STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE CROSSING LVG & REHAB	409 WEST COMANCHE ROAD SHABBONA, IL 60550

(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
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3): 300.610a) 300.1210b) 300.1210d)2)5) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to cleanse a stage four pressure ulcer in a manner to prevent cross contamination and failed to ensure staff were knowledgeable in the use of a pressure reduction device for 1 of 2 residents (R42) reviewed for pressure in the sample of 14. These failures resulted in R42 being at an increased risk of infection and delayed wound healing. The findings include: R42's face sheet printed on 9/13/23 showed diagnoses including but not limited to Alzheimer's disease, chronic obstructive pulmonary disease, diabetes mellitus, protein-calorie malnutrition, chronic kidney disease, neuromuscular bladder, and stage 4 pressure ulcer of the sacral region	S9999		

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S9999	Continued From page 2 (lower back/upper buttock area). R42's facility assessment dated 6/29/23 showed moderate cognitive impairment and extensive staff assistance required for bed mobility, dressing, toilet use, and personal hygiene. The same assessment total staff dependence required for transfers. The assessment showed a urinary catheter in use and R42 is always incontinent of bowel. R42's physician orders showed an order dated 9/12/23 to: "Place calcium alginate into wound on sacrum, after cleansing the wound with N.S. (normal saline) ...cover with protective dressing/bandage, every day shift related to pressure ulcer of sacral region, stage 4". The orders showed an additional order dated 9/12/23 to: "Place pressure relieving device on bed and wheelchair". (Both orders were dated as of the day the survey). R42's Medication Administration Records (MAR) showed recent antibiotic use for wound infections. The August 2023 MAR showed documentation of tigecycline intravenous administered for ten days (8/4 to 8/13) for a MRSA wound infection. The MAR showed amoxicillin-pot clavulanate oral tablets administered for 10 days (8/25 to 9/4) for wound infection. R42's most recent weekly wound assessment dated 9/5/23 showed the stage 4 pressure ulcer to the sacrum present on admission. The assessment showed the wound was 4 cm long, 2 cm wide, and 1 cm deep (centimeters). Visible tissue was epithelial (pink) and granulated (beefy red). On 9/12/23 at 10:29 AM, R42 was lying in bed on	S9999		

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S9999	Continued From page 3	S9999		

her back and stated she has a sore on her butt. R42 said it has been there awhile and they put a dressing on it daily. A pressure reducing air mattress overlay was under R42. The dial on the machine showed it was set at just over the 120 mark. At 10:37 AM, V3 (WCN-Wound Care Nurse) and V4 (CNA-Certified Nurse Aide) rolled R42 to her side. A large white, damp dressing was hanging loosely off her sacral area. V3 stated there was a tele-visit scheduled with the wound doctor in approximately 15 minutes and she would apply a fresh dressing when she was done with the physician's visual assessment. R42's pressure reduction mattress pad was set at the 80 mark. At 10:53 AM, V3 (WCN) and V18 (Nurse Liaison) rolled R42 to her side. V3 removed the dressing and held a tele visit via cell phone with V17 (Wound Physician). V17 stated to continue with the daily cleansing and calcium alginate wound care treatments.

On 9/12/23 at 11:24 AM, V3 (WCN) wore gloves and removed the damp dressing from R42's sacrum. A golf ball size open wound with reddened skin surrounding it was observed. V3 used a gauze pad soaked in normal saline and blotted randomly at the wound. V3 blotted up, down, in and out across the wound. V3 poured more saline solution onto the same gauze pad a second time and blotted the wound again. V3 wore the same contaminated gloves and placed a calcium alginate pad on the wound then used a cotton swab to push it down. V3 readjusted the calcium alginate pad with her finger while wearing the same gloves. V3 placed a bordered foam dressing over the wound while still wearing the same contaminated gloves. V3 did not change gloves or sanitize her hands during the dressing change. V3 said she does the dressing change each day and as needed during the week. The

