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SUNNY ACRES NURSING HOME	19130 SUNNY ACRES ROAD PETERSBURG, IL 62675

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S 000	Initial Comments Complaint Investigation: 24210560/IL183416	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.696d)1) 300.1010h) 300.1210b) 300.1210d)2)3) 300.1220b)7) 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 300.696 Infection Prevention and Control d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health	S9999		

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S9999	Continued From page 1 Administration (see Section 300.340): 1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections 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 accident, injury or change in condition at the time of notification. 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. 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.	S9999		

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S9999	Continued From page 2 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: 7) Coordinating the care and services provided to residents in the nursing facility. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident's indwelling urinary catheter maintained patency, monitor a resident's urinary output, notify the physician of no/decreased urinary output, obtain physician ordered urinalysis results, and follow up with the physician in regards to abnormal urinalysis results, for two of three residents (R1 and R5) reviewed for indwelling urinary catheters and has the potential to affect all five residents (R1, R3, R4,R5, R6) with indwelling urinary catheter out of a total sample of six. These failures resulted in R1 not having urinary output documented for two days, without physician notification or medical intervention, resulting in R1 being sent to the Emergency Room (ER) for evaluation and subsequent hospitalization and treatment receiving intravenous fluid and antibiotic medication for the diagnosis of a UTI (Urinary Tract Infection) positive for ESBL	S9999		

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(Extended-Spectrum Beta-Lactamase an antibiotic resistant urinary tract infection) and E. coli (Escherichia coli bacteria that is a common cause of UTI), as well as cystitis (bladder inflammation) and hydronephrosis (excess fluid in kidney due to a backup of urine). These failures also resulted in a repeated hospitalization for R1 where again she was diagnosed with a UTI as well as encephalopathy (brain disease that alters brain function or structure, common cause includes infections and can be life threatening if left untreated).

Findings include:

The Facility Assessment, revised 7/30/24, documents that the facility provides bladder training programs, urinary catheter maintenance, prevention of infections, and management of medical conditions such as urinary tract infections.

The facility's Guidelines for Physician Notification of Change in Resident Condition policy, revised 4/2019, documents Certified Nursing Assistants (CNA) are responsible for reporting any changes they observe to their charge nurse and it's the responsibility of the charge nurse to notify the physician of a significant change in condition before the end of the shift.

The facility's Catheter Protocol Policy, dated 2/1/10, documents when monitoring for accurate intake and output, the clinical record shall reflect the intake and output for each 24-hour period. Observations of abnormal amounts of urine, color, clarity, or odor shall be documented in the clinical record and notification shall be made to the attending physician and Power of attorney as indicated. Orders shall be followed.

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1.) On 1/7/25 at 9:05 AM, R1 was sitting in a manual wheelchair in R1's room with an indwelling urinary catheter. The catheter drainage bag contained yellow urine with sediment in the catheter tubing.

R1's Nurse progress notes document on 12/19/24 a fax was sent to V9 Medical Director that R1's urine was dark and slimy with a foul odor.

R1's Physician Orders, dated 12/19/24, document V9 gave an order for the facility to obtain a urinalysis for R1.

R1's Nurse Progress Notes, dated 12/23/24, document the facility was notified R1's urinalysis indicated a UTI positive for ESBL and E. coli.

R1's Point of Care Response History documented on 12/25/24 R1 had no documentation of urine output for second shift (3PM-11PM). On 12/26/24 there was no urine output documentation for third shift (11pm-7AM) or dayshift (7AM-3PM) and 50 milliliters of urine output on second shift. On 12/27/24 third shift and dayshift documented R1's urine output as zero and there was no documentation on second shift. R1's medical record did not contain notification to V9 Medical Director of R1's absent/decreased urine output.

R1's current medical chart has no documentation of a physician being notified regarding R1's abnormal urinalysis on 12/23/25 or a follow up with a physician order to treat R1's UTI from 12/23-12/28/24.

On 1/7/24 at 10:30 AM, V2 Director of Nursing confirmed nursing staff did not document follow up regarding R1's decreased/absent urinary

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output and did not document notification of the physician from 12/23/24- 12/28/24. V1 stated I tell the staff all the time to document it, or it didn't happen.

