llinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010144	A. BUILDING: ______ B. WING ______	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ELMHURST, THE	127 WEST DIVERSEY ELMHURST, IL 60126

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S 000	Initial Comments Complaint Investigation: 2274308/IL147548	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210b)3) 300.1210c) 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 300.1010 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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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.

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:

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S9999	Continued From page 2 2) All treatments and procedures shall be administered as ordered by the physician. These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to assess and document urinary output for a resident who had returned from the emergency room with hematuria. The facility also failed to assess, document urine output on residents with indwelling urinary catheters. This failure resulted in R1 experiencing pain due to urinary retention, continued urine retention and hematuria, and a return to the hospital within 24 hours. This applies to 3 of 3 residents (R1, R5, and R10) reviewed for indwelling urinary catheters in a total sample of 10. The findings include: 1. According to the Electronic Health Record (EHR) R1 had diagnoses including hypertensive heart disease, anorexia, albumin abnormality, dysphagia, atrial fibrillation, hypertension, benign prostatic hyperplasia, obstructive uropathy, hyperlipidemia, cerebrovascular accident, depression, malignant neoplasm of bladder, and obstructive sleep apnea. The Minimum Data Set (MDS) dated 04/15/2022 showed R1 needed extensive assistance of one person for bed mobility, transfers, walking, dressing, hygiene, and toilet use; and needed supervision set up help only for eating. R1 had an indwelling urinary catheter and was frequently incontinent of bowel. The MDS showed R1's	S9999		

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cognition was moderately impaired.

A care plan showed R1 is on anticoagulant therapy with interventions to monitor, document and report blood tinged or frank blood in urine; has an indwelling urinary catheter due to obstructive and reflux uropathy with interventions including to keep the collection bag below the level of the bladder, check for kinks and leaks, report any discomfort, blood-tinged urine, no output, or deepening of color.

The Physician Order Sheet (POS) showed an order to monitor and record indwelling urinary drainage catheter output every shift.

On 06/06/2022 at 12:12 PM, V19 (R1's family member) stated she received a telephone call on 05/25/2022 from R1 complaining of extreme abdominal pain. R1 had been to the emergency room (ER) the night before due to blood in his urine and then returned to the facility the same evening. V19 stated she called a facility nurse to assess R1 since he was complaining of pain. Two hours later V19 received a call from R1 again still complaining of abdominal pain. V19 stated when the hospital called to inform her R1 was going to be admitted to the hospital, they had told her R1 came to the ER without an indwelling urinary catheter in place and they obtained one liter of bloody urine when they had inserted an indwelling urinary catheter.

A Hospital Urology Physician Note dated 05/25/2022 at 10:07 PM showed R1 had been seen in the ER on 05/24/2022 with hematuria in the catheter. A three-way catheter was inserted, the bladder was irrigated, and R1 was discharged back to the facility. On 05/25/2022, R1 returned to the ER for urinary retention. "A catheter was

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S9999	Continued From page 4 placed and returned one liter of bloody urine. Continuous bladder irrigation was restarted and the urine has been clearing." An abdominal computerized tomography (CT) did not show any genitourinary pathology for hematuria and the preliminary urine culture was negative. The abdominal CT dated 05/25/2022 showed the urinary bladder collapsed around an indwelling urinary catheter with urinary bladder wall thickening. R1's prostate is enlarged and may relate to bladder outlet obstruction. On 06/07/2022 at 3:25 PM, V4 (Licensed Practical Nurse/LPN agency) stated she was working the evening shift on 05/24/2022 when R1 had complained of feeling weak and noted to have thick maroon blood in his indwelling urinary catheter and drainage bag. V4 stated it was a full drainage bag and it looked like it was all blood and no urine. V4 was told by an unknown CNA (Certified Nursing Assistant) she had emptied R1's urinary drainage bag once already with the same amount and color. V4 stated she did send R1 out to the emergency room and was surprised R1 had returned to the facility around 11:00 PM while she was giving report to the night shift nurse (V9). V4 stated she had told the oncoming night shift nurse what had occurred with R1 and pointed out R1 was the one returning from the hospital as he passed the nurse's station. On 06/06/2022 at 5:53 PM, the hospital emergency room staff member stated R1 arrived at the ER on 05/24/2022 at 7:25 PM and was discharged back to the facility at 10:56 PM the same evening. On 06/06/2022 at 5:03 PM, V9 (LPN agency) stated she had worked on 05/24/2022 from 11:00 PM to 05/25/2022 till 8:15 AM. V9 stated she	S9999		

