STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146082	A. BUILDING _____ B. WING _____	C 05/09/2013

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FRANKFORT HEALTHCARE & REHAB CENTER	**2500 EAST ST. LOUIS STREET WEST FRANKFORT, IL 62896**

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F 315	Continued From page 11 prior. Most likely, the catheter was not in the bladder for several weeks. I think the catheter was not inserted properly".	F 315		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1010h) 300.1210b) 300.1210d)3)4)A)5) 300.1220b)2) 300.3240a) 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	F9999		

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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. Restorative measures shall include, at a minimum, the following procedures:

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 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.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure

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sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to identify, assess, monitor, and provide necessary treatment and services to prevent new pressure ulcers from developing for 1 resident (R2) reviewed for pressure ulcers, and condition

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changes with the use of an indwelling urinary catheter for 1 resident (R2) reviewed for indwelling urinary catheter. This failure resulted in R2 being admitted to the hospital with Urinary Retention, Hematuria, and Balanitis requiring a surgical procedure of Direct Vision Internal Urethrotomy and Circumcision.

Findings include:

R2 was admitted to this facility on 7/27/2012 with diagnoses including Pressure Ulcer Stage II, Acute Pain, Dementia with Behavior Disturbances and Chronic Kidney Disease Stage III, according to the Physician Order Sheet dated 5/1/2013. The Norton Pressure Ulcer Assessment document dated 4/15/2013 notes with a score of 8 that R2 is high risk for pressure sores. Per review on 5/8/2013 of the hospital clinical record (Physician's Preliminary Report dated 5/5/2013), R2 was admitted to the hospital on 5/5/2013 with diagnoses of Urinary Retention, Hematuria, and Balantitis. A review of R2's record noted documentation in the nurse's note on 5/5/2013 that R2 was sent to the hospital after his indwelling urinary catheter was out and facility staff after trying several times was unable to reinsert it.

During an interview on 5/8/2013 at 9:55 A.M. with Z5 (Emergency Room Nurse/RN), Z5 stated that upon arrival at the hospital R2 was noted to have a stage IV pressure ulcer to his coccyx, and he complained of inability to void and pain in the pubic area, R2 did not have a Foley catheter in place at time of admission to the hospital. Z5 stated that upon examination and laboratory testing R2 was found to have approximately 350

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cc of residual urine in his bladder, Z5 also noted that R2 was incontinent of urine.

During an interview on 5/8/2013 at 10:00 A.M. with Z2 (Registered Nurse/RN) Wound Care Nurse at the hospital, Z2 stated she received a referral for wound care to R2's stage IV pressure ulcer to the coccyx and ulcerations to his penis. On 5/6/2013 at 11:18 A.M. Z2 wrote in the clinical record "area bruised from multiple tried and failed attempts to insert Foley". When asked in her opinion if the ulcers to R2's penis were pressure ulcers Z2 states "yes, looking at size, depth, location, and appearance, the area on the top of the penis is a pressure sore".

On 5/8/2013 at 1:30 P.M., E7 (Licensed Practical Nurse/LPN) was interviewed and stated on 5/5/2013 at 7:50 A.M. she went to assess R2 after it was reported he had not voided and that he complained of pain in his penis. E7 stated R2's penis was swollen and scant bloody discharge was noted, the Foley catheter was out and I did not attempt to reinsert it.

Nurse's note written by E7 (Licensed Practical Nurse/LPN) on 5/5/2013 at 9:45 A.M. "res examined d/t not voided at this time, penis very swollen, sl bloody discharge, resident has not voided since 6 A.M., f/c removed from prior shift, res c/o hurting bad in penis and unable to void, pressure there, the Foley catheter was out and I did not attempt to reinsert it".

On 5/8/2013 at 2:30 P.M., E8 (Registered Nurse/RN) was interviewed about R2's Foley catheter, E8 stated I have not seen his catheter

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since it was initially inserted on 4/15/2013. E8 works as an Registered Nurse at the facility from 2:00 P.M. - 10:00 P.M.

On 5/9/2013 at 6:50 A.M., E9 (Registered Nurse/RN) was interviewed about R2's Foley catheter and stated approximately 4:00 A.M., on 5/5/2013, it was reported that R2 had not voided and was complaining of pain in his penis, upon exam E9 stated he noted the catheter bulb on the Foley was felt at the end of R2's penis, E9 denied knowledge of ulceration to the penis. E9 stated he did not see ulcerations to the penis when he tried to reinsert R2's indwelling urinary catheter on 5/5/2013. When asked if he retracted the foreskin to the penis (R2 was uncircumcised), as he attempted to reinsert the catheter, E9 stated "no".

Review of nurse's notes dated 5/5/2013 at 4:00 A.M., written by E9 (Registered Nurse/RN), notes "bulb on Foley felt at end of penis. Removed with bulb intact, attempted to reinsert new cath using sterile technique, unable to do so at this time, catheter left out".

On 5/8/2013 at 11:00 A.M., Z4 (Physician/MD/Urologist) was interviewed about the ulcers to R2's penis. Z4 stated his primary concern was that the trauma to R2's penis was probably due to the catheter not being in the bladder or that it was out for an extended period of time from the stricture in the urethra, and yes there were ulcerations to the penis". When asked if R2 was receiving daily peri care and care to the urinary catheter would the ulcers have been visible, Z4 stated "yes". When asked about the need for the Circumcision Z4 stated " it was done to help with the healing process of the pressure

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F9999	Continued From page 17 areas that had developed on the penis". Review of hospital records (Physicians Note) dated 5/5/2013 written by Z4 states "I attempted catheter placement but immediately got gross hematuria which was very unusual because I only got down to the mid portion of the urethra. This leads me to believe that the patient has had previous catheter trauma, possibly from the balloon being blown up in the urethra. The patient also has Balanitis and terrible sores on the foreskin ". Z4 wrote in a letter dated 5/8/2014 "I admitted the patient to the hospital with a diagnosis of urinary retention, he had terrible ulcerations of his foreskin with a lot of swelling and two areas of what appeared to be pressure sores. As per the etiology of the penile sores I think that most likely the patient could have rolled in the bed opposite from the side that the catheter bag was located and this could have pulled on the foreskin causing some of these sores but still there is no excuse for not cleaning it properly and also getting him to a physician in a timely fashion". (B)	F9999		