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EDWARDSVILLE NURSING & REHABILITATION CENTER	401 ST MARY DRIVE EDWARDSVILLE, IL 62025

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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Complaint #1645206/IL88418 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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by:
Based on interview, observation and record review, the facility failed to immediately inform a residents legal representative or family member of a pressure ulcer for two of three residents (R3, R2) reviewed for notification of changes in a sample of 6.

Findings include:

1. R3's Skilled Medicare A Note, dated 6/24/16, at 18:35 (6:35 PM), written by E12, Licensed Practical Nurse (LPN), documents R3 to have a reddened area identified on R3's coccyx. There is no documentation the family member was notified of R3's pressure ulcer at the time.

A Pressure Ulcer Wound Sheet, dated 6/27/16, at 8:51 AM, written by E10, Registered Nurse/Wound Nurse, documents R3 had an in-house acquired pressure ulcer identified on 6/24/16 measuring 4 centimeters (cms) by (x) 2 cm with no depth and was determined to be a Deep Tissue Injury (DTI). The Wound Sheet documents notification was made to the physician, dietary department and family on 6/24/16 with no times recorded.

On 9/16/16 at 10:17 AM, Z1, R3's family member, stated he was not informed that R3 had a pressure ulcer until she was admitted to the hospital on 7/10/16 for an unrelated issue.

On 9/21/16 at 11:10 AM, E2, Director of Nurses (DON) stated she was unable to locate or provide any documentation of notification to R3's family on 6/24/16 regarding R3's pressure ulcer.

The facility's policy entitled "Health and Medical

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Condition, Informing Residents of" dated 4/2008 documents residents shall be informed of their total medical condition. The policy documents if the resident is medically incapable of understanding his/her medical condition, the resident's representative (sponsor) will be informed of the resident's medical condition and asked to participate in the development of the care plan.

2. R2's Admission Record documents R2 was admitted to the facility on 3/26/15.

R2's Nurse's Note, dated 3/28/16, documents R2 had a left outer ankle DTI.

R2's Weekly Pressure Ulcer Record, dated 3/29/2016, documents R2 had a left DTI that measures 1.5 cm x 1.0 cm. The Record documented the treatment ordered was skin prep.

Additional documentation presented by E10, dated 4/4/2016, documents in part, "Wound noted on L (left) ankle approx (approximately) 1.5 cm x 2.0c m presents self as DTI periwound red also wound noted on L (left) hip approx (approximately) .5 cm x2.0 cm with serous sang (sanguineous) drainage noted in scant amt (amount) without odor red granulation tissue intact 75%...Dr. (Z2) notified new tx (treatment) orders were recd (received) family and pharmacy notified." This notification was made 7 days after the ulcer was initially identified.

On 9/21/16 at 11:00 AM, when asked if there was

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F 157	Continued From page 3 documentation the family was notified at the time R2's left outer ankle pressure ulcer was discovered on 3/28/16, E10 stated, "I don't have any documentation. I am not going to lie. I don't have it." On 9/21/16, at 11:30 AM, E2 confirmed there was no documentation family was notified at the time of discovery.	F 157		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to adequately prevent, timely identify and treat pressure ulcers for 2 of 3 residents (R1 and R3) reviewed for Pressure Ulcer Prevention in a sample of 6. Findings include: 1. R3's Admission Sheet, dated 6/8/16, identified R3 as a 64 year old female admitted to the facility on 6/8/16 following hospitalization for a sacral and right pubis fracture sustained during a home fall. The Admitting orders, Dated 6/8/16, documented	F 314		

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R3 to have a urinary catheter for retention.

R3's Minimum Data Set (MDS), dated 7/4/16, documented R3 as cognitively intact requiring extensive assist of two staff for bed mobility and transfers. The MDS documented R3 to have no skin impairment upon admission to the facility.

R3's Interim Care Plan, dated 6/8/16, identified R3 to have a problem with pressure ulcers due to immobility and pain with interventions including turn/reposition every two hours, protect bony prominences, and monitor skin weekly.

