STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009831	A. BUILDING: _____ B. WING _____	C 07/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWANSEA REHAB HEALTH CARE	1405 NORTH SECOND STREET SWANSEA, IL 62226

(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) COMPLETE DATE
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)3) 300.1210d)3) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as	S9999		

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S9999	Continued From page 1 applicable. (Section 3-202.2a of the Act) 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. 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 300.3240 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 requirements were not met as evidenced by:	S9999		

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S9999	Continued From page 2	S9999		

Based on record review and interview, the Facility failed to obtain a urine sample as ordered by the Nurse Practitioner to rule out a urinary tract infection (UTI), and failed to provide timely treatment for a UTI for one of three residents (R2) reviewed for a UTI in the sample of 8. This failure resulted in R2 being admitted to the hospital on 6/29/2014 for treatment of Sepsis, UTI, Hyponatremia, Acute Dehydration, Acute Renal Failure, Encephalopathy and Metabolic Acidosis.

Findings include:

The Nursing Admission Assessment, dated 5/30/2014 documents R2 was admitted to the Facility with an old gastric bypass, status post bowel obstruction and resection, with a colostomy to the right lower abdomen and a gastrostomy tube. The POS for 6/2014 documents an oral diet order of "Regular with ground/chopped" and "Flush GT (gastrostomy tube) with 90 cc (cubic centimeter) water every shift to maintain patency", and an order for a daily diuretic, Lisinopril-Hydrochlorothiazide 10-12,5 mg (milligram) by mouth daily."

R2's Care Plan, dated 6/17/2014, documents, in part, "Needs monitored for side effects of diuretic medication for treatment related to cardiac issues and HTN (hypertension). Monitor for serious side effects and notify MD (medical doctor) as necessary: dehydration, weakness. (R2) has alteration in bladder elimination as related to episodes of incontinence at times. Will not have any infections. Monitor for infection such as burning urination urinary frequency, complaints of pain, foul odor. Encourage fluids and notify physician if symptoms occur related to UTI."

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The Nurses Note, dated 6/26/2014, at 1:00 AM, documents R2 had a "subdued affect." The Nurses Note, dated 6/26/2014, untimed, documents, "New Order for UA (urinalysis) and C&S (culture and sensitivity) related to confusion" from Z1, Nurse Practitioner (NP) for Z2, Physician. The Nurses Notes from 6/26/2014 through 6/29/2014 fail to document a urine sample was obtained for a urinalysis or C&S for R2. There is no Laboratory Report for R2 in the clinical record for a urinalysis with a C&S dated as collected 6/26/2014 or thereafter.

The Nurses Note, dated 6/27/2014 at 10:00 AM documents, in part, R2 was "sleepy with confusion." The Nurses Note, dated 6/27/2014, at 2:00 PM, documents R2 was seen by Z2 and a new order was received for an appetite stimulator.

The Nurses Note, dated 6/28/2014 at 9:30 AM, documents, in part that R2 began to complain of pain and discomfort to all over her body and pain medication was given and effective.

The Nurses Note, dated 6/29/2014, at 10:00 AM, documents, in part, that R2 was alert with confusion with complaint of "pain all over", with pain medication given. There is no documentation Z1 or Z2 were notified. The Nurses Note, dated 6/29/2014, at 5:30 PM, documents Z1 and Z2's paging service was called and a message was left to call the facility due to R2's confusion and weakness.

The Nurses Note, dated 6/29/2104, at 6:40 PM documents R2's Power of Attorney (POA) wanted R2 to be sent to the local emergency department for evaluation. The Nurses Note, dated

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6/29/2014 at 7:00 PM documents R2 left the Facility by ambulance with her family.

A Nurses Note from E2, Director of Nursing (DON), dated 6/30/2014, at 11:30 AM, documents, in part, " 6/29/2014, client (R2) was noted to be lethargic and no urine output for evening shift. Client's flushes were reviewed with POA (Power of Attorney). UA (urinalysis) was not obtained."

On 7/08/2014, at 2:50 PM, Z1 was interviewed about R2. Z1 reported she was not aware of R2's poor fluid intake or the Facility's failure to obtain a urine sample for a urinalysis or C&S. Z1 reported she was unaware why the message from the facility on 6/29/2014 at 5:30 PM was not received by her until 7:15 PM, after R2 had left for the hospital. Z1 reported if the urinalysis had been obtained at the Facility, R2 could have been treated with an antibiotic, push fluids or increase the G-tube flushes to promote hydration..

