

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Monmouth Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 117 South I Street Monmouth, IL 61462	

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 - 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** 30722</p> <p>Based on record review and interview the facility failed to notify a physician of abnormal radiology results and a change in condition for 1 resident (R1) of 3 residents reviewed for change of condition. This failure resulted in R1 experiencing emesis and diarrhea for two days followed by hospitalization .</p> <p>Findings include:</p> <p>An undated policy titled Significant Condition Change and Notification documents in part: To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: A significant change in the resident's physical, mental or psychosocial status. Emesis and diarrhea or other abnormal assessment findings are included. Within the procedure of this policy documents, when any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner. The medical practitioner will be contacted immediately for any emergencies regardless of the time of day. Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given to the medical practitioner. After two attempts, there is no response to the calls, the medical director will be contacted. A section titled Documentation reads, All significant changes will be recorded on the Communication Board and in (an electronic charting system) and in the resident record.</p> <p>R1's Physician Order Sheet (POS) dated 10/01/24 documents R1 has diagnoses of dysphagia following cerebral infarction, gastrostomy status, hemiplegia and hemiparesis affecting left non-dominant side, aphasia and aphonia. R1's 09/18/24 POS documents orders to clean G-tube (gastrostomy tube) site daily and to provide G-tube feedings four times daily as supplement feeding.</p> <p>V21/Agency LPN/Licensed Practical Nurse documented in R1's Progress note 09/17/24 at 2:32 PM R1 had two episodes of emesis and loose stool.</p> <p>V3/ADON/Assistant Director of Nursing documented in R1's Progress note dated 09/17/24 at 5:07 AM R1 had a large emesis and diarrhea. At 5:37 AM V3 documented R1 feels better but has some audible congestion.</p> <p>R1's radiology results dated 09/17/24 document, Percutaneous gastrostomy tube overlies the left upper abdominal quadrant. For intraluminal confirmation, follow-up imaging is recommended following the administration of either air or oral contrast.</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
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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>V7/Registered Nurse documented in R1's Progress note dated 09/18/24 at 3:06 PM (R1) continues to have emesis episodes. (R1) not tolerating any bolus feeding through G-tube. (R1) had imaging completed through (Contracted Radiology Company) that recommended follow up imaging. R1 was transported via ambulance to the local emergency department. There is no documentation that V4/R1's physician was notified.</p> <p>ED/Emergency Department Triage notes dated 09/18/24 at 3:26 PM and signed by V10, ED RN/Registered Nurse, document, (R1) presents to emergency department with complaints of 'concerning outpatient imaging regarding her G-tube'. V10 further documents, Per nurse report, (R1) has been vomiting after every tube feeding. (R1) was seen here on Saturday (09/14/24) and had G-tube replaced after nursing home could not get it back in. (Indwelling urinary catheter) in place on arrival. At 3:36 PM V10 documented, Per (V2/RN and DON/Director of Nurses) (R1) pulled her G-tube out on Monday (09/16/24) and they replaced it with the (indwelling urinary catheter) on Monday (09/16/24) and have been doing the tube feedings through that since then.</p> <p>R1's Emergency Department (ED) provider note written by V5/ED Physician, dated 09/18/24 at 3:32 PM documents, This is a [AGE] year-old female who presents to the ED for G-tube dislodgement apparently today (we are) not quite sure, nursing home did not report when the tube came out. (R1) was here (ED) on (09/14/24) with G-tube displacement (R1) had a (larger size G-Tube) and that was dislodged, and they replaced it with a (smaller size G-tube). (R1) arrives with (an indwelling urinary catheter) in place today. Patient has a G-tube secondary to stroke and difficulty swallowing. This provider note further documents, (Facility) also reports (R1) has vomiting every time she receives a feed.