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
	IL6009831	A. BUILDING _____ B. WING _____	C 09/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWANSEA REHAB HEALTH CARE	1405 NORTH SECOND STREET SWANSEA, IL 62226

(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 # 1845948 / IL 105678 Complaint # 1846034 / IL 105773	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210a) 300.1210b)3) 300.1210d)2)3) 300.3240a) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the	S9999		

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appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so 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.
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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on interview and record review the facility failed to provide care according to accepted standards of practice by failing to provide close monitoring and assessment change in condition for 1 of 3 residents (R3) reviewed for change in condition in the sample of 12. Facility also failed to provide adequate care for lower abdominal pain, failed to document catheter care in the Treatment Administration Record for 1 of 3 residents,(R3) reviewed for bladder and bowel function in the sample of 12. These failures

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resulted in R3 experiencing increased pain leading to hospitalization with diagnoses of Urinary Tract Infection secondary to Possible Bladder Outlet Obstruction and Constipation.

R3's Minimum Data Set (MDS) dated 7/12/18 documents R3 requires extensive assist with transfers, toilet use, and personal hygiene, occasionally incontinent of bowel and has a urinary indwelling catheter.

R3's Physician Order Sheet with start date 3/21/18 documents, "Change (indwelling urinary catheter) 16 French, 10cc (cubic centimeters) balloon every month on 10-6 shift on the 22nd of the month."

R3's Care Plan dated 7/28/18 documents, "Resident will not have complications related to indwelling urinary catheter. Diagnosis: Obstruction Uropathy, Approaches: Intake and output. Check placement thru output, see POS to determine order for irrigation if applicable. Catheter care every shift. Change catheter per order and as needed if plugged. Monitor for signs and symptoms of infection: dark, foul-smelling urine, blood or mucus in urine, burning/pain at catheter insertion or pelvic/groin/down legs, fever, increased confusion. Notify Physician of s/s/of infection for recommendation and treatment. "

The Treatment Administration Record (TAR) dated 7/2018 documents R3's catheter was not changed in July 2018. R3's TAR for 8/2018 showed catheter care has not been consistently provided to R3 every shift.

R3's Nurse's Notes, dated 8/15/18 documents, "8/15/18. 2:10 PM. Resident complained of lower

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abdomen pain denies any nausea, vomiting. Stomach soft to touch no distention. (V11, Physician) notified of new symptoms, he states to monitor her closely and if she don't feel any better notify him. Vital signs: Blood pressure 111/51 mm (millimeter)/Hg (, Pulse 71, respirations 16, O2 stat. Will continue to monitor." R3's clinical record does not document R3 was closely monitored for her abdominal pain from 8/15/18 through 9/3/18 when she was eventually sent to the ER (Emergency Room).

R3's Situation Background Appearance Review and Notify (SBAR) Communication Form and Progress Note dated 9/3/18 at 12:00 PM, documents, "Appearance. Summarize your observations and evaluation: (No entry). Nursing Notes: Resident been having complaint of abdominal pain last few days, gave treatment of laxatives and stool softeners, no results, abdomen distended, increasing pain, family requesting resident to go to ER. Pain Evaluation: Worsening of chronic pain. Description/location: Abdominal Pain. Intensity: (No entry), Nonverbal Signs of Pain: Grimacing, Wincing."

R3's Physician Order Sheet (POS) dated 9/2018 does not document an order to send R3 to the ER for evaluation and Treatment.

R3's Medication Administration Record (MAR) for 8/2018 does not document R3 was provided any approaches/interventions to address her abdominal pain. R3's MAR for 9/2018 documents R3 was given one dose of Miralax on 9/3/18. There was no documentation in R3's record she was given any enema between 8/15/18 through 9/3/18. R3's record does not document assessment of her indwelling urinary catheter for patency related to the amount of urine output per

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S9999	Continued From page 5 shift from 8/15/18 through 9/3/18. R3's Nursing Home to Hospital Transfer Form dated 9/3/18 at 12:10 PM documents, "Reason for Transfer: Complained of Pain, every intervention not working, family wants to go to ER. Most recent Pain Level: 10/10." R3's Emergency Room Visit Report dated 9/3/18 documents, "Chief Complaint: Constipation. Associated Symptoms: Abdominal Pain. Denies: Fever, Vomiting. Duration: Days. Relieved By: None. Similar Symptoms: Yes. History of Present Illness: Patient sent over from the nursing home for constipation x 4 days. Her daughter states that she has been complaining that she is not feeling well with pain to her abdomen. Then her daughter stated she has began not to want to eat anything. Patient does have mild dementia. No fever or vomiting. Daughter stated she used to get constipation a lot when she lived at home and she would use (laxative) and prune juice and the nursing home did not have it. They did give miralax and 1 enema." R3's ER Computed Tomography (CT) Scan dated 9/3/18 documents, "Abdomen/Pelvis: Impression: 1. Bilateral Hydronephrosis and Hydroureter has shown increase from prior exam (5/6/18). Distended Urinary Bladder, Possible Bladder Outlet Obstruction. 2. Large Amount of Rectal Stool. 3. Small Pericardial Effusion 4. Small Esophageal Hiatal Hernia." R3's Hospital CT Scan Abdomen/Pelvis without Contrast dated 9/5/18 documents, "Impression: 1. Mild stercoral colitis has developed since 9/3/18. Fecal Retention unchanged with rectal diameter 8.5 centimeters (cm) by 7.4 cm. 2. Hydroureteronephrosis has mostly resolved since (catheter) placement."	S9999		

