should have been notified of these issues as they occurred. I would have sent (R2) out to the hospital for evaluation for the hematuria lasting more than 24 hours after catheter self removal."	F 157		
F 309 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to assess, identify and treat for abdominal distention and pain for one of three residents (R2) reviewed for medical follow up in a sample of fourteen. This delay in treatment resulted in Acute	F 309		

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Continued From page 5
Renal Failure Secondary to Obstructive Uropathy with Severe Abdominal Pain for R2.

Findings include:

R2's face sheet documents admission to the facility on 9/1/2016. R2 has a diagnosis of Urinary Tract Infection, Frontaltemporal Dementia, Hypertension, and Nueromuscular Dysfunction of the Bladder.

The Minimum Data Set dated 9/8/2016 document R2's cognition is moderately impaired and requires extensive assistance for toilet use.

On 9/16/2016 at 9:15AM, E11,Certified Nurses Aide (CNA) stated "I was (R2's) CNA on 9/7, 9/8 and 9/9/2016. (R2) complained of abdominal pain all three days. I told the nurse each day. I don't remember who it was I told.

R2's progress notes dated 9/9/2016 document "(R2) complained to family about not having a bowel movement, will assess after lunch." There was no documented bowel assessment or description of the abdomen or physician notification in (R2's) medical record for 9/9/2016. On 9/10/2016 the dietary manager (E15) documents "(R2) states went yesterday and had no discomfort at the time. Visited again in the afternoon and (R2) stated went today." There was no nursing documentation in R2's medical record for 9/10/2016. The next documented progress note for (R2) is on 9/11/2016 at 5:55PM documenting increased confusion, blood in urine, and abdominal distention.

On 9/15/2016 at 1:00PM, Z4 (R2's Physician) stated "I was not notified that (R2) complained of

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F 309	Continued From page 6 any abdominal pain prior to 9/11/2016. On 9/11/2016 when I arrived at the facility (R2) was in acute respiratory distress, gasping, tachycardic and had acute lower abdominal pain and distention with tenderness to touch. (R2's) respirations were 40. I immediately sent (R2) to the hospital. I would have sent (R2) out to the hospital for evaluation with complaint of abdominal pain with distention. I would have also expected the nurses to do a complete abdominal assessment (check for abdominal distension, bowel sounds and tenderness to touch) if a resident complains of pain." On 9/14/2016 at 1:00PM, Z6 (Family of R2) stated "(R2) started complaining about abdominal pain and discomfort at least three days before (R2) was hospitalized. I insisted the doctor be notified and see (R2) on 9/11/2016. When the doctor saw (R2) the doctor immediately sent (R2) to the hospital. The nurses at the facility did not call the doctor or do anything until I insisted." R2's Emergency Room (ER) Report dated 9/11/2016 at 8:50PM, documents "(R2) is noted to have severe lower abdominal pain. Abdomen is distended, firm and painful to touch. Nurses note urine from the indwelling catheter is mostly blood." ER Physical exam documents "distended firm abdomen. Pain in the left lower quadrant. Firm mass in lower abdomen." The ER note at 11:02 PM documents "urinary catheter appears to be in prostate and not in bladder. (R2) has obstructive uropathy on Computerized Tomography Scan (CT) ....Indwelling catheter exchanged and (R2) has had over 2000 milliliters of urine output......." The (CT) dated 9/11/2016 at 10:18PM documents	F 309		

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F 309	Continued From page 7 the impression-"Indwelling catheter balloon inflated in the prostatic urethra. Repositioning into the urinary bladder recommended. Enlarged prostrate gland measuring 6.3 centimeters (cm) by 6.9 cm. Marked distention of the urinary bladder, presumably on the basis of indwelling catheter malposition. Bilateral ureterectasis and hydronephrosis due to bladder distention. Layering intermediate density material in the urinary bladder. Hemorrhage, debris, or cellular inflammatory material could have this appearance." R2's Hospitalist Admission History and Physical dated 9/12/2016 at 9:45AM, documents chief complaint is abdominal pain and Acute Renal Failure secondary to "improper placement of the indwelling catheter. When catheter was removed approximately three liters of urine (2300 cc of bloody urine) was removed......"	F 309		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 315		

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review the facility failed to monitor indwelling catheter output, anchor the indwelling catheter to prevent dislodgment or self removal, and failed to notify the physician of hematuria and abdominal distention for two of three residents (R2 and R3) reviewed for catheter care in a sample of fourteen. This failure resulted in R2 being hospitalized with Acute Renal Failure Secondary to Obstructive Uropathy and Hematuria (Traumatic) with Acute Kidney Injury.

Findings include:

1. R2's face sheet documents admission to the facility on 9/1/2016. R2 has a diagnosis of Urinary Tract Infection, Frontaltemporal Dementia, Hypertension, and Neuromuscular Dysfunction of the Bladder.

The Minimum Data Set dated 9/8/2016 document R2's cognition is moderately impaired and requires extensive assistance for toilet use.

