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
	IL6012553	A. BUILDING: ______ B. WING ______	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA SCHAUMBURG	675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193

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S 000	Initial Comments Complaint Investigation 2313651/ IL#159395	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 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. Section 300.1210 General Requirements for	S9999	**Attachment A** **Statement of Licensure Violations**	

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Nursing and Personal Care
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.

These regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure intravenous therapy to central venous catheters was performed in accordance with standards or practice; failed to ensure staff were qualified and trained to provide care for central venous catheters (long, flexible tubes inserted by providers that lead directly to vena cava, near the heart); and failed to implement policies for the administration of medications and maintenance of the central venous catheter site for 2 of 3 residents (R1, R2) reviewed for intravenous access in the sample of 7. These failures resulted in R1's implanted port (central line) becoming infected, requiring hospitalization and surgical removal of the infected port. R1 developed bacteremia (infection of the blood stream).

The findings include:

1. On 5/5/23 at 7:38 AM, V22 (R1's Power of Attorney) said [R1] had the implanted port in place since 2018 and never had any issues with it prior to it becoming infected. The port was placed because [R1] needed frequent lab draws and medications and she was a hard stick. The port was implanted, under her skin in her upper chest. V22 stated, "I don't think it was ever flushed at the facility. In December 2022, [R1] started getting weird and hallucinating. She would see

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dogs in her bed at night. The doctor said she probably was dehydrated and ordered IV fluids. The nurse called me to report that they were attempting to access [R1's] port and "gook" came out. The nurse said she called the doctor back right away and [R1] was sent to the emergency room. [R1's] port was infected and had to be removed. She was in the hospital for several days for a very aggressive infection. The doctor toil me there wasn't much more we could do, so [R1] went back to the facility in early January 2023. A PICC (Peripherally Inserted Central Catheter) was inserted for IV antibiotics, fluids, and blood draws. R1 never got better, and she was placed on hospice care. [R1] passed away on 2/24/23 at the facility. I had a care meeting with the facility staff when it was obvious that [R1] wasn't improving. They discussed her decline, due to a UTI (Urinary Tract Infection). That frustrated me because the issue was her port became infected and caused an infection in her blood. I asked when [R1's] port had been flushed and none of them could answer me. I requested to see the documentation and it was never provided to me. R1 was doing poorly, so my focus was on her, and I wasn't the best at following-up. The staff never provided in the information about the port care and when I remembered to ask them, they would say, "I'll ask," but no one got back to me. I can't remember names, but I know how they made me feel. R1 was alert and oriented prior to this infection, but at the end she didn't seem to know who I was."

R1's Face sheet dated 5/9/23 showed diagnoses to include, but not limited to: CKD (Chronic Kidney Disease - Stage 4); dysphagia; reduced mobility; need for assistance with personal care; severe protein-calorie malnutrition; MRSA (Methicillin Resistant Staphylococcus Aureus)

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infection; local infection due to central venous catheter; hyperparathyroidism; hypokalemia; noninfective gastroenteritis and colitis; real tubulo-interstitial disease; sleep apnea; bullous pemphigoid; diabetes; chronic respiratory failure; adult failure to thrive; hypothyroidism; anxiety; anemia; COPD (Chronic Obstructive Pulmonary Disease); major depressive disorder; and Crohn's Disease.

R1's facility assessment dated 2/2/23 showed R1 was cognitively intact; required extensive assistance from staff for bed mobility, dressing, toilet use, and personal hygiene; and had limited ROM (Range of Motion) to one upper extremity.

