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| S 000 | Initial Comments<br><br>Complaint Investigation 2444349/IL173901 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.1210 b)3)<br>300.1210 c)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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: | S9999 | | |

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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.

These requirements are not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide complete and timely incontinent care using proper technique; and failed to perform hand hygiene and glove changes for 3 of 4 residents (R6, R7, R8) reviewed for incontinence care in the sample of 10. This failure resulted in R7 obtaining a Urinary Tract Infection, (UTI), and being placed on an Antibiotic.

The findings include:

1. R7's Face Sheet, undated, documents R7 was admitted to the facility on 3/6/24, with diagnoses of Hypertension, (HTN), Respiratory Failure, Atrial-Fibrillation, (A-Fib), Chronic Kidney Disease, (CKD)-stage 3, Type 2 Diabetic Mellitus, (DM), Congestive Heart Failure, (CHF), Cardiac pacemaker, Atherosclerotic Heart Disease, (ASHD), and Hyperlipidemia.

R7's Care Plan, dated 3/7/24, documents R7 has

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bladder incontinence. Interventions: the resident uses disposable briefs. Change, establish voiding patterns, R7 is Incontinent: Check the resident and as required for incontinence, wash, rinse and dry perineum, change clothing PRN, (as needed), after incontinence episodes, monitor/document for s/sx, (signs/symptoms), UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns, observe pattern of incontinence, and initiate toileting schedule if indicated, provide bedpan/bedside commode, provide peri-care after each incontinent episode. R7's on Antibiotic Therapy r/t, (related to), UTI. R7 has Urinary Tract Infection. Interventions: Check at least every two hours for incontinence, wash, rinse and dry soiled areas, give antibiotic therapy as ordered, monitor/document/report to MD, (Medical Doctor), PRN for s/sx of UTI: Frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea and vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes. R7 has an ADL, (Activities of Daily Living), Self Care Performance Deficit r/t mobility disturbance and weakness. Interventions: Toilet Use: The resident requires X 2 staff participation to use toilet. Transfer: The resident requires X 2 staff participation with, (full body mechanical lift device).

R7's Minimum Data Set, (MDS), dated 3/13/24, documents R7 is cognitively intact and is dependent on staff for toileting, bathing, dressing, and transfers. R7 is frequently incontinent of both bowel and bladder.

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R7 Lab Result, dated 6/8/24, documents R7 has a UTI.

R7's Nursing Note, dated 6/8/24 at 12:25 PM, documents, "Resident complained of, (c/o), some burning while urinating. resident is afebrile. MD notified and ordered UA, (urinalysis). Urine collected and in fridge awaiting pick-up."

R7's Physician Order, dated 6/10/24, documents, "Ciprofloxacin HCl, (Hydrochloride), Tablet 250 MG, (milligram). Give 1 tablet by mouth every 12-hours for UTI for 5 Days."

R7's Nursing Note, dated 6/11/24 at 11:35 PM, documents, "ABT, (antibiotic), for UTI with no complaints of pain or discomfort. No s/s of adverse reaction. Fluids encouraged."

R7's Nursing Note, dated 6/12/24 at 1:33 AM, documents, "Resident continues on ABT therapy r/o UTI no c/o pain or burning when voiding, fluids encouraged. Resident is INC, (Incontinent), of urine and using bedpan at night peri care given when in INC, resting quietly in bed at this time, will continue to monitor condition, call light within reach."

On 6/11/24 at 9:48 AM, V14, Certified Nursing Assistant, (CNA), brought in supplies to do peri-care on R7. V14 did hand hygiene, donned gloves, turned R7 to her right side, and the bedpan was removed. R7 had small amount of soft stool on anal area and buttocks. V14 used a wet washcloth and wiped most of the stool from the anal area and put the bedpan in the restroom. V14 changed gloves, with no hand hygiene done. R7's soiled brief was tucked underneath her. V14 sprayed peri-wash onto R7's buttocks and wiped R7's right buttock and anal area. Using the same

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gloves, V14 got a wet washcloth out of the clean water and wiped between R7's legs and anal area again. V14 used the same gloves and rolled R7 to her left side. V14 tucked R7's linen underneath her, and using the same soiled gloves, pulled R7's bedside table with supplies over to the other side of the bed, took R7's pillow out from under her, then got another washcloth from the clean water, sprayed R7's right buttock with peri-wash and wiped it off. V14 sprayed peri-wash onto washcloth and wiped between R7's legs and anal area, using same gloves, got clean towels and dried R7. V14 doffed her gloves, went outside the room door to get more washcloths, then donned gloves then rolled R7 to her right side and pulled out the soiled brief and linen. R7 was then rolled to her back and V14, used the same soiled gloves, lifted R7's left leg and sprayed peri-wash on washcloth and wiped from back to front between R7's legs, including up and through her vagina. V14 fastened R7's brief and gave pillow and blanket to R7, and then doffed her gloves.

