STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AU WELL CARE HOME, INC	152 WILMA DRIVE MARYVILLE, IL 62062

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S 000	Initial Comments Complaint Investigation 2449892/IL181936	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210a) 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	S9999		

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S9999	Continued From page 1	S9999		

of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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 resident to meet the total nursing and personal care needs of the resident.

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:

3) Objective observations of changes in a

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S9999	Continued From page 2	S9999		

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.

These requirements were not met as evidence by:

Based on interviews, observations, and record reviews the facility failed to provide catheter care and incontinence care per standards of practice for 2 out of 2 residents, (R1, R3), reviewed for Incontinence and Catheter Care in the sample of 11. This failure resulted in R3 being admitted to the hospital with septic shock, acute kidney injury superimposed on chronic kidney disease, urinary tract infection, and encephalopathy.

Findings include:

1. R1 was admitted to the facility on 3/05/2021 with diagnosis of, in part, bipolar disorder, post-traumatic stress disorder, and major depressive disorder.

R1's Minimal Data Set (MDS) dated 10/15/24, documented she is moderately cognitively impaired and dependent on staff to provide self-care such as toileting hygiene, bathing and eating.

R1's Care Plan last revised on 10/22/24, documented R1 has the potential for impaired skin integrity due to decreased mobility with intervention to provide incontinence care per facility protocol.

On 12/9/24 at 12:55PM R1 was provided

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S9999	Continued From page 3	S9999		

peri-care by V3, Certified Nursing Assistant (CNA), and V4, CNA. During care, a large area of red patched skin was noted on R1's vaginal area and spread to her entire buttock region. V4 stated R1's skin has been like this since she started working at the facility two weeks ago and when they notice any change in the resident's skin they notify the nurse. V3 stated (Vitamin A&D ointment) is what they are using on her skin to treat it and for prevention. V3 used disposable washcloths to wipe R1's vaginal region, used the same cloth for multiple wipes and did not dry off the region before turning her on her left side. When R1 was turned on her left side, V3 did not perform hand hygiene or change gloves before taking more disposable washcloths out of the package and wiping R1's buttock region multiple times with the same cloth. V3 did not dry off R1's skin after wiping her buttocks. V3 grabbed the ointment for R1's peri-skin and applied it to her buttock and anal region with the same dirty gloves, then rolled her over to her right side. While R1 was on her right side, V4 had V3 squeeze out more ointment on her gloves with the same container using her dirty gloves. V4 applied the ointment to R1's right buttock region. V3 then helped position R1 in bed touching her pillow, placed a new gown on her, covered her with a new sheet and personal blanket, raised her bed and touched her soda can with the same dirty gloves. Both removed their gloves after R1 was situated but did not perform hand hygiene. V4 touched the door handle and opened it before leaving the room.

On 12/10/24 at 3:10 PM, in a joint interview with V1, Administrator and V2, Assistant Director of Nursing (ADON), both stated hand hygiene is supposed to be completed before and after any direct patient care. During peri-care, staff are

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S9999	Continued From page 4	S9999		

expected to perform hand hygiene and change gloves when moving from dirty to clean parts of care. V1 and V2 both stated that the skin is to be dried off after using wipes with peri-care. V1 and V2 stated they expect hand hygiene to be completed after removing gloves and when moving from front peri-region to back peri-region.

2. R3 was admitted to the facility on 1/04/2022 with diagnosis of, in part, Parkinson's disease, acute kidney failure, and transient cerebral ischemic attack. R3 was discharged from the facility on 12/2/24.

R3's MDS dated 10/1/24 documented he was cognitively intact. R3's MDS further failed to document R3 had an indwelling urinary catheter.

R3's Electronic Medical Records did not have a care plan for his indwelling urinary catheter or orders pertaining to it.

R3's Hospital Discharge paperwork dated 11/12/24, documented instructions to have R3 follow up with urology to have indwelling urinary catheter removed. The discharge paperwork further documented R3 was treated for urinary retention.

R3's Progress Notes dated 11/15/2024 at 06:35 AM, documented R3 was noncompliant with his indwelling urinary catheter.

R3's Progress Notes dated 11/16/24 at 4:11 AM, documented R3 had orange colored urine with the indwelling catheter detached from a drainage bag, free flowing on to his clothing and bedding.

