STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145611	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Wellness Rehab Villas	1251 East Richton Road Crete, IL 60417

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observations, interviews and record reviews, the facility failed to implement physician's orders. This applies to 4 of 4 residents (R1-R4) reviewed for history of UTIs (urinary tract infections). The findings include: 1. R3's diagnosis includes UTI (urinary tract infection), prosthetic hyperplasia with urinary tract symptoms, retention of urine, & acute kidney failure. On [DATE] at 10:48 am, R3 was sitting in his wheelchair, his catheter bag was hanging from under the chair, and the bag and tubing was touching the floor. The urine was dark and cloudy. At this time R3's said that he had pain in his penis and testicles, and that he reported it to the staff. At 10:55 am V3 (Nurse) came into the room and saw that the bag and tubing was on the floor and tried to reposition them off the floor. V3 said that she was going to put R3's leg bag on him. V3 said that earlier she put the catheter bag under the wheelchair and R3 did tell her that his penis and testicles were hurting him. V3 said that she was going to notify the doctor. V3 did not change R3's catheter bag or tubing as per R3's [DATE] Physician's order. On [DATE] at 11:02 am, V7 (Nurse) was providing catheter care cleaning R3's penis and catheter tubing with 4 X 4 gauze dressing wet with normal saline. V7 did not use soap and water. R3 complained of pain in his penis and testicles. There was leakage around the opening of the penis and a brown substance both dry and wet around the tubing near the opening. V7 did not change R3's catheter bag and or tubing as per R3's [DATE] Physician's order. On [DATE] at 12:33 pm V8 NP (Nurse Practitioner) said that her expectations are that the nurses changed R3's catheters, bags, and tubing when it is clinically indicated such as when the urine was dark and cloudy, when R3 complained of pain, and when R3's catheter was leaking, just as the [DATE] physician's order shows. R3's physician's orders showed: [DATE] catheter care every shift. [DATE] record output from urinary catheter every shift. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] change foley catheter for blockage and or leaking. [DATE] change catheter, tubing or bag when clinically indicated as needed. R3's EMARs (Electronic Medication Administration Records) were reviewed: November EMAR showed: No documentation for R3's output from [DATE] day shift through [DATE] night shift. R3's progress notes were reviewed, and no notes were found showing resident refused to wear a leg bag or that the catheter was changed on [DATE] or [DATE]. On [DATE] at 12:41 PM V2 DON (Director of Nursing) verified the above findings while looking at R3's electronic health records. V2 said that the nurse should have followed the orders to change the catheter and tubing on [DATE] and [DATE] because if not it could lead to an infection. V2 said, while looking at R3's lab results from [DATE] that it showed that R3 had bacteria in his urine. 2. R4's diagnoses include Type 2 diabetes, acute kidney failure, benign prostatic hyperplasia with lower urinary tract symptoms, chronic kidney disease stage 3, urinary tract infections, and pyuria. On [DATE] at 2:47 pm V5 (Nurse) provided catheter care for R4. When she cleaned R4's penis and catheter tubing, she only used normal saline. V5 did not use soap and water. R4's Physician's orders showed: [DATE] catheter care every shift. [DATE] catheter monitor output every shift. R4's EMARs (Electronic Medication Administration Records) reviewed: [DATE] EMAR showed: No output done for [DATE]th, 2024, at 10:30pm through [DATE]th, 2024, at 630 am. December EMAR showed: On [DATE] the staff did not change catheter securement device. On [DATE] at 12:41 pm V2 DON (Director of Nursing) while looking at R4's electronic health records, verified that the above treatments were not provided. V2 said that by not providing proper catheter care and not changing the securement device it can cause UTIs. 3. R2's diagnoses include type 2 diabetes, retention of urine, neuromuscular dysfunction of the bladder, and UTIs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:07 pm V3 (Nurse) provided catheter care for R2. When she cleaned R2's penis, skin around suprapubic catheter and the tubing, she only used normal saline. V3 did not use soap and water as R2 physician's order showed. When V3 removed the dressing from around the catheter the date on the dressing showed ,d+[DATE]. R2's EMARs reviewed: November EMAR showed: No documentation showing R2's supra pubic dressing was changed on [DATE], [DATE] and [DATE]. Monitoring