STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING: _____ B. WING _____	C 11/12/2021

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HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

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S 000	Initial Comments Complaint 2128156/IL139900	S 000		
S9999	Final Observations State Licensure Violations: 300.610a) 300.1010h) 300.1210b)3) 300.1210c)3) 300.1220b)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and	S9999		

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S9999	Continued From page 2 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed identify and assess the medical justification for R1's catheter use, identify and monitor R1's signs and symptoms of a urinary tract infection, failed to notify the Physican of cloudy urine (symptom of a urinary tract infection) and a significant decline in a resident's mental and physical condition and failed to implement appropriate interventions when R1's	S9999		

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urine became cloudy and R1 experienced increased lethargy, decreased communication and changes in skin integrity (R1). The facility also failed to obtain Physician orders for catheter use and care (R1) reviewed for indwelling catheter use. These failures resulted in R1 experiencing a change in physical and mental status consisting of unresponsiveness, abnormal vital signs, abnormal breathing and being sent to the local hospital where R1 was diagnosed with Sepsis (a life-threatening condition which occurs when the body's response to an infection damages its own tissues) which was the result of R1's urinary tract infection. R1 subsequently expired on 10/22/21 due to R1's urinary tract infection that led to sepsis.

Findings include:

On 11/6/21 at 12:05 p.m., V2 (Director of Nursing) stated, "We don't really have a policy for Catheter Use, Catheter Assessment or on Urinary Tract Infections (UTI) but we follow the standards of practice and refer to the Mayo Clinic UTI symptoms and causes."

The Mayo Clinic UTI Symptoms and Causes material dated 2/9/21, provided by V2, states, "A UTI is an infection in any part of your urinary system-your kidneys, Ureter, bladder and urethra. Most infections involve the lower urinary tract-the bladder and the urethra. (UTI's) don't always cause signs and symptoms, but when they do they may include: A strong, persistent urge to urinate, a burning sensation when urinating, passing frequent small amounts of urine, urine that appears cloudy, strong smelling urine, pelvic pain, in women. Contact your doctor if you have signs and symptoms of a UTI. Other risk factors

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for UTIs include: Catheter Use, People who can't urinate on their own and use a tube (catheter) to urinate have an increased risk of UTIs. When treated promptly and properly, lower urinary tract infections rarely lead to complications. But left untreated, a urinary tract infection can have serious consequences. Complications of a UTI may include: Sepsis, a potentially life-threatening complication of an infection, especially if the infection works its way up your urinary tract to your kidneys."

The facility's Catheter Care: Indwelling Catheter policy dated 4/2019, states, "Catheter bags should be covered with a catheter dignity bag to preserve the dignity of the patient. Secure the catheter to the patient's leg using a securement device or leg strap to prevent traction on the urethra. Catheter securement device must be changed every 7 days."

The Facility's Change in Condition policy dated 11/2016, states, "Purpose: To provide guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications. Note: (The Centers for Medicare and Medicaid Services) requires, 'A facility must immediately inform the resident, consult with the resident's Physician; and notify, consistent with his or her authority, the resident representative(s) when there is: A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial in either life-threatening conditions or clinical complications); According to the American Medical Directors Association (AMDA) Clinical Practice Guidelines-Acute Changes in Condition in the Long-Term Care Setting: Immediate notification is recommended for any symptom,

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sign or apparent discomfort that is acute or sudden in onset and a marked change in relation to usual symptoms and signs, or is unrelieved by measures already prescribed."

1. R1's Admission Assessment dated 10/8/21, documents R1 was admitted from the hospital after sustaining a hip fracture from a fall at home.

On 11/6/21 at 4:44 p.m., V8 (R1's daughter) stated that R1 fell at home on 10/7/21 and sustained a hairline hip fracture that did not require surgical repair. V8 stated that R1 was sent from the local hospital's emergency department to the facility on 10/8/21, for a short term stay to receive skilled therapy and return home as soon as possible. V8 stated prior to R1's fall at home on 10/7/21, R1 lived alone and was able to care for all of her needs independently, with no care givers. V8 stated R1 had never had a catheter prior to R1's emergency room visit on 10/7/21. V8 stated the catheter was inserted so R1 did not have to get out of bed to urinate at the hospital.

R1's Care Plan dated 10/11/21, states, "Use of indwelling urinary catheter needed due to urinary retention. Report to Physician signs of UTI (Urinary Tract Infection) such as blood, cloudy urine, fever, increased restlessness, lethargy, complaints of pain/burning, acute change in mental status, functional decline in activities of daily living. Report any changes in amount and color, or odor of urine."

