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S 000	Initial Comments Annual Licenser and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations Licensure 1 of 2 300.610a) 300.1010e) 3001210b)3) 300.1210d)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 300.1010 Medical Care Policies e) All resident shall be seen by their physician as often as necessary to assure adequate health care.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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: 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.	S9999		

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations were not met as evidenced by:

Based on interviews and record review, the facility failed to immediately inform the physician of a complaint of urinary retention and abdominal pain for one of one resident (R40) reviewed for urinary tract infections and catheters in a sample of 65. This failure resulted in an emergency room visit for urinary obstruction and subsequent urinary catheter for R40.

Findings include:

1. The Electronic Health Record (EHR) dated 7/1/18 at 6:56am; V13 Licensed Practical Nurse (LPN) documented in the progress notes "Abdominal pain" in response to R40's request for pain medication. The Medication Administration Record (MAR) documents V13 gave him Tylenol 325mg tabs 2.

The EHR progress note entry dated 7/1/18 at 9:44am later in the same morning, documents "Resident complained of not urinating in over 24 hours. (V13) reported to writer that R40 had told her that as well. RN told R40 to drink more water. Left note for MD." There is no evidence that either nurse assessed R40's abdomen to determine a causative factor for complaints of abdominal pain and no evidence the physician was informed on this complaint.

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On 7/2/18 at 1957 (7:57pm,) V10 LPN documented "CNA (certified Nurse Aide) to writer and reported that R40 had a small bowel movement and noted blood in the toilet. There was a small amount of bright red blood in the stool. Resident stated resident has been having gas, assessed resident, did not note any abnormalities r/t (related to) rectum area. Resident reported resident does have a hx (history) of hemorrhoids. Writer phoned MD's office..."

On 7/3/18 at 4:29pm, V17(MD) saw R40 at the facility and documented "complains of a change in bowel habits and having a difficult time with a bowel movement. R40 has never had a colonoscopy and I strongly encouraged R40 to get on. We will see about making an appointment with V18 (MD). Resident seems to be reluctant. I'm not sure that R40 will do it. R40 also says R40 had some trouble with urinating but a bladder scan post residual is basically unremarkable, so at this time I think we can observe." There is no evidence V17 was aware at that time that R40 had been having difficulty urinating.

The EHR progress notes have no further documentation toward R40's abdominal pain or monitoring until 7/8/18 at 19:59 (7:59pm,) when V8 RN documents "Resident complained of abdominal discomfort and could not urinate except for little bits. At 1745 when R40 came up for meds (medications), stated R40 had been complaining and laying in R40's room. He ate supper, took meds and went to lay down. R40 came back up to see writer at 1915 stating stomach still hurting, penis was swollen and wanted to go to hospital, vital signs were 118/82, pulse 86, esp (respirations) 18 and temp 97.8.

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Nurse went with resident to resident's room and assessed resident. Penis was not swollen, but abdomen was firm and tender in lower quadrants and distended, writer could not hear bowel sounds except on sides towards back, notified Dr. V16 at 1945, who is on call for Dr V17 and he ordered for resident to be sent to (hospital) ER. Notified V2,(DON), of transfer and called ambulance, they arrived at 1955." There is no evidence V8 assessed R40 at the time of initial complaint at 1745 (5:45pm.)

The EHR Progress notes dated 7/9/2018 00:30 (12:30am) document "Returned with new orders for Keflex and has a foley, dx urinary retention. Skin has no changes, R40 is in a pleasant mood."

Hospital Emergency Discharge record dated 7/8/18 documents R40's diagnoses as Acute Urinary Tract Infection and Acute Urinary Obstruction. The report documented R40 returned with a urinary catheter and Keflex 500mg three times a day (TID) which was started on 7/9/18 per the July MAR.

On 7/31/18 at 11:45am, R40 ambulated independently down the hall to the nurse and asked for pain medication due to "tube" pointing to urinary catheter tubing. The tubing was extending out over the waistband of R40's jogging pants with the collection bag hooked on R40's walker bar. The urine in the tubing was cloudy white with a large amount of mucus and clumps in it.

On 8/1/18, at 3:30pm, V2 stated the nurses should have contacted the physician on 7/1/18 when R40 complained of not urinating in 24 hours. When asked about R40's urine being cloudy and clumpy, V2 stated she didn't think R40

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had a UTI at the time of his emergency room visit and was unaware of R40'ss urine being cloudy with large amount of sediments in it at the time. V2 confirmed that R40's appointment for the Urologist was changed and that documentation of an assessment was not in the clinical record. Was suppose to see the specialist (8/1/18) and they called and rescheduled until next week. V2 stated R40 does have a tendency to have the tubing of the catheter over waist band and it is documented in the nurse's notes. V2 was asked about V17's reference to residual urine on 7/3/18 during his visit and stated it was probably from tests R40 had done in March 2017.

The facility policy entitled "Physician-Family Notification - Change of Condition" dated 10/1/15 documents the purpose as "to ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, effective manner." Guidelines document "the facility will inform the resident,
consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is" "(B) A Significant change in the resident's physical, mental, or psychological status (i.e. a deterioration in health, mental, or psychological status in either life threatening conditions or clinical complications." Examples include are "recurrent urinary tract infection." Under "C", it documents to notify with "(C) A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment."

