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S 000	Initial Comments Complaint Investigation: 2562720/IL189116	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b)3)4) 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 accident, injury or change in condition at the time of notification.	S9999		

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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.

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

d) Pursuant to subsection (a), general nursing

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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 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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to timely report decreased urination and abdominal distention (R1). The facility also failed to perform hand hygiene after toileting assistance (R5) for two (R1, R5) of four residents reviewed for urinary tract infections (UTIs) in the sample list of six. This failure resulted in R1 being hospitalized for a UTI, urinary retention, and acute kidney injury.

Findings include:

1.) R1's Minimum Data Set dated 2/27/25 documents R1 has moderate cognitive impairment, is dependent on staff assistance for toileting, and is always incontinent of bowel and bladder.

R1's Fluid Intake report dated March 2025 documents the following total daily fluid intake:
960 milliliters (ml) on 3/3/25
480 ml on 3/4/25
1100 ml on 3/5/25
360 ml on 3/6/25

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1440 ml on 3/7/25

R1's Bowel and Bladder Elimination log dated March 2025 does not document R1 urinated on all shifts on 3/3/25, second shifts on 3/2/25, 3/6/25, 3/7/25 and third shifts on 3/1-3/5/25 and 3/7/25. This log documents R1 had a medium, loose bowel movement on 3/1/25, formed medium bowel movement on 3/4/25, loose medium bowel movements on 3/5/25-3/7/25 and one large loose bowel movement on 3/6/25.

R1's Nursing Notes document the following:
On 3/7/25 at 11:09 AM R1's abdomen was distended, and a new order was received to obtain a urinalysis. R1 had a loose medium bowel movement.
On 3/7/25 at 7:46 PM R1's urine sample was collected and placed in the fridge for pick up. R1's urine was dark and odorous.
On 3/7/25 at 9:11 PM R1's abdomen remained distended and firm.
On 3/8/25 at 4:44 AM R1 fell during staff assist. R1 was lying on the floor complaining of back and neck pain and wanted to go to the emergency room. Emergency services was called.

The healthcare messaging software documents on 3/6/25 at 2:30 PM R1 had abdominal distention, only one wet brief during the night and once during dayshift, took in 240 ml and had a loose bowel movement. This was reported to V33 (Advanced Practice Registered Nurse/APRN) who ordered a urine sample for urinalysis and culture with sensitivity. There is no documentation in R1's medical record that this order was transcribed until 3/7/25 at 4:33 AM, per R1's physician orders, or that R1 had abdominal distention prior to 3/7/25. There is no documentation that R1's abdominal distention

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and decreased urinary output was reported to V33 prior to 3/6/25 at 2:30 PM.

R1's Emergency Room Note dated 3/8/25 at 6:17 AM documents a urinary catheter was inserted and with a return of over 2500 ml of urine. R1 was admitted with diagnoses of urinary retention, UTI, and acute kidney injury. R1's laboratory results dated 3/8/25 at 8:01 AM documents R1's Blood Urea Nitrogen (BUN) was 42 (high) and Creatinine (Cr) 1.57 (high).

R1's Hospital Discharge Summary dated 3/12/25 documents a urinary catheter was inserted on admission with three liters of urine returned with initial gross hematuria (bloody urine) that resolved. R1's urine culture grew Enterococcus and R1 received antibiotic therapy. R1 was given intravenous fluids and R1's Creatinine levels normalized. Urology was consulted and ordered an abdominal Computed Tomography that showed a large amount of stool in the rectum with surrounding inflammatory changes consisted with stercoral proctitis (rare and serious inflammatory condition). R1 also had bladder wall thickening related to inflammatory changes, mild hydronephrosis, and gaseous bowel distention. Laxatives were ordered and R1 had several bowel movements during his hospitalization.

The facility's Daily Assignment dated 3/5/25 documents V25 (Licensed Practical Nurse/LPN) was assigned to R1's unit for day shift and evening shift, V32 (Certified Nursing Assistant/CNA) was assigned R1's unit on day shift, and V24 (CNA) was assigned to R1's unit on evening shift. The Daily Assignments dated 3/6/25 and 3/7/25 document V24 was assigned to R1's unit on evening shift.

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On 4/7/25 at 1:29 PM V34 (APRN) stated V34 recently started working for the facility on 3/10/25. V34 stated R1 was hospitalized for urinary retention and UTI but had no prior history of UTIs or urinary retention.

On 4/7/25 at 2:16 PM V13 (LPN) confirmed R1's abdomen was distended on 3/7/25. V13 stated there was already an order to collect R1's urine sample that was entered on the prior shift, and it was passed onto V13 that day that R1 had abdominal distention. V13 stated that day V13 had R1 urinate in a urinal, R1 put out almost a full urinal full of urine, and V13 collected R1's urine sample which was dark in color and cloudy. V13 stated unidentified staff had reported that R1 had difficulty urinating days prior.