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S9999	Continued From page 4 floor nurses do it over the weekends. R42's pressure pad dial showed it was just under the 60 mark. On 9/12/23 at 2:41 PM, R42 was lying in bed. The pressure pad dial showed a setting pass the 280 mark. V5 (CNA Supervisor) was questioned by this surveyor what the pressure reduction devices hanging on the foot of resident beds were used for. V5 said she did not know what the machine was and had no idea how they should be set up. V5 stated she needed to ask her DON (Director of Nurses). V5 and V2 (DON) returned to the unit together approximately five minutes later. V2 was shown the pressure reducing device and stated they are used to prevent skin breakdown. V2 observed the setting on R42's device and said it is set well beyond the 280 mark and is as firm as it can be set. V2 said she did not know how the mattress should be set and "will need to look into it". On 9/12/23 at 3:01 PM, V1(Administrator/Registered Nurse) said the air mattresses are set based on resident comfort. If they say it feels fine, then we leave it alone. If the skin looks reddened, it should be turned to a softer setting. We look for facial grimacing if the resident is non-verbal or just looks uncomfortable. V1 said pressure ulcer mattresses are set based on a resident's individual preferences. We turn it softer or firmer based on how they look and what they report as to the feel of it under them. On 9/13/23 at 9:08 AM, R42 was in bed and the pressure reduction pad was set beyond the 280 mark. On 9/13/23 at 1:05 PM, V3 (WCN) stated she had	S9999		

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S9999	Continued From page 5 no idea what R42's mattress setting should be at. V3 said she did not know who sets it or how it is set. V3 said she has nothing to do with the pressure device settings. V3 said wound treatments should be done in a manner to help healing. V3 said the wound should be cleansed as ordered and kept clean while doing the treatment. V3 said it is important not to infect the wound in anyway while doing the treatments. V3 said she starts with hand hygiene and a fresh pair of gloves. V3 said she keeps the same gloves on until she is done with the treatment. V3 did not mention any glove changes were necessary while doing wound treatments. V3 said she wipes the inside and outside of the wound in a blotting manner. V3 said a cotton swab is used to fit the calcium alginate into the wound and it is important nothing dirty touches the wound. It could become contaminated. V3 and the surveyor observed R42's pressure reduction device together. It was set at the 120 mark. V3 said she had no idea what the numbers represent and maybe V1 (Administrator) would know. On 9/13/23 at 2:15 PM, V1 (Administrator/RN) said gloves should be changed anytime they are contaminated. Wounds should probably be cleaned from the inner area to the outer area. Nurses should be doing the dressing changes per the facility policy and the wound care nurse is the one that knows the proper technique. It is important to prevent infection. Poor wound care can delay healing and lead to other complications. Infected wounds can become systemic and R42 had just completed a round of antibiotics related to a sacral wound infection. V1 said the point of the pressure reduction mattress is to reduce pressure. It is based on resident comfort. V1 said we stick our hand under the mattress to judge if it is too soft or too hard. Our	S9999		

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S9999	Continued From page 6	S9999		

technique is based on the manufacturer's instructions. At 2:38 PM, V1 and the surveyor observed R42's mattress setting at the 60 mark. V1 turned the dial to 180 and said, "I have no idea how or why this dial setting works."

On 9/14/23 at 4:33 PM, V17 (Wound Physician) stated R42 has a "tricky" sacral wound. It is a chronic problem and staff should be cleaning it according to the orders. Cleansing the wound bed should be done per the facility's protocol. A fresh gauze pad is needed for each wipe or each time it is touched. The area should not be blotted because that will not thoroughly clean the wound. Gloves should be changed between dirty and clean use. It is important before going on to any treatments. V17 said gloves should be changed after cleansing the wound. New gloves should be worn to apply the calcium alginate and another set of new gloves to put the dressing over the wound. V17 said hand hygiene should be done between glove changes. V17 said R42 was on an antibiotic recently and poor wound cleansing can increase her risk for another infection. V17 said R42's wound has the risk of decreased healing, increased pain, and a septic infection if wound care is not done properly. V17 said R42's pressure reduction mattress should be used per the manufacturer recommendations and staff need to know how to use it. It needs to be more than just comfort based. V17 said the standard is to set it at a level so the mattress sinks to about 20%. The facility should have a policy or procedure to explain to the staff how to use her pressure reduction mattress. Not knowing how to use it puts her at an increased risk for poor wound healing.