R3's Skilled Medicare A Note, dated 6/24/16, at 18:35 (6:35 PM) written by E12, Licensed Practical Nurse (LPN), documented R3 did not walk, was not able to self transfer and had a "reddened bottom" with Ointment applied every shift. There was no further documentation in the Skilled Notes regarding R3's "reddened bottom" until 6/27/16. Progress notes reviewed and were found to have no further information provided on the reddened area identified on R3's coccyx.

R3's Physician's Order Sheet (POS) documents a treatment, dated 6/26/16, for "Cleanse Sacral wound with NS (Normal saline) apply Santyl oint (ointment) wound and apply zinc oxide and antifungal cream periwound with gauze dressing BID (twice daily) for wound."

A Pressure Ulcer Wound Sheet, dated 6/27/16 at 8:51 AM, written by E10, Registered Nurse/Wound Nurse, documented R3 had an in-house acquired pressure ulcer identified on 6/24/16 that measured 4 centimeters (cms) by (x) 2 cm with no depth. The Sheet documents R3's ulcer to have no exudate or epithilialization

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and no granulation or slough. The assessment does identify the area being "dark red" under the necrosis section with treatments being Santyl (a debriding agent) daily with gauze dressing, low air mattress, turn/reposition side to side only. The Assessment documented notification was made to the physician, dietary department and family with no times recorded.

On 9/20/16 at 10:40 AM, when asked why she used the Santyl, E10 stated R3's pressure ulcer looked deep red and crusty. E10 stated she determined it to be a deep tissue injury as it was deep red. E10 could not recall why a debriding agent was ordered at the time. E10 stated the nurse who originally identified it on 6/24/16 should have assessed it but confirmed that no assessment information including size, stage, etc was documented as being done.

On 9/20/16 at 10:40 AM, E10 provided a Evaluation of Pressure Ulcer Avoidability dated 6/27/16 which documented R3 to have continuous urinary incontinence or voiding dysfunction and Chronic bowel incontinence although R3 had a urinary catheter from the time of admission.

The facility's policy entitled "Pressure Ulcers/Skin Breakdown - Clinical Protocol," dated 3/2014, documented "Nursing staff and Attending physician will assess and document an individual's risk factors for developing pressure sores." The policy documents "The nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic issue; pain assessment, resident's mobility status; current treatments,

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including supportive surfaces and all active diagnoses."

The facility's policy entitled "Pressure Ulcer Treatment," dated 10/2010, documented " 1) a suspected deep tissue injury as "purple or maroon localized area of discoloration intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear, 2) stage I document a non-blanchable redness of a localized area usually over a bony prominence. 3) stage II - partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, 4) stage III - full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, 5) Stage IV - full thickness loss with exposed bone, tendon or muscle, 6) Unstageable - full thickness loss in which the base of the ulcer is covered by slough and/or eschar."

2. R1's MDS, dated 8/29/16, documented R1 had cognitive impairment and required extensive assist of two staff for transfers and bed mobility. The MDS documented R1 had an in-house acquired unstageable pressure ulcers.

R1's Care Plan, dated 8/16/16, identified R1 to be at risk of pressure ulcers with interventions to have heel protector (8/22/16), float heels (8/3/16), barrier cream PRN, incontinent care after each episode, turn/reposition every two hours and as needed, and weekly skin assessments in part.

R1's September 2016 POS documented R1 to have a urinary catheter. R1's Albumin level on 8/4/16 is documented by the Registered Dietician as within low normal limits (3.5-5.5) at 3.5.

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Weekly Pressure Sore log, dated 9/7/16, documented R1 to have a stage 2 in-house acquired ulcer on her right heel measuring 3.5 cm x 3.5 cm identified on 8/24/16 and a Deep Tissue Injury (DTI) left heel measuring 2.0 cm x 2.0 cm also identified on 8/24/16.

