

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/28/2024
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NAME OF PROVIDER OR SUPPLIER BETHANY REHAB & HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 3298 RESOURCE PARKWAY DEKALB, IL 60115
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S 000	Initial Comments Complaint Investigation: 2414027/IL173473	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999		

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

TITLE

(X6) DATE
06/16/24

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S9999	<p>Continued From page 1</p> <p>accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</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>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 are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to thoroughly assess a resident's malfunctioning catheter. This failure resulted in the resident (R3) experiencing bleeding, catheter pain and needing to be admitted to the local hospital. The facility also failed to prevent a suprapubic catheter from being displaced during care. This applies to 2 of 3 residents (R3 and R1) reviewed for catheters in</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>the sample of 4.</p> <p>The findings include:</p> <p>1. On 5/28/2024 at 12:50PM, R3 stated staff tried to put a catheter in and wasn't sure what happened. R3 stated his p**** started bleeding and wouldn't stop. R3 stated blood was all over the place. R3 stated he was sent to the hospital and ended up in the intensive care unit.</p> <p>On 5/28/2024 at 1:25PM, V7 Licensed Practical Nurse (LPN) stated she was caring for [R3] on 5/20/2024 during the day shift (7:00AM - 3:00PM). V7 said between 1:00PM - 2:00PM [R3] said "this damn thing is hurting" referring to his p****. V7 said [R3] told her the tip of his p**** was hurting and burning. V7 said she told [R3] she could flush the catheter to see if that helps. V7 said she looked at [R1's] p**** and didn't see any visible trauma. V7 said she did see some sediment in the tubing, but no blood or bleeding noted. V7 said [R3] has a behavior of pulling on his catheter and wrapping it around his wheelchair too tight. V7 said she had re-educated [R3] that because he had been pulling on his catheter. V7 said she did not flush [R3's] catheter before her shift ended that day. V7 said she did not notify a physician regarding [R3's] complaint that the head of his p**** was burning. V7 said if it would have been something more than just the head if his p**** burning, she would have investigated it further. V7 said she did not obtain vitals on [R3]. V7 said she did notice he had a little urine in the bag but not sure how much.</p> <p>On 5/28/2024 at 12:55PM, V4 LPN said she was working on 5/20/2024 and was caring for [R3]. V4 said she worked the 3PM to 11PM shift that day. V4 said after she received report from the day</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>shift nurse she saw [R3] it was "for something." V4 said when she saw [R3] he had a large towel around his catheter because it was leaking. V4 said [R1] was having a lot of pain. V4 said she gave [R3] pain medication per resident's request and came back to see him later after the pain medication had time to work. V4 said [R3] had about 200mLs of urine in the Foley drainage bag, no blood in urine noted at that time. V4 said she didn't come back to see [R3] until sometime after dinner. V4 said she deflated [R3's] balloon because he was complaining of pain 10 out of 10. V4 said when she deflated the catheter balloon the resident expressed immediate relief and decreased pain. V4 said the resident began urinating and then blood started coming out. V4 said she estimates the blood loss to be 100-200mL. V4 said when the catheter was removed [R3] started urinating and it was spraying all over and looked like the resident had been retaining urine. V4 said [R3] does play with his p**** and has scaring at the head of his p**** from years of having catheters in place. V4 said she obtained vitals on [R3]. V4 said she contacted the [V9 Physician] regarding [R3's] continued bleeding from his p**** and received orders to send him to the hospital. V4 said [R3] was admitted to the hospital for UTI, displaced foley and hypotension. V4 said [R3] was supposed to come back to the facility but ended up in the ICU. V4 said when the resident left for the hospital, he was alert and oriented talking about seeing her when he gets back.</p> <p>On 5/28/2024 at 1:46PM, V2 Director of Nursing (DON) said signs and symptoms of a UTI/urinary tract infection would be complaints of pain or burning while urinating. V2 said a UA is normally ordered when a resident complains of burning in their genital area or with urination. V2 said</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>complaints of burning should be assessed right away and the physician notified as soon as possible. V2 said a leaking catheter could be a sign of a malfunctioning catheter. V2 said the catheter may need to be removed, repositioned, or flushed. V2 said a leaking catheter should be addressed right away because the resident is at risk for retaining fluid and UTI. V2 said catheters can be uncomfortable but shouldn't cause 10/10 pain that is abnormal. V2 said something is wrong if its leaking, pain is present, and blood is present upon urination.</p> <p>On 5/28/2024 at 2:48PM, V9 Physician said we sent out [R3] because of the blood being displayed. V9 said catheter problems do occur. V9 said he can't say the UTI is what caused his admission. V9 said he was admitted for a host of issues. V9 said it's not unusual for residents having bladder issues to have hypotension due to a vasovagal response. V9 said sepsis is more of a general term these days and doesn't have the strict requirements it once did to be considered sepsis. V9 said without seeing his labs he wouldn't be able to say he was actually septic or not.</p> <p>R3's Catheter Output documentation shows no documented output on 5/20/2024 for the AM or PM shift. R3's total output trend for per day on 5/14/2024 1400mL, 5/15/2024 1100mL, 5/16/2024 2040mL, 5/17/2024 1400mL, 5/18/2024 600mL, 5/19/2024 600mL.</p> <p>The only set of vitals found on 5/20/2024 were from 6:22-6:23PM, B/P 122/67, HR 64, T 97.6, R18, 97% on RA.</p> <p>Pain Scale documentation from 5/20/2024 shows pain values of 1 at 12:00PM, 7 at 4:12PM, and 8</p>	S9999		