</p> <p>As of 10/01/24 R1's electronic medical record did not have documentation of the facility notifying V4/R1's physician that (R1) experienced emesis and diarrhea after bolus feedings on 09/17/24 and 09/18/24 or R1's abnormal X-Ray results on 9/17/24 recommending follow-up imaging.</p> <p>On 09/26/24 at 3:36 PM V3/Assistant Director of Nursing stated that R1's G-tube would not flush. V3 stated, (V8/Licensed Practical Nurse) couldn't get (R1's) tube feeding through. I told her to take it out and put an (indwelling urinary catheter) in. (R1) started vomiting early Tuesday (09/17/24) around 5:00 AM on my shift.</p> <p>V3/Assistant Director of Nursing stated that she did not contact V4/R1's physician to report R1's vomiting and diarrhea on 09/17/24.</p> <p>On 09/26/24 at 3:46 PM V8/Licensed Practical Nurse stated that R1's feeding tube clogged on 09/16/24. V8 stated twice that she called V4/R1's physician to obtain the order, then stated, I got direct orders from my Assistant Director of Nursing to insert (R1's) indwelling urinary catheter. V8 stated she removed R1's G-tube on 09/16/24 and replaced it with an indwelling urinary catheter. V8 stated she did not contact V4/R1's physician before inserting an indwelling urinary catheter and didn't know if (V3/Assistant Director of Nursing) called (V4/R1's physician) prior to giving the order. V8 stated that she did not contact V4 when R1 vomited after the 10:00 AM feeding on 09/18/24.</p> <p>On 09/27/24 at 9:24 AM, V2/RN/DON/Director of Nurses stated she learned V8/Licensed Practical Nurse had inserted an indwelling urinary catheter after removing R1's G-Tube on 09/16/24 per the direction of V3/Assistant Director of Nursing. V2 stated R1 had begun vomiting early in the morning of 09/17/24. V2 stated V3 had acknowledged V4/R1's physician should have been notified but wasn't.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/27/24 at 1:16 PM V2 confirmed V4/R1's physician should have been notified of R1's G-tube being clogged and R1's change of condition when she was vomiting and having loose stools between 5:07 AM on 09/17/24 and 3:00 PM on 09/18/24 but wasn't.</p> <p>On 09/26/24 at 4:09 PM V4, stated, No, I was never told staff inserted and fed through an (indwelling urinary catheter). I would never say to insert an (indwelling urinary catheter) to use as a feeding tube. I would have ordered the resident to go to the ED for evaluation and tube replacement if they chose to do so. V4 stated he has never talked with staff at the facility about R1's tube being clogged or removed.</p>		

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<p>F 0693</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 30722</p> <p>Based on record review and interview the facility failed to follow facility policy and obtain a physician order for care after a resident's Gastronomy tube (G-tube) became clogged. This failure resulted in R1's G-tube being replaced with an indwelling urinary catheter. This indwelling urinary catheter was used to administer enteral tube feedings for two days resulting in R1 experiencing emesis, loose stools, and being hospitalized. This failure affected 1 of 1 residents reviewed for Gastrostomy Tubes (R1) in a sample of 3.</p> <p>These failures resulted in an Immediate Jeopardy.</p> <p>The facility presented an abatement plan to remove the immediacy on 10/1/24. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned 10/2/24 to the facility for revisions. The facility presented a revised abatement plan on 10/4/24, and the survey team accepted the abatement plan on 10/4/2024.</p> <p>While the Immediate Jeopardy was removed on 10/4/24, the facility remains out of compliance at a severity level two. Additional time is needed to monitor the effectiveness of the implementation of their removal plan and Quality Assurance monitoring.</p> <p>Findings include:</p> <p>Policy titled Care and Treatment of Feeding Tubes revised 04/07/22 documents, It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: 2. Only tubes designed or intended for enteral feeding will be utilized, except under extenuating circumstances and for the shortest time possible. This policy continues, 12. The facility will notify and involve the medical provider or designated practitioner of any complications, and in evaluating and managing care to address the complication and risk factors.