

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER LA Bella at Clifton		STREET ADDRESS, CITY, STATE, ZIP CODE 1190 E 2900 North Road Clifton, IL 60927	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>32853</p> <p>Based on interview and record review the facility failed to obtain informed consent prior to administering an antipsychotic medication to one of three residents (R5) reviewed for chemical restraints in the sample list of 12.</p> <p>Findings include:</p> <p>The facility's Behavioral Health Services Program policy with an effective date of February 2024 documents, The behavioral interventions outlined below are intended to be used only as suggested guidelines for behavior management. Each resident and situation should be considered on an individual basis depending on the nature of the behavior and risk of harm to self or others. Notify the family/resident representative of the change in condition and interventions implemented. Obtain consent for any new psychotropic medications prior to administration.</p> <p>R5's Order Summary dated 8/20/24 documents diagnoses including Anxiety Disorder Unspecified, Altered Mental Status Unspecified and Unspecified Dementia Unspecified Severity with Psychotic Disturbance. This Order Summary documents an order for Quetiapine Fumarate (antipsychotic) oral tablet 25 mg (milligrams) give half a tablet two times a day for Psychosis with a start date of 6/17/24.</p> <p>R5's Medication Administration Record (MAR) dated 6/1/24 through 6/30/24 documents the order for the Quetiapine Fumarate 25 mg oral tablet, give half a tablet by mouth twice a day with a start date of 6/17/24. This MAR documents the first dose was given on 6/19/24.</p> <p>R5's Consent for Psychotropic Medications for Seroquel (Quetiapine Fumarate) 12.5 mg twice a day for a diagnosis of Dementia with Psychosis documents telephone consent was given on 7/9/24 by R5's Power of Attorney (POA) which was after 39 doses of the Seroquel had been administered over 20 days.</p> <p>On 8/20/24 at 2:48 PM, V2 (Director of Nursing) provided a Psychotropic Medication Observation form for R5 dated 6/22/24. V2 stated that this document indicates consent was obtained from the POA on 6/22/24. This form documents a question of who consent was obtained from and has a mark by POA. There is no name documented as to whom gave consent and no Nurse's Note documented regarding who gave consent. This form is dated six days after the Physician's Order for Quetiapine Fumarate 12.5 mg twice a day was obtained and four days after the medication had been administered.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853</p> <p>Based on observation, interview, and record review the facility failed to provide showers to two of three dependent residents (R2, R3) reviewed for showers in the sample list of 12.</p> <p>Findings include:</p> <p>The facility's Bathing - Shower and Tub Bath policy with an effective date of March 2024 documents, Purpose: To ensure resident's cleanliness to maintain proper hygiene and dignity. Guidelines: a shower, tub bath or bed/sponge bath will be offered according to resident's preference, no less than once per week or according to the resident's preferred frequency and as needed or requested.</p> <p>1.) R2's Order Summary Report dated 8/20/24 documents diagnoses including Unsteadiness on Feet, Unspecified Abnormalities of Gait and Mobility and Weakness.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 is cognitively intact and documents R2 requires partial to moderate assistance to shower/bathe.</p> <p>On 8/19/24 at 10:31 AM, R2 stated that she does not always get her showers.</p> <p>R2's ADL (Activities of Daily Living) bathing task dated 7/19/24 through 8/19/24 documents R2 has been given one shower on 8/9/24 and R2 is documented as being totally dependent on staff for that shower.</p> <p>On 8/19/24 at 2:04 PM, V3 (Assistant Director of Nursing) stated she cannot locate any other shower documentation for R2.</p> <p>On 8/20/24 at 1:38 PM, V2 (Director of Nursing) stated their policy states they will give one shower a week and if the resident's preference is more often, they will accommodate when possible.</p> <p>50322</p> <p>2.) R3's wound physician visit notes dated 7/26/24 document R3 having diagnosis including incontinence, deconditioned muscles related to immobility from dislocated right hip and trochanteric bursitis of left hip.</p> <p>R3's care plan with an initiation date of 4/11/24 documents R3 requires assistance with all activities of daily living (ADL's) including all hygiene and bathing tasks.</p> <p>R3's shower sheets provided with shower completion dates of 7/30/24, 8/6/24, and 8/18/24.</p> <p>On 8/20/24 at 1:00 PM R3 states she would like to have more showers. R3 states she has a painful wound on her bottom and feels that more showers would help the wound heal. R3 states she doesn't know what her scheduled shower days are. R3 states she gets a shower once every couple of weeks.