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
	IL6001986	A. BUILDING: ______ B. WING ______	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE NURSING & REHABILITATION	3500 CENTURY DRIVE GRANITE CITY, IL 62040

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S 000	Initial Comments Complaint Investigation 1846473/IL106246 1846657/IL106450 1846706/IL106502	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 3) 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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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:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care

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plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview, observations and record review, the facility failed to provide safe transfers, adequate supervision and an effective falls prevention plan for 5 of 5 residents (R1, R2, R7, R8, R9) reviewed for falls and falls prevention in a sample of 14. These failures resulted in R1 falling numerous times sustaining multiple facial fractures from her last fall.

Findings include:

1. R1's Minimum Data Set (MDS) documents R1 as a 92 year old female admitted to the facility on 10/1/17 with diagnoses of Dementia with Behavioral Disturbances, Alzheimer's disease and Anxiety in part. The MDS documents R1 to have short/long term memory deficits with moderate impaired cognition.

The Falls Scale dated 7/6/18 documents R1 to have a total score of 65 with 46+ being "high risk" with the action for staff to "implement high-risk fall prevention interventions."

R1's Resident Incident Report dated 7/11/18 at 5:11 PM, documents "It was reported to the nurse

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by 3 nurses sitting at West hall nurses station that CNA (Certified Nurse Aide) ran over resident's foot while pushing another resident's wheelchair to dining room." The report documented R1's great toe right foot toenail is loose and bleeding. The immediate action was to assess the injury and educate CNA on importance of safety while pushing wheelchair. An X-ray of R1's right foot was done and reported as negative for fractures.

R1's Resident Incident Report documents on 7/30/18 at 5:31 AM, R1 was found on the floor in the activity room laying on her right side. The report documents that R1 had gripper socks on at the time. The immediate post-incident action added was to encourage resident to stay in traffic areas even though R1 has moderate cognitive impairment. The report documents R1 continues to ambulate about facility independently.

R1's Resident Incident Report dated 8/7/18 documents at 9:21 AM, R1 rolled off couch onto the floor. No injury was noted. The report documents R1 continues to ambulate about facility independently. Intervention added was to encourage R1 to go to her room to rest when she is tired. There is no evidence they took R1's cognitive impairment and poor safety awareness into account when contemplating this added intervention.

R1's Resident Incident Report documents on 9/2/18 at 5:55 PM, R1 was "found on the floor in the hallway." The report documents the fall was unwitnessed with no injuries noted. The Report documents when they stood her up, she fainted and was then lowered to the floor by the nurse. The report documents R1 regained consciousness within 10 seconds and was take to her room in a wheelchair. The Immediate action

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documented as taken was to do neuro (neurological) checks and the follow up documents R1 continues to ambulate throughout the facility.

R1's Resident Incident Report documents on 9/7/18 at 5:46 PM, R1 was in the dining room at supper time walking around tables and tripped on another resident's wheelchair. The report documents R1 fell backwards hitting her head on the edge of the fireplace sustaining a hematoma to the back of her head. Immediate actions taken were to do 15 minute checks and neuro checks. The report documents R1 continues to ambulate independently without any added supervision or increased monitoring.

The Departmental Note dated 10/4/18 entered at 2:17 PM by V11 (Licensed Practical Nurse/LPN) documents "Nurse stated that my resident was on the floor in hallway, went down to nurse who was with resident assessing her, bruising and blood noted from nose." The Note documented a call was placed to physician and family with the ambulance arriving to transport R1 to the emergency department.

The Departmental Note entered by V2 (Director of Nurses/DON) dated 10/4/18 at 5:23 PM documents the facility called the hospital to check the status of R1 and was told that she had multiple facial fractures. The note continues to document that R1's daughter "stated to this nurse that she did not want resident to be confined to wc (wheelchair) and did state to this nurse that she knows that her Mom is mobile and that falls are going to occur. This nurse assured family that resident would be on 15 minute checks when she returns from ER (Emergency Room) and that staff was going to attempt to keep resident on the