On 9/16/16 at 1:32 pm, E8 and E7, Certified Nurse's Aide (CNAs) attached the full body lift sling to the machine to lift R1 from the wheelchair to the bed. After being transferred, E8 and E7 rolled R1 to her left side. R1 had a small open area the size of a lima bean on her inner left buttocks that was beefy red and bleeding. R1's bilateral buttocks were deeply creased with red/white strips throughout which remained during the entire observation of incontinent care. E8 acknowledged the open area and stated it was there when he got her up earlier that day. E8 stated he told E4, Licensed Practical Nurse (LPN) about it but got her up anyway without it being treated or covered. E8 stated he got R1 up between 7:15 AM - 7:30 AM that morning. R1 also had unstagable ulcers present on both heels. The left inner heel was oval in shape with dark edges. The right had black tissue present and was more circular in shape. Neither were open.

On 9/20/16 at 10:40 AM, E10 stated she was not made aware of R1's open area to her buttock until later on 9/16/16 and when she went to look at it, found nothing open.

On 9/20/16 at 2:30 PM, E4 confirmed that E8 told her about R1's open ulcer on the buttocks but thought that E10 looked at it so she didn't follow up.

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F 314	Continued From page 8 On 9/21/16 at 10:00 AM, E10 stated she looked at R1's bottom again and found the pressure ulcer identified on Friday (9/16/16). E10 stated she must have missed it due to R1 having a large amount of barrier cream on her when she looked on Friday. E10 provided documentation ,dated 9/20/16, that identified R1 had a stage II measuring 1.0 cm x 1.0 cm on the coccyx with a treatment order initiated 9/20/16. There is no information or documentation on the opened pressure ulcer identified on 9/16/16 on the inner buttocks. Weekly wound sheets, dated 9/12/16, document R1's left heel was identified as unstageable with slough/eschar present. The weekly report documents the right heel ulcer as stage 2 but was observed to be intact with dark purplish discoloration along the outer edges. On 9/20/16, E10 provided the "Evaluation of Pressure Ulcer Avoidability" sheet dated 8/22/16 although the ulcer were first documented on 8/24/16. The Avoidability sheet documents the clinical primary risk factors for developing wounds is continuous urinary incontinence, chronic bowel incontinence, and Diabetes.	F 314		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure 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; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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function as possible.

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility failed to provide appropriate monitoring and assessment for potential urinary retention following the removal of the urinary catheter and failed to provide services in catheter care for 2 of 3 residents (R1 and R3) reviewed for catheters in a sample of 6. This failure resulted in R3 being hospitalized for Obstructive Uropathy due to urinary retention resulting in acute renal insufficiency and metabolic acidosis.

Findings include:

1. R3's Admission Sheet, dated 6/8/16, identifies R3 as a 64 year old female admitted to the facility on 6/8/16 following hospitalization for a sacral and right pubis fracture sustained during a home fall. R3's Admitting orders document R3 to have a urinary catheter for retention and history of urinary tract infection (UTI.)

R3's Minimum Data Set (MDS), dated 7/4/16, documents R3 as cognitively intact requiring extensive assist of two staff for bed mobility and transfers. The Interim Care Plan, dated 6/8/16, identifies R3 to have an indwelling catheter with interventions being clean/dry skin following each incontinence episode and catheter care. R3's Care Plan, dated 6/22/16, documents R3's Focus areas as "incont (incontinent) of bladder and bowel at X's (times) and has DX (diagnosis) UTI, urinary retention and constipation had cath (catheter) on admit that has been dc'd." The Goal is to be continent during waking hours with

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interventions documented as documents signs/symptoms (s/s) of constipation, urinary retention, UTI's, had KUB (Kidney/Ureters/Bladder), incontinent care after episodes, and take to bathroom before/after meals. R3's Care Plan documents the catheter being discontinued on 7/1/16 but a telephone order, dated 6/9/16, documents the catheter was discontinued on 6/10/16.