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could not recall caring for R1 during this shift and would have to review her notes in the EHR. At 5:23 PM, after looking at the notes in the EHR, V9 stated R1 must have been kept in the hospital overnight because she never did an admission note. V9 stated the hospitals usually don't send residents back to the facility after 8:00 PM. According to V9, the nurses are supposed to do a readmission note when a resident returns from the hospital and she did not see one for R1. "I know I didn't readmit him on the night shift of 05/24/2022 into 05/25/2022 because I never saw him."

On 06/07/2022 at 9:44 AM, V11 (Registered Nurse/RN agency) stated R1 was definitely in the facility on 05/25/2022 when V11 started work at 7:00 AM. V11 stated R1 was not having much urine output, it was hematuria, and R1 was experiencing discomfort. V11 stated he was not going to add to R1's discomfort by flushing or reinserting an indwelling urinary catheter and felt R1 should have returned to the ER to have the issue addressed. V11 could not recall the timing during the day shift but thought he may have sent R1 to the hospital in the afternoon before 3:00 PM. V11 was unaware if any other nurses tried to reinsert R1's indwelling urinary catheter.

On 06/06/2022 at 2:13 PM, V8 (CNA) stated on 05/25/2022 around 9:00 AM, R1 had put the call light on and asked for the nurse to send him back to the hospital for his indwelling urinary catheter. V8 thought his catheter was okay but it did have only a small amount of dark red bloody urine in the drainage bag. V8 stated she reported it to an unknown female nurse (not V11) who had also spoke with R1. V8 stated R1 was able to communicate his needs but he did have confusion.

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S9999	Continued From page 6 On 06/07/2022 at 11:25 AM, V7 (RN agency) stated she had been stopped by R1 in the hallway during the afternoon of 05/25/2022. R1 asked V7 to be sent back to the hospital because his indwelling urinary catheter wasn't working. On 06/06/2022 at 3:21 PM, V3 (LPN Restorative Nurse) stated on 05/25/2022, V11 (RN agency) reported R1 had blood in the urine and bladder pain. V3 thought it was when she was doing rounds with the residents approximately 8:00 AM. V3 stated she did a bladder scan on R1 which revealed over 900 milliliters (ml) in the bladder. V3 stated R1 did not have any urine in the tubing or the drainage bag, just approximately 25 ml of blood. V3 stated she was unable to flush any normal saline into the catheter, called the nurse practitioner, and removed the indwelling urinary catheter. V3 was unable to insert a new catheter and decided to send R1 to the hospital. A Progress Note dated 05/25/2022 at 12:22 PM (V3,Restorative Nurse) showed R1 was "observed with blood in catheter bag with no urine present. Resident readmitted from hospital on 5/24 with hematuria. Resident complains of lower abdominal pain at this time. NP notified with orders to perform bladder scan. Upon scanning resident is noted to have 999 ml currently in bladder, (catheter) taken out and attempt made to insert new (catheter). Attempts were unsuccessful no urine return noted. NP notified with orders to send resident to VA (Veteran's hospital) for further evaluation and (catheter) insertion. Message left for emergency contact." On 06/07/2022 at 12:43 PM, V13 (Attending MD/Medical Director) stated residents should not be retaining 1000 ml of urine. "That is nursing	S9999		

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fault for not caring for the resident and monitoring the urine output. The bleeding is not the fault of the nursing staff but failure to monitor a resident for not having urine output is a nursing fault." V13 stated R1 had gone to the ER with hematuria, had urinary retention, and it was irrigated the night before. The nurses should have been watching the urine output more closely. If the urine output was less than 300 ml, they should be discussing it with the physician or nurse practitioner or doing the bladder scan to find out what is going on with the resident. V13 stated "This is not the first time this has happened with residents not being monitored for urine output. They (the facility) had an IJ (Immediate Jeopardy) there a couple of months ago with a couple of patients. I mean this is the same issue, so what improvement have they had? None."