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S9999	Continued From page 5 east side of the building for closer monitoring." Hospital Records X-ray dated 10/4/18 documents under Findings: Comminuted fracture of the medial wall of the right maxillary sinus communicating with the nasal vault. There is a nondisplaced fracture of the lateral wall of the right maxillary sinus with air within the immediate right para maxilla soft tissues. There is a nondisplaced fracture of the inferior aspect of the right and left maxillary sinus. There is a nondisplaced nasal septal fracture. Comminuted nasal plate fractures noted, right greater than left. The zygomatic arches are intact. The pterygoid processes are intact. Severe tighward nasal septal deviation of the septum is noted. Evidence of an outdistanced fracture of the posterior medial left maxillary sinus wall. A comparison between the MDS dated 7/6/18 which documents R1 to be independent in all aspects of mobility and ambulation and the quarterly completed on 10/4/18 documents a decline in balance and ambulation. The MDS dated 10/4/18 (quarterly) documents R1 to have long/short term memory deficits with moderate cognitive impairment. The MDS also documents R1 to require extensive assist of one staff for transfers and set up/supervision for walking in her room/corridor and for locomotion on/off unit. The MDS section entitled "Balance during transitions and Walking" documents that R1 was steady at all times for moving from seated to standing position, moving on/off toilet and surface to surface but was "not steady, but able to stabilize without staff assistance" for walking and turning around. There is no evidence the facility took this information and revised R1's fall prevention plan to include increased supervision/assistance, monitoring R1 during periods of continual	S9999		

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ambulation for fatigue/weakness and R1's poor safety awareness.

The Care Plan dated 7/2018 documents "Problem/Need" of being at risk for fall r/t (related to) impaired mobility, dx (diagnoses) dementia/Alzheimer's, glaucoma, incontinence, use of antipsychotic medications. Written in documents "Frequent falls r/t (related to) syncope episodes. R1 had multiple falls identified on the care plan as occurring 7/30/18, 8/7/18, 9/2/18 and 10/4/18 with the immediate interventions added in according to the date of the fall. The goal is to have falls/injuries minimized through management of risk factors through next review October 2018. Interventions include: Perform a fall risk assessment quarterly and PRN (as needed), provide a safe environment, place my call light and frequently used items within safe reach, and encourage me to participate in activities safely." The care plan failed to reflect R1's overall decline in mobility over the past quarter including her need for a wheelchair at times. The care plan failed to include her need for supervision or continual monitoring for syncope and/or weakness or her continual wandering about. The interventions used at the time of the falls were ineffective in preventing her from falling and sustaining life threatening injuries. The preventative plan also fails to reflect any interventions toward educating the family who requested that she be ambulating independently.

A Fall Risk Assessment completed 10/4/18 following the fall with facial fractures assesses R1 at a lesser risk with a score of 55 with no explanation as to how that would be since she'd had at least 4 falls since that time.

On 10/10/18 at 1:30 PM, R1 was in bed. R1 had

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extensive dark blue/purple bruising about her face from the eyes down which extended down her neck into the clavicle area and sternum of her chest. R1 did not respond when spoken to but just looked about the room when spoken to.

On 10/17/18 at 3:01 PM, V11 (LPN) stated the facility reviewed the camera feed of R1's fall on 10/4/18 and determined she turned and tripped over her own feet falling to the floor. There were no staff in attendance. V11 stated R1 continually wandered about the facility and had periods of syncope as well but that she was not aware of any spells recently. V11 stated there were times when they would use a wheelchair for R1 but she often refused. V11 stated CNAs would assist but she was never "categorized as a stand by assist until she returned following her fall on 10/4/18."

On 10/17/18 at 10:35 AM, V2 (Director of Nurses/DON) stated she had no explanation as to why R1 would have been assessed at a lesser fall risk in October than in July.

On 10/18/18 at 12:55 PM, V18 (Nurse Practitioner) for V17 (Physician) stated she recalled R1 and stated she walked and walked. V18 stated R1 had poor safety awareness. V18 stated she was told R1 tripped over her own feet when she fell on her face this last time. V18 stated R1's family did not want her confined to a wheelchair but staff would occasionally get her to lay down on the sofa by the nurse's station. V18 stated she would expect the facility to identify decline in mobility such as was identified in the MDS and put forth effective interventions to ensure safety and would consider increased supervision and monitoring for weakness a part of that.

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The facility's policy/procedure entitled "Interdisciplinary Fall Reductions/Injury Prevention Protocol" dated 7/2012 document the intent as "An Interdisciplinary approach at reducing falls, preventing injury and increasing safety awareness ultimately resulting in improved quality of care for our residents." Under Recommendations, it documents "Nursing to complete a fall risk evaluation upon admission, re-admission, quarterly and with significant change." The policy documents safety devices being checked for placement, staff to wear/use gait belts at all times but fails to reflect any interventions of supervision and/or increased monitoring.

2. The MDS dated 9/18/18 documents R2 as a 59 year old male admitted to the facility on 6/8/17 with diagnoses of Peripheral Vascular disease, amputation of the left lower leg and cellulitis of the right lower leg in part. The MDS documents R2 to be cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15. The MDS also documents R2 required extensive assist of two staff for transfers.