R3's Progress notes from admission on 6/8/16 through 7/10/16 when R3 was discharged to the hospital has only 2 references to R3's catheter and no reference to voiding. The first entry is on 6/9/16 and documents R3's catheter is intact and draining and the second is on 6/10/16 and documents the catheter to be patent draining clear yellow urine. There is no documentation of the catheter being removed and no documentation of any monitoring the nurses did following removal to ensure R3 was voiding appropriately in sufficient amounts.

The Medicare Skilled noted document only that the catheter was present on 6/9/16 and 6/10/16 and also fails to document any assessments and/or monitoring toward R3's urinary output to ensure it was sufficient and no retention was occurring.

On 6/12/16, R3's POS documented an order for Cipro (antibiotic) was given for a UTI. The POS documented on 6/16/16, an order was received for a Stat KUB for decreased bowel sounds and distended bladder, constipation but no documentation that the KUB was done. On 9/21/16, the facility provided R3's KUB report was provided that identified no problems except constipation.

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R3's Skilled Nursing note written by E12, Licensed Practical Nurse LPN on 7/10/16 at 1:38 AM documents nothing toward a condition change for R3 with vitals documented as blood pressure 122/82, Temperature 97.9, pulse 86 and respirations 22. There is no indication that E12 identified the low temperature and slightly elevated pulse and respirations as a concern.

R3's Nursing-Situation Background Assessment Recommendation (N-SBAR), dated 7/10/16, (unsigned) documents at 14:20 (2:20 PM) that at 9:30 AM on 7/10/16, R3 had a condition change with blood pressure 86/52, pulse 76, respirations 16, pulse Oximetry 88% on 2 Liters of Oxygen. The N-SBAR documented "Patient unable to stand to assist with transfer d/t (due to) weakness, lethargy, decreased urinary output, and unable to eat/drink d/t lethargy" and under "A" Assessment or appearance as to what the nurse thought was going on documented "Dehydration, Kidney failure" as the resident appeared "lethargic, sluggish." The N-SBAR documented Z2, Medical Doctor, ordered to send R3 to emergency room to evaluate and treat if necessary.

R3's Nursing Progress notes did not document R3's condition change. However, on 7/10/16, E4, Licensed Practical Nurse (LPN) documented "admitted to hospital with obstructive uropathy."

The Emergency Department (ED) documentation, dated 7/10/16, documents R3 presented to the ER at 14:40 PM with the chief complaint of "abdominal distention, pedal edema" with the comment documenting "presents to the ED from her skilled nursing facility with new abdominal

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distention and pedal edema. Patient is nonverbal at this time... per nursing home, patient has been more lethargic and weak." The ED Notes physical exam documents "abdomen tender, distended, (bowel sounds diminished, pain pump of Lt (left) side with swelling (pedal edema)." The ED Notes document R3's differential diagnoses was Obstructive Uropathy and UTI. R3's Computerized Tomography (CT) scan documented "abdomen and pelvis demonstrates severely distended bladder with retrograde and moderate hydronephrosis bilaterally. Foley catheter did not appear to be functioning" and under Assessment and Plan, the report documents "Obstructive uropathy due to urinary retention resulting in acute renal insufficiency and metabolic acidosis". The report documented "The patient's obstructive uropathy, I suspect there may be some chronic component to this, but is not helped by her chronic narcotic use" and "The patient had at least 3.5 L (liter) of urine out since the catheter was placed in ED. Her abdomen is now soft and nontender. I suspect that just the compression of the bladder will significantly improve the patient's renal function." The report also documents the physician "suspect there may be some chronic component to this, but is not helped by her chronic narcotic use" and "Large amount of colonic stool likely due to relative obstruction from the severely distended bladder compressing the descending/sigmoid junction."