</p> <p>An undated policy titled Significant Condition Change and Notification documents in part: To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: A significant change in the resident's physical, mental or psychosocial status. Emesis and diarrhea or other abnormal assessment findings are included. Within the procedure of this policy documents, when any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner. The medical practitioner will be contacted immediately for any emergencies regardless of the time of day. Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given to the medical practitioner. After two attempts, there is no response to the calls, the medical director will be contacted. A section titled Documentation reads, All significant changes will be recorded on the Communication Board and in (an electronic charting system) and in the resident record.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Policy reviewed 01/2017 and titled Changing a Gastrostomy Feeding Tube documents, 1. Verify that there is a physician's order for this procedure. Under a section titled General Guidelines documents, 2. Feeding tube replacement must be performed by a licensed nurse who has received training and demonstrated competency in this procedure as allowed by state practice act.</p> <p>Policy Charting and Documentation reviewed 01/2017 documents, Policy 1. Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc. (etcetera), as well as routine observations. 2. Be concise, accurate, and complete and use objective terms. This policy documents, 3. Chart as often as necessary and as need arises. A section titled Procedures documents, 17. Tube Feedings: a. Documentation that proper tube placement is verified prior to each feeding. b. Intake data, c. Resident's tolerance to tube feeding. d. Any removal and/or reinsertion of the tube. e. Any complications as a result of the tube feeding.</p> <p>Physician Order Sheet (POS) dated 10/01/24 document R1 has diagnoses of dysphagia following cerebral infarction, gastrostomy status, hemiplegia and hemiparesis affecting left non-dominant side, aphasia and aphonia. R1's 09/18/24 POS documents orders to clean G-tube site daily and to provide G-tube feedings four times daily as supplement feeding.</p> <p>R1's Progress notes have no documentation between 09/14/24 when R1 returned from the local hospital after having a G-tube replaced and 09/17/24 at 5:07 AM when R1 had a large emesis and diarrhea.</p> <p>V3/ADON/Assistant Director of Nursing documented in R1's Progress note dated 09/17/24 at 5:07 AM R1 had a large emesis and diarrhea. At 5:37 AM V3 documented R1 feels better but has some audible congestion.</p> <p>V6/LPN/Licensed Practical Nurse/MDS/Minimum Date Set documented in R1's Progress note dated 09/17/24 at 11:26 AM X-Ray d/t (due to) possible aspiration and monitor for placement of G-Tube was ordered. (R1) had episodes of vomiting.</p> <p>V23/Advanced Practice RN-Registered Nurse documented a Rehabilitation evaluation status post functional decline on 09/17/24 at 1:38 PM stating that (R1) was seen and had emesis all over the front of her gown, and staff reported (R1) was seen in (ED-Emergency Department) on 9/14/24 due to G-tube being pulled out. V23 documented. Staff reports (R1) has had large, soft (bowel movements) in the last 24 hours. (R1) does have rhonchi and an order for chest and abdomen X-rays have been ordered. V23 further documents, Nursing staff notified that if these complications remain, (R1) needs to be seen in the emergency department to rule out aspiration pneumonia, displacement of the catheter tubing or an intestinal blockage. V23's documentation concluded with, Physiatry (sic) on consultation for additional recommendations. Medical management per attending physician and team.</p> <p>V21/Agency LPN/Licensed Practical Nurse documented in R1's Progress note dated 09/17/24 at 2:32 PM that R1 had two episodes of emesis and loose stool. X-Ray was ordered due to R1 abdomen being distended, crackles in lungs, abdomen firm to the touch.</p> <p>V9/LPN documented in R1's Progress note dated 09/17/24 at 3:45 PM that Contracted Radiology Company arrived and obtained a one view X-Ray of R1's abdomen and two view X-Ray of R1's chest due to vomiting and possible aspiration and to check placement of R1's G-tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's Patient Report form with a fax time stamp of 9/17/24 at 8:44 PM documents that Contracted Radiology Company performed a one view X-Ray of R1's abdomen for cough, severe emesis, diarrhea, possible aspiration, pneumonia, verify G-tube placement.</p> <p>R1's radiology results dated 09/17/24 document, Percutaneous gastrostomy tube overlies the left upper abdominal quadrant. For intraluminal confirmation, follow-up imaging is recommended following the administration of either air or oral contrast.