</p> <p>(continued on next page)</p>		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 2:00 PM on 8/20/24, V3 (Assistant Director of Nursing) confirms that there are no other documented shower dates for R3 within the last 30 days.		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>32853</p> <p>Based on observation, interview, and record review the facility failed to timely administer a resident's oral and intravenous antibiotic medication for an infected j-tube (jejunostomy tube) as prescribed to avoid a significant medication error. R2 received the first dose of IV antibiotics 10 days after it was ordered for the multi drug resistant organism in the J-tube site. This failure affects one of three residents (R2) reviewed for medications in the sample list of 12.</p> <p>Findings include:</p> <p>The facility's Medication Administration Policy with an effective date of March 2024 documents, Medications must be administered in accordance with a physician's order, e.g. (for example), the right resident, right medication, right dosage, right route and right time.</p> <p>The facility's Physician Orders -Entering and Processing policy with an effective date of November 2023 documents, Fax or call the orders to the appropriate pharmacy as needed.</p> <p>R2's Order Summary Report dated 8/20/24 documents diagnosis of Extended Spectrum Beta Lactamase (ESBL) Resistance, Gastrostomy Infection and Resistance to Vancomycin Related Antibiotics.</p> <p>R2's Medication Administration Record (MAR) dated 8/1/24 through 8/31/24 documents orders to assess PICC (peripherally inserted central catheter)/midline for complications every shift with a start date of 8/16/24. This MAR documents an order for Colistimethate Sodium (Colistin) (antibiotic) Injection Solution Reconstituted 150 mg (milligrams). Use one dose IV (intravenous) every 12 hours for VRE (Vancomycin Resistant Enterococci) for 21 days with a start date of 8/17/24.</p> <p>R2's MAR dated 8/1/24 through 8/31/24 documents an order to observe Contact Isolation Precautions for MDRO (multi drug resistant organism)/VRE to J-Tube site with a start date of 7/25/24, an order for Polymyxin B Sulfate (antibiotic) Injection Solution Reconstituted use one dose intravenously every 12 hours related to Extended Spectrum Beta Lactamase (ESBL) Resistance administer 2.5 mg/kg (kilograms) with a start date of 8/9/24, an order for Zyvox (antibiotic) oral tablet 600 mg (Linezolid) one tablet by mouth every 12 hours for J-tube infection for 21 days with a start date of 8/12/24.</p> <p>R2's MAR dated 8/1/24 through 8/31/24 documents an order for a wound panel/wound culture for gastrostomy infection with a start date of 7/25/24, and order to insert PICC line for IV antibiotics one time related to ESBL resistance to Vancomycin related antibiotics with a start date of 8/8/24, an order for a wound culture dated 7/22/24 and an order for a wound culture dated 8/5/24.</p> <p>R2's Nurse's Notes dated 7/25/24 at 10:06 AM documents a culture and sensitivity was obtained from R2's J-tube site with results reported to V11 (R2's Physician) and awaiting a response. Nurse's Notes dated 7/25/24 at 12:06 PM documents V11 responded and said that the organism is susceptible to Piperacillin (antibiotic) but R2 is allergic to this antibiotic so V11 referred R2 to V10 or V12 (Infectious Disease Physicians) and ordered to continue to treat the site with Gentamicin 0.1% (percent) ointment and zinc.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R2's Nurse's Notes dated 7/26/24 at 1:32 PM documents that R2 has a telehealth appointment with Infectious Disease on 7/30/24 at 4:00 PM. There are no further Nurse's Notes documented regarding the J-tube site antibiotics/infection until 8/5/24 at 4:47 PM that another wound culture was obtained from the J-tube site.</p> <p>R2's Laboratory Report dated 8/8/24 at 9:48 AM documents the wound culture results of Pseudomonas Aeruginosa and Enterococcus Faecalis.</p> <p>R2's Nurse's Notes dated 8/8/24 at 2:34 PM documents that the telehealth visit with V10 (Infectious Disease Physician) was completed and orders were received for oral and IV antibiotic for R2. At 5:40 PM, R2's Nurse's Notes document that clarification was needed for the antibiotic order. The IV order was initiated, and the pharmacy called and were unable to provide the medication. They attempted to page V10 (Infectious Disease Physician) and V10 was not on call. They document that they will contact him in the morning.</p> <p>R2's Nurse's Notes dated 8/9/24 at 12:37 PM document that they attempted to contact V10 again and he was not in the office so they documented they would attempt to get updated orders on Monday, 8/12/24. On 8/12/24 at 8:50 AM, V13 (Advanced Practice Nurse) placed an order in the electronic system for R2 for Zyxon (antibiotic) 600 mg every 12 hours for 21 days. R2 finally received an oral antibiotic for the J-tube infection on 8/13/24 but still had not received the IV antibiotics.</p> <p>R2's Nurse's Notes dated 8/17/24 at 1:02 AM documents the laboratory was there to place the PICC line in the right upper arm and requested an x-ray to confirm placement prior to use. R2 received the first dose of IV antibiotics on 8/18/24 at 7:53 AM, 10 days after it was ordered for the multi drug resistant organism in the J-tube site.