The manufacturer instructions for R42's pressure reduction pad (undated) showed: "7. Please use

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S9999	Continued From page 7 pressure adjust knob to give maximum patient comfort." The facility was unable to provide any additional information related how to ensure it was providing the necessary pressure reduction or instructions on how to use the pad. The facility's Clean Dressing Change policy last review dated 7/28/2023 states under the purpose section: "It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination." The policy states under the steps in the procedure section: "9. Loosen the tape and remove the existing dressing ...10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e., clean outward from the center of the wound). Pat dry with gauze. 13. Measure wound using disposable measuring guide as indicated. 14. Wash hands and put on clean gloves. 15. Apply topical ointments or creams and dress the wound as ordered ...16. Secure the dressing.)" (B) Statement of Licensure Violations (2 of 3): 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies	S9999		

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S9999	Continued From page 8 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. 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 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	S9999		

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S9999	Continued From page 9 resident to meet the total nursing and personal care needs of the resident. 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: 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by:	S9999		

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S9999	Continued From page 10 Based on observation, interview and record review, the facility failed to supervise a resident at high risk for falls, with previous falls in the facility, and failed to supervise a resident with wandering behaviors for 2 of 8 residents (R41, R26) reviewed for safety and supervision in the sample of 14. This failure resulted in R41 falling, sustaining a hip fracture, and being sent out to a local hospital for evaluation and surgical treatment. The findings include: 1. R41's Admission Record, printed by the facility on 9/13/23, showed she had diagnoses including vascular dementia, severe, with behavioral disturbance, a history of falling, unsteadiness on feet, and abnormalities of gait and mobility. The Admission Record also showed a diagnoses added on 4/29/23 (upon readmission from a local hospital) of nondisplaced intertrochanteric fracture of left femur (left hip fracture). The Admission Record showed R41 resides on the dementia care unit of the facility. R41's progress note dated 4/21/23 showed 7:15 PM, V6 (Licensed Practical Nurse-LPN) heard a noise coming from the dementia care unit's dining room. Upon investigation, R41 was observed lying on the floor of the dining room. R41's progress note dated 4/22/23 at 6:00 AM showed R41's doctor was updated about R41 having increased pain during the night. R41 was able to bear weight but was refusing to take steps. The note showed R41 was favoring her left leg and knee. The note showed a new order was given to X-ray R41's left hip, femur and knee.	S9999		

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S9999	Continued From page 11	S9999		

R41's progress note dated 4/22/23 at 9:30 AM showed R41 had another fall in her room and was found lying on her left side on the floor. The note showed R41 was attempting to stand up unassisted and continued to put her left hand on her left thigh, saying "Ouch" when R41 attempted to take a step. The note showed the company that was notified to perform the X-ray was on the way to the facility. R41 was placed on one-to-one staff supervision at that time, due to attempts to self-transfer/ambulate.

R41's progress note dated 4/22/23 at 11:58 AM showed R41's X-ray results showed an acute intertrochanteric hip fracture.

R41's progress note dated 4/22/23 at 12:14 PM showed a new order was received from R41's Physician to send her to a local hospital's emergency department for evaluation and treatment of her left hip, due to X-ray results and signs of pain.

The facility's document titled Incidents by Incident Type, printed by the facility on 9/13/23, showed between 7/25/22 - 9/13/23 R41 had 17 falls in the facility. The document showed 12 of R41's falls occurred before the fall resulting in a fracture that occurred on 4/21/23. The document showed R41's falls had occurred in the hallway, in the dining room, in R41's room, in R41's bathroom, and in the lounge area.

R41's facility assessment dated 2/6/23 showed R41 had severe cognitive impairment, short-term and long-term memory problems, and continuous inattention. The assessment also showed R41 had falls in the facility and wandering behaviors. The assessment also showed R41 required supervision when walking.

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S9999	Continued From page 12	S9999		

R41's Morse Fall Scale (a tool to determine a resident's risk for falls) dated 4/4/23 showed R41 had a high risk for falling.