R1's November 2022 TAR (Treatment Administration Records) showed, "If the port has not been accessed: Access the port monthly and flush with 5 ml normal saline followed by 5 ml Heparin (100 Units/ml) every night shift starting on the 15th of every month." This entry was signed out as completed by V18 (LPN - Licensed Practical Nurse). (The care and use of port (central venous catheter) is beyond the scope of practice for LPNs). This document showed, "Implanted port (lumen is used for blood draws). For blood draws: flush before, draw 10 ml blood then waste; draw 10 ml for blood draw. For patency: flush with 10 ml NS daily every day shift." This was signed out as completed on 19 of the 30 days in November. (During this investigation, the facility and staff interview were unable to prove when R1's port was accessed with a needle and dressing in place and unable to report how long the needle was left in place. They were unable to explain the conflicting orders for the care of the port.) This document showed, "Only if in use, change dressing and the non-coring needle on day shift on Saturday for

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right chest mediport." This was signed out on 11/5 (by V12, RN - Registered Nurse), 11/12, and 11/26. (This entry was left blank on 11/19.

R1's December 2022 TAR showed on 12/15/22 the port was not accessed by V19 (LPN). The document showed the initials NN, which means there should be a nurses' note explaining why the port was not accessed and flushed, as ordered. There was no nurse note entry by V19 on 12/15/22. The document showed the facility nurses documented the blood draw flushes and flushes were performed 21 of 30 days. The document showed, "Only if in use, change dressing and non-coring needle on day shift every Saturday for right chest mediport." This was signed out on 12/3 (by V12, RN) and 12/17 by V20 (Agency LPN). During interviews, V12 (RN) reported she was uncomfortable providing care for implanted ports. A dressing change and needle chart of a mediport requires sterile procedure to prevent the risk of infection and should only be performed by qualified, competent staff. V20 is an LPN and care of an implanted port is beyond the scope of practice.

R1's Progress Notes dated 12/27/22 showed, "Patient appeared lethargic and had loose stools." V17 (R1's PCP - Primary Care Physician) was notified. V17 ordered labs, IV fluids, and antifungal medication.

R1's Medical Professional Progress Note dated 12/27/22 showed R1 was seen for a change in condition. CNA (Certified Nursing Aide) felt R1 had an altered mental status. V17 (R1's PCP) saw R1 and found her to be complaining of loose stools, nausea, and no appetite. R1's diaper was filled with loose, mucoid, liquid, foul-smelling bowel movement. There were orders placed for

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immediate labs and IV fluids for an acute flare up of her Crohn's disease. R1 had an implanted port in place due to difficult IV access.

R1's Change of Condition (SBAR) report dated 12/27/22 at 4:16 PM showed R1 had purulent (infectious) drainage from the implanted port and diarrhea. R1 had a low-grade temperature and was lethargic. V17 was notified at 2:45 PM and orders were given to send R1 to the emergency room.

R1's Admission Summary dated 1/6/23 at 7:41 PM, showed R1 was readmitted to the facility from the local hospital. R1 was placed on contact isolation for MRSA in her blood. Per the hospital nurse, the right chest (chemo) port was infected, and the port was removed. R1 is on IV antibiotics every 48 hours for 10 days, for the infected port. R1's port removal incision area was seen by the wound nurse. R1 had a PICC line with 2 lumens to the left upper arm.

R1's Progress Notes showed R1 continued to decline, upon return to the facility. R1 was refusing to eat, drink, and take some medications. A Palliative Care Consult was performed on 1/20/23. R1 continued to refuse to eat/drink and take medications. R1 was placed on hospice on 1/26/23 and passed away on 2/24/23.

R1's EMR (Electronic Medical Record) did not contain a Care Plan for the implanted port prior to R1 being re-admitted to the facility, after her port became infected. R1's Care Plan was updated on 1/6/23 and showed, "Resident requires Contact Precautions related to MRSA in the blood. and resident has potential for infection related to chemo port removal incision; and resident is on

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antibiotic therapy.

R1's hospital records faxed on 5/8/23 showed R1 was admitted to the hospital from 12/27/23 - 1/6/23 for an infected right chest port. The port was scabbed over with puss noted. R1's wound culture and blood cultures were both positive for the same organism, MRSA. MRSA is a drug-resistant bacteria. R1 was placed on isolation and an Infectious Disease Consult was in place. R1's medi-port was removed on 12/29/23. R1 had a PICC placed on 1/5/23 and returned to the nursing home on 1/6/23.

