

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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  Complaint Investigation 2427573/IL178268	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a) 300.1210b) 300.1210d)2)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 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Electronically Signed

TITLE

(X6) DATE  
10/23/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 1</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on record review and interview the facility failed to follow facility policy and obtain a physician order for care after a resident's Gastronomy tube (G-tube) became clogged. This failure resulted in R1's G-tube being replaced with an indwelling urinary catheter. This indwelling urinary catheter was used to administer enteral tube feedings for two days resulting in R1 experiencing emesis, loose stools, and being hospitalized. This failure affected 1 of 1 resident reviewed for Gastrostomy Tubes (R1) in a sample of 3.</p> <p>Findings include:</p> <p>Policy titled Care and Treatment of Feeding Tubes revised 04/07/22 documents, "It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 2</p> <p>Explanation and Compliance Guidelines: 2. Only tubes designed or intended for enteral feeding will be utilized, except under extenuating circumstances and for the shortest time possible." This policy continues, "12. The facility will notify and involve the medical provider or designated practitioner of any complications, and in evaluating and managing care to address the complication and risk factors."</p> <p>An undated policy titled Significant Condition Change and Notification documents in part: To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: A significant change in the resident's physical, mental or psychosocial status. Emesis and diarrhea or other abnormal assessment findings are included. Within the procedure of this policy documents, when any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner. The medical practitioner will be contacted immediately for any emergencies regardless of the time of day. Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given to the medical practitioner. After two attempts, there is no response to the calls, the medical director will be contacted. A section titled Documentation reads, "All significant changes will be recorded on the Communication Board and in (an electronic charting system) and in the resident record."</p> <p>Policy reviewed 01/2017 and titled Changing a Gastrostomy Feeding Tube documents, "1. Verify that there is a physician's order for this procedure." Under a section titled General Guidelines documents, "2. Feeding tube replacement must be performed by a licensed</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 3</p> <p>nurse who has received training and demonstrated competency in this procedure as allowed by state practice act."</p> <p>Policy Charting and Documentation reviewed 01/2017 documents, "Policy 1. Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc. (etcetera), as well as routine observations. 2. Be concise, accurate, and complete and use objective terms." This policy documents, "3. Chart as often as necessary and as need arises." A section titled Procedures documents, "17. Tube Feedings: a. Documentation that proper tube placement is verified prior to each feeding. b. Intake data, c. Resident's tolerance to tube feeding. d. Any removal and/or reinsertion of the tube. e. Any complications as a result of the tube feeding."</p> <p>Physician Order Sheet (POS) dated 10/01/24 document R1 has diagnoses of dysphagia following cerebral infarction, gastrostomy status, hemiplegia and hemiparesis affecting left non-dominant side, aphasia and aponia. R1's 09/18/24 POS documents orders to clean G-tube site daily and to provide G-tube feedings four times daily as supplement feeding.</p> <p>R1's Progress notes have no documentation between 09/14/24 when R1 returned from the local hospital after having a G-tube replaced and 09/17/24 at 5:07 AM when R1 had a large emesis and diarrhea.</p> <p>V3/ADON/Assistant Director of Nursing documented in R1's Progress note dated 09/17/24 at 5:07 AM "R1 had a large emesis and diarrhea." At 5:37 AM V3 documented "R1 feels better but has some audible congestion."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 4</p> <p>V6/LPN/Licensed Practical Nurse/MDS/Minimum Date Set documented in R1's Progress note dated 09/17/24 at 11:26 AM "X-Ray d/t (due to) possible aspiration and monitor for placement of G-Tube was ordered. (R1) had episodes of vomiting."</p> <p>V23/Advanced Practice RN documented a Rehabilitation evaluation status post functional decline on 09/17/24 at 1:38 PM stating that (R1) was seen and had emesis all over the front of her gown, and staff reported (R1) was seen in (ED) on 9/14/24 due to G-tube being pulled out. V23 documented. "Staff reports (R1) has had large, soft (bowel movements) in the last 24 hours. (R1) does have rhonchi and an order for chest and abdomen X-rays have been ordered." V23 further documents, "Nursing staff notified that if these complications remain, (R1) needs to be seen in the emergency department to rule out aspiration pneumonia, displacement of the catheter tubing or an intestinal blockage." V23's documentation concluded with, "Physiatry (sic) on consultation for additional recommendations. Medical management per attending physician and team."