On 9/14/23 at 8:38 AM V6 (LPN) said she thinks R41 was in the dining room when R41 fell on 4/21/23. V6 stated, she (R41) had so many falls, I (V6) think this is the one where she was in the dining room. V6 said she was in the hallway passing medications when she heard R41 fall. V6 said she went into the dining room and R41 was on the floor. V6 said R41 did not complain of pain at the time and was trying to get up on her own. V6 said no staff were in the dining room at the time of R41's fall, they were getting other residents up. V6 said there were other residents in the dining room at that time, however, she does not recall which residents. V6 said R41 had falls before that incident. V6 said R41 had been sitting up at a table in the dining room, prior to her fall. V6 said R41 would not stay anywhere, she was walking at the time and got up on her own. V6 said R41 was, and still is, restless and is constantly going. V6 said R41 was a fall risk. V6 said it is probably not a good idea to have her (R41) in the dining room with no staff present, considering she is a fall risk.

On 9/14/23 at 12:28 PM, V13 (Certified Nursing Assistant-CNA) said the day R41 fell in the dining room and sustained a hip fracture, V13 was in another resident's room assisting the resident. V13 said by the time she got done assisting the other resident and went out of the room, R41 had already been assessed and was back up in her chair. V13 said V6 (LPN) informed her R41 had fallen. V13 said she did not consider R41 a fall risk, prior to that incident, because R41 had not had any falls on her shift. V13 said the only time

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	IL6008502	A. BUILDING: _____ B. WING _____	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13	S9999		

she would consider R41 a fall risk was when she was agitated and pacing, but that did not happen very often. V13 said when she went through her initial training at the facility, she was told that staff should be in the dining room at all times when there are any residents in the dining room; regardless of whether it is when they are serving food or eating. V13 said she does not know if there were staff in the dining room at the time or not because was assisting another resident.

On 9/14/23 11:00 AM, V16 (Psychiatric Nurse Practitioner) said R41 has dementia, wandering behaviors, and a history of falls and should not be left in the dining room unsupervised. V16 said she feels that no residents should be in the dining room unsupervised; whether it is during a meal, or before a meal, in case there is an emergency situation. V16 said there should be someone in the dining room when there are residents in there. Staff should respond as soon as they hear the sensor alarm going off.

R41's care plan, with a revision date of 5/1/23, showed R41 is at risk for a decline in physical mobility due to Alzheimer's and a recent hip fracture with repair, significant mobility change. The care plan showed R41 was non-ambulatory with CNA and is totally dependent on one staff for locomotion, using a wheelchair. R41's care plan initiated on 6/15/22 showed R41 is at risk for falls related to cognitive deficit and poor safety awareness secondary to dementia. The care plan showed R41 wandered and had impulsive behaviors.

The facility assessment dated 7/31/23 showed R41 requires extensive assist from two staff members for transfers. The assessment showed R41 had two falls in the facility since reentry or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	09/15/2023

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S9999	Continued From page 14 the prior assessment. R41's History and Physical documentation printed on 4/29//23 (the day R41 returned to the facility) showed, "Assessment: 1. Left hip intertrochanteric fracture. 2. Advanced dementia...Plan: Case discussed with orthopedic surgery. Tentative plan for surgical fixation on Monday, 4/24/23." R41's progress note dated 4/29/23 showed R41 returned to the facility via ambulance post hospitalization for intertrochanteric fracture of left femur. Post-op dressing dry and intact to left hip surgical incision. On 9/12/23 at 9:39 AM, A bed alarm went off on the dementia care unit of the facility. The alarm was coming from R41's room. R41 was sitting up in bed. Her left leg was over the side of her bed and she was bringing her right leg over to the side of the bed. R41's hands were on the bed on both sides of her, like she was getting ready to push herself up to stand up. This surveyor cued R41 to stay in bed and wait for staff 3 times (whenever she was making the motion to attempt to stand up) between 9:39 - 9:42 AM. At 9:42 AM, V11 CNA came through the door of the memory care unit and went into R41's room. Just prior to R41's alarm sounding, V14 (CNA) had entered a resident's room next to R41's room and closed the door. On 9/13/23 at 2:16 PM, V4 (CNA) was asked what intervention were in place to prevent R41 from falling. V4 said she thinks the interventions in place are to her pull alarm and low bed right now. V4 said as soon as we hear her alarm, we come running.	S9999		