On 06/07/2022 at 3:51 PM, approximately 350 milliliters (ml) cloudy yellow urine was noted in R1's indwelling urinary catheter drainage bag. R1 did not think anyone had emptied his bag after the day shift.

2. According to the EHR, R10 had diagnoses including osteomyelitis of vertebra, Vancomycin resistance, dysphagia, acute embolism and thrombosis, cognitive communication deficit, vitamin D deficiency, hypotension, protein calorie malnutrition, gastroesophageal reflux disease, anemia, osteoporosis, history of transient ischemic attack, constipation, hyperlipidemia, colostomy, and stage four pressure ulcer.

The MDS dated 04/28/2022 showed R10 needed extensive assistance of two people for bed mobility; needed extensive assistance of one person for dressing, eating, and toilet use; and

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needed total dependence of two people for transfers. R10 had a colostomy and an indwelling urinary catheter. The MDS showed R10's cognition was severely impaired.

R10 did not have a care plan for an indwelling urinary catheter.

The POS showed an order to monitor and record indwelling urinary drainage catheter output every shift.

On 06/07/2022 at 4:09 PM, V15 (CNA) stated she was working the evening shift and did not think anyone had emptied R10's indwelling urinary catheter drainage bag. Approximately 400 ml of cloudy yellow urine was noted in the tubing and the drainage bag. R10 was unsure how often they emptied the drainage bag.

The Monitoring Record showed R10 only had urine output recorded only six out of 19 shifts in June 2022 and 53 out of 93 shifts in May 2022.

The CNA task tab from 05/07/2022 to 06/07/2022 did not have any documented urinary output.

3. According to the EHR, R5 had diagnoses including multiple sclerosis, palliative care, muscle wasting, depressive disorder, diabetes, hypertension, trigeminal neuralgia, paraplegia, and colostomy.

The MDS dated 04/13/2022 showed R5 needed extensive assistance of two people for bed mobility, dressing; was totally dependent on two staff for transfers; and needed extensive assistance of one person for toilet use. R5 had a colostomy and a suprapubic urinary catheter. The MDS showed R5's cognition was intact.

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A care plan showed R5 had a suprapubic urinary catheter with interventions to monitor and report for no output.

The POS showed an order to monitor and record suprapubic urinary drainage catheter output every shift.

On 06/07/2022 at 4:00 PM, R5 stated she didn't think the urinary drainage bag was emptied at the end of the day shift. Approximately 400 ml of slightly cloudy urine in tubing and urinary catheter drainage bag noted. V20 (CNA) stated "let me tell you about the catheter drainage bag." V20 stated the regular CNA staff members will empty the drainage bag at the end of their shift. V20 stated the agency CNAs disregard emptying the urinary drainage bags and most of them won't empty the drainage bag. V20 stated the CNAs are not supposed to combine the output for two shifts so the drainage bags should be emptied at the end of the shift.

A sign posted at the nurse's station showed the CNAs should report a resident's urine output towards the end of their shift to the nurse on duty, The nurses should document the urine volume in the Monitoring Tab section "monitor and record (indwelling urinary catheter)/suprapubic catheter output every shift.

The facility's Urinary Catheter Care policy dated 07/28/2021 included to observe the urine output for increases or decreases and report to the physician or supervisor if it stays the same or in the event of bleeding. Maintain an accurate record of the resident's daily output. Empty the collection bag at least every eight hours.

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