On 1/16/25 at 9:08 AM, V13 CNA stated V13 came into work on the 12/28/24 at 6:00 AM, and V13 noticed R1 had no urine in her indwelling catheter bag. V13 stated she reported to V10 Registered Nurse on 12/28/24 in the afternoon that R1 had no urinary output on dayshift. V13 stated V13 and V10 laid R1 in bed after being notified from dining room staff that R1 was throwing up in dining room and was more confused. V13 stated she noticed brown urine in R1's depend, but not in R1's indwelling catheter bag. V13 stated V10 told V13 she was going to irrigate R1's indwelling catheter, but V13 was not successful.

R1's Nurse's note, dated 12/28/24 at 9:18 PM, document, "R1 complains of pain at the indwelling urinary catheter site, brown mucus discharge coming from vagina. R1 hasn't voided in two days per CNA and documentation. Tried to flush indwelling urinary catheter unable to flush. Took indwelling urinary catheter out and R1 urinated large amount in adult incontinent brief two times. R1 is positive for ESBL and E. coli per urinalysis culture. R1 is more confused than normal. Notified V9 ordered to take indwelling urinary catheter out and send to ER."

On 1/8/24 at 11:35 AM, V10 Registered Nurse stated after V13 made her aware that R1 had no urine output in R1's indwelling catheter. V10 called V8 R1's Family Member who requested R1 be sent to Emergency Room since R1 had not urinated in two days. V10 stated she called 911 and sent R1 to the local Emergency Room for

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evaluation.

R1's Emergency Department progress notes, dated 12/28/24, document R1 was kept in the hospital overnight and received IV fluids and antibiotics. R1 was noted to have a UTI due to urinary retention and evidence of cystitis and hydronephrosis secondary to urinary retention. The physician documents in R1's Emergency Department/Room progress note, "At presentation: the differential diagnosis considered could potentially be life threatening or risk to bodily function."

On 1/7/25 at 1:00 PM, V6 Emergency Room Nurse, stated V6 was working in Emergency Room when R1 arrived on 12/28/24 and provided her care. V6 stated the facility nurse reported to V6 that R1 had not urinated in her indwelling urinary catheter drainage bag in two days. V6 stated the Emergency Room placed a new indwelling catheter in R1 and had dark gold urine return. V6 further stated that he felt it was concerning that R1 had not voided in two days before R1 was sent to the emergency room.

R1's Nurse Progress note, dated 12/29/24 documents "R1 came back from Emergency Room with orders for Cephalexin (antibiotic) 5 milligrams by mouth, three times a day for seven days for the treatment of a UTI.

R1's Point of Care Response History, dated 1/2/25 to 1/23/25, documents that R1's urinary output should be documented every shift. However, there is no documentation of R1's urinary output being obtained on the following dates: 1/2/25 day shift and second shift; 1/3/25 day shift; 1/4/25 day shift; 1/5/25 day shift and second shift; 1/6/25 day shift and third shift;

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1/7/25 day shift; 1/9/25 day shift. The Point of Care Response History also documents the following decreased urinary outputs: 1/5/25 100 milliliters on third shift; 1/6/25 15 milliliters on second shift; 1/9/25 50 milliliters on second shift. R1's medical chart has no documentation of V9 being notified of R1's decreased urinary output until 1/9/25.

R1's Nurse Progress Note, dated 1/9/25 at 1:06 PM, documents, "This nurse was informed that R1's output was 75 milliliters and urine is thick with foul smell. V9 informed through fax, awaiting reply."

R1's Nurse progress Note signed by V3 Licensed Practical Nurse, dated 1/9/25 at 2:40 PM, documents "Received orders from V9 to recheck R1's urinalysis."

On 1/16/25 at 12:31 PM, V3 stated that V3 worked on 1/9/25 and received the order for R1's urinalysis on 1/9/25 because R1 was having decreased urinary output. V3 stated she didn't obtain R1's urinalysis on 1/9/25 because she didn't have time and she passed it on to the oncoming nurse. V3 further stated she returned to work on 1/13/25 and R1's urinalysis was still in the refrigerator at the nurse's station. V3 stated V3 obtained a new urinalysis after finding the lab was not processed on 1/10/25.

