

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/06/2023
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NAME OF PROVIDER OR SUPPLIER TUSCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1203 EGYPTIAN TRAIL TUSCOLA, IL 61953
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S 000	Initial Comments Complaint Investigation: 2364395/IL160316	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.696d)1) 300.1010h) 300.1210b) 300.1210d)1)2)3)6) 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 300.696 Infection Prevention and Control d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340):	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.	S9999		

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S9999	<p>Continued From page 2</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>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.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to follow physician's orders, assess, monitor, and complete follow-up for a Urinary tract Infection with indwelling urinary catheter for one resident (R1) of three residents reviewed for catheters in a sample list of three residents. This failure caused R1 to develop a Catheter Associated Urinary Tract Infection resulting in hospitalization for Sepsis.</p> <p>Findings Include:</p> <p>R1's Post Hospital Evaluation dated 5/1/23 by V10, Advanced Practice Nurse documents the following diagnoses: Congestive Heart Failure, Syncope, Fall with Fractured Ankle, and Urinary Retention with a Urinary Tract Infection. This evaluation also documents "Indwelling Catheter</p>	S9999		

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S9999	Continued From page 3 would like it out as soon as possible." This evaluation also documents "Perioperative urine retention, noted to be associated with Urinary Tract Infection of E. coli (Escherichia coli). Continue Keflex (sensitive) through 5/5/23." R1's Discharge Physician's Orders from the hospital dated 4/28/23 document a physician's order for Keflex 500 (MG) Milligrams four times daily for seven days. This would be 28 500 MG doses in 7 days. R1's Medication Administration Record for April and May 2023 documents the facility gave a total of 22 doses of Keflex from 4/29/23 until 5/10/23 (10 days). Six of the 28 doses were omitted completely. There is no documentation the physician was notified of these errors. R1's Post-Acute Note dated 5/8/23 by V5, Medical Director documents "please plan to follow-up with our Urology Clinic outpatient for further care of your urinary retention." This evaluation also documents "follow up on your urine cultures." R1's Physician's Order Sheet documents an order dated 5/8/23 "(R1) has a Foley Catheter in place. Please keep it in place one more week." There is no documentation to support a Urology consult was ever obtained. There is no documentation to support follow-up cultures were ever obtained. On 6/5/23 at 8:45AM V9, R1's family member stated "R1 called us 5/17/23 at 5:33PM and complained to be shivering, not feeling well, and call light not being answered. We called the facility and asked them to check on R1. On 5/18/23 at 1:24 PM two family members visited R1 and saw that R1 "looked terrible and was under eight blankets and still chilling. We were	S9999		

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S9999	<p>Continued From page 4</p> <p>also told by staff R1 had diarrhea since 5/17/23. We called V2 the Director of Nursing and she kept kind of brushing us off saying R1 did not have a fever and was being taken care of. At the hospital R1's temperature was 102.2." R1's hospital record from 5/19/23 documents R1's temperature was 102.2</p> <p>On 5/19/23 R1's 8:40AM R1's AIMS (Assess, Intercommunicate, and Manage) note by V2, Director of Nursing documents "R1 sent to emergency room for evaluation and treatment. The symptoms included in this assessment are malaise, fever, low back pain, decreased mobility, and weakness. R1's Nurse's Note dated 5/19/23 documents "R1 complained of diarrhea times three days"</p> <p>R1's hospital note dated 5/20/23 at 3:24PM by V11 Medical Hospitalist documents: "R1 sent to emergency room with patient having fever, chills, as well as not eating and drinking much and on arrival at emergency department patient diagnoses Sepsis secondary to complicated Urinary Tract Infection due to chronic foley catheterization. R1's blood culture is positive for E. coli (Escherichia coli)."</p> <p>On 6/5/23 at 4:05PM V2 Director of Nursing confirmed the facility failed to correctly administer the ordered antibiotic, did not follow-up with the recommendations to seek Urology consult or re-culture the urine and did not remove the catheter as ordered. V2 stated "my expectation would be that a skilled assessment and baseline care plan should be done on admission and a skilled nursing assessment should be completed every shift and the Urinary Tract infection and catheter should be addressed in all of this</p>	S9999			

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S9999	<p>Continued From page 5</p> <p>documentation." When asked if V2 could provide the documentation V2 expected for R1 V2 stated "I cannot."</p> <p>On 5/6/23 at 10:30AM V5, Medical Director stated "If the antibiotic was not completed as ordered it actually could decrease its effectiveness against the infection. R1 had some urinary retention after her surgery and a Urinary Tract Infection. V5 stated it should have been re-cultured as we recommended, and we would expect the facility to follow-up on the recommendation to see Urology. It would be safe to say the E. coli did not clear up from the UTI we treated a few weeks ago and that was seen in the blood cultures, but in any case, the infection got worse again and R1 became septic and was hospitalized."</p> <p>(A)</p>	S9999		