</p> <p>On 8/19/24 at 10:31 AM, R2 stated that she is on two antibiotics for the infection in her J-tube. R2 has a PICC line placed in the right upper arm and has contact isolation signs posted on her door. There is an IV pole in her room with an empty bag of Colistimethate Sodium 150 mg hanging on it.</p> <p>On 8/19/24 at 12:38 PM, V3 (Assistant Director of Nursing) confirmed R2's antibiotic did not get started right away due to a lot of back and forth with the doctor and the pharmacy.</p> <p>On 8/20/24 at 8:50 AM, V2 (Director of Nursing) stated at one point they had to get prior authorization for the medication from the pharmacy which caused delay. V2 confirmed the antibiotics were not started for several days after they have been ordered by V10 (Infectious Disease Physician).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853</p> <p>Based upon observation, interview, and record review the facility failed to prevent the transmission of clostridium difficile (C-Diff) infections, failed to ensure shower rooms were disinfected to prevent the spread of infection, failed to obtain lab results, and failed to follow hand hygiene guidelines. This affected 8 (R1, R2, R7, R8, R9, R10, R11, R12) of 12 residents reviewed for infection with the potential to affect all 68 residents residing at facility.</p> <p>Findings include:</p> <p>Document identified as outbreak letter that is undated was provided by V2 (Director of Nursing) which documents facility is a 99-bed facility with a current census of 86 patients. 3 patient clostridium difficile (c-diff) positives identified on 7/30/2024. 20 symptomatic patients overall. All have been tested . 3 additional positives identified on 8/2/2024 for a total of 6 confirmed cases. Review of labs documented indicate that no two-step c-diff testing had been performed. Observation documents facility has 2 sets of jack and [NAME] style shower rooms with doors on both hall ways. Halls A and B share a shower room. Halls C and D share a shower room. Shower rooms need to be terminally, deep cleaned, and maintained moving forward. No shared products. Keep products in cabinet and use dispenser cups or med cups to take only the amount needed into the shower area with the patient. Ensure shower rooms are being cleaned thoroughly and in between each use. Ensure chemicals are available and in a locked cabinet. Document details recommendations for facility as in service all housekeeping staff on how to use bleach cleaning product properly and safely. Implement bleach cleaning until outbreak is resolved. Outbreak can be considered resolved 4-weeks after last positive. Moving forward, implement Bleach Mondays to continue to keep the bioburden down. Remember that re-infection can occur. The average time to resolution of diarrhea with treatment is about 3 days, but diarrhea may not resolve for 6 to 7 days. 45 Recurrences of diarrhea occur in 15 to 25 percent of patients treated for c. diff. Implement Environmental Marking program immediately to check competencies and to audit staff cleaning moving forward. Isolation: perform in service on staff on the proper use of PPE. Ensure you also reach ancillary staff, such as physical therapy for compliance. Ensure there are visual reminders to use soap and water and not hand sanitizer for C. Diff rooms.</p> <p>The facility's Infection Precaution Guidelines with an effective date of February 2024 documents, Transmission-Based precautions. Use the CDC Guidelines for Isolation precautions. Handwashing is the single most important precaution to prevent the transmission of infection, gather all equipment and supplies needed before going into room, . when use of common equipment is unavoidable, then adequately clean and disinfect them before use for another resident.</p> <p>The facility's Hand Hygiene/Handwashing policy with an effective date of March 2024 documents, Hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, or antiseptic hand rub. Examples of When to Perform Hand Hygiene (Either Alcohol Based Hand Sanitizer or Handwashing): before glove placement, after glove removal.</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 - Many</p>	<p>1.) R1's Order Summary Report dated 8/20/24 documents diagnoses including Colostomy Status, Methicillin Resistant Staphylococcus Aureus Infection as the Cause of Diseases Classified Elsewhere, Urinary Tract Infection, Pressure Ulcer of Sacral Region Stage 4 and Extended Spectrum Beta Lactamase (ESBL) Resistance. This Order Summary documents an order for Enhanced Barrier Precautions for (Indwelling Urinary Catheter), Colostomy and history of ESBL.</p> <p>On 8/19/24 at 10:28 AM, R1 had a Contact Isolation sign posted on the door to her room. On 8/19/24 at 10:48 AM, R1 stated that she has finished the IV (intravenous) medications that she had been receiving.