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S 000	Initial Comments Complaint investigation - 2314861/IL160866	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)3) 300.1210d)2)3) 300.1220b)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 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	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of	S9999		

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S9999	Continued From page 2 the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not med as evidence by: Based on interview and record review the facility failed follow facility policies and failed to notify a resident's provider and provide emergency services for a resident with a change in condition, and the facility failed to follow-up with a resident's physician regarding signs and symptoms relating to a urinary tract infection. This applies to 1 of 3 residents (R1) reviewed for change in condition in the sample of 7. This failure resulted in R1 developing septic shock (Serious Condition that occurs when a body-wide infection leads to dangerously low blood pressure) and requiring hospitalization. The findings include: 1. R1's Admission Record showed an original admission date of 5/20/23 with diagnoses to include major depression; nausea, and acid reflux disease. R1's 5/29/23 Minimum Data Set (MDS) showed she was cognitively intact with a brief interview for	S9999		

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mental status (BIMS) score of 14 out 15. The MDS showed she was able to make herself understood, she was able to understand others, and she had clear speech. The MDS showed R1 was totally dependent upon two staff for bed mobility (turning in bed); transferring from bed to chair; dressing; personal hygiene; and toilet use. The MDS showed she was frequently incontinent of urine and she was always incontinent of bowel. The MDS showed she had a stage II pressure sore.

R1's Care Plan showed she was a Full Code (In the event her heart or lung function would cease; resuscitation interventions should be initiated).

R1's 5/20/23 Admission Note from 7:50 PM showed R1 was admitted from a hospital approximately 45 minutes from the facility. R1 was alert and she was oriented to person, place, time and curent condition. R1's note showed R1 stated R1 was not able to walk due to a pinched nerved and R1 required surgery. The note showed R1 was unable to move or straighten R1's left leg. (Note was authored by V18 Licensed Practical Nurse, LPN)

R1's Hospital Records (obtained from the facility) showed R1 "is a 45 year old female admitted on 5/9/23. Patient active problem list: Urinary Tract infection without hematuria (no bleeding)...and Sepsis, due to unspecified organism..." The records also showed diagnoses to include Failure to thrive in adult; malnutrition; and low blood pressure.

R1's 6/1/23 psychiatry note showed "...there are no symptoms of mania, paranoia, or delusional thoughts elicited this visit...Appearance/Behaviors: Calm, cooperative,

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Good eye contact, Well groomed. Speech: Clear, normal rate, tone, and volume...Mood: Depressed; Attention: Good; Insight: Fair; Judgment: Fair." The note showed she was awake; alert; and oriented to person, place, and time.

R1's Physician Notification from V22 Registered Nurse sent to V4 Medical Director/Physician on 6/1/23 showed, R1 was complaining of burning with urination, urinary urgency, and bloody discharge. V22 requested a urine analysis (Urinalysis, UA) and, if needed, catheterize the resident to obtain the sample. V4 responded on 6/1/23 to do urine analysis (UA) and catheterize the resident if needed. The same fax sheet showed, "Update 6/6/23 - resident refuses straight cath (catheter that is inserted for sample then immediately removed), says she has a fear of catheters, has been refusing."

R1's Fax sheet sent to V4 showed R1 had "blood tinged urine" and her vaginal area was swollen and she was experiencing vaginal discharge. The note showed a request for catheterization for urine analysis and to culture the urine if indicated. V4 responded, via fax, on 6/4/23 stating "Ok to do above." (The nurse's signature who authored the fax was not legible; V18 LPN confirmed she sent the fax. The "date" box on the fax is blank; however, the fax was stamped with a date of 6/2/23. Staff schedules showed V18 worked the evening of 6/1/23 to the morning of 6/2/23.)

R1's 6/4/23 Nurse's Note from 8:02 PM, showed, R1 refused straight catheterization for a UA and that she would do a bed pan for the UA. (Note authored by V18)

R1's 6/6/23 Nurse's Note from 3:18 AM, showed

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"Resident refused to be straight cathed, stated that she has a fear of catheters."

R1's 6/11/23 Nurse's Note from 4:57 PM, showed R1 was experiencing a "change in condition." The note showed, "Altered mental status, lethargy, slow to respond. Unable to get blood pressure reading. Oxygen saturation ranging from 79 percent to 86 percent. Oxygen started at 3 liters per nasal cannula..." The note showed she had a low heart rate of 38 beats per minute (Normal range is 60 to 100 beats per minute, BPM) and 911 was called. The note showed V4 was notified of the transfer.