On 7/09/2014, at 10:15 AM, E5, LPN was interviewed about R2's condition the evening of 6/29/2014. E5 reported she had called Z2's answering service when she noticed R2 had increased confusion and needed a physician order for a UA. E5 reported R2's (family member) had come to visit that evening and he had noticed a change in her mental status, requesting her to call the physician back when there was no immediate response. E5 reported she sent R2 out to the hospital by ambulance before any response was obtained from Z2 or Z1.

On 7/08/2014, at 2:20 PM, E3, LPN was interviewed about R2. E3 reported she took care of R2 the day of 6/28/2014. E3 reported she did not obtain a urine sample from R2 for a UA or call

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the physician.

On 7/09/2014, at 4:29 PM, E4, LPN was interviewed about R2 on the evening and night shift of 6/26/2014. E4 reported E5, LPN for the evening shift had reported to her R2 was having increased confusion and she (E5) had been waiting for Z1, NP to call back to the Facility about R2. E4 reported Z1 called the Facility between 10:30 PM or 11:00 PM of 6/26/2014,and gave her an order for a UA and C&S to be obtained for R2. E4 reported she did not obtain a urine sample from R2, and told the day shift the morning of 6/27/2014 during shift report.

The Emergency Room Visit Report, dated 6/29/2014, documents, in part, "(R2) here with altered mental status. Per (family) patient has had confusion beginning 1 week prior. (Family) came to see her at the care Facility and she was noted to be worse. Was not responding appropriately so patient sent in for further evaluation. Patient currently altered and unable to provide any history. Lab Results Comment: Remarkable. Patient confused. Clinical Impression: Acute Urinary Tract Infection, Sepsis, Hyponatremia, Altered Mental Status."

The Hospitalist History and Physical, dated 6/30/2014, documents, in part, "Sepsis with elevated WBC (white blood cell), SIRS (Systemic Inflammatory Response Syndrome) criteria, and with suspected UTI. Hyponatremia related to poor intake. For now will hydrate the patient gently and monitor. Acute Renal Failure-acute dehydration suspect related to poor intake. UTI-significant pyuria (pus in urine). On Zosyn (antibiotic used to treat UTI) to cover."

The Hematology Report for R2, dated 6/29/2014,

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S9999	Continued From page 6 at 8:57 PM, documents, in part, an elevated WBC of 15.5, normal =4.6-10.2. The Urinalysis Report, dated 6/29/2014 at 8:28 PM, documents R2's urine was cloudy, normal=clear and contained Leuocytes of 500, normal=negative, with WBC's in R2's urine of 1702, normal =0-2. R2's Urine C&S, dated 6/29/2014, documents a colony count of over 100,000 CFu/mL (colony forming units per milliliter) of the bacteria, Klebsiella pneumoniae, ESB (extended spectrum beta lactamase, a multi-drug resistant organism-MDRO) and 50,000 CFU/mL of a gram positive organism, and 50,000 CFU/mL of a gram negative Bacilli, resembling Proteus Mirabilis." (A)	S9999		

Swansea Rehabilitation & Health Care Center
Provider #: 145981
Survey Date: 07/10/2014

F315 483.25(d) NO CATHETER, PREVENT UTI, RESOTRE BLADDER
Based on the resident's comprehensive assessment, the facility must ensure that a resident that enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates.....and to restore as much normal bladder function as possible.

1. The corrective action for the alleged deficient practice has been achieved by the following:
    a. On 7/25/2014 licensed nursing personnel were in-serviced regarding the facility policy related to lab protocols and timeliness of treatment (Attachment A).
    b. Director of Nursing is reviewing the 24 hour nursing reports to ensure that lab requests have been reported and completed within a reasonable amount of time.

2. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1a-b, the alleged practice will not recur.

3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur:
    a. The DON and/or designee will inservice all newly hired licensed nursing personnel regarding the facility's policy and procedure for lab protocols and communication with physician.
    b. The DON will review the 24 hour nursing report to ensure compliance with lab requests and communication with physician.

4. The following Quality Assurance programs have been implemented to ensure continued compliance.
    a. The DON and/or designee will conduct weekly random audits for completion of labs and proper notification of appropriate parties.
    b. The DON will discuss any lab requisitions and communication with physicians during the daily QA meeting.
    c. Nursing administration will assure compliance through the internal Quality Assurance process.

5. Completion Date: 08/08/2014

This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the Facility violated any federal or state regulation or failed to follow any applicable standard of care.