R2's Intake (fluid) and Output (urinary) record for September 2016 documents no intake on the night shift from 9/1/2016 through 9/10/2016, the only intake documented on the morning shift was 240 cubic centimeters (cc) on 9/7/2016, and evening shift documented 250 cc of fluid intake on 9/1 and 9/4 and 300 cc intake on 9/2 and 9/5. R2's output sheet documents an output of 1000 plus cc on 9/1 through 9/4/2016 and 9/6/2016, 75 cc out on 9/7/2016, 925 cc out on 9/7, 500 cc out on 9/8 with nothing documented for the night shift, 850 cc on 9/9/2016, 100 cc out on the PM (afternoon/evening) shift for 9/10 with crossed out areas for AM (morning) and NI (night) shifts and 250 cc out on the NI and AM shifts for 9/11/2026.

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On 9/16/2016 at 9:30AM, E12 Certified Nurses Aide (CNA) stated "the CNA's empty the indwelling catheter bags and document the output on the output sheet. The nurses review the outputs at the end of the shift."

On 9/14/2016 at 10:00AM, E2 (Director of Nursing) stated "The nurses are to monitor the output and notify the physician if the output is low. The out put sheet for (R2) should have been questioned by the nurses since it was blank. There is no way to know if (R2) had an adequate output on those days the sheet is blank. No, the nurses did not accurately monitor (R2's) output. They should have also assessed the abdomen for distention and the indwelling catheter for proper placement, asking the physician for irrigation orders if needed. They should always notify a physician if a resident has hematuria. There is no facility protocol or policy for intake and output."

R2's Progress Note dated 9/3/2016 at 11:32AM, documents "(R2) got up to go to the bathroom and pulled out (R2's) indwelling catheter. Re-inserted without any issues. Urine is blood tinged with a few clots noted." The next documented Progress note was 9/4/2016 at 3:23PM documenting "(R2) is alert and oriented. (R2) requires assistance with transfers. Urine has a large amount of blood in it. Catheter pulled out by accident by (R2) at the end of the shift. Second shift nurse re-inserted the new one." (R2's) progress notes document hematuria again on 9/7/2016 at 4:43PM and 9/8/2016 at 9:21PM. R2's medical record has no documentation that the physician was notified of the catheter being pulled out by the resident on 9/3/2016 or 9/4/2016 or the hematuria on 9/7 or 9/8.

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On 9/14/2016 at 2:45PM, E6 (Nurse) stated "I inserted a 16 french indwelling catheter with a 10cc balloon on 9/3/2016. (R2) got up to go to the bathroom and forgot the indwelling catheter bag was attached to the bed, self removing the catheter with the balloon intact. I did not document the size of indwelling catheter I inserted in the progress notes, just that I reinserted the indwelling catheter. The facility does not have any indwelling catheter anchors so none was utilized on (R2). On 9/4/2016 (R2) again self removed the indwelling catheter with the balloon intact. The evening shift nurse (E8) reinserted the indwelling catheter at that time. The indwelling catheter change is to be documented on the Treatment Sheet, I did not document the reinsertion there either. I replaced the catheter with the size that (R2) had before removal. There are no indwelling catheter orders on the Physicians Order Sheet for size or daily catheter care. I should have called the physician for orders as well as notified the physician of the catheter self removal and hematuria."

On 9/14/2016 at 3:15PM, E2 (Director of Nursing) stated " The physician is to give the orders for the size catheter and daily catheter care." E2 verified no orders were available in R2's medical record for catheter care or re-insertion size. E2 also stated "the facility does not anchor indwelling catheter to the residents leg to prevent accidental removal of the indwelling catheters. We do not have catheter anchors in the facility to utilize."

On 9/16/2016 at 9:15AM, E11,Certified Nurses Aide (CNA) stated "I was (R2's) CNA on 9/7, 9/8 and 9/9/2016. I did indwelling catheter care for (R2) all three days. (R2) would say "my bladder hurts." (R2) would tell that to anyone who would

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listen, my bladder hurts. I told the nurse each day,but I don't remember who the nurses were."

On 9/13/2016 at 11:15AM, E13 (Nurse) stated "(R2) complained of abdominal pain for a couple of days before (R2) was transferred to the hospital. (R2) said "my bowels need to move." I was told by (E12) CNA that (R2) had a bowel movement on 9/10/2016. I did not do an abdominal assessment (check bowel sound or abdominal distention) or notify the physician of the complaint of abdominal pain until 9/11/2016, the day (R2) was transferred to the hospital. I did not check to ensure the indwelling catheter was in the proper placement or attempt to irrigate the catheter."