</p> <p>R1's X-Ray was electronically signed by V22/Physician Contracted Radiology Company on 09/17/24 at 8:27 PM.</p> <p>R1's Medication Administration Record documents V8/Licensed Practical Nurse administered 240 cc's/cubic centimeters of feeding per tube on 09/18/24 at 10:00 AM.</p> <p>V7/Registered Nurse documented in R1's Progress note dated 09/18/24 at 3:06 PM (R1) continues to have emesis episodes. (R1) not tolerating any bolus feeding through G-tube. (R1) had imaging completed through (Contracted Radiology Company) that recommended follow up imaging. R1 was transported via ambulance to the local emergency department.</p> <p>ED/Emergency Department Triage notes dated 09/18/24 at 3:26 PM and signed by V10, ED RN/Registered Nurse, document, (R1) presents to emergency department with complaints of 'concerning outpatient imaging regarding her G-tube'. V10 further documents, Per nurse report, (R1) has been vomiting after every tube feeding. (R1) was seen here on Saturday (09/14/24) and had G-tube replaced after nursing home could not get it back in. (Indwelling urinary catheter) in place on arrival. At 3:36 PM V10 documented, Per (V2/RN and DON/Director of Nurses) (R1) pulled her G-tube out on Monday (09/16/24) and they replaced it with the (indwelling urinary catheter) on Monday (09/16/24) and have been doing the tube feedings through that since then.</p> <p>(ED) provider note written by V5/ED Physician, dated 09/18/24 at 3:32 PM document, This is a [AGE] year-old female who presents to the ED for G-tube dislodgement apparently today (we are) not quite sure, nursing home did not report when the tube came out. (R1) was here (ED) on (09/14/24) with G-tube displacement (R1) had a (larger size G-Tube) and that was dislodged, and they replaced it with a (smaller size G-tube). (R1) arrives with (an indwelling urinary catheter) in place today. Patient has a G-tube secondary to stroke and difficulty swallowing. This provider note further documents, (Facility) also reports (R1) has vomiting every time she receives a feed. At 3:35 PM, V5 documented, (R1's long term care facility) states they have been giving feeds through the (indwelling urinary catheter) since Monday (09/16/24). V5's Provider Note (continued) documents, Medical Decision Making: Differential includes displacement of G-tube (indwelling urinary catheter), dehydration, electrolyte disturbance, SBO (small bowel obstruction) among other diagnoses.</p> <p>09/18/24 at 6:17 PM, V5 documented, Radiology just called and states that they see (R1's) feeding tube is actually in the transverse colon and not the stomach.</p> <p>10/02/24 at 2:07 PM, V3, ADON/Assistant Director of Nursing stated that the facility is notified of radiology results via fax. V3 stated, They come to our fax, they are usually pretty quick.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/26/24 at 3:36 PM V3 stated that R1's G-tube which was placed on 09/14/24 would not flush on Sunday (09/15/24) or Monday (09/16/24) per V8/Licensed Practical Nurse. V3 stated, (V8) couldn't get (R1's) tube feeding through. I told her (V8) to take it out and put an (indwelling urinary catheter) in. (R1) started vomiting early Tuesday (09/17/24) around 5:00 AM on my shift. V3 stated she did not contact V4/R1's physician to obtain an order to insert an indwelling urinary catheter. V3 stated she did not advise V8 to check placement or order an X-Ray to check R1's tube placement. V3 stated she did not advise V8 to send R1 to the ED to replace R1's G-tube or to check placement before administering tube feeding through the newly inserted tube. V3 stated I didn't suggest it, maybe I should have. I was charge nurse on duty that day. V3 stated she was unsure what the policy regarding trouble shooting G-tubes stated.</p> <p>Employee corrective action form dated 09/27/24 documents V3 was given a three-day suspension for Manager's failure to follow/enforce departmental policies and procedures. Practiced outside of scope - failed to provide nurse manager oversight.</p> <p>On 09/26/24 at 3:46 PM V8 stated that R1's feeding tube clogged on 09/16/24. V8 stated twice that she called V4/R1's physician to obtain the order, then stated, I got direct orders from my (V3) Assistant Director of Nursing to insert R1's indwelling urinary catheter. V8 stated that she removed R1's G-tube on 09/16/24 and replaced it with an indwelling urinary catheter. V8 confirmed she has not received training or competency on replacing G-tubes and was not sure what the facility policy states regarding troubleshooting G-tubes.