R1's Emergency Room Record dated 12/27/23 showed R1 reported to the emergency room for a possible port infection. "R1 stated that a nurse at the nursing home accessed the port, and she thinks she did it wrong. Since then, she has had pain, redness, and discharge from the area." R1's chest assessment showed port with overlying redness and crusted lesion. R1 was alert and oriented to person, place, and time. R1 was diagnosed with cellulites over the port and concerns of bacteremia (systemic infection of the blood stream).

On 5/9/23 at 12:09 PM, V4 (RN) she usually works second shift, on second floor. She said she had taken care of R1. R1's port was used for medications, IV fluids, and blood draws. If the RN is activating (accessing) the port, then they should be performing flushes according to facility protocol. The nurses should be following the correct orders for flushing and care of a central venous line (port or PICC). V4 stated, "There are special nurses that have been trained to access the ports. I've never done it. The managers usually do it. I went on leave for a couple months. When I left R1 was fine and when I came back,

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she was declining and on hospice. R1 had a poor appetite and often refused to eat/drink or take medications.

On 5/9/23 at 12:59 PM, V12 (RN) said she was not comfortable with implanted ports. V12 stated, "I was working the day R1 started to be lethargic and have increased diarrhea. V17 (R1's PCP) went to see R1 and ordered labs and IV fluids. I had never accessed a port before, so I had V13 (RN/Nursing Supervisor) come with me. I gathered the supplies, and we went in the room. R1 had teeny scab over the port area. V13 picked at it and purulent drainage came out. We didn't continue with accessing the port. I called V17 (R1's PCP) and got orders to send R1 to the emergency room. R1 had been having severe diarrhea so V17 wanted us to try IV fluids and obtain labs at the facility. R1 refused the medications. She was lethargic and her hands were twitchy. I was glad V17 sent R1 out. I think R1's port was infected and had to be removed. I saw her a couple times after she came back. She seemed depressed and was refusing to eat/drink and take medications."

On 5/9/23 at 1:19 PM, V14 (ADON - Assistant Director of Nursing/Unit Manager) said central venous catheters should only be cared for by RNs. LPNs are not allowed to provide care for central venous access. R1 had a port. The nurses should follow facility protocol for flushes and blood draws. There is a set of orders in the EMR that the nurse can chose. The RN should make sure the proper orders are entered for the proper use of the central venous catheter. The RN should be checking the site daily to assess for any changes and ensure they are not developing an infection. The proper maintenance of a port depends on if the site is accessed (needle in

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place) or not. The RNs should be following facility protocol for flushing and maintaining the port. The port should only be accessed by an RN that is trained. Most of the supervisors can access the port and have received training. I'm not sure who provided the training or when it was done. There should be records of the RNs training. The surveyor requested to see the specialized training.

On 5/9/23 at 2:17 PM, V17 (R1's PCP) said R1 had several chronic illnesses that required close monitoring and treatment. R1 had a port because she was "a difficult stick," and required frequent infusions and blood draws. R1 did not have an implanted port for the typical reason most residents do. R1's port was not used for chemo or dialysis. R1 had Gitelman syndrome, a kidney disorder that causes imbalances of potassium and magnesium. R1 had Crohn's and would have flare ups and become dehydrated, required IV fluids administration. Generally, the RN would access the port for the chemo or blood draw, administer the flushes, and remove the needle. The fluctuations in R1's labs and IV fluids resulted in R1's needle needing to be left in for a short time. The RN would usually change the needle every 4-5 days, but the maximum a needle could be left in place is 7 days. R1 was seen at least monthly by myself and my NP. I remember seeing R1 with the port accessed, needle in place and dressing covering it. R1 was in and out of the hospital for flare ups, from chronic Crohn's and bullous pemphigoid (autoimmune pruritic skin disease). In December, the nurse called me to report that R1 was lethargic and was having severe diarrhea. I ordered STAT (immediate) labs, IV fluids, and some medications. A little while later I received a call from the nurse that R1's port may be infected.