R1's Hospital records from the evening of 6/11/23 showed R1 was in septic shock, she had bladder inflammation, and a urinary tract infection. The records showed a physician note on 6/11/23 at 9:13 PM, "... It is difficult to obtain history from patient but patient's mother is at bedside and stated that 2 to 3 days ago the patient started not looking so well. Patient's face appeared pale and she was having increasing her jerking movements. Patient's mother states the patient was treated for UTI 2 weeks ago..." The note continued "...Septic shock with acute (recent onset) organ dysfunction present on admission...Source of infection is urinary and respiratory..."

On 6/14/23 at 1:00 PM, V18 LPN stated she works 6:00 PM to 6:00 AM mainly on the first floor of the facility. (R1 was a first floor resident of the facility.) V18 stated, on admission, R1 was alert, oriented, and conversational. V18 said R1 was "...very 'spot on' and deliberate with her statements, she could make her needs known..." V18 said she worked the evening of 6/11/23. V18 said the day nurse on 6/11/23, V19 Registered

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Nurse, had a one hour and 45 minute drive home, therefore, she came in early so V19 could start her long drive home. V18 said she arrived at the facility between 4:30 PM and 5:00 PM. V18 said the report she received from V19 regarding her shift that day was uneventful. V18 said while she was receiving report, V20 Certified Nursing Assistant stated R1 was "talking crazy...she was talking about asparagus and how the CNA had blue eyes and pretty pale skin but she (V20) is dark skinned and has dark eyes. I asked the CNA, was she saying this stuff with her eyes open and the CNA said no..." V18 said the CNA reported R1 had not eaten breakfast or lunch and she had not drank any fluids that day. V18 said R1 not eating breakfast or lunch was normal for R1. V18 said, "So I said send her out, she has altered mental status. If she is seeing stuff with her eyes closed, that is weird and not normal for her..." V18 said V19 went to do vitals while she called for transportation. V18 said when she entered the room the staff were not able to get a blood pressure with the machine. V18 said she attempted a manual blood pressure and she "could not hear anything." V18 said she attempted to feel for a pulse in R1's wrist and she was unsuccessful. V18 said R1 appeared "pale; almost grey." V18 said, "A week and a half ago Monday, or Sunday, I went to straight cath her for a UA because her urine was nasty smelling and blood tinged...I asked [V4] for UA and culture if indicated. She (R1) said she can't use a bed pan because of what happened at [previous long-term care facility]; then she would start crying. Then I went to straight cath her and she said no. I told her she can't use bed pan but I told her to press the call light next time she had to go and we would do the bed pan. She was not willing to do the bed pan for the UA then [V22 Registered Nurse] tried (straight catheter) and she said No

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again. The night they sent her to the ER, I told them (R1's family that was in the room that night) she is in bad shape; I think she has Sepsis...I think she was septic from the UTI. She had nasty foul smelling urine for 1 to 2 weeks and you don't let anyone get a UA; these UTI's don't go away on their own. I think [V22] sent him (V4) something or faxed him something that she refused straight cath or UA. I don't remember getting a fax back that he (V4) respond. If we fax and there is no response, we sometimes have to send a couple faxes..." V18 said providers will not order antibiotics without a UA. V18 said the foul smelling urine was reported to her by the CNA staff. V18 said, "If someone told me something is not right with her (R1), I would go down and see for myself. I don't know why [V20] didn't tell her (V19) what she told us [during report] earlier on in the shift. If I was told she was not right, I would go down there with the vitals machine and talk to her and do an assessment and see what's up and do vitals."

On 6/15/23 at 10:05 AM, V18 stated she knew R1 needed to be sent out without seeing the resident. V18 said, "What they were describing was a change in her mental condition and she needed to be sent out."

On 6/14/23 at 9:43 AM, V20 CNA said she was scheduled to work 6:00 AM to 6:00 PM on 6/10/23 (Saturday) and 6/11/23 (Sunday.) V20 said, in regards to R1 on Saturday, "She was a lot more with it, at least more than Sunday...Saturday she was not even talking in a normal conversation but she could at least talk. She asked to talk to her mom. She was trying to help us turn her on Saturday but you could tell something was going but it was not as bad as Sunday. She could say she was hurting and she