</p> <p>On 09/27/24 at 11:30 AM V2/RN/ DON/Director of Nurses stated the facility has not offered G-tube training to nurses.</p> <p>Employee corrective action form dated 09/27/24 documents V8 was suspended for three days due to failure to follow department policies and procedures. The corrective action further documents V8 failed to notify a physician or document on difficulty with and changing a G-tube on 09/16/24.</p> <p>V8 was unable to provide paper or electronic documentation of changing R1's G-tube to an indwelling urinary catheter. V8 stated to ensure R1's newly placed indwelling urinary catheter was correctly positioned, I would check for residual, or push it in until it stops (feels resistance), or get an X-Ray, that would be the best option. V8 stated she did not obtain an X-Ray to check for correct placement of R1's feeding tube prior to administering R1's bolus feeding and stated, I was not directed to by my (V3) Assistant Director of Nursing. R1's Medication Administration Record documents V8 administered R1's bolus feedings at 10:00 AM on 09/16/24 and 09/18/24 at 10:00 AM.</p> <p>On 09/27/24 at 9:24 AM, V2/RN/ DON/Director of Nurses stated she learned on 09/17/24 that V8 had inserted an indwelling urinary catheter after removing R1's G-Tube per the direction of V3/Assistant Director of Nursing. V2 stated that R1 had begun vomiting early in the morning of 09/17/24. V2 stated that V3 had acknowledged R1's physician should have been notified.</p> <p>V2 stated the indwelling urinary catheter should have been checked for placement by X-ray and that R1 was not sent to the ED until two days after R1's indwelling urinary catheter was inserted. V2 confirmed R1's indwelling urinary catheter should not have been used bolus feedings and placement should have been verified.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/27/24 at 1:16 PM V2 stated she there is no electronic or paper charting from 09/16/24 when V8 stated she removed R1's G-tube and placed an indwelling urinary catheter. V2 confirmed V4/R1's physician should have been notified and she would have sent R1 to the ED but wasn't.</p> <p>On 09/26/24 at 4:09 PM V4 stated, No, I was never told staff inserted and fed through an (indwelling urinary catheter). I would never say to insert an (indwelling urinary catheter) to use as a feeding tube. I would have ordered the resident to go to the ED for evaluation and tube replacement if they chose to do so. V4 stated he has never talked with staff at the facility about R1's tube being clogged or removed.</p> <p>On 10/01/24 at 8:04 AM V10, Emergency Department Registered Nurse stated that it is not safe nursing practice to administer tube feeding through an indwelling urinary catheter. V10 stated it was apparent R1's indwelling had been used to administer feeding because it had feeding residue left in it. V10 stated she called the facility, who advised the G-tube had been changed to the indwelling urinary catheter which they had been using to bolus feed R1 since Monday (09/16/24). V10 stated R1 was vomiting because the tube was in her transverse colon.</p> <p>On 09/26/24 at 2:30 PM V5/ED Physician stated R1 had been to the ED on 09/14/24 and left after having a G-tube replaced. When R1 arrived at the ED on 09/18/24, she had an indwelling urinary catheter in place of her G-tube. V5 stated while it may be common to insert an indwelling urinary catheter in the G-tube site, it should only be done temporarily to keep the site open, and the resident should be immediately sent to the ED. V5 stated he wouldn't recommend feeding through an indwelling urinary catheter. V5 stated, My concern is (the facility) didn't check placement with an X-Ray and fed through it for two days. V5 stated hospital X-Ray confirmed R1's indwelling urinary catheter was located in her transverse colon which caused her to have emesis and diarrhea for two days.</p> <p>An Immediate Jeopardy situation was identified to have occurred on 09/16/24 at approximately 10:00am when V8/LPN removed R1's G-tube and replaced it with an indwelling urinary catheter without obtaining a physician order or verifying placement. V8 and other licensed nurses proceeded to administer bolus tube feedings via R1's indwelling urinary catheter intermittently through 09/18/24 causing R1 to have vomiting, diarrhea and hospitalization .</p> <p>On 10/01/24 at 10:14 AM, V1/Administrator was notified of the Immediate Jeopardy.