R3's Progress Notes dated 11/17/2024 at 2:20 PM, documented R3 continues to tug and cause

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S9999	Continued From page 5	S9999		

blood-tinged urine in bag.

R3's Hospital History and Physical/History of Present Illness (HPI) dated 12/2/24 at 5:51 PM, documented R3 presented with altered mental status, and fever. It further documented the facility staff reported to the hospital R3 was altered starting sometime the previous day. HPI documented R3's existing catheter bag was holding 1200 milliliters (mL). the maximal capacity of the bag was 600 mL and urine appearance was dark, thick, and cloudy; R3 was also noted to be incontinent of feces which appeared to have been present for some extended time. The HPI documented family had reports that the patient had complained several days ago that his foley (catheter) was not being exchanged.

R3's Hospital Records dated 12/2/24, documented R3's clinical impression being septic shock, acute kidney injury superimposed on chronic kidney disease, urinary tract infection, and encephalopathy; his condition being serious.

On 12/9/24 at 9:07 AM, V6, Emergency Room Nurse, stated resident R3 ended up dying at the hospital not too long ago, on 12/4 or 12/5 from septic shock. V6 stated R3 came into the Emergency Room (ER) where she was working as his nurse, unresponsive and he had a urinary catheter with a leg bag completely full of what she described to look like as days old apple cider. V6 stated the leg bag was holding 600 mL of urine and after draining it was able to get another 600 mLs out that was backed up into R3's bladder. A total of 1200 mLs was drained on arrival to the ER. V6 stated R3 was given 3400 mLs of fluid while in the ER and by the time he was transferred to the Intensive Care Unit (ICU) he only had a total of 100 mLs out, which showed

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S9999	Continued From page 6	S9999		

how dehydrated he was when he came in. V6 stated she called the facility while R3 was in the ER to get accurate input and outputs on him, but the facility told her they don't document those, but they did mention the CNA said she had emptied it at 8:30 AM that morning. V6 stated there would be no way the catheter bag would be that backed up if they had completely emptied it at 8:00AM that morning and arrived at the ER around noon. V6 stated R3 was only responsive to pain when he arrived. V6 stated the death note said R3 died of septic shock due to an Escherichia coli (E. coli) bacteria based urinary tract infection (UTI) causing sepsis, Acute Kidney Injury (AKI) secondary to chronic kidney disease (CKD) along with rhabdomyolysis and eventually got hemodialysis started but declined. V6 stated R3's death was so preventable and bothered her so much because all the facility had to do was empty his catheter timely which they neglected to do.

On 12/9/24 at 10:52 AM, V7, Intensive Care Doctor, stated he had taken care of R3 while he was in the ICU. V7 stated R3 had told ER staff the facility hadn't changed his catheter in several days. V7, stated R3 had been admitted on 12/2/24 and had a urinary catheter filled with more than its capacity to hold of cloudy, urine that ended up being infected. V7 stated that if his catheter had not been emptied and changed according to orders, it could have caused an infection.

On 12/10/24 at 9:15 AM, V8, Medical Director, stated he did not have any concerns specifically on R3 for the past month he was at the facility other than he was weaker. V8 stated he was not aware R3 was having any issues or concerns with his indwelling urinary catheter. V8 stated he had not seen R3 recently. V8 stated the staff notified

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S9999	Continued From page 7	S9999		

him of concerns the day he went out to the hospital. V8 stated for ongoing issues with noncompliance of the catheter, he would have sent him back or to be seen by urology.

On 12/10/24 at 3:10 PM, in a joint interview with V1, Administrator and V2, Assistant Director of Nursing (ADON), V2 stated the CNA's are responsible for emptying the catheter bags and reporting measurements to the nurse.

On 12/10/24 at 3:15 PM, V1, Administrator, stated she would have expected the nurses to have notified the physician of R3's noncompliance and catheter concerns because we could have tried to get the catheter removed sooner. V1 stated she expects staff to update orders and care plans for residents when they return from the hospital. V1 stated there should have been a care plan and orders for R3's indwelling urinary catheter. V1 stated, "I'm very unhappy with how (R3) was provided care, I can tell you it has a lot to do with lack of nursing oversite and nursing judgement." V2 agreed to V1's statement.

On 12/11/24 at 11:32 AM, V1, stated they could not find any policies with explicit details pertaining to the steps and procedures of incontinence and catheter care.

(A)