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really did not like to reposition. The weekend before I only saw her a little but she was a lot more alert and conversational (The weekend prior to 6/10/23 and 6/11/23)... it was a big change to the next weekend... It was painful for her when I would provide incontinence care...I even told the night CNA, if she doesn't get sent out, that he needed to check on her every hour and don't go longer than that." V20 said, in regards to R1 on Sunday 6/11/23, "She was a lot worse. She was totally out of it. I tried to wake her up for breakfast and she wouldn't wake up at all, she mumbled a few things but that was it. I told her I would leave her breakfast and I would come back. I asked if she needed help, but she didn't say anything. I tried to get her a drink with a straw and the water just ran out of her mouth... Then at lunch she did nothing again. I told the nurse that she has gotten way worse; it was around lunch time. I don't know the exact time, but it was right around lunch time. Then, sometime between 3:00 PM and 5:00 PM, [V19 RN] went down there to check her (R1) vitals and they couldn't get vitals on her. I did see [V19] go down and check on her at lunch time. I don't know if she did a set a vitals on her at lunch time but, I did tell [V19] I would do a set of vitals and with everything going on I forgot to do them. (R1's Electronic Charting showed no vital signs on or about 12:00 PM on 6/11/23) When [V19] saw her at lunch time, [R1] would not have been alert and oriented. She was not alert for me at all; the entire shift. I would say her condition from Saturday to Sunday, she had a change in condition. Even on Sunday morning she already had a change in condition. I even asked what meds she was on Sunday morning because she appeared snowed (sedated) to me, and she was on Seroquel so I thought that was the cause of it but she never came around. I don't think [V19]

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had ever taken care of her before so I don't think she knew if this was a change in condition. [V19] would not have known this was change. The family came in later in the afternoon, they came in right before, as everybody decided she (R1) needed to be sent out....The way [R1] was when she was sent out she was not in any different condition than she was in the morning. [R1] was talking about asparagus and she said I had pretty pale skin, but I am super dark and tan and I have brownish green eyes but she said I have beautiful blue eyes. She said that around lunch time, and that was when I told [V19] that she was not really waking up at all." V20 said, "It wasn't until the full time employee came in on Sunday night; she came in early around 4:30 PM or so, and we told her how [R1] was acting...It was the night nurse (V18) that prompted us to send her out. I think if [V19] knew she (R1) was alert and oriented prior to Sunday, she (V19) would have sent her (R1) out earlier that day. But no one knew how she was normally and it wasn't until [V18] came in that we were aware how she was acting was not normal. [V19] didn't work Saturday either." V20 said, R1 had yellow drainage that was not urine. V20 said, in regards to the drainage, "I've never seen anything like that before and I have 28 years of experience...The yellow discharge smelled like, It's hard to explain, I've never smelled anything like that before, it was not normal. I don't think it was a yeast infection, It seemed like it was vaginal discharge but I did not think it was a yeast infection. I've had residents with yeast infections and it didn't look like any of those that I have seen before." V20 said, "Oh god yes, most definitely with UTI's and infections, there is a big change in cognition. I remember, I think [V18] said, they were trying to get a UA on her but she wouldn't let them straight cath her. I don't know how long they had been trying to get one."

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S9999	Continued From page 10 On 6/13/23 at 3:49 PM, V16 CNA stated she worked the day shift on Sunday 6/11/23. V16 said, "Sunday was my first time meeting [R1]. She was really out of it. She had her eyes closed and she could not form a sentence. That was how she was at the beginning and the end of the shift...She did have a brief (incontinence brief) I didn't notice any blood but I did notice some yellow pus like discharge. The yellow pus was mixed with the urine. I didn't see any yeast like discharge when I cleaned her up. My understanding that was her normal condition...the nurse [V19] said she was out of it as well. [V19] did not say this was abnormal for her. My shift that day was 6:00 PM to 2:00 PM that day. She was definitely not alert, oriented, and answering questions when I saw her. She was the same my entire shift. If I had cared for her previously and she was alert and oriented at that time, I would have told the nurse she needed to be evaluated because the way I saw her on Sunday that would have been a change...She (R1) was just gibberish nothing that she said was understandable. I did not do the vital signs on her that day the nurses will sometimes give us a list of residents that need vitals but they did not give us a list that day. I did try talk to her and I tried to feed her both meals but she pushed them away both times." On 6/14/23 at 8:15 AM, V19 stated, prior to 6/11/23, she had never cared for R1. V19 said she saw R1 for morning medication pass, then again shortly after medication pass. V19 stated she saw R1 for less than 10 minutes during the day. V19 said during morning medication pass R1 stopped V19 from giving her medications water and she wanted to take them with soda; however, she did not really speak with R1. V19	S9999		

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returned to apply a cream to R1's vaginal area and R1 did not say anything. V19 stated she believed R1 was alert and oriented in the morning of 6/11/23.

