STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145626	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Generations Oakton Pavillion	1660 Oakton Place Des Plaines, IL 60018

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 0690 Level of Harm - Actual harm Residents Affected - Few	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** 39537 Based on observation, interview, and record review the facility failed to obtain a urine specimen from a catheter in a timely manner, document indwelling catheter output, ensure catheter care was provided and identify/respond to signs and symptoms of a UTI (Urinary Tract Infection) in a timely manner for 2 of 3 residents (R1, R3) reviewed for indwelling catheters in the sample of 3. These failures resulted in R1 requiring emergency treatment and hospitalization for a severe UTI with sepsis. The findings include: 1. The facility's Grievance Form dated 8/30/24 showed a representative from the Public Guardian's Office expressed concern regarding a phone call received by the emergency department. The ER (emergency room) informed them that R1 was admitted to the hospital with a sludged catheter. The back page of this form titled, Facility Grievance - Written Decision Form was blank. There were four sections including: Facility information, Grievance/complaint information; Investigation and Results; Was the grievance/complaint confirm (y/n); Resolution. All these sections were blank. R1's Face Sheet 9/29/24 showed diagnoses to include, but no limited to heart failure, chronic kidney disease (Stage 4), history or UTIs, dementia, diabetes, prosthetic heart valve, functional quadriplegia, neuromuscular dysfunction of the bladder, and presence of a chronic indwelling catheter. R1's facility assessment dated [DATE] showed she had severe cognitive impairment; had an indwelling catheter; was dependent on staff assistance for toilet hygiene and shower/bathe; and required substantial/maximal assistance with personal hygiene and bed mobility. R1's Physician Order Sheet dated 8/1/24 to 9/30/24 showed orders for UA (urinalysis), Reflex to Culture dated 8/8/24 and 8/13/24. It does not show an order for the UA ordered on 8/2/24 (per the facility's progress notes). This document showed orders for: Foley catheter care every shift and PRN and Document Foley output every shift. R1's August 2024 MAR (Medication Administration Record) showed Document Foley output every shift, there were no documented urine outputs for 3-11 and 11-7 shifts the entire month. The urine output was not charted 3 times for the day shift and 5 days the facility staff entered medium or large, instead of a volume of urine in milliliters (ml). This document showed R1's Foley Care every shift and PRN was not documented by 3-11 and 11-7 shifts the entire month of August and was not completed on 8/18/24 by the 7-3 shift. This document showed R1's Foley Catheter was changed on 8/11/24. (continued on next page)

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

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F 0690 Level of Harm - Actual harm Residents Affected - Few	R1's Progress Notes showed on 8/2/24 at 9:44 AM, R1's daughter visited and was concerned that R1 was crying, seemed more confused, and couldn't recognize family members. R1's daughter requested a urinalysis to check for a UTI. The writer notified V10 (R1's Physician) and obtained an order for a lab and a urinalysis. R1's Progress Notes dated 8/8/24 showed lab was called for the urinalysis results and the lab employee reported the urine specimen had not been collected. At 2:19 PM, the urine sample was collected and placed in the first-floor refrigerator for lab pick up. R1's Nurse Practitioner Note dated 8/8/24 showed she was seen for concerns with increased confusion. This document showed the resident slept through the entire visit but did not appear to be in pain or distress. This note showed that the urinalysis and labs ordered were discussed with the nurse. This note showed the indwelling catheter was draining clear yellow urine. R1's Progress Notes dated 8/12/24 showed the nurse called the lab to check on the urinalysis results and multiple bacterial morphotypes were found. The lab recommenced re-collecting a urine specimen. V10 was notified and orders were received to recollect the urine specimen. The nurse was unable to collect the urine sample from the indwelling catheter and reported to the next shift to obtain R1's urine specimen. R1's Progress Note on 8/28/24 by V2 (Director of Nursing/DON) showed R1's daughter called public guardian's office to have R1 sent to the ER. ADON (Assistant Director of Nursing) called R1's doctor (V10) to make him aware of the change in condition and poor appetite. The order to send R1 to the hospital was received. 