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There was pus noted at the port site and R1 was complaining of pain when the area was touched. I went to assess R1 and decided to send her to the emergency room. When I sent her to the emergency room, I was more concerned about the diarrhea and need for treatment. The next day I rounded on R1 at the hospital and found out R1's port culture and blood culture were positive for the same organism (MRSA). That was concerning. When the cultures grow same organism, then it is likely the port was the source of R1's blood infection. Then the focus shifted to the infected port. R1 was placed on isolation and followed by several specialties at the hospital. R1's port was removed at the hospital due to infection. The facility should be following protocol for the care central venous catheters. I would expect they were following the standards of practice. If they were not, then it is possible the port could become clogged or infected. The nurses should call me if there are any issues with the central venous access. The nurses should be documenting the care and maintenance of the port, as well as any assessments or changes in assessments. If it's not charted, then how do we know what is going on.

On 5/9/23 at 3:11 PM, V13 (RN/Nursing Supervisor) said she has 30 years of experience at the facility. The nurses will call me if they are uncomfortable with something. They usually call me to access an implanted port. There are order sets in the EMR for the proper care of the central venous lines and the nurse must enter the orders. The orders will then populate on the MAR or TAR for the RN to chart the assessments, dressings, and flushes. A port should only be accessed by an RN. Not everyone is comfortable, so they usually call the supervisors or managers. There isn't any "proper training," for the central lines, but

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there had been in-services in the past. There was a change in ownership a couple years ago. That was the last time I remember having training on central venous catheters. I accessed R1's port. I'm not sure how long R1's needle would remain in place. Normally we access the port to draw blood and de-access it after flushing. The day R1 was sent to the hospital (12/27/23) I was asked to assist with accessing R1's port because the nurse was uncomfortable. When we looked at the port site, we noticed there was a white dot with pus over the port. We called the doctor because it looked infected. The skin over the port was red and R1 had facial grimacing and complained of pain when we touched it. The port was not accessed. R1 was sent to the emergency room. V13 reviewed R1's November and December 2022 MARs and TARs. V13 said the port site should be assessed daily. I'm not sure if R1's port was access on the 15th? This charting is confusing. If there is any abnormal finding or I can't access the port, then I enter a progress note.

On 5/9/23 at 3:39 PM, V2 (DON) said LPNs are not allowed to access or care for central lines, only peripheral lines. The RNs are the only ones that should be taking care of R1's port. I'm not sure if there has been any specialized training for central lines at the facility. The RN is certified for central lines access as part of their licensure, but they may not see them often and be uncomfortable. If they are uncomfortable, they can call someone for help. I'm not sure if there has been an formalized in-services or training for central venous lines at the facility. I'd have to look. The EMR has order bundles for the proper care of the central lines. The nurse must enter the appropriate orders and follow the facility protocol. There should be clear orders in the

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Physician's Order Sheet and the care should be documented on the MAR or TAR, and possible the progress notes.

On 5/10/23 at 3:13 PM, V2 (DON) was asked to review R1's November and December 2022 MAR and TAR with the surveyor. V2 said a "checkmark with initials" means the care was provided. On 11/15/22 the care was provided and signed out by V18 (LPN). The surveyor asked if LPNs were allowed to provide care to R1's port. V2 stated, "No, and I'm not sure he's the only LPN that accessed that. He's not supposed to do that." The surveyor read the order for the blood draw flushes to V2 and asked how often the flush was performed, as the order has conflicting information. V2 stated, "if it was signed as completed, then I would think the flushes were done. That order should be separated, so it's not confusing." V2 said R1's port was not accessed on 12/15/22 but is unsure why. V2 stated, "I can't find any information in the nurses notes. NN, means there should be more information in a nurses' note." On 12/17/22 R1's TAR showed V20 (Agency LPN) completed R1's port access, flushes and dressing changed. V2 was asked how often the port was accessed. V2 had difficulty providing information about when R1's port was accessed for blood draws, medication infusions, and IV fluids.