</p> <p>V21/Agency LPN/Licensed Practical Nurse documented in R1's Progress note dated 09/17/24 at 2:32 PM that R1 had two episodes of emesis and loose stool. X-Ray was ordered due to R1 abdomen being distended, crackles in lungs, abdomen firm to the touch.</p> <p>V9/LPN documented in R1's Progress note dated 09/17/24 at 3:45 PM that Contracted Radiology Company arrived and obtained a one view X-Ray of R1's abdomen and two view X-Ray of R1's chest due to vomiting and possible aspiration and to check placement of R1's G-tube.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 5</p> <p>R1's Patient Report form with a fax time stamp of 9/17/24 at 8:44 PM documents that Contracted Radiology Company performed a one view X-Ray of R1's abdomen for "cough, severe emesis, diarrhea, possible aspiration, pneumonia, verify G-tube placement."</p> <p>R1's radiology results dated 09/17/24 document, "Percutaneous gastrostomy tube overlies the left upper abdominal quadrant. For intraluminal confirmation, follow-up imaging is recommended following the administration of either air or oral contrast."</p> <p>R1's X-Ray was electronically signed by V22/Physician Contracted Radiology Company on 09/17/24 at 8:27 PM.</p> <p>R1's Medication Administration Record documents V8/Licensed Practical Nurse administered 240 cc's/cubic centimeters of feeding per tube on 09/18/24 at 10:00 AM.</p> <p>V7/Registered Nurse documented in R1's Progress note dated 09/18/24 at 3:06 PM "(R1) continues to have emesis episodes. (R1) not tolerating any bolus feeding through G-tube. (R1) had imaging completed through (Contracted Radiology Company) that recommended follow up imaging." R1 was transported via ambulance to the local emergency department.</p> <p>ED/Emergency Department Triage notes dated 09/18/24 at 3:26 PM and signed by V10, ED RN/Registered Nurse, document, "(R1) presents to emergency department with complaints of 'concerning outpatient imaging regarding her G-tube'. " V10 further documents, "Per nurse report, (R1) has been vomiting after every tube feeding. (R1) was seen here on Saturday</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 6</p> <p>(09/14/24) and had G-tube replaced after nursing home could not get it back in. (Indwelling urinary catheter) in place on arrival." At 3:36 PM V10 documented, "Per (V2/RN and DON/Director of Nurses) (R1) pulled her G-tube out on Monday (09/16/24) and they replaced it with the (indwelling urinary catheter) on Monday (09/16/24) and have been doing the tube feedings through that since then."</p> <p>(ED) provider note written by V5/ED Physician, dated 09/18/24 at 3:32 PM document, "This is a 62-year-old female who presents to the ED for G-tube dislodgement apparently today (we are) not quite sure, nursing home did not report when the tube came out. (R1) was here (ED) on (09/14/24) with G-tube displacement (R1) had a (larger size G-Tube) and that was dislodged, and they replaced it with a (smaller size G-tube). (R1) arrives with (an indwelling urinary catheter) in place today. Patient has a G-tube secondary to stroke and difficulty swallowing." This provider note further documents, "(Facility) also reports (R1) has vomiting every time she receives a feed." At 3:35 PM, V5 documented, "(R1's long term care facility) states they have been giving feeds through the (indwelling urinary catheter) since Monday (09/16/24)." V5's Provider Note (continued) documents, "Medical Decision Making: Differential includes displacement of G-tube (indwelling urinary catheter), dehydration, electrolyte disturbance, SBO (small bowel obstruction) among other diagnoses."</p> <p>09/18/24 at 6:17 PM, V5 documented, "Radiology just called and states that they see (R1's) feeding tube is actually in the transverse colon and not the stomach."</p> <p>10/02/24 at 2:07 PM, V3, ADON/Assistant</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 7</p> <p>Director of Nursing stated that the facility is notified of radiology results via fax. V3 stated, "They come to our fax, they are usually pretty quick."</p> <p>On 09/26/24 at 3:36 PM V3 stated that R1's G-tube which was placed on 09/14/24 would not flush on Sunday (09/15/24) or Monday (09/16/24) per V8/Licensed Practical Nurse. V3 stated, "(V8) couldn't get (R1's) tube feeding through. I told her (V8) to take it out and put an (indwelling urinary catheter) in. (R1) started vomiting early Tuesday (09/17/24) around 5:00 AM on my shift." V3 stated she did not contact V4/R1's physician to obtain an order to insert an indwelling urinary catheter. V3 stated she did not advise V8 to check placement or order an X-Ray to check R1's tube placement. V3 stated she did not advise V8 to send R1 to the ED to replace R1's G-tube or to check placement before administering tube feeding through the newly inserted tube. V3 stated "I didn't suggest it, maybe I should have. I was charge nurse on duty that day." V3 stated she was unsure what the policy regarding trouble shooting G-tubes stated.</p> <p>Employee corrective action form dated 09/27/24 documents V3 was given a three-day suspension for "Manager's failure to follow/enforce departmental policies and procedures. Practiced outside of scope - failed to provide nurse manager oversight."</p> <p>On 09/26/24 at 3:46 PM V8 stated that R1's feeding tube clogged on 09/16/24. V8 stated twice that she called V4/R1's physician to obtain the order, then stated, "I got direct orders from my (V3) Assistant Director of Nursing to insert R1's indwelling urinary catheter." V8 stated that she removed R1's G-tube on 09/16/24 and</p>	S9999		



Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 8</p> <p>replaced it with an indwelling urinary catheter. V8 confirmed she has not received training or competency on replacing G-tubes and was "not sure" what the facility policy states regarding troubleshooting G-tubes.</p> <p>On 09/27/24 at 11:30 AM V2/RN/ DON/Director of Nurses stated the facility has not offered G-tube training to nurses.</p> <p>Employee corrective action form dated 09/27/24 documents V8 was suspended for three days due to "failure to follow department policies and procedures." The corrective action further documents V8 failed to notify a physician or document on difficulty with and changing a G-tube on 09/16/24.</p> <p>V8 was unable to provide paper or electronic documentation of changing R1's G-tube to an indwelling urinary catheter. V8 stated to ensure R1's newly placed indwelling urinary catheter was correctly positioned, "I would check for residual, or push it in until it stops (feels resistance), or get an X-Ray, that would be the best option." V8 stated she did not obtain an X-Ray to check for correct placement of R1's feeding tube prior to administering R1's bolus feeding and stated, "I was not directed to by my (V3) Assistant Director of Nursing." R1's Medication Administration Record documents V8 administered R1's bolus feedings at 10:00 AM on 09/16/24 and 09/18/24 at 10:00 AM.</p> <p>On 09/27/24 at 9:24 AM, V2/RN/ DON/Director of Nurses stated she learned on 09/17/24 that V8 had inserted an indwelling urinary catheter after removing R1's G-Tube per the direction of V3/Assistant Director of Nursing. V2 stated that R1 had begun vomiting early in the morning of</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 9</p> <p>09/17/24. V2 stated that V3 "had acknowledged" R1's physician should have been notified.</p> <p>V2 stated the indwelling urinary catheter should have been checked for placement by X-ray and that R1 was not sent to the ED until two days after R1's indwelling urinary catheter was inserted. V2 confirmed R1's indwelling urinary catheter should not have been used bolus feedings and placement should have been verified.</p> <p>On 09/27/24 at 1:16 PM V2 stated she there is no electronic or paper charting from 09/16/24 when V8 stated she removed R1's G-tube and placed an indwelling urinary catheter. V2 confirmed V4/R1's physician should have been notified and she would have sent R1 to the ED but wasn't.</p> <p>On 09/26/24 at 4:09 PM V4 stated, "No, I was never told staff inserted and fed through an (indwelling urinary catheter). I would never say to insert an (indwelling urinary catheter) to use as a feeding tube. I would have ordered the resident to go to the ED for evaluation and tube replacement if they chose to do so." V4 stated he has never talked with staff at the facility about R1's tube being clogged or removed.</p> <p>On 10/01/24 at 8:04 AM V10, Emergency Department Registered Nurse stated that it is not safe nursing practice to administer tube feeding through an indwelling urinary catheter. V10 stated it was apparent R1's indwelling had been used to administer feeding because it had feeding residue left in it. V10 stated she called the facility, who advised the G-tube had been changed to the indwelling urinary catheter which they had been using to bolus feed R1 since Monday (09/16/24). V10 stated R1 was vomiting because the tube</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006266</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONMOUTH NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>117 SOUTH I STREET MONMOUTH, IL 61462</b>
--	---

(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	<p>Continued From page 10</p> <p>was in her transverse colon.</p> <p>On 09/26/24 at 2:30 PM V5/ED Physician stated R1 had been to the ED on 09/14/24 and left after having a G-tube replaced. When R1 arrived at the ED on 09/18/24, she had an indwelling urinary catheter in place of her G-tube. V5 stated while it may be common to insert an indwelling urinary catheter in the G-tube site, it should only be done temporarily to keep the site open, and the resident should be immediately sent to the ED. V5 stated he wouldn't recommend feeding through an indwelling urinary catheter. V5 stated, "My concern is (the facility) didn't check placement with an X-Ray and fed through it for two days." V5 stated hospital X-Ray confirmed R1's indwelling urinary catheter was located in her transverse colon which caused her to have emesis and diarrhea for two days.</p> <p>(A)</p>	S9999		