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S9999	Continued From page 15 On 9/14/23 at 8:18 AM, V2 (Director of Nursing-DON) was asked which residents would be a candidate for a sensor alarm. V2 said residents who have fallen a million times. V2 said the alarm gives staff a little time to get to the resident before they fall on the ground. V2 said staff should respond to the alarm as soon as possible when the alarm goes off. On 9/14/23 at 11:00 AM, V16 (Psychiatric Nurse Practitioner) said staff should respond as soon as they hear the sensor alarm going off. The facility's policy and procedure titled Fall Prevention and Management, approved on 5/18/18, showed "Fall Prevention: 1. Conduct fall assessments on the day of admission, quarterly, and review after each fall...7. All staff must observe residents for safety. If residents with a high-risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident..." 2. R26's Admission Record, printed by the facility on 9/13/23, showed R26 was admitted to the facility on 8/14/23 and had diagnoses including dementia with behavioral disturbance, restlessness and agitation, anxiety disorder, and major depressive disorder. R26's facility assessment dated 8/21/23 showed she had severe cognitive impairment and wandering behaviors. The assessment showed R26 required supervision of staff when walking in her room and in the corridor on the unit. R26's Wandering/Elopement Assessment dated 8/14/23 showed she was able to be independently mobile and had a diagnosis of dementia/Alzheimer's/Confusion. The assessment showed R26 exhibited pacing, wandering, trying to get out of the door, find	S9999		

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S9999	Continued From page 16	S9999		

family or friend, and/or perceived the need to be doing something other than what they are doing (e.g., go to work, get home, fix supper, do chores).

On 9/12/23 At 2:58 PM, R26 was not in her room, or in the dining room of the dementia care unit. This surveyor walked down the hall, looking into other resident rooms that had the door open. At 2:59 PM, V4 and V10 (Certified Nursing Assistants-CNAs) were coming out of another resident's room and were asked if they knew where R26 was. V4 and V10 said R26 was in the dining room coloring. V12 (Agency Manager) had just entered the dementia care unit and was informed that this surveyor was looking for R26. V12 looked in R26's room and knocked on the bathroom door in R26's room, with no reply. V12 told V4 and V10 to start checking the other residents' rooms. The rooms were searched and R26 was found in the bathroom belonging to R44 (a male resident). R26 said she was using the bathroom.

R26's care plans were reviewed, showing no care plan that addresses R26's wandering behaviors.

On 9/13/23 at 2:18 PM, V4 (CNA) said she did not see anything in R26's electronic charting about wandering behaviors.

On 9/13/23 at 2:40 PM, V15 (MDS/Care Plan Coordinator) was asked to look in R26's care plans for one that addresses her wandering behaviors. V15 looked through the care plans and said she did not see anything in R26's Care plans about wandering/ elopement risk. Adding, "Unfortunately". V15 said R26's facility assessment dated 8/21/23 showed she had wandering behaviors. V15 said "We usually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 17 address that in the care plans." V15 brought up section V Care Area Assessment Summary (CAAs) and said the CAAS section of the 8/21/23 MDS (facility assessment) triggered for wandering under behaviors. V15 said a care plan should have been initiated. R26's progress note dated 8/15/23 showed R26 sometimes wanders into the wrong room but is easily redirected. R26's progress note dated 8/19/23 showed, R26 refusing to stay out of other residents' room. When redirected, R26 tells staff to shut up. R26 is restless and non-stop pacing the hall, entering other resident rooms. R26's behavior note dated 8/20/23 showed she was repeatedly trying to exit the building from any door possible. Pacing back and forth up and down the halls and taking things from other residents' rooms. The note showed, "Resident requires constant supervision." Another behavior note dated 8/20/23 showed R26 eating other residents' food. R26's Care plan conference note dated 9/6/23 showed R26 does wander into other resident's rooms and gets in other residents' personal space. On 9/13/23 at 2:53 PM, V1 (Administrator) said the purpose of the care plans are so staff know how to care for a resident, and to put interventions in place to keep the residents safe. The facility's policy and procedure titled Resident Wandering and Elopement, with an approval date of 2/13/2019, showed "1. The staff will identify residents who are at risk for harm because of	S9999		