R2's output ever shift was not done on [DATE] Evenings, [DATE] 10:30pm, [DATE] 630 am, & [DATE] 2:30 PM. December EMAR showed: [DATE]th, 12th & 22nd no documentation for R2's urine output was done. January EMAR showed: On [DATE] at 10:30 pm no urine output documented. On [DATE] no output document for all three shifts. On [DATE] at 9:00 am Bactrim DS ,d+[DATE]mg was not given as ordered. On [DATE] at 12:41 PM V2 DON, while looking at R2's electronic health records, verified that the above treatments and medications were not provided. V2 said that the nurse should have used soap and water when providing catheter care as the order and the facility policy shows. V2 said that by the nurse not giving R2 his Bactrim as ordered could have caused him to get another UTI or his current UTI not be treated appropriately as the doctor ordered. V2 said as she looked in R2's record, R2's [DATE] UA showed that his urine was positive for bacteria, a moderate amount, and his [DATE] culture and sensitivity came back positive for pseudomonas and E. coli (Bacteria). V2 said that she is noticing a trend with the residents having UTI's and becoming septic. 4. R1 was discharged to the local community hospital on [DATE] for altered mental status and died on [DATE]. R1's diagnoses included hydronephrosis with renal and ureteral calculous obstruction, retention of urine, urinary tract infection, benign prosthetic hyperplasia with lower urinary tract symptoms, and kidney failure. R1's October EMAR showed: On [DATE] day shift, [DATE] day shift and [DATE] day shift there was no recording of urine output for R1. R1's November EMAR showed: On [DATE] at 10:30 pm, [DATE] at 630 am, & [DATE] at 630 am no recording of urine output for R1. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's December EMAR showed: On [DATE] and [DATE] no recording of urine output for R1. On [DATE] at 12:41 PM V2 DON said that poor catheter care could be the cause of the UTI's and sepsis of all four residents. V2 said that it is a facility's policy that all nurses follow physicians orders and believes that the nurses do not follow the physician's orders it can contribute to the residents being hospitalized with UTI's and septicemia. The facility's Catheter Care policy dated [DATE] showed: The purpose of this procedure is to prevent infections of the resident's urinary tract. Be sure the catheter tubing and drainage bag are kept off the floor. Ensure that the catheter remains secure with a leg strap to reduce friction and movement at the insertion site, catheter tubing should be strapped to the resident's inner thigh. Report to the supervisor any complaints the resident may have of burning, tenderness, or pain in the urethral area. Supplies soap and water. For the male use a washcloth with warm water and soap to cleanse around the meatus. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately 4 inches outward. Remove gloves and discard into designated container. Wash hands and dry thoroughly, clean the bedside stand, wash and dry hands thoroughly. The following information should be recorded in the resident's medical records the date and time that the catheter care was given, the name and title of the individuals giving the catheter care all assessment data obtained when giving catheter care, character of urine such as color and odor, any problems noted at the catheter urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. The facility Suprapubic Catheter care policy dated [DATE] showed: The purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. Maintain an accurate record of the resident's daily output. Equipment: soap and water. Wash around the catheter site with soap and water, note if the resident has a drainage sponge around the stoma site, remove the drainage sponge before washing with soap and water, wash the outer part of the catheter tubing with soap and water. Document the date and time the procedure was performed, the name and title of the individual who performed the procedure, assessment data obtained during the procedure, character of the urine such as color and odor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observations, interviews, and record reviews, the facility failed to provide proper catheter care for 4 of 4 residents (R1-R4) that were reviewed for catheter care. The findings include: 1. R3's diagnoses includes UTI (urinary tract infection), prosthetic hyperplasia with urinary tract symptoms, retention of urine, & acute kidney failure. On [DATE] at 10:48 am, R3 was sitting in his wheelchair, his catheter bag was hanging from under the chair, and the bag and tubing was touching the floor. The urine was dark and cloudy. At this time R3 stated that he (R3) had pain in his penis and