

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Bloomington Rehabilitation & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 1925 South Main Street Bloomington, IL 61701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on interview and record review, the facility failed to notify a resident's emergency contact person of a change in condition and new physician orders for one of four residents (R1) reviewed for notifications in a sample list of four residents.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 as severely cognitively impaired. This same MDS documents R1 is able to self-propel in his wheelchair.</p> <p>R1's Physician Order Sheet (POS), date July 2024, documents a physician order, dated 7/24/24, for Modified Barium Swallow for Diagnosis of Dysphagia. This same POS, dated August 2024, documents a physician order, dated 8/20/24, for Swallow evaluation. Speech therapy to evaluate and treat and a separate physician order, dated 8/20/24, for STAT (immediate) Chest X-Ray Two views for possible Aspiration portable due to immobility.</p> <p>R1's After Visit Summary, dated 8/13/24, documents R1's reason for hospital visit was Feeding tube problem.</p> <p>R1's Nurse Progress Note, dated 8/20/24 at 3:00 PM, documents, Notified that (R1) reported (R1) ate food today. New order for swallow evaluation and treatment.</p> <p>On 8/21/24 at 3:30 PM, V14, R1's Responsible Party, stated the facility did not notify V14 of any changes in R1's medical condition, physician orders, or of R1's trip to the emergency room due to a malfunctioning Gastrostomy Tube (G-Tube). V14 stated, (R1) has three daughters. I am listed as the responsible party so that (the facility) doesn't have to call three people every time something happens. We (R1's family) stay in contact with each other. None of us were notified of anything. We have not been to any kind of careplan meeting. We have not been included in any decision making for (R1). (R1) can not make decisions on his own. We need to be kept up to date if there are any changes.</p> <p>On 8/21/24 at 3:00 PM, V17, Assistant Director of Nurses (ADON), stated anytime there is a change in condition, a resident goes to the hospital, has a medication change, testing ordered or being done, the Physician and/or Nurse Practitioner, resident, and resident's representative should be notified. V17 stated the facility is not able to provide any documentation R1's representative was notified of any part of his care.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145610
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/22/24 at 2:00 PM, V26, Regional Director of Operations, stated staff are expected to notify the Physician, resident, resident's representative if applicable, and any other pertinent parties of any change in condition for any given resident.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on interview and record review, the facility failed to supervise a resident with a physician order to have nothing by mouth except ice chips to prevent the resident from eating/drinking for one of three residents (R1) reviewed for diet orders in a sample list of four residents.</p> <p>Findings include:</p> <p>R1's undated Face Sheet documents R1 admitted to the facility on [DATE], with medical diagnoses of Moderate Protein-Calorie Malnutrition, Alcohol Dependence with Alcohol-Induced Persisting Dementia, Metabolic Encephalopathy, Sepsis, Gastrostomy Status, and Pneumonitis with inhalation of food and vomit.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 as severely cognitively impaired. This same MDS documents R1 is able to self-propel in his wheelchair.</p> <p>R1's Physician Order Sheet (POS), dated August 2024, documents a physician order starting 7/12/24 with no end date of nothing by mouth (NPO). This same POS documents a physician order, starting 7/17/24 with no end date, of R1 may have ice chips only per Speech Therapy.</p> <p>R1's current Care Plan documents R1 receives nutrition through a feeding tube due to swallowing problems. R1's current Careplan does not include R1's behaviors of eating foods and/or drinking liquids while on NPO status.</p> <p>R1's Nurse Progress Note dated:</p> <p>7/13/24 at 8:00 PM, documents, (R1) Attempted to eat solid food multiple times, educated about nothing by mouth (NPO) status.</p> <p>7/22/24 at 6:00 AM, documents, Staff reported that (R1) consumed food from roommates tray.</p> <p>8/17/24 at 11:00 PM, documents, (R1) mistakenly received water from staff. (R1) drank all of the water from the pitcher. Educated staff on asking for resident diets for safety.