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R3's Hospital Discharge Summary dated 9/10/18 documents, "Hospital Course: 87 y/o female from a nursing home with past medical history of diabetes, congestive heart failure, obstructive uropathy requiring indwelling urinary catheter who was brought in by Emergency Medical Service from nursing home since she did not have a bowel movement for a week with abdominal discomfort. The patient's indwelling catheter was draining only very little amount of urine. She was found to have Urinary Tract Infection with ESBL (Extended-spectrum beta-lactamase) Infection and her blood cultures also grew ESBL. Her chronic indwelling catheter was not draining and another new catheter was placed. This new catheter drained almost 2 liters of urine once it was placed. She was started on intravenous ertapenem and completed her 7 days' course." The Summary further documents, "Her mental status greatly improved with treatment of the infection. Had constipation resolved with enema."

On 9/13/18 at 12:31 PM, V15, R3's Power of Attorney for HealthCare/Daughter, stated she visited R3 four times a week in the facility and during one visit on 8/28/18 around lunch time V15 noticed R3 was in a lot of pain, verbalizing pain on lower abdomen and not having had a bowel movement for a few days, was moaning and grimacing and ate only 2-3 spoonfuls of food. V15 stated she asked staff to check on R3's condition and she was told R3 was given a laxative and it should help. V15 stated she visited on 8/31/18 and R3 was still in pain and it seemed to her R3's pain was worse. V15 stated R3 has a high tolerance for pain and if she says it hurts so bad that meant she wanted to go to the hospital. V15 told V1, Administrator, about R3's pain and V15 asked V1 to send her to the hospital. V15 stated

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V1 replied nursing will be taking care of R3. V15 stated V1 asked the nurse to check on R3 who came back and reported to V1 and V15 that R3's bowels were moving per stethoscope check and told V15 that R3 will be given Miralax. V15 stated she did not get the name of the nurse working for R3. V15 stated the nurses she talked to every visit did not seem to know what was wrong with R3. V15 stated she came again to visit R3 on 9/3/18 at lunch time, and saw R3 was looking terrible, in extreme pain, moaning and grimacing, guarding her lower abdomen and refusing to eat. V15 stated she touched R3's lower abdomen and it was so distended she told V6, Licensed Practical Nurse (LPN) that R3 has to go to the hospital "now". V15 stated when R3 arrived at the ER R3's catheter was replaced with a new one and immediately was able to drain 2 urinals full of urine. V15 stated the urine was dark yellow, cloudy and had mucus in it. V15 stated R3 went off to sleep readily right away, so much relief showed on her face. V15 stated the ER staff told her R3 was impacted as well. V15 stated the facility never notified her of R3's lower abdominal pain and she learned of it first hand when she visited on 8/28/18. V15 stated she felt if she was not there and insisted for R3 to go to the ER, the facility would not have sent her on 9/3/18.

On 9/19/18 at 3:15 PM, V14, Certified Nursing Aide (CNA), stated she took care of R3 a few days before R3 was transferred to the hospital. V6 stated R3 had very little bowel movement and urine output which she documented at the end of the shift on the ADL (Activities of Daily Living) book so the nurses are aware of what is going on.

On 9/19/18 at 3:18 PM, V17, CNA, stated R3 had no bowel movement for 2 days that V17 was assigned to R3 days prior to being transferred to

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S9999	Continued From page 8 the hospital. V17 stated R3 always have very little urine output because she did not like to drink when offered. I notified the nurse when R3 would have no bowel movement during the shift and the nurse would tell me to let her sit in the toilet. On 9/13/18 at 1:33 PM, V6, LPN, stated she does not recall being aware R3 had abdominal pain prior to the day when she transferred R3 to the ER. V6 stated R3 would complain of upset stomach from time to time but not abdominal pain. V6 added vital signs are taken by the aides and the nurse would write them in the MAR. V6 stated the nurses fill out the residents' Monthly Intake/Output Flow Sheet from data collected by the aides. On 9/19/18 at 8:41 AM, V11, R3's Physician, stated it is hard to say if the facility should have sent R3 to the hospital prior to 9/3/18. V11 stated when the facility called him the first time on 8/15/18 it was early in the process so he would have expected the nurses to monitor the resident closely to observe for changes, like checking vital signs, asking the resident how she feels, palpating the resident, monitoring for output and bowel movement. V11 stated it is a straightforward process and part of basic nursing care to document that they have been closely monitoring the resident to determine if her symptoms progress/she was not feeling any better. V11 stated he expects the nurses to document that they were closely monitoring the resident, there is actually no excuse for failure to document. V11 stated even if you did it if it was not documented then you did not do it, and any excuse does not cut it. (A)	S9999		