On 1/16/25 at 1:13 PM, V14 Registered Nurse stated that V14 worked third shift the night on 1/9-1/10. V14 stated V3 asked V14 to obtain the urinalysis for R1. V14 stated R1's urine was dark yellow, contained sediment and was murky. V14 stated she made V3 aware that V14 collected R1's urine early Friday morning (1/10/25) and gave R1's urine sample to V3 on 1/10/25 at shift

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change. V3 placed R1's urinalysis in refrigerator and stated she would take care of it.

R1's medical record has no documentation of R1's urinalysis being obtained from 1/9/25 thru 1/13/25.

R1's Point of Care Response History, dated 1/2/25 to 1/23/25, lacks documentation on 1/12/25 of R1's urinary output being obtained on 2nd shift.

R1's Nurse Progress Note signed by V3, dated 1/13/25 at 11:45 AM, documents "R1 straight catheterized to get urine sample. R1 fought with staff the whole time and stated it hurt. R1's urine sample is green, thick, and has a foul odor so R1 will be sent out to hospital."

R1's hospital records dated 1/13/25, documents R1 was admitted to hospital to receive intravenous antibiotics for treatment of a Urinary Tract Infection (UTI) and encephalopathy (brain disease that alters brain function or structure, common cause includes infections and can be life threatening if left untreated).

R1's Point of Care Response History, dated 1/2/25 to 1/23/25, documents decreased or absent urinary output on the following days: 1/17/25 zero urine output on third shift, 150 milliliters on day shift; 1/18/25 125 milliliters on second shift. There is no documentation of urinary outputs being obtained on 1/18/25 day shift and third shift. R1's medical record does not contain documentation of physician notification of R1's absent/decreased urine output.

On 1/21/25 at 10:00 AM, V2 Director of Nursing confirms there is no documentation of a urinalysis

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being obtained on 1/9/25. V2 stated that urinalysis should have been collected the same day it was ordered. V2 further stated she was not aware R1's medical chart had days with absent or decreased urinary output.

On 1/22/25 at 9:05AM, V9 Medical Director stated V9 would expect the facility to call and notify V9 if a resident with a catheter has not voided in an eight-hour shift. V9 stated my office, nor I received a phone call from the facility that they did not receive antibiotic orders for R1 on 12/23/24. V9 stated she reviewed all phone calls with her office which are documented, and none were received from the facility from 12/23/24-12/28/24. V9 further stated the facility also has my personal cell phone and I was not notified on my cell phone either. V9 stated R1 could have become very sick because of the facility not notifying V9 of absent or low urine output. V9 stated R1 could have developed sepsis (life threatening complication of an infection) and had to be admitted to hospital and receive IV antibiotics. V9 stated the facility has not made V9 aware of low or no urine output for R1. V9 confirms she was not notified R1s urinalysis was not collected on 1/9/25. V9 stated I was not made aware until sometime after. V9 stated there are a couple of good nurses here but the facility uses a lot of agency staff, and it scares me what kind of care they are providing when they work because it's not the same.

2.) R5's Point of Care Response History, documents R5 has a suprapubic indwelling catheter and on 12/31/24, no urine output documented on second shift. On 1/3/25 no urine output documented on dayshift, and second shift documented 100 milliliters. On 1/5/25 200 milliliters of urine output on dayshift and there

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S9999	Continued From page 10 was no documentation on second shift. On 1/8/25 zero urine output was documented on second shift. On 1/9/25, zero output was documented on third shift, dayshift 150 milliliters of urine output and second shift 50 milliliters. On 1/10/25, 250 milliliters of urine output on third shift, zero output on dayshift, and 250 milliliters on second shift. 1/11/25 175 milliliters on third shift, zero output on day shift and no documentation for second shift. On 1/12/25 zero output documented on third shift and zero on day shift. There is no documentation in R5's medical record that an MD (Medical Doctor) was notified of absent/decreased urine output. (A)	S9999		