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F 441	Continued From page 27 that she focused on residents with catheters and implemented re-education in 2/2013 on technique for indwelling insertion and for cleansing of collection bags in an effort to decrease the number of facility acquired UTI's. In April 2013, (after educating on catheter techniques), the infection tracking log showed a sharp increase in facility acquired UTI's. The infection control log did not document infectious causing organisms, showed between June 2012 and April 2013, the facility had 19 individuals with facility acquired UTI's. Thirteen of the 19 people with UTI's resided on the south wing of the facility and 10 of those 13 individuals did not have catheters. E2 said she had not identified that most of the UTI's in the building were occurring on one wing in residents who did not have an indwelling catheter. E2 said "I believed poor catheter care was the cause of the problems and I know we have a problem with poor catheter care, but I never suspected it was a handwashing problem." E2 acknowledged that if culture results, specifically the E. Coli/E. Faecuim (VRE) organisms, had been placed on the tracking log, she might have identified a handwashing/peri care problem sooner.	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.696a) 300.696c)1)2) 300.1010h) 300.1210b)3)	F9999		

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F9999	Continued From page 28 300.1210d)3) 300.1220b)2)3)9) 300.3240a) 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 Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention,	F9999		

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F9999	Continued From page 29 United States Public Health Service, Department of Health and Human Services (see Section 300.340): 1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2) Guideline for Hand Hygiene in Health-Care Settings 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. Restorative measures shall include, at a minimum, the following	F9999		

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procedures:

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.

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.

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

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F9999	Continued From page 31 potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These Requirements are not met as evidenced by: Based on observation, interview and record	F9999		

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review, the facility failed to ensure staff performed peri care in a manner to prevent infections. This failure contributed to R5's development of a Urinary Tract Infection (UTI) with Sepsis and subsequent admission to the Intensive Care Unit of a local hospital for treatment. The facility also failed to ensure staff did not place indwelling urinary collection bags on potentially contaminated/soiled surfaces.

This applies to 3 of 9 residents (R5, R37 & R42) in the sample of 11 reviewed for UTI's and Catheters, and 11 reviewed in the supplemental sample.

The findings include:

1. R5 has diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), Diabetes Mellitus (DM), Seasonal Affective Disorder (SAD), Depression, Gasteroesophageal Reflux Disease (GERD), Osteoarthritis (OA) and Incontinence according to the Physician Progress Note of 2/3/13 and Physician Order Sheet (POS) 5/13.

On 5/21/13 at 10:10 AM, R5 was in her room seated in a reclining geriatric chair, (in the upright position), watching TV. R5 was alert and oriented. R5 stated she had an indwelling catheter inserted about 2 weeks ago. R5 stated she wasn't sure of the exact reason for the placement of the indwelling catheter, but stated she had been having a lot of urinary tract infections which were making her very sick.

On 5/21/13 at 1:20 PM, peri care was given to R5 by E6 and E10 (Certified Nursing Assistants). E6 and E10 donned gloves then rolled R5 from side

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to side to remove her slacks and incontinent brief which contained feces. E6 used peri-wipes to cleanse the feces from R5's buttocks. Without removing gloves, R5 was rolled to her back for E6 to provide anterior peri care (back to front cleansing). E6 used a peri wipe to remove excess stool from her gloves then proceeded to give R5 vaginal care. At no time was R5's catheter tubing cleansed. E6 opened drawers, obtained and applied a clean incontinent brief, applied barrier cream, pulled up linens, touched pillows and bolster pads, opened blinds and drapes all while wearing the soiled/contaminated gloves. Upon completion of care, both CNA's removed their gloves and left the room without washing their hands. E6 entered a room which housed a resident on contact isolation. E6 did not locate the resident and proceeded to the nurses station and began touching papers and items on the desk without washing her hands.

The nursing note of 2/7/13 documents R5 complained of nausea and had a large green emesis. The Nurse Practitioner (NP-Z1) note dated 2/14/13 shows R5 was having "occasional nausea episodes...appetite is very poor and she has lost weight recently."