</p> <p>On 10/04/24, the surveyor confirmed through observation, interview and record review the facility took the following actions to remove the Immediate Jeopardy.</p> <p>1. On 10/1/24, V15/Regional Director of Operations educated V1 and V2/RN and DON/Director of Nurses on their responsibilities to provide nursing staff with education and resources to provide appropriate oversight. Educational Tools included in the teaching also consisted of Audit tools, Weekly Committee Meeting policy, Rounding forms, Nurse's Skills Checklist Schedule, Monthly Education Calendar 2024, and CNA's (Certified Nurses Aide) Competency schedule.</p> <p>On 10/2/24, V15 ensured V2/RN/ DON/Director of Nurses was competent to perform the education and in-servicing with the staff.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Monmouth Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 117 South I Street Monmouth, IL 61462	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0693</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. On 10/2/24 and 10/3/24, facility nurses were in-serviced, and competencies were completed on Enteral Feeding via Gravity Bag, via Continuous pump via Syringe, Enteral Feedings-Safety Precautions, Confirming Placement of Feeding Tubes, Changing a Gastrostomy Feeding Tube, Significant Condition Change & Notification and Charting and Documentation. Two nurses (one prn staff and one on medical leave) are scheduled to receive training/competency.</p> <p>3 & 4. The Employee Orientation Nursing Policies/Agency Orientation included a review of the following policies: Enteral Feeding via Gravity Bag, via Continuous pump via Syringe, Enteral Feedings-Safety Precautions, Confirming Placement of Feeding Tubes, Changing a Gastrostomy Feeding Tube, Significant Condition Change & Notification and Charting and Documentation. Two nurses (1 prn/as needed staff and 1 on medical leave) are scheduled to receive training/competency. The Administrator or Director of Clinical Operations ensures when an Agency staff member books an open position, the DON or Nurse Manager receives the required documentation.</p> <p>5. V8's (Licensed Practical Nurse) Employee Corrective Action Plan Form dated 9/27/24 documented a 3-day suspension for failure to follow department policies and procedures: no MD notification, no documentation of G-tube difficulty or the G-tube was changed on 9/16/24.</p> <p>V3's (Assistant Director of Nursing/Registered Nurse) Employee Corrective Action Form dated 9/27/24 documented a 3-day suspension for failure to follow/enforce department policies and procedures, practiced outside of scope, failed to provide nurse manager oversight. The Time Detail Reports documented V3 nor V8 worked 9/28/24, 9/29/24 or 9/30/24.</p> <p>6. On 10/3/24, the Change of Condition Audit was revised and accurately completed.</p> <p>7. Dietary Order Audit completed by V2/RN and DON/Director of Nurses on dated 9/28/24 and on 10/3/24.</p> <p>8. The Order Recap Report dated 9/26/24 through 10/3/24 was reviewed for new orders and proper notifications.</p> <p>9. On 10/2/24 and 10/3/24, the In-service Education Record documented education to all nurses regarding the Change in Condition Bulletin Board Documentation (Electronic Health Record).</p> <p>10. The New Order Audit tool was reviewed and appropriate for use.</p> <p>11. The In-service Education Report- Admission Policy dated 10/1/24 was attended by V2 (Director of Nursing) and V6 (MDS Coordinator/Care Planning/LPN). Quality Assurance audit tool was reviewed and appropriate for use. Admission policy revised on 10/1/24.</p> <p>12. Medical Doctor notified, and policies reviewed on 10/3/24.</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>30722</p> <p>Based on record review and interview the facility failed to ensure licensed nurses were trained and competent in skills necessary to care for residents with a G-tube (gastrostomy tube) affecting 1 resident reviewed for Gastrostomy Tubes (R1) in a sample of 3. This failure led to R1 having emesis and diarrhea for two days and being hospitalized .</p> <p>Findings include:</p> <p>Policy titled Care and Treatment of Feeding Tubes revised 04/07/22 documents, It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: 2. Only tubes designed or intended for enteral feeding will be utilized, except under extenuating circumstances and for the shortest time possible. This policy continues, 12. The facility will notify and involve the medical provider or designated practitioner of any complications, and in evaluating and managing care to address the complication and risk factors.