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S9999	<p>Continued From page 5 at 6:11PM.</p> <p>Hospital records indicate [R3] arrived at the hospital on 5/20/2024 in the ER/emergency room at 9:31PM for acute UTI, hypotension, and displacement of foley catheter. [R3] was started on Norepinephrine (vasopressor used to increase blood pressure) on 5/21/2024 at 6:30AM.</p> <p>Hospital H&P (History and Physical) completed on 5/21/2024 states reason for consult septic shock. Patient was seen in ED/emergency department after hematuria (blood in urine) when exchanging Foley catheter. Patient was noted to tachypneic febrile rigorous mildly hypoxia on nasal cannula. Patient became hypotensive was given IV/intravenous fluids started on norepinephrine admit to the ICU and critical care was consulted. Appears to have received 2L fluids in the ED... Foley catheter chronic for years per patient. . . drips/pressors: norepinephrine at 5 normal Salines at 83. . . LABS . . . chemistry shows creatinine likely consistent with acute kidney injury given baseline somewhere between 0.4 0.5 and now 0.69 . . . urine could be consistent with UTI 3+ blood red cell. . . HGB 10-11 . . . potential problems hypotension septic shock probably hypovolemia.</p> <p>R3's Admission Record shows he was admitted on 5/23/2024, original admission date of 3/2/2024.</p> <p>2. On 5/28/2024 at 8:50AM, R1 said he does have a catheter but it's a suprapubic catheter. R1 said last week during care a CNA pulled down his brief and pulled out his suprapubic catheter. R1 said the CNA was in a hurry. R1 said his nurse was unable to put in another catheter and he had to go to the hospital to get one placed again.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>On 5/28/2024 at 11:58AM, V6 CNA said she was working with [R1] the day his catheter came out (5/20/2024). V6 said she had assisted [R1] to the bathroom and [R1] wanted his pull up off because he had already started going to the bathroom. V6 said she tore the left side of the brief off and the brief shifted, and the catheter came out.</p> <p>On 5/28/2024 at 11:33AM, V4 LPN said she was caring for [R1] on 5/20/2024. V4 said [V6] had reported to her [R1's] catheter had come out during care. V4 said she attempted to reinsert the catheter but was unsuccessful. V4 said she reached out to [V8 - Physician] and [R1] was sent out to the hospital for catheter placement. V4 said [R1] returned later that day. V4 said suprapubic catheters shouldn't come out. V4 said they are secured with a balloon inflated inside of the bladder.</p> <p>On 5/28/2024 at 9:27AM, V2 Director of Nursing (DON) said the goal is for catheters not to be dislodged during care.</p> <p>R1's MDS (Minimum Data Set) section "C" dated 5/1/2024 lists R1's BIMs score at 15, cognitively intact.</p> <p>R1's Progress Notes dated 5/20/2024 state at 4:28PM CNA came to [V4] stating that his suprapubic catheter came out . . . resident picked up by ambulance service at 4:40PM . . . resident returned to the facility at 7:30PM.</p> <p>(A)</p>	S9999		