The nursing note dated 2/16/12 showed R5 complained of feeling tired and unable to move wheel chair around as per usual. R5's family was visiting and reported that R5 appeared agitated. The nursing note of 2/17/13 states R5 continued to complain of feeling tired with "frequency in voiding and changes in behavior". A straight catheter urinalysis (UA) was obtained and R5 was started on Bactrim DS twice daily for 7 days while culture results were pending. The NP note dated 2/18/13 documents: "(R5) became very agitated

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and irritable this weekend towards family which is not like her. Continued to have nausea, fatigue and not feeling good."

The culture and sensitivity report dated 2/19/13 showed the UTI infectious causing organisms, from the UA collected on 2/17/13, were Escherichia Coli (E. Coli) and Klebsiella Pneumoniae. On 2/20/13 at 10:55 AM, the nursing note documents R5 is "pale, diaphoretic, weak." The note continues to document that Z1 (Nurse Practitioner) was in the facility and was called to see R5. Z1 "offered hospital ER evaluation after telling (R5) she (Z1) felt (R5) had a mild heart attack and explained (R5) also had the choice to stay here instead of the hospital and she (R5) could have some lab work done on Thursday when lab comes." Z1's progress note dated 2/20/13 showed R5 was "very weak, pale. diaphoretic this AM-now...Shirt drenched with sweat. Dusky appearing face drenched with sweat....discussed options with R5. Strongly encouraged ER visit due to probable MI (Myocardial Infarction) and needing further evaluation."

On 5/22/13 at 8:50 AM, E3 (Registered Nurse) stated labs are not obtained the same day unless they are ordered "STAT". Non-STAT labs are not obtained until the following morning. E3 stated despite R5 being so ill it was felt an ER evaluation was warranted, the labs were not ordered STAT by Z1. On 5/22/13 at 10:35 AM, Z1 was interviewed regarding R5's 2/20/13 illness. Z1 said R5 had not been feeling well for several days prior, was nauseated, pale and diaphoretic. Z1 said "I strongly encouraged (R5) to go to the hospital and she refused so I recommended lab work." Z1 said, "Labs can't be obtained ASAP

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(as soon as possible). The soonest is to go to the hospital to get STAT labs." When Z1 was questioned about STAT labs at the facility, Z1 stated, "Well we can get STAT labs but it is such a hassle. So we will tell them (residents) to go to the ER if we need STAT labs." Z1 mentioned several times how obtaining labs at the facility on a non-scheduled bases was "such a hassle."

R5 continued to complain of not feeling well throughout the night. On 2/21/13, the nursing note timed (6:00 AM - 1:10 PM) documented Z1 was notified of critical lab result of WBC (white blood count) 29.7, (normal = 4.5-11.0); BUN (blood urea nitrogen) 47, (normal = 5-24 mg/dL); and Creatinine 2.73, (normal = 0.44-1.00 mg/dL). R5's Potassium was 5.6 (normal = 3.5-5.1 mmol/L). R5 was sent to the hospital via ambulance at 12:55 PM.

The hospital admission History and Physical dated 2/21/13 at 9:30 PM, (after ER stabilization), stated R5 "looks in distress". Temperature 99.1 (Normal 98.6), heart rate 95 (normal = 60-80), and blood pressure of 88/37 (normal = 120/80). The Assessment/Plan reads "Sepsis secondary to urinary tract infection...Lactic acid is elevated up to 2.1. It could be secondary to urinary tract infection...The patient looks compensated...Admit patient to ICU for Acute Care...hyperkalemia, will give kayexelate...".

The hospital discharge summary dated 2/26/13 documents: R5 "came in with abdominal pain, nausea, found to have urinary tract infection and her blood pressure was low. She was tachycardic, so she was admitted for sepsis secondary to urinary tract infection. Initially she was admitted to ICU....The patient will be

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discharged to Skilled Nursing Facility to continue a total of 10-14 days of IV antibiotics."