</p> <p>Policy reviewed 01/2017 and titled Changing a Gastrostomy Feeding Tube documents, 1. Verify that there is a physician's order for this procedure. Under a section titled General Guidelines documents, 2. Feeding tube replacement must be performed by a licensed nurse who has received training and demonstrated competency in this procedure as allowed by state practice act.</p> <p>R1's Physician Order Sheet (POS) dated 10/01/24 document R1 has diagnoses of dysphagia following cerebral infarction, gastrostomy status, hemiplegia and hemiparesis affecting left non-dominant side, aphasia and aphonia. R1's 09/18/24 POS documents orders to clean G-tube site daily and to provide G-tube feedings four times daily as supplement feeding.</p> <p>R1's Emergency Department (ED) medical records document R1 was seen in the ED on 09/18/24 for a G-tube dislodgement. R1 arrived in the ED with an indwelling urinary catheter in place which the facility had placed on 09/16/24 and were administering bolus tube feedings through.</p> <p>On 09/18/24 at 6:17 PM, V5/ED Physician documented he was notified by radiology R1's indwelling urinary catheter was located in her transverse colon, not in her stomach.</p> <p>R1's Progress note document R1 experienced emesis and diarrhea between 09/17/24 at 5:07 AM and 09/18/24 at 3:06 PM when she was transferred to the ED.</p> <p>V9/LPN/Licensed Practical Nurse documented in R1's Progress note dated 09/17/24 at 3:45 PM contracted radiology company arrived and obtained a one view X-Ray of R1's abdomen and two view X-Ray of R1's chest due to vomiting and possible aspiration and to check placement of R1's G-tube.</p> <p>R1's radiology results dated 09/17/24 document, Percutaneous gastrostomy tube overlies the left upper abdominal quadrant. For intraluminal confirmation, follow-up imaging is recommended following the administration of either air or oral contrast.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's X-Ray was electronically signed by V22/Physician Contracted Radiology Company on 09/17/24 at 8:27 PM.</p> <p>R1's Medication Administration Record documents V8/LPN administered 240 cc's/cubic centimeters of feeding per tube on 09/18/24 at 10:00 AM.</p> <p>V7/Registered Nurse documented in R1's Progress note dated 09/18/24 at 3:06 PM (R1) continues to have emesis episodes. (R1) not tolerating any bolus feeding through G-tube. (R1) had imaging completed through (Contracted Radiology Company) that recommended follow up imaging. R1 was transported via ambulance to the local emergency department.</p> <p>On 09/26/24 at 2:30 PM V5/ED Physician stated R1 had been to the ED on 09/14/24 and left after having a G-tube replaced. When R1 arrived at the ED on 09/18/24, she had an indwelling urinary catheter in place of her G-tube. V5 stated while it may be common to insert an indwelling urinary catheter in the G-tube site, it should only be done temporarily to keep the site open, and the resident should be immediately sent to the ED. V5 stated he wouldn't recommend feeding through an indwelling urinary catheter. V5 stated, My concern is (the facility) didn't check placement with an X-Ray and fed through it for two days. V5 stated hospital X-Ray confirmed R1's indwelling urinary catheter was located in her transverse colon which caused her to have emesis and diarrhea for two days.</p> <p>On 09/26/24 at 3:36 PM V3/Assistant Director of Nursing stated V8/Licensed Practical Nurse reported R1's G-tube was not patent. V3 stated she directed V8 to remove the G-Tube and insert an indwelling urinary catheter. V3 stated R1 began vomiting around 5:00 AM on 09/17/24 after her morning tube feeding.</p> <p>On 09/26/24 at 3:36 PM V3 stated that R1's G-tube which was placed on 09/14/24 would not flush on Sunday (09/15/24) or Monday (09/16/24) per V8/Licensed Practical Nurse. V3 stated, (V8) couldn't get (R1's) tube feeding through. I told her (V8) to take it out and put an (indwelling urinary catheter) in. (R1) started vomiting early Tuesday (09/17/24) around 5:00 AM on my shift. V3 stated she did not contact V4/R1's physician to obtain an order to insert an indwelling urinary catheter. V3 stated she did not advise V8 to check placement or order an X-Ray to check R1's tube placement. V3 stated she did not advise V8 to send R1 to the ED to replace R1's G-tube or to check placement before administering tube feeding through the newly inserted tube. V3 stated I didn't suggest it, maybe I should have. I was charge nurse on duty that day. V3 stated she was unsure what the policy regarding trouble shooting G-tubes stated.