On 6/15/23 at 11:24 AM, V19 denied being told at lunch time on 6/11/23 of a declining condition. V19 denied requesting a CNA do vitals for R1 and denied being aware of the CNA stating she would perform vitals on R1. V19 said, "I would have gone down and done an evaluation, if I had known there was a change, but that was my first time taking care of her and I know she has a history of behaviors. I told [V18] maybe she (R1) was having behaviors that afternoon. I would say when I went in in the morning she was awake and alert. I would say that not being able to make her needs known, not opening eyes, and being out of it would be a change in condition. If I had been told that, I would have gone down and done an assessment. I would expect the CNA's to tell me if the resident was having a change in condition... A change in cognition is not uncommon for residents with a UTI..."

On 6/14/23 at 3:01 PM, V22 RN stated he sent the fax on 6/1/23 to R1's physician. V22 said, said R1 was incontinent; alert and oriented; and she could make her needs known. V22 stated, R1 reported to him the symptoms listed on the fax sheet. V22 said the symptoms he reported are consistent with the symptoms of a UTI. V22 stated he notified the physician of R1's refusal for catheterization and he was not aware if V4 responded. V22 stated an untreated UTI can lead to sepsis. V22 said if resident is unable to provide a urine sample for UA but the resident has symptoms of a UTI, he would encourage fluids and contact the resident's physician to "see if we can get an antibiotic due to the signs and

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(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
S9999	Continued From page 12 symptoms of a UTI." On 6/14/23 at 12:25 PM, V3 Assistant Director of Nursing stated if a resident refuses straight catheterization the nurse should attempt alternatives such as a bedside commode or bed pan if needed. V3 said the doctor should be notified if the staff are unable to obtain a UA. V3 said there should be follow up if nursing does not hear back from the doctor and the resident continues to have symptoms. V3 said she did not interact extensively with R1; however, "[R1] could respond appropriately." On 6/15/23 at 12:48 PM, V4 Medical Director/Physician stated signs and symptoms of a urinary tract infections in females are discomfort with urination and urinary frequency. V4 said UTI's are typically diagnosed based on UA results. V4 said UTI's left untreated, "can resolve on their own but the infection could get worse, it could spread. A person can become septic from a UTI. It's variable but it takes longer than a day to become septic from a UTI." V4 stated he was R1's physician; however, he had not yet met her in person for an examination. V4 said he did not recall the fax messages regarding R1. V4 stated he did not recall being notified of R1 refusing to be catheterized or the facility being unable to obtain a UA for R1. V4 said the symptoms described on the fax message sent on 6/1/23 of burning with urination, urinary urgency, and bloody discharge are symptoms consistent with a UTI. V4 said he does not recall the facility notifying him of foul smelling urine and pus like discharge, which V4 stated are symptoms of a UTI. V4 said, "If the staff are not able to get a UA and the resident is having symptoms, if I don't respond to the fax, I would expect the staff to do some sort of a follow up with me." V4 stated, if	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	C 06/15/2023

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S9999	Continued From page 13	S9999		

he had been notified of urgency with urination, burning with urination, blood tinged urine, yellow discharge, and foul smelling urine, refusal of catheterization, and staff were not able to do a hat (a hat is a urine catch device placed in a toilet) then V4 would have said "lets go ahead and treat it with an antibiotic. If I had been called and she was treated with an antibiotic, it's possible that she would not have become septic." V4 said that based on the quick diagnosis of a UTI at the hospital (within a few hours of arriving at the hospital) and based on the symptoms she had at the facility; R1 had the UTI while she was living at the facility. V4 said a change in cognition is not an uncommon symptom of a UTI. V4 stated, "prompt care of a UTI can be important. It is better to treat it sooner rather than later. It's not the best case scenario to let it go a week or two." V4 stated he does not recall being notified of a change in cognition for R1and he would expect to be notified of such a change. V4 stated nurses may use their best judgement and send a resident out for evaluation without notifying him.

R1's Physician Order Sheet showed no orders for antibiotics during her stay at the facility.

R1's Progress notes from 6/1/23 through 6/11/23 (with the exception R1's note on 6/11/23 when she was sent out for evaluation) showed no communication with R1's physician regarding an inability to obtain a UA or notification of a change in cognition.

On 6/14/23 Documentation of R1's UA results, if done, was requested and not provided

The facility's Change in Condition Physician Notification Overview Guidelines policy (Reviewed 4/22) showed, "Theses guidelines

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S9999	Continued From page 14 were developed to ensure that: All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record...medical care emergency problems are communicated to attending physician and family as soon as possible." The policy continued, "The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgement requires immediate medical intervention...Any calls to or from the physician will be documented in the nurse's notes indicating information conveyed and received. (A)	S9999		