testicles, and that he reported it to the staff. At 10:55 am V3 (Nurse) came into the room and saw that the bag and tubing was on the floor and tried to reposition them off the floor. V3 stated that she was going to put R3's leg bag on him. V3 stated that earlier she put the catheter bag under the wheelchair and R3 did tell her that his penis and testicles were hurting him. V3 stated that she was going to notify the doctor. V3 did not change R3's catheter bag or tubing as per R3's [DATE] Physician's order. On [DATE] at 11:02 am, V7 (Nurse) was providing catheter care cleaning R3's penis and catheter tubing with 4 X 4 gauze dressing wet with normal saline. V7 did not use soap and water. R3 complained of pain in his penis and testicles. There was leakage around the opening of the penis and a brown substance both dry and wet around the tubing near the opening. V7 did not change R3's catheter bag and or tubing as per R3's [DATE] Physician's order. On [DATE] at 12:33 pm V8 NP (Nurse Practitioner) stated that her expectations are that the nurses changed R3's catheter, bag, and tubing when it is clinically indicated such as when the urine was dark and cloudy, when R3 complained of pain, and when R3's catheter was leaking, just as the [DATE] physician's order shows. R3's physician's orders showed: [DATE] catheter care every shift. [DATE] record output from urinary catheter every shift. [DATE] change foley catheter for blockage and or leaking. [DATE] change catheter, tubing or bag when clinically indicated as needed. R3's EMARs (Electronic Medication Administration Records) were reviewed: November EMAR showed: No documentation for R3's output from [DATE] day shift through [DATE] night shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's progress notes were reviewed, and no notes were found showing resident refused to wear a leg bag or that the catheter was changed on [DATE] or [DATE]. On [DATE] at 12:41 PM V2 DON (Director of Nursing) verified the above findings while looking at R3's electronic health records. V2 stated that the nurse should have followed the orders to change the catheter and tubing on [DATE] and [DATE] because if not it could lead to an infection. V2 stated, while looking at R3's lab results from [DATE] that it showed that R3 had bacteria in his urine. 2. R4's diagnoses include Type 2 diabetes, acute kidney failure, benign prostatic hyperplasia with lower urinary tract symptoms, chronic kidney disease stage 3, urinary tract infections, and pyuria. On [DATE] at 2:47 pm V5 (Nurse) provided catheter care for R4. When V5 cleaned R4's penis and catheter tubing, she (V5) only used normal saline. V5 did not use soap and water. V5 only cleaned her hands twice while providing care. V5 washed her hands before she put on her gloves at the beginning of care, and after she was done providing care, she removed her gloves and washed her hands the 2nd time. V5 did not clean her hands after cleaning R4's penis and catheter tubing after she removed her gloves. V5 only replaced her dirty gloves with clean gloves and continued drying R4's penis, then again removed gloves and put on new gloves and attached the brief and placed R4's blanket on him with her dirty gloved hands. R4's Physician's orders showed: [DATE] catheter care every shift. [DATE] catheter monitor output every shift. R4's EMARs (Electronic Medication Administration Records) reviewed: [DATE] EMAR showed: No output done for [DATE]th, 2024, at 10:30pm through [DATE]th, 2024, at 630 am. December EMAR showed: On [DATE] the staff did not change catheter securement device. On [DATE] at 12:41 pm V2 DON (Director of Nursing) while looking at R4's electronic health records, verified that the above treatments were not provided. V2 stated that by not providing proper catheter care and not changing the securement device it can cause UTIs. 3. R2's diagnoses include type 2 diabetes, retention of urine, neuromuscular dysfunction of the bladder, and UTIs. On [DATE] at 1:07 pm V3 (Nurse) provided catheter care for R2. When she cleaned R2's penis, skin around suprapubic catheter and the tubing, she (V3) only used normal saline. V3 did not use soap and water as R2 physician's order showed. When V3 removed the dressing from around the catheter the date on the dressing showed ,d+[DATE]. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's EMARs reviewed: November EMAR showed: No documentation showing R2's supra pubic dressing was changed on [DATE], [DATE] and [DATE]. Monitoring R2's output ever shift was not done on [DATE] Evenings, [DATE] 10:30pm, [DATE] 630 am, & [DATE] 2:30 PM. December EMAR showed: [DATE]th, 12th & 22nd no documentation for R2's urine output was done. January EMAR showed: On [DATE] at 10:30 pm no urine output documented. On [DATE] no output document for all three shifts. On [DATE] at 9:00 am Bactrim DS ,d+[DATE]mg was not given as ordered. On [DATE] at 12:41 PM V2 DON, while looking at R2's electronic health records, verified that the above treatments and medications were not provided. V2 stated that the nurse should have used soap and water when providing catheter care as the order and the facility policy shows. V2 stated that by the nurse not giving R2 his Bactrim as ordered could have caused him to get another UTI or his current UTI not be treated appropriately as the doctor ordered. V2 stated as she looked in R2's record, R2's [DATE] UA showed that his urine was positive for bacteria, a moderate amount, and his [DATE] culture and sensitivity came back positive for pseudomonas and E. coli (Bacteria). V2 stated that she is noticing a trend with the residents having UTI's and becoming septic. 4. R1 was discharged to the local community hospital on [DATE] for altered mental status and died on [DATE]. R1's diagnoses included hydronephrosis with renal and ureteral calculous obstruction, retention of urine, urinary tract infection, benign prosthetic hyperplasia with lower urinary tract symptoms, and kidney failure. R1's October EMAR showed: On [DATE] day shift, [DATE] day shift and [DATE] day shift there was no recording of urine output for R1. R1's November EMAR showed: On [DATE] at 10:30 pm, [DATE] at 630 am, & [DATE] at 630 am no recording of urine output for R1. R1's December EMAR showed: On [DATE] and [DATE] no recording of urine output for R1. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:41 PM V2 DON stated that poor catheter care could be the cause of the UTI's and sepsis of all four residents. V2 stated that it is a facility's policy that all nurses follow physicians orders and believes that the nurses do not follow the physician's orders it can contribute to the residents being hospitalized with UTI's and septicemia. The facility's Catheter Care policy dated [DATE] showed: The purpose of this procedure is to prevent infections of the resident's urinary tract. Be sure the catheter tubing and drainage bag are kept off the floor. Ensure that the catheter remains secure with a leg strap to reduce friction and movement at the insertion site, catheter tubing should be strapped to the resident's inner thigh. Report to the supervisor any complaints the resident may have of burning, tenderness, or pain in the urethral area. Supplies soap and water. For the male use a washcloth with warm water and soap to cleanse around the meatus. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately 4 inches outward. Remove gloves and discard into designated container. Wash hands and dry thoroughly, clean the bedside stand, wash and dry hands thoroughly. The following information should be recorded in the resident's medical records the date and time that the catheter care was given, the name and title of the individuals giving the catheter care all assessment data obtained when giving catheter care, character of urine such as color and odor, any problems noted at the catheter urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. The facility Suprapubic Catheter care policy dated [DATE] showed: The purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. Maintain an accurate record of the resident's daily output. Equipment: soap and water. Wash around the catheter site with soap and water, note if the resident has a drainage sponge around the stoma site, remove the drainage sponge before washing with soap and water, wash the outer part of the catheter tubing with soap and water. Document the date and time the procedure was performed, the name and title of the individual who performed the procedure, assessment data obtained during the procedure, character of the urine such as color and odor. The facility's Handwashing/Hand Hygiene policy dated [DATE] showed that the facility recognizes hand hygiene procedures as primary means to prevent the spread of infections among residents, personnel, and visitors. Hand hygiene should be performed before direct contact with residents after direct contact with residents before putting on gloves, before handling clean or soiled dressings gauze pads etc, before moving from a contaminated body site to a clean body site during resident care, before and after putting on PPE (personal protective equipment) including gloves, after contact with resident's intact skin, after handling used dressings, potentially contaminated equipment, ect., after contact with objects such as medical devices or equipment in the immediate vicinity of the resident that may be potentially contaminated, after contact with potentially infectious material., and after removing gloves.