The nursing notes show R5 was re-admitted to the facility on 3/8/13. Two nursing notes of 3/14/12 documents R5 stated she wasn't feeling well through out the day. On 3/15/13, R5's lab results showed a UTI with the causative organism Enterococcus Faecium and the resident was placed on VRE (Vancomycin Resistant Enterococcus) Isolation Precautions and treated with Macrodantin 100 mg twice daily for 7 days. The notes and labs showed R5 was positive for an Asymptomatic UTI, (untreated), on 3/28/13. The nursing notes documented the following: 4/21/13 - R5 with generalized weakness and fatigue; 4/22/13 - Stares into space at times; 4/25/13 Nauseated and tired at times. On 4/30/13 another straight cath UA was obtained. On 5/2/13 the lab results came back showing R5 had a UTI and the infectious causing organism of E. Coli was identified. R5 again required treatment of Bactrim DS twice daily for 7 days.

On 5/22/13 at 8:20 AM, E2 (Director of Nursing) stated she has been aware since November of an increasing number of facility acquired UTI's. E2 said "there is a problem with CNA's not cleansing residents in the 'proper direction', (front to back)", but denied having implemented any interventions/oversight into the provision of handwashing/peri care. E2 said she focused her concern interventions towards residents with catheters.

The undated policy and procedure for handwashing documents hands are to be washed: "8. After handling items or work surfaces potentially contaminated with a

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resident's blood, excretions, or secretions;" and "12. Upon completion of duty."

2. R42 has the diagnosis of Benign Prosthetic Hypertrophy (BPH) requiring the need of an indwelling Urinary Catheter, according to the Physician Order Sheet (POS) for 5/2013. R42 requires extensive assistance with transfers, dressing, and bathing, according to the Minimum Data Set (MDS) of 2/16/2013.

On 5/21/2012 at 1:00 PM, E8 and E9 were observed transferring R42 from his wheelchair to his recliner, using a mechanical standing lift. During the transfer, the staff placed the uncovered catheter urinary bag on the floor of the soiled stand lift, causing possible cross contamination of organisms. The urine in the drainage tubing and bag was tea-colored and concentrated appearing.

The facility's Catheter/Urinary/Catheter Care policy and procedure dated 11/1/05 states the purpose of the policy is to minimize the risk of catheter associated urinary tract infection and its related problems.

On 5/22/2013 at 8:45 AM, E2 (Director of Nursing) verified the catheter drainage bag should always be kept below the level of the bladder and off of soiled surfaces, to prevent cross contamination.

3. The Physician Order Sheet (POS) dated 5/2013 shows R37 has a diagnosis of Overactive Bladder with Chronic Urinary Tract Infections (UTI's). The Minimum Data Set (MDS) of

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F9999	Continued From page 38 05/09/13 shows that R37 requires extensive assistance with transfers, dressing, and personal hygiene. On 5/22/13 at 12:50 PM, E8 (Certified Nurse Assistant - CNA) used the mechanical stand lift to transfer R37 from the reclining chair to the bed. E8 placed R37's catheter bag on the floor of the mechanical stand lift during the transfer, exposing the catheter bag to possible contaminants. E9 transferred R37 from the bed back to the chair, and placed the catheter drainage bag onto the floor of the mechanical stand lift during the transfer. (B) 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information 300.615 e) In addition to the screening required by Section 2-201.5 (a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the	F9999		

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F9999	Continued From page 39 resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5 (b) of the Act). f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This regulation was not met as evidenced by: Based on Interview and Record Review, the facility failed to complete criminal background checks and failed to check the Illinois Department Of Corrections (IDOC) website on newly admitted residents to the facility. This applies to 10 of 10 residents (R3, R4, R7, R14, R15, R19, R21, R23, R24 and R42) reviewed for offender checks. The findings include: R3, R4, R7, R14, R15, R19, R21, R23, R24 and R42 were admitted to the facility between 8/30/12 and 3/8/13. No criminal background checks or IDOC checks could be produced for these individuals. On 5/22/13 at 12:00 PM, E1 (Administrator), said she did not keep hard copies of any of the checks. E1 said the checks are done and then stored on her computer. E1 stated her computer crashed and the documents were unable to be retrieved.	F9999		

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