The Care Plan dated September 2018 documents R2 was at risk for falls related to impaired mobility due to Cerebral Vascular Accident (CVA) with left side hemiplegia, hypertension, use of diuretics, anemia, impaired vision, use of antipsychotic medication for sleep and dementia with recent left above knee amputation. The goal is to have injuries minimized through management of risk factors though the next review. Interventions include, in part, transfer with 2 assist and full body mechanical lift.

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A Resident Incident Report documents on 10/8/18 at 9:20 AM, "was in resident room and resident stated that on Saturday 10/6/18, CNA was in residents room transferring resident when she left go of residents chair and resident fell back." No injuries were documented.

Departmental Notes dated 10/9/18 at 2:07 PM document "Resident self reported fall that occurred on 10/6/2018. Resident stated that around 1:30 PM staff was attempting to get him from the bed to the w/c (wheelchair). Staff was successful and did get resident into w/c and unhooked from the (full body mechanical) lift. w/c was reclined and tilted back to the floor. Resident stated that he did not get injured and he did not hit his head."

On 10/10/18 at 1:00 PM, R2 was sitting in his wheelchair in his room. R2 recalled the fall well and stated the CNA (didn't know the name) was on her cell phone by herself when the back of his w/c fell backward causing him to slide out the back of the chair when she lowered him into it. R2 stated the CNA went and got another CNA and with her help, used the mechanical lift to get him off the floor. R2 stated no nurse came down before he was lifted off the floor and he didn't say anything to anyone until that Sunday morning. R2 stated the staff are supposed to always use two staff during a full body lift. R2 denied injuries.

On 10/10/18 at 2:00 PM, V2 (DON) stated the CNA who transferred R2 without assistance was V13 and is no longer employed by the facility as they have a policy that requires two to use a full body mechanical lift to transfer. V2 stated it is the policy of the facility to have at least 2 staff to transfer with a full body mechanical lift. V2 stated V13 did not report the fall to the nurse and they

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did not know about it until R2 self reported the incident two days later.

The policy/procedure entitled "Total Lift" dated 8/2016 documents "The Total lift is to be used for total lifts and/or to obtain a resident's weight from bed to chair, or from the floor."

3. The MDS dated 10/5/18 documents R7 as having no cognitive impairment with a BIMS score of 15. The MDS documents R7 to require extensive assist of 2 staff for transfers.

The Care plan dated October, 2018 documented R7 to be at risk for falls due to impaired mobility in part. Interventions include "transfers with the assist of three staff" and a full body mechanical lift.

On 10/10/18 at 1:30 PM, R7 confirmed she is transferred with a full body mechanical lift. R7 stated ,"They are supposed to use three staff but sometimes use only two." When asked if she is ever transferred by just one CNA, R7 responded, "Yes, but not very often."

4. The MDS dated 9/15/18 documents R8 to be cognitively intact with a BIMS score of 15. The MDS documents R8 requires extensive assist of two staff for transfers.

The care plan dated 8/2018 documents R8 to be at risk of falls due to impaired mobility with an intervention documented as "I transfer with a (full body mechanical lift) and 2 assist."

On 10/10/18 at 1:25 PM, R8 stated he is transferred using the full body mechanical lift. R8 stated he has been transferred by one staff with the lift and at times, lifted by a CNA to transfer

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too. R8 stated he has never fallen during a transfer and added that the CNA who lifts him "is strong."

5. The MDS dated 10/12/18 identifies R9 as an 86 year old female admitted to the facility on 10/2/18. The MDS documents R9 to have short/long term memory deficits with severe cognitive impairment. The MDS documents R9 requires extensive assist of two staff for transfers.

The Baseline Care Plan (undated) documents under "safety," that R9 is to be transferred with 2 assist and gait belt.

A Resident Incident Report documents on 10/12/18 at 2:31pm, the nurse was "called into residents room from Hospice nurse and resident was noted in sitting position on floor. V15 (Hospice staff) stated that she took resident into room to toilet alone. Resident scooted buttocks to the end of the chair and began to fall to the floor. Nurse was able to intervene and lower resident to the floor." No injuries were noted at the time except bruising and redness to left eye reported on 10/13/18. The report does not document whether R9 had on a gait belt during the transfer or not.

Departmental Notes dated 10/12/18 at 4:58 PM entered by V16 documented R9 "was taken to bathroom by Hospice nurse. The hospice nurse reported that while she was transferring (R9) to the toilet she lost control of the transfer and gently lowered (R9) to the floor while holding the gait belt. (R9's) buttocks made soft contact with the floor. (R9's) head and other body parts did not make contact with the floor, wall or toilet. (R9) was able to stand and transfer to toilet and chair afterwards. No injuries were found to her buttocks

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or other body parts. (R9) did not lose consciousness or become suddenly weak or dizzy."