</p> <p>On 09/26/24 at 3:46 PM V8 stated that R1's feeding tube clogged on 09/16/24. V8 stated twice that she called V4/R1's physician to obtain the order, then stated, I got direct orders from my (V3) Assistant Director of Nursing to insert R1's indwelling urinary catheter. V8 stated that she removed R1's G-tube on 09/16/24 and replaced it with an indwelling urinary catheter. V8 confirmed she has not received training or competency on replacing G-tubes and was not sure what the facility policy states regarding troubleshooting G-tubes.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>V8 further stated to ensure R1's newly placed indwelling urinary catheter was correctly positioned, I would check for residual, or push it in until it stops (feels resistance), or get an X-Ray, that would be the best option. V8 stated she did not obtain an X-Ray to check for correct placement of R1's feeding tube prior to administering R1's bolus feeding and stated I was not directed to by my (V3) Assistant Director of Nursing. R1's Medication Administration Record documents V8 administered R1's bolus feedings at 10:00 AM on 09/16/24 and 09/18/24 at 10:00 AM, after the 09/17/24 X-Ray recommended follow up imaging with air or contrast.</p> <p>On 09/27/24 at 9:24 AM, V2/Director of Nursing stated she learned on 9/17/24 that V8 had inserted an indwelling urinary catheter after removing R1's G-Tube on 09/16/24. V2 stated the indwelling urinary catheter should have been checked for placement by X-ray and that R1 was not sent to the ED until two days after R1's indwelling urinary catheter was inserted. V2 confirmed R1's indwelling urinary catheter should not have been used bolus feedings and placement should have been verified but wasn't.</p> <p>On 09/27/24 at 11:30 AM, V1/Administrator stated the facility has not offered specialized G-tube training to nursing staff.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>32189</p> <p>Based on interview and record review the facility failed to ensure four of four Certified Nurse Aides/CNA reviewed (V17, V18, V19, V20) in a total sample of four completed the required 12 hours of education per year. This failure has the potential to affect all 41 residents residing in the facility.</p> <p>Findings include:</p> <p>The Facility Assessment 2024-2025 documented the facility cares for residents with associated dementia symptoms, such as Parkinson's disease, Alzheimer's disease and residents with Psychiatric/Mood Disorders, The Facility Assessment documented Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training. Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff. For nurse aids providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>The facility's Certified Nursing Assistant job description, not dated, documented Staff Development: Attend and participate in scheduled training and educational classes to maintain current certification as a Nursing Assistant (example 15 hours of in-service required in a 12 month period).</p> <p>V17 (CNA) was hired on 2/8/23. V17's Employee In-Service/Education Record documented 6.91 hours of training were completed annually from 2/23-2/24 and no dementia management training or care of the cognitively impaired resident training was documented.</p> <p>V18 (CNA) was hired on 7/15/21. V18's Employee In-Service/Education Record documented 3.58 hours of training were completed annually 7/23-7/24 and no dementia management training or care of the cognitively impaired resident training was documented.</p> <p>V19 (CNA) was hired on 11/24/04. V19's Employee In-Service/Education Record documented 3.83 hours of training were completed annually 11/23-10/24 and no dementia management training or care of the cognitively impaired resident training was documented.</p> <p>V20 (CNA) was hired on 1/12/12. V20's Employee In-Service/Education Record documented 8.25 hours of training were completed annually 1/23-1/24 and no dementia management training or care of the cognitively impaired resident training was documented.</p> <p>On 10/4/24, at 11:40 AM, V16 (Clinical Director) stated the facility's expectation is for the CNAs to complete their 12 hours of education annually from the date of hire. V16 confirmed the required 12 hours of education training had not been completed.</p> <p>The facility's Resident Listing Report, dated 10/4/24, documents 41 residents are currently residing in the facility.</p>		