R1's computerized medical record, including Physician orders, progress notes, assessments, medication administration record and treatment administration record, dated 10/8/21 through 10/21/21, does not include a Physician order for

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the use of the catheter, catheter care or documentation that a catheter assessment was completed to document justification for the continued use of R1's catheter.

R1's computerized medical record does not document a diagnosis of any infection or orders for antibiotics from admission date of 10/8/21 to date of discharge 10/21/21.

R1's Nursing Progress Notes dated 10/8/21 (Admission) at 8:29 p.m., states, "(R1) is continent of stool and has an indwelling (urinary catheter) present (16 french/10 cubic centimeter) bulb. It is draining adequate amounts of yellow urine."

R1's medical record does not document any further assessment of R1's catheter or urine characteristics after 10/8/21 at 8:29 p.m. until 10/16/21.

R1's Nursing Progress Notes dated 10/16/21 at 5:29 a.m., states, "(R1's Indwelling urinary catheter) is patent and draining cloudy yellow urine."

R1's Nursing Progress Notes dated 10/17/21 at 4:27 a.m., states, "(R1's Indwelling urinary catheter) is patent and draining cloudy yellow urine."

R1's medical record does not document any further assessment of R1's catheter or urine characteristics after 10/17/21 through 10/21/21 when R1 was transferred to the hospital for a significant change in condition.

R1's medical record does not document R1's Physician was notified of R1's cloudy urine on

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S9999	Continued From page 7 10/16/21 and 10/17/21. R1's medical record does not document any further notification of V13 (R1's Physician) regarding R1's significant change in mental and physical status. R1's medical record does not document V13's response to the fax sent by V5 on 10/20/21. R1's Progress Note dated 10/21/21 at 1:50 p.m., documents that R1 had a significant change in condition and was sent to the local emergency department for evaluation. R1's Occupational Therapy Treatment Encounter Note(s) dated 10/20/21, documents, "(R1) Required additional cueing to stay on task and focused. (R1) not quite herself today. Lethargic, presents with increased tremors, and drooling/running nose. Nurse notified. (Blood Pressure) 96/56 manually. (R1's) therapy session decreased." R1's Speech Therapy Treatment Encounter Notes dated 10/20/21, documents, "Decline in (R1's) status since last session (on 10/18/21). Decline in (R1's) ability to attend to and participate in tasks and respond appropriately to communication." R1's Progress Notes dated 10/20/21 at 9:40 p.m., V5 (Licensed Practical Nurse/LPN) document, "(R1) has seemed more lethargic than normal this shift. Appetite has been poor and (R1) not communicating as much this shift. Reddened area to buttocks noted. (R1) repositioned and turned (every) 2 hours. Fax out to Physician. Will continue to monitor." R1's medical record does not document any	S9999		

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further notification of V13 (R1's Physician) regarding R1's significant change in mental and physical status. R1's medical record does not document V13's response to the fax sent by V5 on 10/20/21.

R1's medical record did not include any further documentation of R1's condition until 10/21/21 at 1:50 p.m. (over 16 hours later).

R1's Progress Note dated 10/21/21 at 1:50 p.m., V6 (Registered Nurse) documents, "(Certified Nurse Aide) came and got (V6) to look at (R1's) bottom. Both buttocks are red and slightly purple in color and blanchable. (R1's) mid spine is red (with) purple hue. Did apply (foam) dressing for protection and it is blanchable as well. (R1) would not open eyes and noted to be diaphoretic. Respirations 50, very labored (abdominal) breathing. (Temperature 99.0 degrees Fahrenheit, Heart Rate 86 and irregular.)" V6 documented V6 called and gave report to (local hospital), called 911, and ambulance arrived at 1:45 p.m. to transport R1 to the local Emergency Department.

R1's Ambulance Report dated 10/21/21 at 1:46 p.m., documents, "(Ambulance) was dispatched to (the facility) for a 74-year-old female with possible Sepsis. On arrival, the nursing staff states (R1) has been sick since yesterday. The nursing staff stated (R1) became unresponsive in the morning and has been getting worse. The nursing staff state (R1) usually (Alert and oriented). Upon (R1) contact, (R1) was lying in bed and was only responsive to pain. (R1) was hot to touch, (R1's) respiration was rapid, pulse was rapid and weak, (R1's) (urine in the catheter drainage bag) was dark brown and cloudy."