On 10/16/18 at 12:45 PM, R9 was in the dining room being assisted with her meal. R9 was sitting in a reclining chair. R9 had a blackened eye on the left which extended down into her cheek area.

On 10/16/18 at 3:23 PM, V2 (DON) stated she has yet to get a report from Hospice on the incident and doesn't understand how R9 received a black eye when R9 was supposedly lower to the floor. V2 stated V15 stated she had a gait belt on but no one recalls seeing it at the time of the fall. V2 also stated the Hospice notes fail to reflect the fall/improper transfer and she has been unable to reach anyone at Hospice in regards to this incident. V2 stated R9 is a 2 staff pivot transfer with a gait belt and she would expect Hospice to do a safe transfer as identified by R9's care plan.

On 10/18/18 at 12:55 PM, V18 stated she understands the facility assesses each resident for safe transfers and would expect staff to follow recommendations for full body mechanical lifts and/or pivot transfers.

The policy/procedure entitled "Transfer Screen" dated 8/2011 documents the policy as: To determine a safe and appropriate method of transferring a resident, nursing staff will perform a transfer screen on each resident." The policy continues to document "Nursing is to enter the appropriate transfer on the resident's care plan and pocket care guide."

(B)

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(Violation 2 of 3)

300.610a)
300.1210b)3)
300.1210d)2)
300.1220)b)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 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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

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incontinent of bowel and/or bladder receives the 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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or

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agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview, observations and record review, the facility failed to provide appropriate consistent catheter care including insertion for 3 of 3 residents (R6, R10, R12) reviewed for urinary catheter services in a sample of 12. This failure resulted in hospitalization for R6 after a catheter was inserted improperly with the bulb inflated in the urethra.

Findings include:

1. The Admission Record documents R6 was admitted to the facility on 7/14/17. The Interdisciplinary Progress Note dated 7/14/17 documents R6 had a free flowing urinary catheter and is continent of bowel.

R6's Physician's Order dated 7/14/17 documented "Change foley cath Q (every) month on the 15th 18 FR (French) 10 ml (milliters)."

R6's Instant Care Plan dated 7/14/17 documents R6 had a urinary catheter and staff were to do catheter care every shift and record output every shift.

The Medication Administration Record (MAR) for August 2017 has the output every shift initialed as done but reflects no amounts. There was no documentation the staff changed R6's catheter or initialed this as being done in August 2017.

The September 2017 MAR documents amounts twice daily for output but again, does not reflect

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S9999	Continued From page 16 initials that R6's catheter was changed. A Departmental Note dated 8/16/17 at 1:47 PM entered by V8 (Licensed Practical Nurse/LPN) documents R6 was seen by V18 (Nurse Practitioner) for V17 (Physician) and received the following orders for a urinalysis "(UA) with C&S (culture and sensitivity) if indicated. Urine collection via catheter bag and stored in refrigerator. Resident urine clear yellow in color, foul odor noted. No noted hematuria." R6's Urinalysis results, dated 8/20/17, document R6 to have a urinary tract infection (UTI) of > (greater than) 100,000 colony forming unit/milliliter (CFU/ML) of Escherichia coli (E. coli) which required an antibiotic of Amoxicillin 875 milligrams (mg) twice daily. The Departmental Notes dated 9/10/17 at 5:06 PM document "new order from (V17) for UA C&S if ind (indicated). POA (power of attorney) aware." There is no information present in the departmental notes from 9/10/17 through to 9/18/17 that would explain why R6 had a UA done. The UA results dated 9/17/17 document R6 to have a UTI culturing > 100,000cfu/ml. The Departmental Notes dated 9/18/17 at 5:27 AM documents "ua (urinalysis) results received, awaiting C&S (culture and sensitivity). (V18 Nurse Practitioner) aware, no (no new orders) received, resp (responsible) party aware." At 9:29 AM, V2 (Registered Nurse/RN) documents "CNA (Certified Nurse Aide) approached this nurse this am stating that the resident had blood in catheter bag. Resident was assessed abd	S9999		

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(abdomen) soft nontender, bowel sounds present x (times) 4 quads." The note continues that R6 seemed weak, stating he would like to stay in bed. The Note continued that V17 was notified and an antibiotic Rocephin 1 gram was given. There was no further documentation regarding R6's urine until 9/19/17 at 5:16 AM.

