| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000855 | A. BUILDING: _____ B. WING _____ | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S 000 | Initial Comments<br><br>Annual Licensure and Certification Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations (1 of 2)<br><br>300.650c)<br>300.650d)<br>300.661<br>955.165c)<br><br>Section 300.650 Personnel Policies<br><br>c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Financial and Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file.<br><br>d) The facility shall check the status of all applicants with the Health Care Worker Registry prior to hiring.<br><br>Section 300.661 Health Care Worker Background Check<br><br>A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.<br><br>PART 955 HEALTH CARE WORKER BACKGROUND CHECK CODE<br>SECTION 955.165 FINGERPRINT-BASED CRIMINAL HISTORY RECORDS CHECK<br><br>c) Educational entities and health care employers shall conduct Internet searches on | S9999 | | |

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certain web sites, including without limitation the Illinois Sex Offender Registry, the Department of Corrections' Sex Offender Search Engine, the Department of Corrections' Inmate Search Engine, the Department of Corrections Wanted Fugitives Search Engine, the National Sex Offender Public Registry, and the website of the Health and Human Services Office of Inspector General to determine if the applicant has been adjudicated a sex offender, has been a prison inmate, or has committed Medicare or Medicaid fraud, or shall conduct similar searches as provided by the web-based application. (Section 15 of the Act)

These requirements are NOT MET as evidenced by:

Based on interview and record review, the facility failed to complete web site checks for seven staff prior to hire. These failures have the potential to affect all 32 residents residing in the facility.

The findings include:

Facility employee records document the following employment start dates for staff: V11 (Certified Nurse Aide) on 10/17/2024, V12 (Certified Nurse Aide) on 10/21/2024, V22 (Certified Nurse Aide) on 10/4/2024, V23 (Certified Nurse Aide) on 10/31/2024, V24 (Certified Nurse Aide) on 11/21/2024, V25 (Dietary Aide) on 11/21/2024, and V26 (Housekeeping) on 11/4/2024. The same records document the facility did not complete the required web site checks for V11, V22, V23, V25, and V26 until 12/11/2024 and did not complete the checks for V24 until 11/22/2024. V12's employee records do not document the facility completed any web site checks for V12. On 12/12/2024 at 10:30AM, V1 (Administrator)

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reported the facility completed background checks for all staff prior to hire but the facility could not document the checks were done.

(C)

Statement of Licensure Violations (2 of 2)

300.610a)
300.1210b)
300.1210c)
300.1210d)6)

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

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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.

These requirements were not met as evidenced by:

The facility's Notification for Change in Resident Condition or Status policy dated 12/7/17 documents to notify the resident's physician for sudden, change or unrelieved symptoms, when there is a need to alter treatment significantly and when there are symptoms of infection. This policy documents to record information related to the resident's change in condition in the resident's medical record.

The facility's Enhanced Barrier Precautions (EBP) dated 7/13/23 documents EBP are used to reduce transmission of multidrug-resistant organisms and includes wearing a gown and gloves for high-contact care activities for residents with an indwelling medical device.

The findings include:

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On 12/11/24 at 11:10 AM R32 stated R32 admitted to the facility with a urinary catheter in May 2024, R32's urine had blood (hematuria) for a few weeks and R32 was hospitalized for urosepsis. R32 stated on 7/19/24 R32 felt the urge to urinate, urine leaked around R32's catheter, R32 had the nurse remove the catheter and R32 was able to urinate. R32 stated R32's catheter was blocked with mucus that had been present in R32's urine for a few days prior. R32 stated
R32 went to the emergency room on 7/19/24 and was prescribed an antibiotic for UTI and the urine culture results came back on 7/21/24 resistant to specific antibiotic, but R32's antibiotic was not changed until 7/24/24. R32 stated R32 started to feel worse on the evening of 7/24/24 and was admitted to the hospital for seven days for a UTI and treated with intravenous (IV) antibiotics. R32 stated staff emptied R32's catheter and was aware of the blood and mucus, but was unsure if any follow up was done. R32 stated R32 was concerned that R32's urinary changes weren't addressed timely, but R32 had never had a catheter before so R32 was not sure what the protocol was. R32 stated the facility did not implement EBP until November 2024.