On 4/7/25 at 3:10 PM V24 (CNA) stated V24 went to get R1 up for supper one night, R1 was really sweaty and not acting himself, and R1 was sent to the hospital. V24 stated a week later R1 was sent to the hospital again (3/8/25) and returned to the facility with a urinary catheter. V24 stated during the week prior, R1 had been drinking well but R1's brief was dry most of the time which was unusual for R1 since R1 would usually pull his pants down and urinate a large amount "all over." V24 stated V24 reported this to V25 (LPN). V24 stated R1's stomach looked more swollen on 3/7/25.

On 4/8/25 at 9:46 AM V25 (LPN) stated R1 had no reported problems on 3/4/25. V25 confirmed on 3/5/25 V24 (CNA) reported R1 had not urinated that day. V25 stated R1's abdomen was also distended that day. V25 stated V25 just passed this information onto night shift and to monitor R1's urination. V25 confirmed V25 did not report R1's abdominal distention and decreased

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urine output to a physician or APRN.

On 4/8/25 at 10:02 AM V32 (CNA) stated a few days prior to R1's hospitalization R1 wasn't himself, was urinating very little and did not have good bowel movements, which was new for R1. V32 stated R1 was still drinking well at that time, R1's abdomen started getting harder and bigger and V32 reported this to V25 (LPN).

On 4/8/25 at 12:22 PM V35 (Registered Nurse/RN) stated V35 works through an agency, night shift on 3/7/25 was the only day that V35 had worked at the facility, and V35 was not very familiar with R1. V35 stated V35 sent R1 to the hospital early that morning following a staff assisted fall and complaints of back and neck pain. V35 stated nothing had been reported about R1 having decreased urination or abdominal distention.

On 4/8/25 at 3:40 PM V2 (RN) stated V2 entered R1's urinalysis order on 3/7/25 which V2 obtained off the healthcare messaging software. V2 stated staff on the prior shift, second shift, had notified V33 (APRN) through the messaging software.

On 4/8/25 at 1:15 PM V12 (Quality Assurance Nurse/Infection Preventionist) stated the CNAs should document continence/incontinence for urine output every shift. V12 verified the lack of this documentation from 3/1/25-3/7/25 on R1's bladder elimination log. V12 stated the CNAs should report decreased urine output to the nurse, the nurse should monitor for symptoms and notify the physician. V12 stated provider notification would be documented in a nursing note. At 2:15 PM V12 stated V36 (R1's Family) contacted V12 after R1's hospitalization to ask how the staff didn't notice R1's abdominal

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distention and decreased urine output. V12 confirmed R1's nursing notes do not document R1's decreased urine output and abdominal distention or that this was reported to a physician or APRN prior to 3/7/25.

On 4/8/25 at 2:35 PM V33 (APRN) stated R1's abdominal distention and decreased urinary output should have been reported immediately. V33 stated a UTI can cause an obstruction in urinary flow and a UTI. V33 stated a delay in treatment of UTI and/or urinary retention can affect laboratory values, including elevated BUN and Cr, and cause an acute kidney injury. V33 stated V33 was assigned to receive calls for the facility between 9:00 AM and 5:00 PM Monday through Friday. V33 stated the on-call provider took call after 5:00 PM until 9:00 PM and outside of those hours the facility would have to contact the physician or medical director.

The facility's Notification for Change in Resident Condition or Status policy dated 12/7/17 documents the charge nurse will notify the resident's attending physician or on-call physician when there are any signs or symptoms or apparent discomfort of sudden onset, a marked change, and unrelieved by previously prescribed measures; when there is a significant change in the resident's physical/emotional/mental condition; and when there is a need to significantly alter treatment. This policy documents that the nurse will document information related to the changes in a resident's condition in the resident's medical record.

2.) On 4/9/25 at 11:37 AM V8 and V26 (CNAs) assisted R5 with toileting. V26 removed R5's soiled brief, applied a clean brief, and cleansed

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S9999	Continued From page 8 R5's perineal area. V26 removed her gloves and did not perform hand hygiene prior to leaving the room and transporting R5 in a wheelchair to the common area. On 4/9/25 at 11:48 AM V26 stated hand hygiene should be performed after providing toileting or incontinence cares. V26 confirmed V26 did not perform hand hygiene after providing R5's with toileting care. The facility's undated General Procedure for Toileting policy documents to wash your hands after providing toileting assistance and perineal care. "A"	S9999		