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S9999	Continued From page 18 unsafe wandering) including elopement). 2. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. 3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety will be included. 4. Nursing staff will document circumstances related to unsafe actions, including wandering, by a resident. Staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high-risk of elopement or other unsafe behavior". (A) Statement of Licensure Violations (3 of 3): 300.610a) 300.1210b) 300.1210c)2)3) 300.1220b)3) 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. Section 300.1210 General Requirements for	S9999		

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S9999	Continued From page 19 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 2) All treatments and procedures shall be administered as ordered by the physician. 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in	S9999		

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S9999	Continued From page 20	S9999		

the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure catheter changes were performed as ordered and failed to ensure catheter care orders were in place for 2 of 3 residents (R6, R20) reviewed for catheters in the sample of 14. This failure resulted in catheters having a gray discoloration for residents with recurrent urinary tract infections (R6, R20), R6's urine was cloudy yellow with sediment, and R20's urine was thick, foul-smelling, and amber in color.

The findings include:

1. On 9/14/23 at 10:05 AM, V10 and V11 (Certified Nursing Assistants - CNAs) transferred R6 to bed from the wheelchair. V10 and V11 laid R6 on her back and removed her pants and incontinence brief. R6 had an indwelling catheter inserted. The catheter was attached to a leg bag. The leg back was secured to R6's right inner leg. There was cloudy yellow urine, with sediment draining into the leg bag. V11 used a washcloth to cleanse R6's catheter tubing. The catheter tubing was discolored from the insertion site (nearest the body) to the "Y" in the tubing. (This type of indwelling catheter had a "Y" at the distal end of the tubing, one side connected to the drainage system and the other was used to inflate the balloon of the catheter). The catheter tubing from R6's body to the beginning of the "Y" was a dark gray discoloration. The tubing at the of the "Y"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	09/15/2023

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S9999	Continued From page 21	S9999		

was a tan color (The original color of this type of indwelling catheter was tan). V10 and V11 provided catheter care, emptied R6's leg bag, and attached R6's regular drainage bag.

R6's Face Sheet dated 9/14/23 showed diagnoses to include, but not limited to: TBI (traumatic brain injury), asthma, diabetes, generalized muscle weakness, diabetes, need for assistance with personal cares, difficulty walking, unsteadiness on feet, Extended Spectrum Beta Lactamase (ESBL) Resistance (a multi-drug resistant organism that causes bladder infections (UTIs), anxiety, history of bladder infections, neuromuscular dysfunction of the bladder, chronic obstructive pyelonephritis, retention of urine, vascular dementia, depression, and bipolar disorder.

R6's facility assessment dated 6/26/23 showed R6 had long and short-term memory problems; required extensive assistance from staff for transfers, personal hygiene, and toilet use; and had an indwelling urinary catheter.

R6's Physician Visit dated 8/10/23 showed R6 had recurrent UTIs.

R6's Urology Visit Summary dated 4/26/23 showed R6 was seen for a UTI associated with an indwelling catheter and recurrent UTIs.

R6's Lab Report dated 4/15/23 showed R6's Urine Culture was positive for ESBL.

R6's Physician Order Sheet dated 9/14/23 showed R6 had an order for catheter care every shift. This document showed R6 had an order for Contact Isolation precautions (due to an UTI caused by ESBL), initiated on 4/20/23. R6 had an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 22 order a 16 French (catheter size), 10 cc balloon change monthly and as needed, to be initiated 4/20/23. R6's Treatment Administration Records (TARs) dated June 2023 through Sept 2023 were reviewed. R6's TARs showed R6's catheter had not been changed since 6/9/23 (3 months prior to this observation). R6's TARs showed that R6's indwelling catheter was not changed monthly, as ordered. R6's Progress Notes were reviewed from 6/10/23 to 9/13/23. There were no entries that showed R6's indwelling catheter had been changed. These progress notes showed R6 was hospitalized for ESBL from 4/14/23 - 4/20/23. R6's Progress Note dated 9/13/23 showed the facility had collected a urine specimen for urinalysis and culture and sensitivity. R6's Care Plan revised 1/11/23 showed R6 had an indwelling catheter related to a neurogenic bladder. The interventions included "Change per MD orders." On 9/14/23 at 10:21 AM, V6 (Licensed Practical Nurse) said she was the nurse for R6's hall. V6 stated, "I think the catheters are changed monthly and PRN (as needed). There should be a doctor's order for that. We (the nurses) should follow the physician's order." V6 said she thought the facility might have changed the policy and she wasn't sure exactly. V8 (RN) walked up to the nurses' station. V6 asked V8 what the policy was for changing the indwelling catheters. V8 stated, "I know it has changed recently. I believe the catheter change is now PRN (as needed), but I would have to check our policy to be sure." V6 said some reasons to change an indwelling	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	09/15/2023