911 was called. R1's Progress Note by V3 (ADON) was a late entry created on 8/30/24 at 5:45 PM (after R1's Guardian filed a Grievance with the facility). This note showed R1 was able to respond to commands, denied pain. Her family was at the bedside and vital signs were obtained. This note did not address the appearance of R1's urine. (There are no progress notes dated 8/28/24 by the V12 (Licensed Practical Nurse/LPN) that was caring for R1). R1's Progress Note dated 8/29/24 showed R1 was admitted to the hospital for a UTI. R1's UA collected on 8/8/24 showed R1's urine was cloudy yellow, had large leukocytes (white blood cells) and MANY bacteria. This report showed that multiple bacteria morphotypes were present (likely a contaminated specimen) and recommended re-collection of the urine specimen. There was no evidence of a urine specimen obtained by the facility from 8/2/24 to 8/7/24 (the first UA ordered was received 8/2/24 per to R1's progress notes), nor was there a urinalysis report after the 8/11/24 specimen report. R1's UA Report collected 8/13/24 showed R1 had cloudy, yellow urine. This report showed R1's urine contained Large leukocytes, had protein in it, MANY bacteria, had 11-20 HPF (Normal range is 0-5 HPF) Red Blood Cells and had 21-50 HPF (normal range is 0-5 HPF) [NAME] Blood Cells. R1's Lab Report showed on 7/24/24 R1's WBC (White Blood Cell Count) 5.95 and on 8/3/24 R1's WBC increased to 11.82 (Double the last result, indicating a possible infection). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan initiated 12/18/23 showed R1 was at risk for UTI related to history of UTIs. The interventions included, but were not limited to: Monitor for signs/symptoms of sepsis (fever, confusion, lethargy, elevated BP, tachycardia) and report to PCP (Primary Care Physician); Monitor lab work and report abnormalities; Provide peri-care as appropriate to decrease skin contact with moisture; and Report signs of UTI (acute confusion urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul order, concentrated urine, blood in urine) and notify MD as appropriate. R1's Care Plan initiated 10/14/21 showed R1 required a Foley catheter related to neuromuscular dysfunction of the bladder. The interventions included, but were not limited to: Monitor for complications related to catheter use such as catheter obstructions, bladder distension, and pain; Observe drainage (amount, type, color, odor); Provide catheter care daily and as needed; Report UTI (acute R1's emergency room records dated 8/28/24 showed R1 had a temperature of 99.9 degrees Fahrenheit; elevated lactate level (used to diagnose sepsis); elevated kidney function tests (BUN/Creat); elevated WBCs at 26.7 (normal range is 4.2 to 11 K/mcl). (This number is more than double the last WBC obtained at the facility on 8/3/24). This document showed R1 will respond to her name, but continues to say, Yes Lord, and will not answer any other questions. This document showed R1's urine was straw colored with sediment. This document showed that during ED triage, the family reported they called the ambulance because she was less responsive than normal and did not eat as much food as usual today. This document showed at 7:27 PM, the ED nurse spoke with the County Public Guardian regarding R1's condition. R1's Hospital Records dated 8/29/24 showed R1 presented with fatigue and AMS (altered mental status). This record showed R1's family visited her and noted that she was weaker than normal and was not eating/drinking. R1 appears disoriented. R1's CT of her abdomen and pelvis showed bladder wall thickening and perivesicular stranding that may represent acute cystitis (recommend correlation with urinalysis). This document showed R1 was diagnosed with acute toxic metabolic encephalopathy likely due to a CAUTI (Catheter Associated Urinary Tract Infection), sepsis, leukocytosis, and lactic acidosis. R1 was placed on intravenous antibiotics and was hospitalized from 8/28/24 to 9/5/24. On 9/30/24 at 3:04 PM, V18 (County Public Guardian) said R1 had a history of UTIs and had been in and out of the hospital. V18 said the ER nurse reported that R1 had sludge in her urine, and she was concerned with the appearance of the urine. V18 said that gave us concern for how the facility was taking care of R1's catheter. V18 said they had temporary guardianship of R1's financial and healthcare needs and they are responsible for ensuring R1's needs were met at the facility. On 9/29/24 at 12:12 PM, V5 (Registered Nurse/RN) said if a resident is having increased confusion or a change in their mental status, it could be a sign of a UTI or something else going on. V5 said the nurse should complete an assessment and call the doctor for orders. V5 said if a UA is order, it can be obtained for the indwelling catheter right away. The UA results are usually available within 24 hours, but the culture may take 2-3 days. The nurses can look in the chart to see if the labs are completed. V5 said a resident with an indwelling catheter should receive catheter care and urine outputs should be monitored every shift. The purpose of catheter care is to keep the area clean and reduce the risk of infections. V5 said the urine output is records and the nurses should be reviewing to see if there are any trends. V5 said the catheter care and urine output should be charted in the MAR. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 9/29/24 at 12:33 PM, V7 (LPN) said the nurses can collect a UA directly from the Foley catheter and it shouldn't take more than 24 hours to collect the specimen. The surveyor asked V7 if she remembered calling lab for the UA results on 8/8/24 and being told that the UA had not been collected. V7 stated, I don't remember, but if I documented it, then that's what happened. V7 said the nurse should document a volume of urine (in milliliters), not small, medium, large. V7 said we look at the urine output to ensure the catheter is working, the resident isn't having any health issues, and they are hydrated. V7 said the catheter care and urine output should be charted once a shift on the MAR. On 9/29/24 at 1:25 PM, V1 (Administrator) said on 8/30/24 the Grievance Form was completed because the Public Guardian's Supervisor came to the building and reported she was concerned because the ED nurse reported that R1's catheter was sludged. V1 said she assigned the investigation to V2 (DON). V1 said she wasn't sure why the back of the Grievance Form had been blank, and she would have to check with V2 (DON). On 9/29/24 at 1:37 PM, V3 (ADON) said the basic care of an indwelling catheter should include catheter care every shift; measuring the urine output every shift; securing the device; ensure its draining; and changing the catheter as needed. V3 said the resident should have orders for each item and the nurse should sign them off in the MAR as completed. This catheter maintenance is completed to reduce the risk of infections. V3 said an actual amount should be documented for urine output because there is no way to identify what small, medium, and large means. V3 said those should only be used for BMs and incontinence. V3 said the importance of measuring the urine output is to ensure the catheter is patent and monitor the resident's status. V3 said an increased WBC count shows there's possibly an infection. V3 said if a resident is experiencing fever, change in level of consciousness, poor appetite, changes in the color and clarity of the urine, then he would expect the nurse to call the doctor and obtain orders. V3 said the nurse should ensure the orders are completed. V3 said a UA can be obtained quickly from an indwelling catheter and the facility has a specimen refrigerator for storage. V3 said lab usually picks up specimens daily, Monday-Saturday. V3 said he was approached by R1's daughter on 8/28/24 and she said something was wrong with R1. V3 said he did not remember if he looked at R1's catheter, but he obtained vital signs from R1. V3 said 911 was called and R1 left for the ER with 5-10 minutes. On 9/29/24 at 2:30 Pm, V16 (Certified Nursing Assistant/CNA) said she was R1's CNA on 8/28/24. V16 said R1 wasn't acting like herself, she refused to eat breakfast. V16 said she reported it to R1's nurse, but she was an agency nurse and couldn't remember her name. V16 said R1 was screaming like she was in pain and that's not normal. V16 said the only time R1 normally screamed was during care. V16 stated, I told the nurse that too. But I didn't see the nurse go in there. Then her daughter came and asked if I saw her mom crying. I told her that she had cried most of the day. She didn't have much urine in her catheter, but she didn't eat or drink anything. She was definitely different. She is normally able to make her needs known, but she was more confused that day. She looked very tired and wasn't very alert. She was the same way at lunch. That's why I told the nurse again. I tried and tried. Her daughter called 911. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 9/30/24 at 11:11 AM, V12 (LPN) said she no longer worked at the facility, but she was R1's nurse the day she was sent to the hospital (8/28/24). V12 said she talked to R1's Guardian because R1's daughter insisted we sent her to the hospital. V12 said she doesn't remember any of the specifics, just that the daughter thought she was more confused than usual. V12 said she doesn't remember the exact time, just that she had gone on break and when she returned the Guardian called. V12 said the DON and ADON were there too. V12 said she didn't recall the CNA reported R1's poor appetite, crying, and not acting herself. V12 said she remembers giving R1 a pill and she took it fine. V12 said if she knew R1 wasn't eating, had an altered mental status, and was crying then she would have called the doctor. V12 said she didn't recall what R1's urine looked like. On 9/30/24 at 11: 25 AM, V9 (Nurse Practitioner) said the signs and symptoms of a UTI can vary with age. V9 said some possible side effects included: altered mental status, frequency, fever, dysuria, back/flank pain. V9 said if a nurse calls me because the family is concerned about increased confusion and requests a UTI, then I will discuss it with the nurse and usually order an UA. V9 said she expects the facility to collect a UA from a catheter quickly and results are usually available within 48 hours. V9 said the culture will take 2-3 days, but the UA results can be difficult to get/view through the facility's EMR. V9 said R1 is usually up in her chair and can carry on a conversation with her. V9 said R1 doesn't complain much and can tell the staff