</p> <p>-8/20/24 at 3:00 PM, documents, (Staff) was notified that (R1) reported (R1) ate food today. New order for swallow evaluation and treatment.</p> <p>On 8/20/24 at 8:40 AM, V7, Certified Nurse Aide (CNA), stated, I saw (R1) yesterday afternoon with a fudge brownie and a cup of hot chocolate. I told him the doctor didn't want him to have it, and he gave it to me. (R1) had eaten a good amount of it.</p> <p>On 8/21/24 at 3:30 PM, V14, (R1's) Responsible Party, stated, (R1) can not make decisions on his own. (R1) needs to be watched closely because he does not realize what he is doing and can choke or become very sick if he eats foods. The staff are supposed to be watching him and they don't.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/21/24 at 3:00 PM, V17, Assistant Director of Nurses (ADON), stated R1 is not able to make safe decisions about R1's care. V17, ADON, stated, Our staff need to supervise (R1) closely because he is known to eat foods and drink things when he is not supposed to. It could cause (R1) to choke or worse. (R1) wheels himself around the building, so he does have access to other resident's foods if the staff are not watching him. (R1) has shown us (facility) that he will eat foods and drink liquids if we (staff) aren't watching him.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview, and record review, the facility failed to follow Gastrostomy Tube (G-Tube) medication/feeding administration guidelines, and failed to weigh a resident for one of three residents (R1) reviewed for diet/nutrition in a sample list of four residents.</p> <p>Findings include:</p> <p>R1's undated Face Sheet documents R1 admitted to the facility on [DATE], with medical diagnoses of Moderate Protein-Calorie Malnutrition, Alcohol Dependence with Alcohol-Induced Persisting Dementia, Metabolic Encephalopathy, Sepsis, Gastrostomy Status, and Pneumonitis with inhalation of food and vomit.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 as severely cognitively impaired. This same MDS documents R1 is able to self-propel in his wheelchair.</p> <p>R1's Physician Order Sheet (POS), dated August 2024, documents a physician order, starting 7/12/24 with no end date, of nothing by mouth (NPO). This same POS documents a physician order, starting 7/17/24 with no end date, of R1 may have ice chips only per Speech Therapy. This same POS documents a physician order for Sucralfate (Carafate)(Stomach Protectant) 1 Gram (gm) per Gastrostomy Tube four times per day. Dissolve Sucralfate in 10 milliliters (ml) water to form slurry. This same POS documents physician orders to elevate head of bed 30-45 degrees when feeding, feed bolus Jevity 1.2 332 milliliters (ml) five times daily and flush 30 milliliters (ml) of water before and after bolus five times daily.</p> <p>R1's Medical Record documents R1 was weighed on 8/15/24 at 122.0 pounds (lbs) and on 8/21/24 at 123.6 lbs. No further weights are recorded.</p> <p>R1's Registered Dietician Progress Note, dated 7/29/24, documents, Registered Dietician (RD) Tube Feed Note: [AGE] year old male admitted on [DATE]. RD not informed. (R1) is nothing by mouth (NPO) on full enteral nutrition Jevity 1.2 332 milliliters (ml) five times per day with Fresh Water Flush (FWF) 30 ml before and after each feeding. No height or weight in chart. Unable to calculate weight status or estimated nutritional needs without height or weight . Please add to chart. RD to plan to follow up monthly and as needed while on Tube Feeding.</p> <p>On 8/21/24 at 10:05 AM, V6, Registered Nurse (RN), crushed R1's Carafate and mixed with it 90 ml water. V6 administered R1's 30 milliliter (ml) water flush, Carafate 1 Gram (gm), and then another 30 ml water flush per R1's Gastrostomy Tube (G-Tube). V6, RN, then administered 30 ml water, 322 ml Jevity 1.2 calorie supplement and then another 30 ml of water. V6, RN, did not check placement of R1's G-Tube prior to administering water flushes, enteral feeding nor medication. V6, RN, did not raise R1's head of bed 30-45 degrees while administering R1's medication, enteral feeding, and flushes. V6, RN, administered R1's medication, bolus feeding, and water flushes by pushing them through a syringe. V6, RN, did not allow R1's medication, bolus feeding, and flushes to be administered by gravity.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/21/24 at 10:35 AM, V6, Registered Nurse (RN), confirmed V6 did not raise R1's head or check for tube placement before administering the medication and feeding. V6 stated, I always push (R1's) water flushes, enteral feedings, and medications through using a syringe. It takes too long to do if you just let the fluids go in by gravity.