2. R6's Face Sheet, undated, documents, R6 was originally admitted to the facility on 5/23/24, with diagnoses of CHF, CKD-stage 3, Gastroenteritis/colitis, Cardiac Pacemaker, Intestinal malabsorption, COVID-19, Chronic Obstructive Pulmonary Disease, (COPD), Non-ST Elevation MI, (myocardial infarction), (NSTEMI), Major depressive disorder, Idiopathic Neuropathy, Hyperlipidemia, HTN, Osteoporosis, Sick Sinus Syndrome, (SSS), A-Fib, and Anxiety disorder.

R6's Care Plan, dated 5/23/24, documents, R6 has bladder incontinence. Interventions: Incontinent: Check the resident every two hours and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after

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incontinence episodes, monitor/document for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. R6 has bowel incontinence r/t impaired mobility. Interventions: Observe pattern of incontinence, and initiate toileting schedule if indicated, provide bedpan/bedside commode, provide peri-care after each incontinent episode, take resident to toilet at same time each day resident usually has bowel movement. R6 has Urinary Tract Infection. Interventions: Give antibiotic therapy as ordered, monitor/document for side effects and effectiveness, monitor/document/report to MD PRN for s/sx of UTI: Frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea and vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes. R6 has an ADL Self Care Performance Deficit r/t Musculoskeletal impairment. Interventions: Toilet Use: The resident is totally dependent on staff for toilet use, the resident requires 2 staff participation to use toilet. Transfer: The resident requires 2 staff participation with transfers, the resident requires Mechanical Aid Sit-To-Stand device for transfers.

R6 MDS, dated 5/24/24, documents, R6 is cognitively intact and is totally dependent on staff for toileting, bathing, and dressing. R6 is always incontinent of both bowel and bladder.

On 6/11/24 at 10:37 AM, R6 stated she has diarrhea all the time, and there are times when she has to sit in it for about 15-30 minutes before staff cleans her up.

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R6's Nursing Note, dated, 5/23/24, at 11:05 PM, documents, "Resident is on po ABT r/t UTI. No ASE (adverse side effects) noted. Afebrile. A&Ox4, (alert and oriented X 4). Able to make needs known. PO, (oral), fluids encouraged and tolerated. Appetite is fair. No c/o pain or discomfort. Resident is resting in bed with call light in reach. Will continue to monitor."

R6's Physician Order, dated 5/23/24, documents, "Cephalexin Oral Capsule 500 MG, (Cephalexin). Give 1 capsule by mouth two times a day for UTI for 7 Days." This order was completed and discontinued on 5/31/24.

R6's Nursing Note, dated 5/31/24, at 6:13 AM, documents, "Remains on PO abt, (antibiotic), for UTI no ASE noted. Denies any pain or discomfort with urination. PO fluids encouraged tolerated well. Call light in reach."

On 6/11/24 at 10:29 AM, R6, seen lying in bed, and had put her call light on after having BM (bowel movement), while on the bedpan, and she needed cleaned up. V12, CNA, entered with supplies to provide peri-care to R6. V12 obtained wash basin of water, wet a washcloth, and wiped both of R6's groins, and then using same washcloth, wiped down the middle of R6 vagina, which appeared very reddened with R6 complaining of pain upon touch. V12 tucked R6's soiled brief between her legs and underneath R6, then rolled R6 over to her left side. V12 did not change her gloves. V12 obtained another wet washcloth and wiped R6's anal area, which was also very reddened, then using the same soiled gloves, put clean bed linen and a bath blanket on the bed, rolled R6 over to her right side and pulled the soiled linen out from under R6 and adjusted the clean linen under R6. There was no

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wiping of R6's left buttock while turned to her right side. V12 rolled R6 to her back and still using her same soiled gloves, got moisture barrier cream, and put cream on R6's reddened vaginal area, and nothing to her anal area/buttocks. V12 secured R6's incontinence brief, adjusted R6 in bed, including her pillow, put socks on R6, then covered R6 with sheet and blanket, all while using same soiled gloves. V12 pulled the bedside table with personal belongings over to bed, then doffed gloves.