Departmental notes dated 9/19/17 at 5:16 AM, documents "late entry for 9/18/17, lab results back. V18 notified of labs, new orders received to send resident to hospital" for evaluation and treatment. The note continues to document freely draining per gravity but again, fails to document the characteristics of the urine. The next entry is documented in the Departmental Notes is dated 9/19/17 at 5:55am and is a "late entry" for 9/18/17 at 5:45pm which documents the ambulance is here to transfer resident to hospital.

Hospital Transfer Form dated 9/23/17 for "offsite extended care" documents discharge orders to include: "1. Rocephen 1gm IM (intramuscular) daily times 4 days 2. BMP (Basic Metabolic Panel) Monday - Call physician with results 3. "Last (catheter) place by NH (nursing home) had balloon blown up in urethra - please have RN (Registered Nurse) confirm placement next time" in part.

The care plan dated October 2017 identifies R6 to have a catheter and an increased risk of infection and other complications with interventions to change catheter per orders, observe for s/s (signs/symptoms) of infection; color, amount, consistency, odor, abdominal fullness, pain, keep drainage bag lower than level of bladder, maintain closed system, monitor output, observe for positioning of tubing, leg strap, catheter care every shift and PRN (as

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needed) and follow-up with urologist PRN. There is no intervention listed to ensure correct pericare given or that R6 had a UTI culturing E. coli, which is an intestinal bacteria. The care plan also failed to ensure correct collection of a urine specimen.

R6 continued to have UTI's as follows: 10/17/17 - >100,000cfu/ml Enterobacter Cloacae, 10/31/17 and 1/13/18 > 100,000cfu/ml E. coli. The care plan reviewed quarterly fails to reflect any added interventions in light of R6's multiple UTI's.

Departmental Notes reviewed from 7/15/18 through 7/22/18 document R6 to be on a routine Antibiotic for chronic UTI's with the catheter draining but includes no characteristics of his urine and no abnormal behavior including lethargy as occurring.

The MAR for July 2018 documents R6 to receive Macrobid 100 mg daily for frequent UTI's with catheter care and output recorded twice daily. The MAR has no initials for the catheter to be changed on the 15th of the month. The departmental notes from 7/12/18 through 7/22/18 fail to reflect a catheter change.

On 7/22/18 at 9:53 PM, the departmental notes entered by V2 (DON/RN) document "Resident con't (continues) on LT (long term) abt (antibiotic) therapy for chronic UTI, resident took all medications without difficulty. Resident con't to have catheter in place and draining well." and "resident has an output recorded as 275ml at 9:45 PM. Resident was noted to have scant bleeding from cath insertion site."

On 7/23/18 at 4:09 PM Departmental Notes entered by V11 (LPN) document "Was passing by resident at dining room table this am at 8am

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noted that residents hands were shaking, looked at resident and his color was off kind of gray, did not respond to my voice, could not follow commands, got stethoscope, heard audible wheezing, shaky color change, could not get a reading on by pulse ox (Oximetry), immediately took resident to room had staff lay him down could not get a reading on BP (blood pressure), 99.2 was his temp (temperature) and 108 was his pulse. Resident was having difficult time breathing. Looked at resident, Resident catheter and noted blood and urine mixed to together in bag as well as tube, got O2 (oxygen) applied it with pulse ox on finger @ (at) 2 L (liter) no oxygen level noted, turned up to 3 L noted level was 79% took to 3.5 L and stayed at 79%. asked another nurse to stay with resident; call placed to V17, Physician, at 7:56am, call placed to ambulance at 8:02, call placed to" family member.

Hospital Records dated 7/23/18 document R6 to have a UTI caused by baterium E. coli. The History and Physical (H&P) dated 7/23/18 documents "He presented to hospital with lethargy, He was sent from a nursing home. According to family members, he was just sleeping all day, not communicating with staff as he usually does." Upon physical Exam, the H&P documents "Temperature was 103.1, pulse 101 with blood pressure in the emergency room as 83/56. Under Assessment, the H&P documents "1. Severe Sepsis, most likely coming from Urinary tract infection in a patient with underlying dementia," in part.

The Departmental notes document R6 being readmitted to the facility on 7/24/18 and expired on 7/25/18.

On 10/16/18 at 9:40 AM, V20 (R6's family

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member) stated R6 continually had UTI's and would exhibit certain behaviors and symptoms which the facility had difficulty picking up on. V20 stated R6 would get really sick before staff noticed and would end up in the hospital. V20 stated when R6 was hospitalized in September 2017, the physician at the hospital told them about the catheter being inserted wrong with the balloon blown up in the urethra. V20 stated often times, family would note his urine being cloudy, etc before staff and would have to tell them to get a UA. V20 questioned the E. coli and stated often R6 would sit for periods of time in bowel movement.