R32's Minimum Data Set (MDS) dated 10/18/24 documents R32 is cognitively intact. R32's MDS dated 7/19/24 documents R32 was dependent on staff assistance for toileting hygiene. R32's Care Plan initiated 5/11/24 and resolved 7/22/24 documents R32 had a urinary catheter for obstructive uropathy and includes an intervention to monitor/record/report signs/symptoms of UTI including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills,

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altered mental status, change in behavior, and change in eating patterns to the physician.

R32's Nursing Note dated 5/11/2024 at 3:00 PM documents R32's urinary catheter was draining clear urine and R32's stool softener was held due to loose stools. There is no documentation of R32's urine characteristics and monitoring after this note until 5/24/24 at 9:49 AM when R32 had hematuria and blood clots in R32's urinary collection bag and R32 was sent to the emergency room.

R32's Hospital History & Physical dated 5/24/24 documents R32 reported having cloudy/dark urine intermittently in

R32's urinary catheter. R32's workup was notable for elevated white blood cell count of 14.96, and his urinalysis appeared to show infection. R32 was admitted for sepsis secondary to CAUTI.

R32 returned to the facility with a urinary catheter and there is no documentation that R32's urine was assessed and monitored between 7/6/24 and 7/18/24. R32's Nursing Note dated 7/19/24 at 6:59 AM documents R32 complained of lower abdominal pain and R32's urinary collection bag was empty and the catheter was not draining. R32's urine contained a large amount of sediment and mucus and had a foul odor. R32 requested to remove the catheter, upon removal R32 urinated intermittently and R32 complained of burning with urination. R32 was transported to the local emergency room per R32's request.

R32's Emergency Room Notes dated 7/19/24 documents CAUTI, culture pending, R32's catheter was discontinued and

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R32 discharged back to the facility with orders for antibiotic 500 milligrams (mg) by mouth daily for five days.

R32's July 2024 Medication Administration Record documents antibiotic was administered 7/19-7/23/24. R32's Urine Culture with result date of 7/21/24 documents the hospital sent the results to the facility via electronic facsimile on 7/21/24 at 4:44 PM, and the organism Proteus Mirabilis was resistant to ordered antibiotic. There is no documentation in

R32's medical record that this culture was reported to a practitioner prior to 7/24/24 at 10:11AM when new orders were given for a different antibiotic, 750 mg intramuscularly (IM) every 12 hours for five days.

R32's Nursing Note dated 7/24/24 at 9:43 PM documents at 8:47 PM R32 was given one dose of IM antibiotics prior to being sent to the hospital for complaints of numbness in R32's arms and hands and generally not feeling well and R32 was clammy and sweating. This note documents V18, R32's Family, was present and was concerned R32 was septic from UTI due to R32's prior history of being septic from UTIs.

R32's Hospital History & Physical dated 7/24/24 at 11:36 PM documents R32 reported that despite taking the first antibiotic, R32 developed feelings of palpitation as if R32's heart was racing and associated numbness and generalized weakness which is usually consistent with an infection. R32 was admitted for complicated UTI and treated with IV antibiotics.

On 12/11/24 at 12:07 PM V6 Infection Preventionist/MDS Coordinator stated for

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residents with urinary catheters the nurses should monitor urine characteristics for infection and notify the provider of UTI symptoms and document this in the nursing notes. V6 confirmed R32's urine culture results were received on 7/21/24 and indicated a resistance to the first antibiotic, and this was not reported until 7/24/24. V6 stated it was a weekend and the floor nurses should have reported the results to the provider immediately. On 12/11/24 at 12:45 PM V6 stated EBP was implemented in October 2024, confirming R32 was not on EBP when R32 had a catheter in May and July 2024.

On 12/11/24 at 1:53 PM V15 Nurse Practitioner stated staff should be routinely monitoring urine color and characteristics, including discharge and sediment, and ensure the urinary catheter is clean. V15 stated if R32 had hematuria the nurses should have notified V15 and V15 would have ordered a repeat urinalysis and assessed R32. V15 confirmed R32 was hospitalized for urosepsis in May and then a UTI in July 2024. V15 stated the nurses "definitely" should have been assessing R32's urine routinely and documenting this. In regards to R32's 7/21/24 urine culture, V15 stated R32's culture should have been reported as soon as the report was available, and V15 would have changed the antibiotic as soon as V15 was notified. V15 confirmed the facility should have implemented EBP for R32, which is a measure to prevent infections.
(A)