how she is feeling. V9 said the facility had in-house Providers that would give orders if resident's UA showed UTI and sometimes, she doesn't hear about the UA results until she is in to round on patients. V9 said it's a system that they are trying to improve. V9 said the facility has an in-house Infectious Disease Provider and a consult can be ordered right away. V9 said R1's WBCs doubling could have been a sign of a possible infection, but the providers are careful to not order antibiotics before the culture results. V9 said if she knew the UA had not been collected, R1 was having increased confusion, and the WBCs had doubled, then she may have ordered prophylactic antibiotics. V9 said she was not aware the UA collection was delayed. The surveyor asked V9 what increased confusion, crying, poor appetite, and poor urine output could demonstrate. V9 replied, All her symptoms are signs of UTI, septicemia, and possibly renal failure. I'm sorry to hear this about [R1]. This should have been addressed sooner. On 9/30/24 at 2:05 PM, V2 (DON) said the nurse on the floor is responsible for obtaining a urine specimen. V2 said it shouldn't take long to obtain a urine specimen from an indwelling catheter. V2 said if the resident had other labs ordered, then the nurse should try to collect the urine specimen before lab comes to draw the labs, so they can take it with them. V2 said the nurses are responsible for checking the EMR to ensure an order was entered, the specimen was obtained, the specimen was received by lab, and the results are relayed to the physician. V2 said this is done to catch a possible UTI as soon as possible and start treatment. The surveyor asked V2 what cause sludge in a catheter. V2 said it could be from a buildup of sediment or infection. V2 said catheter care every shift and monitor urine output every shift are part of routine catheter care and she expects it to be done every shift, as ordered. The surveyor asked V2 to review R1's MAR and asked why there were no 3-11 or 11-7 entries. V2 said she did not know. V2 said on 8/28/24 V3 (ADON) exited R1's room and said R1's daughter wanted her sent to the ED and she called the Guardian. V2 said she did not enter R1's room, nor did she assess R1. The surveyor asked V2 why R1's nurse (V12) did not document on R1's status 8/28/24. V2 replied, I don't know. There should be something in the legal documentation to show that something was done. She (V12) was terminated. V2 said she did not see a UA collected between 8/2/24 and 8/8/24. V2 said R1 had a catheter, and the nurse should have been able to collect a urine specimen as soon as possible. V2 said catheter care is done to protect residents from infection and can be completed by the nurse or CNA. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The facility's Collecting Urine Specimen from Urinary Catheter Policy dated 2/2023 showed, Objective: To obtain a urine specimen from urinary catheter. Procedure: 1. Verify the order and assemble the supplies . 9. Urine specimens may also be collected by changing the Foley catheter and drainage bag. The facility's Catheter Care Policy dated 7/22 showed, Objective: 1. To cleanse the perineum. 2. To prevent infection and odors . 2. On 9/29/24 at 12:02 PM, R3 was sitting in his wheelchair, in his room, watching TV. R3 had catheter tubing extending from the bottom of his right pant leg. There was a large amount of brown/tan sediment noted in the catheter tubing. R3 said he's had the catheter for a while. R3 said he wasn't having any more problems with it, since they changed it last Friday. R3 said before that it was hurting him, and urine was leaking around the catheter. R3's Face sheet dated 9/29/24 showed diagnoses to include, but not limited to: COPD (chronic obstructive pulmonary disease); ataxia; anemia; bladder neck obstruction; retention of urine; obstructive and reflux uropathy; protein-calorie malnutrition; spinal stenosis; tremor; anxiety; congestive heart failure; and peripheral vascular disease. R3's facility assessment dated [DATE] showed he was cognitively intact; required substantial/maximal assist with personal hygiene; shower/bathe; and bed mobility; was dependent on staff for bed mobility and transfers; and had an indwelling catheter. R3's Physician Order Sheet showed he had orders to: Document urine output every shift and catheter care every shift and PRN (as needed). R3's September 2024 MAR showed 20 missing urine outputs and 31 entries that showed Small, medium, or large (not a volume of urine output). This document showed that R3's catheter care was not documented 8 times. R3's Urinalysis Report collected 9/3/24 showed R3's urine was cloudy, yellow, and contained nitrites, protein, MANY bacteria, RBCs, and >100 WBCs. R3's Care Plan initiated 9/9/24 showed R3 was on antibiotic therapy related positive urine culture for ESBL. R3's ID (Infectious Disease) Follow up Note dated 9/17/24 showed R3 was being seen for ESBL UTI and R3 had mild gross hematuria. On 10/4/24 at 12:23 PM, V2 (DON) said R3 was admitted to the facility with COPD, frequent UTIs, generalized weakness, and had an indwelling catheter.