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S9999	Continued From page 23	S9999		

catheter PRN could be the catheter isn't flowing right, it's leaking, or it doesn't flush. The surveyor asked V6 if discoloration of the catheter tubing was an indication to change the catheter. V6 said she wasn't sure what that meant. The surveyor described the dark gray, discoloration on R6's tan catheter tubing. V6 replied, "That would be concerning. They shouldn't change color." V6 said it is important the nurses change the catheter to ensure it is working properly and not building up infection. V6 said R6 has had UTIs. The surveyor asked how the nurse knows when the catheter was changed last. V6 said she would have to check the TAR. V6 reviewed R6's September TAR and stated, "I don't see that the catheter was changed in September, but this order says to change it monthly." V6 reviewed R6's TARs until she found the last time R6's catheter change was documented. V6 stated, "It looks like it wasn't changed since 6/9/23. That's not right. It should have been changed." V6 informed V7 (LPN in training), "Let's get those sizes (of the catheters) written down. We'll need to change those." V6 said the facility's supply of catheters was kept on the front hall.

On 9/14/23 at 10:40 AM, V1 (Administrator) said the facility has two types of catheters. The 100% silicone that R20 needs (this catheter tubing is clear) and the silicone coated one that has latex (this catheter tubing is tan). R6 used the tan catheter. The surveyor informed V1 that R6's catheter had a dark gray discoloration from the insertion site to the "Y" on the catheter. V1 replied, "I will have to take a look." At 11:15 AM, V1 said she did see the discoloration on R6 and R20's catheters. V1 said both R6 and R20 were seen by urology. At 12:07 PM, V1 said the only policy related to catheters that the facility had was the Catheter Care Policy that was provided. (This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 24 policy did not contain any information regarding "when" to change the indwelling catheter.) On 9/14/23 at 1:20 PM, V9 (Urologist) said R6 was seen in his office, V9 does not go to the facility. V9 said he saw R6 in April 2023 for urinary tract infections. V9 said he expects the catheter to be changed monthly. V9 said he would expect the facility to follow the physician's orders. V9 said he had never heard of indwelling catheters being changed PRN. The surveyor informed V9 that R6's last catheter changed was 6/9/23. V9 replied, "Well that's a month or two late." V9 said R6's catheter should not be discolored. V9 said that should be an indication to change the catheter, but it really should be done monthly and this wouldn't be an issue. The surveyor asked for a catheter policy. The facility provided Catheter Care Policy (reviewed 7/28/23). This policy does not include information regarding when to change an indwelling catheter. (V1 (Administrator) said this was the only policy the facility had for catheters. 2. On 9/14/23 at 9:39 AM, V10 and V11 (CNAs) transferred R20 from her wheelchair to her bed, using a total lift. R20 was laid on her back and her pants were removed. R20 had an indwelling catheter attached to a leg back. The leg back was secured to her right leg. There was dark amber urine in the leg bag. V10 and V11 provided catheter care. R20's catheter was gray from her body to the "Y" in the tubing. (R20's catheter color is normally clear). V11 emptied R20's leg bag. The urine was sluggish to drain. V11 stated, "It gets like this from time to time. Her position doesn't help." R20 was lying on her back in bed with her right leg slightly bent. The urine wasn't flowing freely down to the drain spot. V11 moved	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 25 R20's leg, so the urine could be drained. Thick, amber, foul-smelling urine slowly drained from the leg bag. There were strings of sediment that were hanging from the drain spot. R20's urine appeared thick and was sluggish to drain. V11 (CNA) said it gets like this sometimes. R20's Face Sheet dated 9/14/23 showed diagnoses to include, but no limited to: chronic pain syndrome, MRSA (Methicillin Resistant Staph Aureus) infection, multiple sclerosis, dysphagia, anxiety, depression, generalized muscle weakness, seizures, and bipolar disorder. R20's facility assessment dated 8/14/23 showed she had severe cognitive impairment; required extensive assistance for personal hygiene and bed mobility; was totally dependent on staff for transfers and toilet use; and had an indwelling catheter. R20's POS dated 9/14/23 showed orders for an indwelling catheter, size 16 French with a 10 ml balloon. Change PRN (as needed). R20 did not have orders of Catheter Care every shift. R20's July 2023 to Sept 2023 TARs were reviewed. The last documented catheter change was 7/25/23. There was no documentation of catheter care being provided every shift. On 9/14/23 at 10:21 AM, V6 (Licensed Practical Nurse) said she was the nurse for R20's hall. V6 stated, "I think the catheters are changed monthly and PRN (as needed). There should be a doctor's order for that." V6 said she thought the facility might have changed the policy and she wasn't sure exactly. V8 (RN) walked up to the nurses' station. V6 asked V8 what the policy was for changing the indwelling catheters. V8 stated, "I	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008502	A. BUILDING: _____ B. WING _____	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 26	S9999		