</p> <p>On 8/21/24 at 10:50 AM, V17, Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN), stated V6, Registered Nurse (RN), should have checked the placement of R1's Gastrostomy Tube prior to administering any kind of medication, feeding supplement, or water flush. V17, ADON, stated, (R1) was weighed on 8/9/24 at 122.0 pounds (lbs) and again today (8/21/22) at 123.6 lbs. (R1's) Medical Record does not show any weights done prior to 8/9/24. (R1's) Hospital Record does not show a weight obtained either. I know this is a big problem. (R1) had orders for weekly weights when he admitted, but the facility did not do them. I really don't know if (R1) gained, lost, or remained the same weight.</p> <p>The facility policy titled Enteral Tube Medication Administration, revised August 2020, documents, elevate the head of the bed to 30-45 degrees (Semi Fowler's or High Fowler's position) and leave the bed in this position for at least 30 minutes after administration of medications. With gloves on, check for proper tube placement in accordance with facility policy. Check gastric content for residual feeding. Return residual volumes to the stomach. Remove the plunger from the 60 milliliter (ml) syringe and connect the syringe to the clamped tubing using the appropriate port. Pour dissolved/diluted medication in the syringe and unclamp tubing, allowing medication to flow by gravity.</p> <p>The facility policy titled Weight Assessment and Intervention, revised 11/2/2021, documents, the nursing staff will measure resident weights on admission and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precautions while administering medications and feeding through a Gastrostomy Tube (G-Tube) for one of one residents (R1) reviewed for Enhanced Barrier Precautions on the sample list of four residents.</p> <p>Findings include:</p> <p>R1's undated Face Sheet documents R1 admitted to the facility on [DATE], with medical diagnoses of Moderate Protein-Calorie Malnutrition, Alcohol Dependence with Alcohol-Induced Persisting Dementia, Metabolic Encephalopathy, Sepsis, Gastrostomy Status, and Pneumonitis with inhalation of food and vomit.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 as severely cognitively impaired.</p> <p>R1's Physician Order Sheet (POS), dated August 2024, documents a physician order, starting 7/12/24 with no end date, of nothing by mouth (NPO). R1's August 2024 POS documents an order for bolus feedings of Jevity 1.2 332 milliliters (ml) five times daily and flush 30 milliliters (ml) of water before and after bolus five times daily.</p> <p>On 8/20/24 at 10:00 AM, R1 was laying in his bed in his room. R1's room did not have an 'Enhanced Barrier Precaution' sign posted, nor did R1's room have Personal Protective Equipment supplies available outside R1's room, nor did R1's room have designated linen and/or trash disposal bins.</p> <p>On 8/21/24 at 10:05 AM, V6, Registered Nurse (RN), administered medication and feeding through R1's G-Tube. V6 did not wear a mask or gown while administering R1's medications and feeding.</p> <p>On 8/21/24 at 2:45 PM, R1 was laying in his bed in his room. R1's room did not have an 'Enhanced Barrier Precaution' sign posted, nor did R1's room have Personal Protective Equipment supplies available outside R1's room, nor did R1's room have designated linen and/or trash disposal bins.</p> <p>On 8/21/24 at 10:50 AM, V17, Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN), stated, (R1) should be placed on Enhanced Barrier Precautions because he has a G-Tube. (V6), RN, should have worn a mask, gown and gloves when having direct contact with (R1's) G Tube.</p> <p>On 8/22/24 at 12:30 PM, V3, Director of Nurses (DON), stated, (R1) admitted to this facility on 7/12/24 with his G-Tube. (R1) should have been placed on Enhanced Barrier Precautions (EBP) when he admitted . (R1) was placed on EBP today (8/22/24). V3, DON, stated the residents who should have been placed on EBP are at higher risk of getting an infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Enhanced Barrier Precautions, revised 4/22/2024, documents nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with Multiple Drug Resistant Organisms (MDRO's). The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply for nursing home residents with wound and/or indwelling medical devices regardless of MDRO colonization as well as for residents with an MDRO infection or colonization. Face protection may also be needed if performing activity with risk of splash or spray. Examples of high-contact resident care activities requiring gown and glove use for EBP include: device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator.</p>