(B)

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S9999	Continued From page 6 Licensure 2 of 2 300.610a) 300.1210a 3001210b)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. 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with	S9999		

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the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations were not met as evidenced by:

Based on interview, observation and record review, the facility failed to provide correct Range

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of Motion (ROM) exercises that included all joints, failed to identify/assess limitations for 2 of 8 residents (R43, R14) reviewed for ROM exercises in a sample of 65. This failure resulted in a decline in ROM for R43 of lower extremities that the facility had not identified.

Findings include:

1. The Minimum Data Set (MDS) dated 06/05/18, documents R43 to have short/long term memory deficits, with severe cognitive impairment and requires extensive assist of one to two staff for transfers and mobility. The MDS identifies no limitations of ROM, but does document R43 receives active ROM 7 days a week.

On 07/31/18 at 12:55pm, V5 and V7 entered R43's room to transfer R43 from the bed to chair. A sit to stand mechanical transfer was done with R43. R43 remained stooped over during the transfer and did not stand up straight as R43's knees remained bent.

On 08/02/18 at 2:45pm, R43 was in bed. V15 Certified Nurse Aide (CNA) was asked if she did ROM on R43 and responded yes. V15 repositioned R43 on R43's back and lowered the head of bed. R43's legs remained bent. V15 completed Flexion/Extension of R43's left arm, but failed to do abduction/adduction, horizontal abduction/adduction, internal/external rotations or hyperextension of shoulder joint. V15 then did flexion/extension of left elbow joint, but failed to do supination/pronation. R43 was calm and cooperative. V15 then did flexion/extension and hyperextension of R43's left wrist, but failed to do ulnar/radial deviation or circumduction of the wrist joint. V15 did flexion/extension of R43's fingers, but failed to do abduction/adduction on each

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finger. V15 did only the abduction/adduction exercise for the thumb joint and failed to include flexion/extension or opposition. Knee and hip joint received only flexion/extension with no abduction/adduction, internal/external or hyperextension of the hip joint. R43 was unable to straighten knees out. V15 did dorsiflexion/planter flexion of the ankle joint, but failed to do inversion/eversion and only did flexion/extension of the toe joints failed to complete the abduction/adduction of R43's toes.

On 08/02/18 at 2:50pm, V15 stated R43 has declined adding that R43 doesn't straighten out legs and they do a full body mechanical lift on R43 at times.

There is no full assessment, including limitations in degrees in R43's Electronic Health Record Assessment section.

The Care plan dated 06/05/18 documents R43 "to have limited range of motion" with a goal to "be able to complete 2 repetitions of BUE/BLE (bilateral upper extremities/bilateral lower extremities) with interventions for staff to assess pain, encourage socialization during exercises, provide encouragement, and provide pain medication prior to exercise.

The policy/procedure entitled "Passive Range of Motion Exercises" undated documents the policy as "residents will receive passive range of motion exercises as the need indicates per the Functional Limitation in Range of Motion assessment or per physician order. The procedure documents "residents will be assessed for their need of passive range of motion (PROM) per the Functional Limitation in Range of Motion assessment, If the resident is recommended for a

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PROM program, trained nursing staff will provide the range of motion exercises as outlined under ROM technique, and AROM is provided when the resident performs the movement and the staff provides instructions on range completion." The policy also documents "PROM is provided by the staff with no assist from the resident." The policy continues to identify all planes for shoulder, elbow, wrist, fingers, hips, knees, ankles and toes with instructions for the staff on how to do them.

2. On 08/02/18 at 3:33 pm V21 Certified Nursing Assistant (CNA), conducted range of motion on R14. V21 conducted on shoulder joint flexion, extension, abduction, adduction and internal and external rotation, but failed horizontal abduction and adduction and hyperextension.
Conducted on elbow, joint flexion and extension, but failed supination and pronation.
V21 failed on wrist joint flexion, extension, hyperextension, ulnar, radial deviation and circumduction.
Conducted on finger joint flexion and extension, but failed on abduction and adduction.
V21 conducted on thumb joint opposition, but failed on thumb joint flexion, extension, adduction, and abduction.
Conducted on hip joint flexion, extension, abduction, adduction failed on internal and external rotation and hyperextension.
Conducted knee joint flexion and extension.
Conducted ankle joint, dorsiflexion and plantar flexion, but failed inversion and eversion.
V21 failed flexion, extension, abduction and adduction on toe joint.
On 08/02/18 at 3:40 pm R14 stated, "I need this every day."
On 08/02/18 V21 stated, "I think I got everything.", "I try to do 10 reps, if I have the

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S9999	Continued From page 11 time." "It depends on the resident, but I conduct range of motion every other day." R14's Minimum Data Set (MDS) dated 02/05/18 documents, R14 to be extensive/limited assistance with all ADL's (activities of daily living). R14's care plan dated 08/02/18 documents in part; (R14) has an ADL self-care performance deficit r/t (right) Limited Mobility, Pain to bilateral knees, Activity Intolerance. (C)	S9999		