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S9999	Continued From page 9 R1's Hospital Laboratory Urine Culture dated 10/21/21 at 5:45 p.m., documents R1 had a Urinary Tract Infection with Escherichia Coli (bacteria). R1's Hospital Emergency Medicine Physician note dated 10/21/21 at 2:27 p.m., documents, "(R1) has a chronic indwelling catheter at this time. (R1) is nonverbal appears ill and septic. Apparently had a fever of 102 this morning. Smells of foul urine at this time with very dark cloudy urine with sediment in her catheter. (R1) is toxic appearing. (R1) is lethargic and disoriented. Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Sepsis, Shock, Dehydration and Renal Failure." R1's Hospital Nephrology Physician consult dated 10/21/21 at 5:30 p.m., documents Septic Shock, likely source is urine. Altered mental status likely in the setting of Sepsis/UTI. Prognosis quite guarded at this point." R1's Hospital Pulmonary Disease Physician consult dated 10/21/21 at 6:03 p.m., documents, "(R1) is basically severely septic, septic shock with acute renal failure. (R1) currently is being admitted with severe septic shock, Hypotension, mainly due to septic shock sources. Apparently, urine looked like pus." R1's Hospital Emergency Medicine Physician note dated 10/21/21 at 9:14 p.m., documents, "(R1's) prognosis extremely poor. Source likely (urine) as catheter was changed and (there) was pus in it. (Diagnosis): Septic Shock, Hyperkalemia (elevated potassium), Sepsis with multi-organ dysfunction."	S9999		

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S9999	Continued From page 10 R1's Hospital Nurses Note date 10/22/21 at 1:53 a.m., documents, "Preparing for intubation when (R1's) blood pressure began to decrease, (R1) declined in mental status, with no response to pain, gasping breaths, no palpable pulse. Time of Death called at (1:40 a.m.)." R1's Death Certificate dated 10/22/21, documents R1's cause of death as "Sepsis with Multi Organ Failure." On 11/6/21 at 10:42 a.m., V9 (Certified Nurse Aide) stated, "I didn't work on 10/20/21 or 10/21/21 when (R1) was discharged but I (took care of R1) several days prior to those dates. I do remember that her urine had a terrible odor. I can't recall exactly what (R1's) urine looked like at that time." On 11/7/21 at 11:55 a.m., V5 (LPN) stated, "On 10/20/22, therapy (staff) had noticed and reported that (R1) had a change in condition and that (R1) was more lethargic. (R1) went in and out. I didn't know if (R1) was just having an episode or what. (R1) didn't speak to me like she normally did. (R1) is usually more talkative. (I sent a) fax to (R1's) physician. (R1's physician) did not return the call on my shift. I don't know what the guideline is for faxing versus calling the Physician. The fax was just a notice that (R1) had a change. I noticed there was something off with (R1). (R1's physician) wouldn't have received the fax that late at night (9:40 p.m.) and it would have been the next day before anyone would have given the fax to him. On 11/8/21 at 9:23 a.m., V11 (Speech Therapist/Director of Rehab) stated V11 worked with R1 during lunch on 10/20/21 and noticed a change in her condition. V11 stated that R1 is	S9999		

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S9999	Continued From page 11 normally able to converse but on 10/20/21, R1 might answer yes or no on occasion but nothing like she normally did. V11 stated that R1 did not eat or drink for V11 that day. V11 stated R1's change in condition was reported to the nursing staff. On 11/8/21 at 1:43 p.m., V4 (Agency Registered Nurse) stated, "I did take care of (R1) on 10/20/21 day shift. I do remember therapy reporting some changes with (R1) and I took her blood pressure and thought it wasn't that low or concerning. I do remember the therapists reporting that she was lethargic. I didn't feel that Physician notification was needed at that time. I don't remember if I charted anything or not." On 11/9/21 at 11:09 a.m., V15 (Certified Nurse Aide) stated V15 was R1's Certified Nurse Aide on 10/21/21. V15 stated she had taken care of R1 a lot since R1 was admitted and knew a lot about R1's normal required care. V15 stated when R1 was first admitted her urine was clear yellow. V15 stated, "I do remember (R1's) urine turning cloudy and reminded me of pale milk with things floating in it. I can't remember the date that her urine started getting cloudy. I would say approximately one week prior to 10/21/21. I know the nurses were aware of it." V15 stated when V15 came to work on 10/21/21 at 6:00 a.m., the night certified nurse aide (unknown) reported that V15 had not been herself and was extremely lethargic and the staff had decided to leave her in bed to rest instead of getting R1 up for breakfast as usual. V15 stated the other (Certified Nurse Aide) that was working with V15 was also very concerned about R1 and had taken care of R1 the day before (10/20/21) and R1 was sick then also. V15 stated when V15 went to check on R1 on 10/21/21 at approximately 6:45 a.m., R1 could	S9999		