know it has changed recently. I believe the catheter change is now PRN (as needed), but I would have to check our policy to be sure." V6 said some reasons to change an indwelling catheter PRN could be the catheter isn't flowing right, it's leaking, or it doesn't flush. The surveyor asked V6 if discoloration of the catheter tubing was an indication to change the catheter. V6 said she wasn't sure what that meant. The surveyor described the gray, discoloration on R20's clear catheter tubing. V6 replied, "That would be concerning. They shouldn't change color." V6 said it is important the nurses change the catheter to ensure it is working properly and not building up infection. V6 said R20 had a history of UTIs. The surveyor asked how the nurse knows when the catheter was changed last. V6 said she would have to check the TAR. V6 reviewed R6's September TAR and stated, "I don't see that the catheter was changed in September." V6 reviewed R20's TARs until she found the last time R20's catheter change was documented. V6 stated, "It looks like it wasn't changed since 7/25/23. That's not right. It should have been changed." V6 informed V7 (LPN in training), "Lets write get those sizes (of the catheters) written down. We'll need to change those." V6 said the facility's supply of catheters was kept on the front hall. V6 said catheter care should be ordered every shift for all residents with catheters. V6 said she did not see catheter care orders for R20. V6 said catheter care is important to decrease the risk of infection. The surveyor described R20's urine as thick, amber, and foul-smelling. V6 replied, "That could be a sign of an UTI. I don't see that she (R20) has had urinalysis done since May."

On 9/14/23 at 10:40 AM, V1 (Administrator) said the facility has two types of catheters. The 100%

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S9999	Continued From page 27 silicone that R20 needs (this catheter tubing is clear) and the silicone coated one that has latex (this catheter tubing is tan). The surveyor informed V1 that R20's catheter had a gray discoloration from the insertion site to the "Y" on the catheter. V1 replied, "I will have to take a look." At 11:15 AM, V1 said she did see the discoloration on R6 and R20's catheters. V1 said both R6 and R20 were seen by urology. At 12:07 PM, V1 said the only policy related to Catheters that the facility had was the Catheter Care Policy that was provided. (This policy did not contain any information regarding "when" to change the indwelling catheter.) On 9/14/23 at 1:20 PM, V9 (Urologist) said R6 was seen in his office, he does not go to the facility. V9 said he had not seen R20 since November 2022. V9 said he expects the catheter to be changed monthly and for catheter care to be ordered. V9 said he had never heard of indwelling catheters being changed PRN. The surveyor informed V9 that R20's last catheter change was 7/25/23. V9 said R20's catheter should not be discolored. V9 said that should be an indication to change the catheter, but it really should be done monthly and this wouldn't be an issue. The surveyor asked for a Catheter policy. The facility provided Catheter Care Policy (reviewed 7/28/23). This policy does not include information regarding when to change an indwelling catheter. (V1 (Administrator) said this was the only policy the facility had for catheters). (B)	S9999		