The facility's undated Order Set Screenshot showed the type of port and the picklist of orders for the nurse to add. The nurse must check the orders to enter them into the MAR and TAR.

The facility's Competency Skills Forms for Central Line Dressing Change Skilled were dated 2021 and only provided for 3 RNs.

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	IL6012553	A. BUILDING: ____ B. WING ____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA SCHAUMBURG	675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193

(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
S9999	Continued From page 12	S9999		

2. On 5/5/23 at 1:34 PM, V3 (RN) gathered R2's IV antibiotic and NS flushes. R2's room had a sign for Enhanced Barrier Precautions on the door and an isolation cart, stocked with gowns and gloves outside the door. V3 donned a gown and gloves before entering R2's room. V3 used the add-a-vial set to mix the antibiotic medication. R2 was sitting up in the recliner with a dual lumen PICC inserted in his right upper arm. The dressing was dry and intact and both lumens were capped. V3 primed the tubing for the antibiotic and set up the infusion pump. V3 cleansed both ports with alcohol swabs and flushed each port with 10 ml NS, after obtaining blood return. V3 said the facility has a lot of IV lines and she is familiar with PICC lines. The PICC lines are flushed before and after use with 10 ml NS. The NS flushes should be entered in the R2's orders because it's considered a medication. After completing the NS flushes, the nurse will sign them off on the MAR or TAR. If the flushes are not documented, then there is no way of knowing when it was done. The RNs are responsible for care and management of the central lines, including Port-a-caths, midline catheters, and PICCs.

R2's Face-sheet dated 5/9/23 showed R2 was admitted to the facility on 4/14/23. R2 had diagnoses to include, but not limited to abdominal wall abscess, pleural effusion, other bacterial infections, candidiasis, iron deficiency anemia, mild protein-calorie malnutrition, esophageal varices, peritoneal abscess, alcoholic cirrhosis of the liver, hepatic encephalopathy, weakness, fatigue, reduced mobility, and presence of other specified devices for long-term use of antibiotics.

R2's Physician's Order Sheet dated 5/9/23 did not show any orders for NS flushes to R2's PICC line.

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	IL6012553	A. BUILDING: ______ B. WING ______	C 05/10/2023

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BELLA TERRA SCHAUMBURG	675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193

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S9999	Continued From page 13 There were no documented PICC line flushes on R2's April or May 2023 MARs (Medication Administration Records). R2's Care Plan dated 4/14/23 showed, "Resident has potential for infection at IV site (on IV ABT (antibiotics) due to abdominal abscess. Interventions: Initiate proper precaution per facility protocol. On 5/5/23 at 1:19 PM, V14 (ADON/2nd floor manager) said only RNs can completed IV infusions and dressing changes for PICC lines. The NS flushes should be done before and after each use. There should be an order for the flushes, so the nurse is aware it is due. I don't see any orders for NS flushes to R2's PICC line. I only see dressing change orders and the measurements. There should be an order because NS is a medication. It's important to perform the flushes as order to keep the line open, prevent clotting issues, and reduce the risk of infection. The facility's Intravenous Therapy revised 7/28/22 showed, "It is the facility's policy to ensure that intravenous policy and procedures are complaint to federal standards of care. Procedures: All IV access will be assessed by the nurse to ensure that no signs and symptoms of infection and infiltration are left unaddressed. 2. Dressing Change: b. All Central line dressing (PICC lines, single and multi-lumen central catheters inserted in subclavian, Juglar, or inguinal area) will be changed every 7 days and PRN (as needed). c. Implanted ports such as Portacath (PAC) dressing will be changed every 7 days and PRN during Huber needle change. 3. Flushing: B: Central line including PICC lines are flushed with	S9999		

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S9999	Continued From page 14 5 to 10 ml NSS. c. Implanted ports including Portacath will be flushed with 5 to 10 ml of NSS before and after infusion. If implanted port is not accessed, flush with 5 ml NSS followed by 5 ml of Heparin (100 Units/ml) every month." (A)	S9999		