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not open her eyes or talk like usual. V15 stated R1 is usually up and talking by the time V15 gets to her room in the morning. V15 stated this was a "huge change" for R1. V15 stated R1's temperature was 102.3 degrees (Fahrenheit). V15 stated, "I felt like that was really high. I reported this temperature to (V14-Licensed Practical Nurse) and she did not seem very concerned and told me (R1) had been warm and to recheck it in a while. (R1's) urine was very dark. When we were changing (R1) there was a brown liquid that had absorbed in the incontinence brief. I don't think it was bowel (movement). I think it was drainage from around the catheter that leaked out, but I truly don't know. I was really worried about the lack of response to (R1's) change in condition so I went and told (V6-Registered Nurse). (V6) immediately came to assess (R1) and got her sent to the hospital."

On 11/9/21 at 10:07 a.m., V14 (Licensed Practical Nurse) stated, "I did notice (R1) starting to decline around lunchtime on 10/21/21." V14 stated R1 was in bed at the time and didn't remember getting any information at shift change about R1's condition. V14 stated she did not recall assessing R1's urine on 10/21/21. V14 stated she helped V6 get R1 ready to send to the hospital.

On 11/8/21 at 2:52 p.m., V6 (Registered Nurse) stated that V15 came to get V6 and asked her to come and look at R1. V6 stated, "I did look at her skin that (V15) stated was new redness on her buttocks and spine. (R1) was warm to the touch. I checked (R1's) temperature and it was 99.2. As I continued to assess (R1) and put some protective dressings on her spinal area, she took a further decline. (R1's) fever spiked higher and her respirations jumped up to 50. I literally ran to the nurse's station to call (R1's physician). In less

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	IL6003446	A. BUILDING: _____ B. WING _____	C 11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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
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than 15 minutes (R1) was transferred to the hospital. If a resident has cloudy urine, a urinalysis should be collected to check for infection. When a resident has a change in condition, the sooner it is acted upon the sooner we can get the resident help. A part of the nurse's daily assessment should be to assess the urine of a resident with a catheter.

On 11/9/21 at 12:55 p.m., V7 (Hospital Registered Nurse) stated that she was R1's nurse when R1 was brought into the Emergency Department on 10/21/21. V7 stated R1 was very ill and critical upon admission. V7 stated R1 was mottling (blotchy, red-purplish marbling of the skin) from her feet to above her knees, hands, chest, shoulders, and even at the tip of her nose had a purplish color to it. V7 stated that R1 was pale and unresponsive to anything but sternal rubbing. V7 stated R1's urine in the catheter bag was brown and yellow and had thick mucus like substance or pus moving through the urine. V7 stated, "Before I even took (R1's) catheter out I could smell the odor of the urine. It was horrible and made me nauseous. When I removed the catheter, there was mucous clogging the insertions site. I put a new catheter in. We did a bladder scan to make sure she wasn't holding large amount of urine, but it was empty. Her kidneys were already shutting down at that point. After inserting the new catheter, she only had about 35 milliliters of urine output in 7-8 hours. We did everything we could for (R1), but she was so severely septic that her organs were already failing."

On 11/8/21 at 11:40 a.m., V13 (R1's Physician) stated nursing staff should have intervened and notified V13 when R1's urine was first noted to be cloudy. V13 stated that V13 would have had them

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S9999	Continued From page 14 do a urinalysis to see if there was any infection in R1's urine. V13 stated, "I've known (R1) for years and she has never had a catheter prior to this hip fracture. V13 stated she had no known diagnoses to justify the continued use of the catheter that he was aware of. V13 stated V13 or the on-call physician should have also been called on 10/20/21 when R1 had a change in her condition. V13 stated V13 would expect to be called after hours if a resident has a change in condition rather than a fax be sent. V13 stated, "I wouldn't even seen the fax until at least the next business day. By the time I saw the fax that was sent to me on 10/20/21 at 9:40 p.m., (R1) was already in the hospital (10/21/21). I had no indication from the facility that (R1) continued to present with a decline in her condition. I was shocked to say the least." V13 stated a quicker response from the nursing staff to (R1's) cloudy urine could have potentially prevented R1's decline in status, hospitalization and even death. V13 stated that V13 had no knowledge that there was ever an issue with R1's urine. (AA)	S9999		