The policy entitled "Catheter Insertion" dated 11/2010 documents the policy as: A catheter is utilized to establish/maintain drainage from the bladder and to ensure routine urinary elimination." Under procedure, it documents "* NOTE: Male catheterization: Continue inserting catheter 2-4 inches after urine flow starts. Inflate balloon. Pull back gently on catheter until resistance is met, indicating proper placement."

On 10/19/18 at 11:38 PM, V1 (Administrator/Nurse) stated she has no policy/procedure on proper method of collecting a urine specimen from a resident with a catheter but probably wouldn't collect it from the drainage bag.

Mosby's Manual of Diagnostic and Laboratory Tests, Third Edition, dated 2006, by Pagana and Pagana, Chapter 11 Urine Studies, page 957, documents "In patients with an indwelling urinary catheter in place, a specimen is obtained by attaching a small-gauge needle syringe and aseptically inserting the needle into the catheter at a point distal to the sleeve leading to the

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balloon." The manual documents "The urine that accumulates in a plastic reservoir bag should never be used for a urine test."

2. The Minimum Data Set (MDS) dated 10/1/18 documentsR10 as a 71 year old male readmitted to the facility on 10/10/17 with diagnoses of Cerebral Infarct, Hemiplegia, Obstructive and Reflux uropathy in part. The MDS documents R10 to be cognitively intact with a Brief Interview of Mental Status score of 15. The MDS documents R10 to have urinary catheter and be occasionally incontinent of bowel movement.

The care plan dated October 2018 documents R6's to have obstructive uropathy and an indwelling catheter. The interventions include: refer to urology PRN, obtain my output every shift, perform catheter care every shift and PRN, ensure proper positioning of my catheter tubing, drainage bag, encourage to use a leg strap, utilize privacy bag for my dignity, observe me for s/s of UTI, encourage oral intake, and change catheter monthly.

On 10/18/18 at 1200 PM, R10 stated he "never gets catheter care" but they do change it every month. R10 was sitting in his room in his wheelchair with the catheter tubing going down his pant leg. The tubing was resting on the floor. Urine in the tubing was cloudy, yellow with moderate sediment. R10 stated he is a mechanical lift sit to stand transfer. R10 denied having catheter care.

On 10/18/18 at 3:30 PM, R10 was laying on his back in bed. V21 (CNA) explained to R10 that she was going to do catheter care. R10 had on a paper brief which appeared wrinkled, damp. When R21 pulled the brief off, R10 was noted to

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S9999	Continued From page 22 have dried bowel movement (BM) on his scrotum. R10 had no leg strap on securing his catheter. V21 provided care then rolled R10 to his left side. R10 had dried BM on bilateral inner buttocks but had no BM at his rectum. R10 stated he last had a BM earlier that morning on the toilet and had the brief on since that time. 3. R12's MDS, dated 7/20/18, documents R12 had a BIMS score of 15 indicating that R12 has intact cognition. R12's Physician Order Sheet (POS) dated 10/2018 documents diagnosis of Benign Prostatic Hyperplasia without lower urinary tract symptoms. R12's POS sheets for May 2018 through October 2018 document in part, "Change cath (catheter) monthly on the 15th and as needed. Catheter care every shift 7AM-7PM and 7PM-7AM." R12's POS dated 10/18/18 documents "Catheter change monthly at urologist doctor's office per RP (responsible party) request." R12's POS dated 6/30/18 documents Macrobid 100 mg twice a day for Urinary Tract Infection. R12's Urine culture dated 6/30/18 documents greater than 100,000 Escherichia coli (E-Coli). R12's progress note dated 7/23/18 documents in part, "F/C (Foley cath) changed using sterile technique." R12's Progress Note dated 9/17/18 at 4:42 PM documents "Made aware by PT (Physical Therapy) that resident has blood draining from catheter, Foley tube assessed and blood clot noted in tubing, call made to Physician and office refer to Urologist, call made to daughter V19 to	S9999		

