STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145225	A. BUILDING _____ B. WING _____	09/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOSPITAL LTC UNIT	800 EAST CARPENTER, 11TH FLOOR SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 312 SS=D	Annual Certification Survey 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide thorough incontinent care for two of two residents (R7, R9) observed for incontinent care in the sample of ten. Findings include: 1. On 9/3/15 at 10:00 AM, E10, Certified Nurse Aide (CNA), provided incontinent care for R7. E10 used 1 disposable bath wipe and no rinse foam, went across and down both sides of groin and labia, back and forth with the same disposable wipe. 2. On 9/8/15 at 11:15 AM, E16, CNA, and E17, CNA, provided incontinent care for R9. E16 used disposable ready bath wipes. While cleansing R9's labia, E16 used a clean wipe, cleansed front to back and with the same wipe rewiped back up and down, in a back and forth motion several times. The facilities Perineal care of the female patient	F 312		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 312	Continued From page 1 Policy and Procedure, dated 10/3/2014, documents, "Implementation * Separate the patient's labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum to prevent intestinal organisms from contaminating the urethra or vagina. Avoid the area around the anus, and use a clean section of washcloth for each stroke by folding each used section inward. This method prevents the spread of contaminated secretions or discharge." On 9/8/15 at 4:00 PM, regarding staff using one wipe to cleanse the labia in a back and forth motion, E1, Nursing Administration, stated, "I would expect staff to cleanse front to back and dispose of the wipe."	F 312		
F 315 SS=D	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 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to provide appropriate catheter care for 1 of 2 residents (R8) reviewed for catheter care in the sample of 10.	F 315		

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F 315	Continued From page 2	F 315		

Findings include:

R8's electronic medical record documents R8 was admitted from the acute care hospital to the long term care unit on 8/20/15 following a fall that resulted in a pelvic fracture, left hip pain and urinary retention.

R8's Indwelling Catheter Assessment, completed at 8:19 PM on 8/20/15, documents R8's indwelling catheter present upon arrival to the long term care unit, R8's indwelling catheter was inserted on 8/19/15 due to Urinary Retention.

R8's urinalysis, completed on 8/21/15, documents the following abnormal results: trace - urine leukocyte esterase, 1 urine red blood cell, 11 urine white blood cells, less than 1 squamous epithelial cells and 1 hyaline casts. R8's final urine culture and sensitivity on 8/22/15 documents no growth.

R8's (Indwelling) Catheterization Assessment, dated 8/25/15, documents R8's indwelling catheter collection bag had 200 milliliters (ml) of foul smelling urine before the indwelling catheter was removed at 2:00 PM.

R8's Bladder Scan Assessment, dated 8/25/15 at 10:37 PM, for urine retention documents a volume amount of 72 ml. R8 was reassessed at 6:30 AM on 8/26/15 for bladder distention with a result of 374 ml and indwelling catheter was reinserted due to obstruction and acute urinary retention.

At 10:30 AM on 9/3/15, E12, Nurse Tech/Certified Nursing Assistant (CNA), provided

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F 315	Continued From page 3	F 315		

indwelling catheter care for R8. E12 obtained tub of soap and water, wash cloths and towels. E12 used the same wash cloth wadded up to wipe down leg creases and back up without repositioning the wash cloth, resulting in recontamination. This was repeated one more time with soap and water and then E12 placed the used wash cloth back in the clean soap and water tub, and reused the same cloth to wash from the meatus down the catheter tubing. E12 did use a clean wash cloth and repeated this process when rinsing off R8's skin. E12 obtained a clean towel and dried the area that was washed and rinsed previously. As E12 lowered R8's bed, R8's urinary drainage bag landed on the floor with the front of the bag face down on the floor. As E12 removed the tub of soap and rinse water, E12 stepped on the edge of the urinary drainage bag on the floor. Upon E12's return to R8's side, E12 picked R8's urinary drainage bag up off the floor and hooked it on the side rail. Due to R8's bed being in the lowest position to prevent falls, E8's urinary drainage bag dragged on the floor.

The facility's Indwelling Urinary Catheter Care and Management Policy and Procedure, dated and revised 10/3/14, documents under "Implementation": "...to avoid contaminating the urinary tract, always clean by wiping away from - never - toward - urinary meatus...avoid frequent and vigorous cleaning of the area...". "Keep the catheter and drainage tubing free from kinks to allow the free flow of urine...". "Don't place the drainage bag on the floor to reduce the risk of contamination and subsequent Catheter-associated urinary tract infections (CAUTIs)."