3. R8's Care Plan, dated 4/10/21, shows R8 is at risk for complications with her skin integrity r/t her preference to sit up in her recliner for longer periods of time rather than changing position, h/o, (history of), pressure area, incontinence. Interventions: Pressure reducing cushion to wheelchair when up in wheelchair, the resident needs one assist/encouragement to turn/reposition at least every 2-hours, more often as needed or requested. R8 has an ADL Self Care Performance Deficit due to confusion and hearing deficit. Alert with confusion. Needs 1 assist for most tasks. Incontinent of bowel and bladder. Interventions: Toilet Use: The resident is not toileted. R8 is incontinent of bowel and bladder, The resident requires X 1 staff participation with transfers.

R8's MDS dated, 4/16/24, scored her with being severely cognitively impaired, and is dependent on staff for toileting, bathing, and transfers. R8 is always incontinent of both bowel and bladder.

On 6/11/24 at 10:43 AM, V13, CNA, performed incontinent care on R8. V13 donned gloves and removed R8's soiled brief by rolling it between R8's legs. V13 then instructed R8 to roll over and took a wet towel and wiped R8's buttock from

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back to front, folded the same towel, and had R8 roll onto her back again and used the same towel to wipe R8's vaginal region from back to front and rolled V8 to her other side. While using the same towel and same soiled gloves, V13 wiped the other side of R8's buttock region from front to back. R8's peri region is visibly red and irritated. V13 stated she used one towel but folded it up to a new section for each region. V13 then removed the dirty linen and brief and placed them on the floor. V13 then donned new gloves and placed a new incontinence brief on R8.

On 6/12/24 at 8:25 AM, V4, Licensed Practical Nurse, (LPN), stated she does not get to witness the CNAs often, and was unsure if they change their gloves properly in-between care procedures.

On 6/12/24 at 8:43 AM, V17, CNA, stated she does hand hygiene before touching residents and when leaving the resident's room. V17 stated she puts on gloves every time she enters a room to provide care on a resident. V17 stated residents should be checked for incontinence care and have position changes every 2 hours, but that doesn't always happen due to having busy workloads. V17 feels like more training on hand hygiene and glove use would be useful.

On 6/12/24 at 8:45 AM, V18, CNA, stated gloves must be changed in between dirty to clean care, on top of when entering the room. V18 stated more training would be useful for the CNAs on proper hand hygiene and glove use.

On 6/12/24 at 11:00 AM, R10, Resident Council President, stated he frequently monitors the residents on his floor for the care they receive, and he does not observe staff checking on residents every two hours like they should.

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R10's MDS, dated 5/3/24, documents, R10 is cognitively intact.

On 6/12/24 at 1:20 PM, V1, Administrator, stated, "I would expect the staff to perform timely and complete incontinence care to the residents. I would expect the staff to perform hand hygiene before resident care, during glove changes, and after resident care, and glove changes when going from a dirty area to a clean area."

On 6/12/24 at 1:25 PM, V1, stated, "We don't have a policy on incontinent care, we always just use the checklist."

The Facility's "Peri-Care (Female) Policy/Checklist, undated, documents, "Wash Hands, Put on Gloves, Wash and dry upper thighs covering thighs with bath blanket when finished, Apply soap to wet washcloth, Separate Labia and wash Urethral area first, Wash between and outside Labia in downward strokes alternating from side to side moving outward to thighs, Use different part of washcloth for each stroke, With fresh water and a clean washcloth, rinse area thoroughly with same strokes, Gently pat dry in same direction, Clean rectal area wiping from base of Labia over Buttocks using a different part of washcloth for each stroke, Rinse and dry Anal area thoroughly, Remove gloves and wash hands."

The Facility's "Infection Control/PPE" Policy, dated 2019, documents, "Gloves are worn as per standard precautions."

The Facility's "Infection Control" Policy, dated 2019, documents "The primary mission is to establish and maintain an infection prevention

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| S9999 | Continued From page 10<br>and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. c. Standard and transmission-based precautions to be followed to prevent the spread of infections. a. Selection and Use of PPE. f. The hand hygiene procedures to be followed by staff involved in direct resident contact. Elements of the program: Implementing measures to prevent the transmission of infectious agents and to reduce risks for device and procedure-related infections."<br><br>The Facility's "Hand Hygiene" Policy, dated 2019, documents, "Appropriate hand hygiene is essential in preventing transmission of infectious agents."<br><br>(B) | S9999 | | |