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S9999	Continued From page 23 make aware and daughter stated 'the cath needs to be changed' made aware that there were no 16 F cath in the building, call made to Nurse Practioner to increase cath size to 18 F, daughter okay with new order, cath to be changed by staff nurses." R12's progress note dated 9/17/18 at 5:22PM documents "16 F coude cath inserted, scant amount of blood noted in return, straw colored urine noted. Resident denies pain or discomfort before, during and post insertion of cath, will continue to monitor for changes of condition." R12's Care Plan undated documents in part, "Problem Onset: I have a diagnosis of Benign Prostatic Hyperplasia (BPH) and obstructive uropathy. I have a catheter. I am at risk for UTI's (Urinary Tract Infections) related to my Foley catheter. (16 French Coude). Goal/target date: I will have no complications associated with my catheter use thru next review Oct/2018. Approaches: Change my catheter per orders, Offer me acid ash drinks (for example cranberry juice), Ensure proper positioning of my catheter tubing and drainage bag, Utilize leg strap, Provide me a privacy bag for dignity. Record my output every shift. Provide me with Foley catheter care every shift and as needed. Observe me for signs and symptoms of UTI." On 10/18/18 at 2:30 PM, V19 (R12's Power of Attorney) stated that the facility does not complete catheter care twice a day and further stated that the facility is supposed to change the catheter monthly on the 15th, however there have been times that R12 has gone over 6 weeks without getting his catheter changed. V19 has now set up appointments with the Urologist monthly to ensure R12's catheter gets changed timely. V19 stated that R12 has a history of	S9999		

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urinary tract infections and was diagnosed with Benign Prostatic Hyperplasia in April during a hospitalization. R12 had a catheter inserted at that time. V19 stated that during an Urologist visit on 10/5/18, when R12's incontinent brief was removed there was a foul odor and purulent drainage coming from the tip of R12's penis. V19 stated R12 was placed on antibiotics at that time for a urinary tract infection.

R12's POS dated 10/5/18 documents Bactrim SS every day for 10 days for UTI.

On 10/18/18 at 2:30 PM, R12 was laying in bed with catheter bag attached to the right side of the bedrail draining clear amber urine. R12 stated that the facility staff do not complete catheter care twice a day.

On 10/19/18 at 9:30 AM, R12 was sitting up in his recliner. R12's catheter bag was laying on the floor with clear amber urine present.

During interview with V2 (DON) on 10/19/18 at 11:05 AM, V2 stated "Yes, I would expect the nurses to follow Physician orders and change the catheter on the 15th of each month." V2 further stated, "The catheter bags should not be laying on the floor."

(B)

(Violation 3 of 3)

300.610a)
300.1210b)
300.1210d)2)
300.1210d)3)

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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 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a

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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. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure that oxygen therapy and saturation monitoring was provided as ordered for 1 of 3 residents (R3) reviewed for oxygen therapy in a sample of 14. This failure resulted in R3 becoming hypoxic/unresponsive and requiring hospitalization.

Findings include:

1. The Admission Record documents R3 was initially admitted to the facility on 9/13/17 with diagnoses of malignant Neoplasm of Larynx, Chronic Obstructive Pulmonary Disease with exacerbation and Diabetes Mellitus in part. The Hospital Record also documents that R3 was verbal with an electronic device and had a tracheostomy (trach) collar on.

R3's Hospital Discharge Orders and Summary, dated 9/13/17, document medications to be given but did not document any orders for oxygen (O2) and/or SpO2 (Peripheral capillary oxygen saturation) to be done.

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The facility's Interim Care Plan dated 9/13/17 did not document R3 had a trach collar and did not identify any use of oxygen or the needs/orders for SpO2 being done.

The Medication Administration Record (MAR) for September 2017 did not document if and when R3 should receive oxygen and when staff should monitor SpO2.

The Interdisciplinary Progress Notes dated 9/13/17 (no time) documents "Resident was admitted via ambulance from hospital around 4:30 pm. Resident is AOx3 (alert oriented time three) and can make all needs known. Resident has a fresh stoma but can speak using a voice box. Resident is full code." The admission Note includes no information as to R3's Tracheostomy collar and whether she had the need for oxygen and/or SpO2.

The Progress Notes entered on 9/14/17 at 6:06 PM by V8 (Licensed Practical Nurse/LPN) document "at approximately 11am, R3's respirations were even non labored. No sob (shortness of breath) noted. cap (capillary) refill less than 3 seconds" and "at approximately 12:50 PM grandson alerted staff to come to room. Vital signs: bp (blood pressure) 160/84, pulse 134, respirations 22 non labored, spO2 81% O2 applied at 2L (Liter)-5L for comfort. SpO2 increased to 88% - unable to maintain SpO2 at a good level. Resident responded to tactile stimulation and when writer calls residents name loudly resident opened her eyes for a very brief period. Code status verified as Full Code. EMS (Emergency Medical Services) dispatched. Resident sent to hospital for further evaluation. Respective Party notified."