R2's Progress Notes dated 9/9/2016 document "(R2) complained to family about not having a bowel movement, will assess after lunch." There was no documented bowel assessment or description of the abdomen or physician notification in (R2's) medical record for 9/9/2016. On 9/10/2016 the Dietary Manager (E15) documents "(R2) states went yesterday and had no discomfort at the time. Visited again in the afternoon and (R2) stated went today." There is no nursing documentation in R2's medical record for 9/10/2016. The next Progress Note for (R2) is on 9/11/2016 at 5:55PM documenting increased confusion, blood in urine, and abdominal distention. The Progress Note dated 9/11/16 at 8:05pm documents that Z4, R2's Physician came to see R2.

On 9/15/2016 at 1:00PM, Z4 (R2's Physician) stated "I was not notified that (R2) self removed the indwelling catheter twice, was having hematuria or that (R2) complained of any

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	146010	A. BUILDING ______ B. WING ______	C 09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTIAC HEALTHCARE AND REHAB	**300 WEST LOWELL PONTIAC, IL 61764**

(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 315	Continued From page 12 abdominal pain prior to 9/11/2016. On 9/11/2016 when I arrived at the facility (R2) was in acute respiratory distress, gasping, tachycardic and had acute lower abdominal pain and distention with tenderness to touch. (R2's) respirations were 40. I immediately sent (R2) to the hospital. I should have been notified of these issues as they occurred. I would have sent (R2) out to the hospital for evaluation for the hematuria lasting more than 24 hours after catheter self removal." R2's Emergency Room (ER) Report dated 9/11/2016 at 8:50PM, documents "(R2) is noted to have severe lower abdominal pain. Abdomen is distended, firm and painful to touch. Nurses note urine from the indwelling catheter is mostly blood." ER Physical exam documents "distended firm abdomen. Pain in the left lower quadrant. Firm mass in lower abdomen." The ER note at 11:02 PM documents "urinary catheter appears to be in prostate and not in bladder. (R2) has obstructive uropathy on Computerized Tomography Scan (CT) with stranding of bilateral kidneys. Indwelling catheter exchanged and (R2) has had over 2000 milliliters of urine output. Urine is dark in color. Per family, patient (R2) pulled catheter out on (R2's) first day at the nursing home on 9/1/2016. Indwelling catheter was replaced. It is not clear how long the indwelling catheter has been in the prostate or had poor output." The (CT) dated 9/11/2016 at 10:18PM documents the impression-"Indwelling catheter balloon inflated in the prostatic urethra. Repositioning into the urinary bladder recommended. Enlarged prostrate gland measuring 6.3 centimeters (cm) by 6.9 cm. Marked distention of the urinary bladder, presumably on the basis of indwelling	F 315		

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F 315	Continued From page 13 catheter malposition. Bilateral ureterectasis and hydronephrosis due to bladder distention. Layering intermediate density material in the urinary bladder. Hemorrhage, debris, or cellular inflammatory material could have this appearance." R2's Hospitalist Admission History and Physical dated 9/12/2016 at 9:45AM, documents chief complaint is abdominal pain and Acute Renal Failure secondary to improper placement of the indwelling catheter. When catheter was removed approximately three liters of urine (2300 cc of bloody urine) was removed and (R2) had an elevated creatine level of 8.10 (normal 0.70-1.30). (R2) was also hyperkalemic and kayexylate was given." R2's hospital Discharge Summary dated 9/14/2016 documents "(R2) presented with acute renal failure secondary to obstructive uropathy. Urology was consulted for further management for (R2's) urinary obstruction and indwelling catheter was placed in the operating room with subsequent improvement in (R2's) renal function and urinary drainage." 2. On 9/14/16 at 2:05pm R3's indwelling urinary catheter was not anchored/secured to R3's leg. On 9/14/2016 at 2:05PM, R3 stated "They do not use indwelling catheter anchors here. I have had my indwelling catheter tubing tugged on multiple occasions, but it has never been removed by being pulled out. It hurts when the tubing is pulled. On a pain scale of one to ten about an eight or nine when the tubing is pulled."	F 315		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 14	F 323		

HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to ensure medical equipment was not plugged into an extension cord-type power strip for nine of 14 residents (R4, R1, R8-R14) reviewed for electrical safety, on the sample of 14.

Findings include:

1. On 9/14/16 at 10:05 am R4's CPAP (Continuous Positive Airway Pressure) and nebulizer machine were plugged into an electrical power strip. On 9/14/16 at 10:10am E9, CNA (Certified Nurse Aide) confirmed that R4's CPAP and nebulizer machine were plugged into an electrical power strip.

2. On 9/14/16 at 9:10am the plug for R1's bed was plugged into an electrical power strip. On 9/14/16 at 9:10am E5, LPN (Licensed Practical Nurse) confirmed the bed was plugged into a power strip.

On 9/14/16 at 12:00pm E1, Administrator confirmed medical devices are not to be plugged into electrical power strips.

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F 323	Continued From page 15 The facility's Powerstrip Check dated 9/14/16 identified R1, R4, R8-R14 as having medical equipment plugged into power strips. On 9/14/16 at 8:30am E10, Maintenance Coordinator stated he wasn't aware that the resident's electric beds were considered medical equipment, so they were plugged into electrical power strips.	F 323		