R3's Hospital History/Physical, dated 7/10/16, documented "The patient had a Foley Catheter placed at the nursing home with very little urine output" and R3 was cathed with "procurement of around 4 L of urine, with evidence of a UTI." Urinalysis dated 7/10/16 documents R3 to have a

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	145555	A. BUILDING _____ B. WING _____	C 09/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDSVILLE NURSING & REHABILITATION CENTER	401 ST MARY DRIVE EDWARDSVILLE, IL 62025

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UTI culturing positive for Escherichia Coli. An Ultra Sound Kidney study, dated 7/13/16, documented R3 to have diffuse bladder wall thickening, likely secondary to neurogenic bladder or chronic outlet obstruction.

R3's Facility's Progress Notes and Skilled Notes did not document a catheter insertion on 7/10/16 prior to R3 going to the hospital. The N-SBAR of 7/10/16 also fails to reflect the catheter insertion referred to in the hospital note.

On 9/20/16 at 3:10 PM, E2, Director of Nursing stated R3 condition declined rapidly with increased pedal edema and some distention along with lethargy. E2 stated E5, LPN, inserted a catheter and did get some return prior to sending her out to the ED. E2 was asked why the catheter was removed and stated they assess to remove all catheters when they are admitted with one from the hospital and put them back in if needed. E2 stated she was unaware of why R3 had the catheter on admission to begin with and was unable to provide any documentation of assessment towards removing the catheter.

On 9/21/16 at 9:30 AM, E5 stated she was the nurse who cared for R3 and sent her to the ED on 7/10/16. E5 stated she received no information on concerns from the night shift nurse that morning in regards to R3 and first saw R3 around 8-8:30 AM. E5 stated R3 had slight edema bilateral lower extremities 3+ which was a new onset. E5 stated a little after breakfast, R3 was lethargic so she had the Certified Nurses Aides (CNAs) put her to bed. E5 stated she assessed R3 again and found no bladder retention, distention and her abdomen was soft, chest sounds clear. E5 stated she inserted a catheter

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and got around 350 cubic centimeters (cc) of clear urine. E5 stated she decided to send R3 to the ED because she was going downhill fast with her blood pressure dropping. E5 was asked why she inserted a catheter when R3 had no retention or distention noted on assessment and E5 stated "because of the edema, I wanted to try to pull some of that fluid out off her legs." E5 stated she documented the catheter insertion on the SBAR. E5 stated she was unsure why R3 had the catheter to begin with and was unaware that R3 had urinary retention history.

The facility policy entitled "Foley Catheter Removal" dated 10/2010 documents the purpose of the policy is to provide guidelines for the approval method of removing a Foley catheter. The policy documents staff are to review the resident's care plan to assess for any special needs of the resident. The policy does not refer to any monitoring and/or assessment following discontinued use of the catheter to ensure retention does not occur as is standard nursing practice.

2. R1's MDS dated 8/29/16 documents R1 as having cognitive impairment and has a urinary catheter. R1's Care Plan dated 8/16/16 identifies R1 to have a catheter for urinary obstruction with interventions to keep tubing off floor, catheter care as ordered, cranberry pills, as ordered and monitor for s/s of pain, burning, blood tinged or cloudiness, and no output in part.

On 9/16/16 at 11:10 until 1:32 PM, R1's urinary catheter was laying on the floor under her wheelchair. At 12:56 PM, E8, CNA propelled her from the dining room to bedside in her room with

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F 315	Continued From page 15 the tubing dragging on the floor as they went down the hall. E8 and E7, CNAs attached the full body lift sling to the machine to lift R1 from the wheelchair to the bed. E8 placed the catheter drainage bag onto R1's lap and E7 started to lift R1 from the chair. As they lifted R1 up, the front of the wheelchair started to come up with her. The catheter tubing was caught on the backside of the leg guard across the pedals. E7 and E8 were told the tubing was caught and they lowered her, unhooked the tubing and then proceeded with the transfer to bed. R1's urine was cloudy and some white sediment in it. On 9/21/16 at 10:30 AM, E2 acknowledged that the collection bag should not have been placed onto R1's lap during the transfer and more care should have been taken to ensure that the tubing was properly placed to ensure a safe transfer.	F 315		