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Hospital Records dated 9/14/17 document under History of Present Illness "Pt (patient) is a 79 y/o (year old) CF (Caucasian female) who presents to the ED (emergency department) with C/O (complaints of) unresponsive. Per pts grandson at bedside, she was also off of O2 for unknown time span" and "When he saw her this afternoon, he states that she was only responding to pain. However, she is normally a & o x 3. Per pt's grandson, her pulse ox (oximetry) was in the 70's and A Fib at 120. While en route to ED, the pt's pulse ox was 99 while on O2." Under the Assessment and Plan, it documents: "Altered Mental status could be due to the hypoxia. It was reported that the patient has been off her trach collar for almost 24 hours. Arterial blood gases were drawn, and she is hypoxic with her O2 of 62."

The Hospital Records Discharge dated 9/21/17 document physician's orders along with a directive that reads "Can use supplemental oxygen as needed through the trach collar to keep saturations greater than 90%" but does not include specifics for oxygen therapy.

The Progress notes on readmission dated 9/21/17 document "resident arrived at 5pm via ambulance with 2 EMT's present." The notes document "continues on humidified trach collar setting in place."

The Progress note reflect random entries regarding R3's oxygen and trach collar as such: 9/22/17 at 3:34pm "O2 @ (at) 3 L per O2 collar covering tracheostomy site," 9/23/17 at 5:36am "on humidified air, sats 98%," 9/23/17 2:14pm "O2 at 3L per O2 collar covering tracheostomy site" with an O2 sat of 97% on room air, 9/24/17

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at 2:53am, "O2 @ 2L per O2 collar covering tracheostomy site." 9/24/17 at 11:14pm, "O2 at 2L per O2 collar," and on 9/27/17 at 2:44am, the same as is on 9/29/17 at 3:27am.

Neither the Treatment Administration Record nor the MAR includes orders for Oxygen therapy and how/when to apply it but only documents to keep R3's SpO2 saturations above 90%.

A Weekly Respiratory Assessment dated 9/27/17 signed by V10 (Respiratory Therapist) documents "(R3's) respiratory rate as 18, unlabored, diminished breath sounds, with the SpO2% as 77% then up to 90-94%." Under Comments and Recommendations, V10 documents "Resident was sitting up in chair w/no (with no) and SpO2 up to 90-94%." noted distress, SpO2 (low) but fixed humidity + (and) O2 and SpO2 went up to 90-94%. Talked with nursing for orders and to talk with home health care company to get size of Larry tube. Will re-evaluate as needed."

The next progress note dated 10/2/17 at 6:42 AM documents "CNA (certified nurse aide) came to this writer and stated 'resident with the trach is not breathing.' Went to resident room and on the way there had the CNA call 911. Upon entering residents room resident was unresponsive. Resident full code therefore CPR (cardiopulmonary resuscitation) was initiated by this nurse." The note documents EMS arriving and transporting R3 to the hospital.

Hospital Records dated 10/2/17 dated 10/2/17 document the diagnoses as "Cardiac Arrest."

MAR's from 9/21/17 on R3's readmission following her hypoxic episode document "Trach collar to keep ox sats > 90%" but fail to reflect

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S9999	Continued From page 30 any initials as being done from 9/21/17 through 9/30/17. The MAR for October 2017 reflects only initials for O2 sats being done on each shift 10/1/17 but fails to reflect the level itself. On 10/16/18 at 12:55 PM, V2 (Director of Nurses) stated she was unable to locate any documentation that SpO2's were done and documented but did see a random one in the progress notes. On 10/17/18 at 1:35pm, V2 stated R3 did not have a trach inner tube but only had a stoma. V2 stated R3 had a cover for it which she refused to wear. V2 stated the nurses should have been documenting R3's use of oxygen in light of the SpO2 levels but couldn't find where they had consistently documented it. On 10/19/18 at 12:45 PM, V1 (Administrator/Nurse) stated that R3's order did not include any specifics on how to maintain SpO2 sats but just keep it above 90%. V1 was unable to state how staff were to do that without checking the oxygen levels or SpO2's regularly to determine what exactly the levels were. In addition, V1 confirmed there were no orders for Oxygen administration but that the nurses did document administering it to R3 on several occasions. The policy/procedure entitled "Oxygen Therapy" dated 8/2014 fails to document any information in regards to obtaining SpO2s or how to maintain levels of Oxygen above 90%. On 10/18/18 at 12:55 PM, V18 (Nurse Practitioner) for V17 (Physician) stated they don't usually give specifics but to keep O2 sats above 90-92% and would expect them to have protocols	S9999		

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S9999	Continued From page 31 to follow such as every shift. V18 stated she would also expect them to do it and document monitoring the resident for signs/symptoms of hypoxia in a consistent manner. (A)	S9999		