</p> <p>On 8/19/24 at 1:28 PM, V4 (Registered Nurse/RN) and V5 (Certified Nursing Assistant/CNA) donned a gown and gloves and entered R1's room. V5 opened R1's incontinent brief and V4 and V5 assisted R1 to roll onto her right side. There was a wound vacuum attached to the wound on her coccyx. They assisted R1 to roll back and closed her brief, repositioned her and covered her back up with her blanket. V5 quickly removed the gown and gloves and exited the room without performing any hand hygiene. There was still a Contact Isolation sign posted on R1's door.</p> <p>On 8/20/24 at 8:50 AM, V2 (Director of Nursing) stated PPE (personal protective equipment) should be removed in the room and hand hygiene should be perform prior to leaving the contact isolation room.</p> <p>50322</p> <p>2.) On 8/20/24 at 8:45 AM V7 (Housekeeper) was observed entering R3's isolation room without any personal protective equipment. There was a Contact Isolation sign on door and isolation cart noted outside room. V7 was observed collecting trash and taking to her cart for disposal. No hand hygiene was observed.</p> <p>On 8/20/24 at 9:15 AM V2 (Director of Nursing) states that she identified a possible resident that was most likely the source of the infection, but that said resident was currently hospitalized . V2 states that an (state surveying agency) Infection Control Consultant had been present during initial outbreak and had provided recommendations including proper disinfection of shared shower rooms. V2 provided copy of letter sent to facility from said consultant identified as outbreak document that is undated. V2 stated that they had been using bleach wipes for cleaning instead of recommended bleach solution. Facility was also using shared supplies in shower room for all residents. V2 stated that halls A and B share the shower room on the 200-hall and that halls C and D share the shower room on the 300-hall.</p> <p>On 8/20/24 at 10:00 AM the shower room on the 200-hall observed to be free of debris and dirty linens. Bathing products in closed cabinet. No cleaning products seen within shower room. 300-hall shower room also had general bathing products in open cabinet, one towel hung over half wall in shower stall and next to shower room door, a pair of slip-on sandals were visualized.</p> <p>On 8/20/24 at 10:17 AM V6 (Housekeeping and Maintenance Manager) and V7 (Housekeeper) stated that a bleach solution is now being used to clean instead of bleach wipes. V6 states he mixes the solution every morning for one day use only. V7 confirmed that she also saw the slides in the 300-hall shower room and stated that the certified nursing assistants (CNAs) take off their shoes and put the sandals on when showering residents.</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 - Many</p>	<p>On 8/20/24 at 10:30 AM V3 (Assistant Director of Nursing/ADON), confirmed the use of the sandals and stated she was going to immediately dispose of said sandals.</p> <p>The facility's Isolation Room Cleaning-Housekeeping policy with an effective date of February 2024 documents Follow facility's requirements for donning personal protective equipment before entering room, . wash hands with soap and water Policy also states, use germicidal solution containing 1ml (milliliter) or 5-6% sodium hypochlorite solution (household bleach) and 9ml of water to achieve a 1:10 dilution final concentration of 0.5-0.6% sodium hypochlorite.</p> <p>3.) R2's nursing notes dated 7/28/24 at 1:49 PM documents gastrointestinal symptoms and physician order to obtain stool for clostridium difficile (C-Diff) and parasite laboratory testing. Nursing notes dated 7/29/24 document a stool sample was obtained and sent to lab at 3:05 AM. Medical record fails to document results of lab testing.</p> <p>On 8/19/24, V3 (ADON) confirmed through interview that R2's lab report was not available and no follow up of lab had been done.</p> <p>4.) R7's laboratory report dated 7/29/24 documents positive result of C-Diff test.</p> <p>R8's laboratory report dated 8/2/24 documents positive result of C-Diff test.</p> <p>5.) R9's nursing notes dated 7/31/24 at 3:05 AM, documents gastrointestinal symptoms and physician order to obtain stool for clostridium difficile (C-Diff) and parasite laboratory testing. R9's physician order sheet (POS) dated 8/1/24 at 7:36 PM documents order for lab test and that lab sample was obtained and sent to laboratory. R9's lab results report log dated 8/20/24 fails to document that sample was tested . Medical record failed to document follow up with laboratory.</p> <p>6.) R10's nursing notes dated 7/28/24 at 4:41 PM, documents gastrointestinal symptoms and physician order to obtain stool for clostridium difficile (C-Diff) and parasite laboratory testing. R10's physician order sheet (POS) dated 7/28/24 at 3:21 PM documents order for lab test and that lab sample was obtained and sent to laboratory. R10's lab results report log dated 8/20/24 fails to document that sample was tested . Medical record failed to document follow up with laboratory.</p> <p>7.) R11's nursing notes dated 7/28/24 at 4:31 PM, documents gastrointestinal symptoms and physician order to obtain stool for clostridium difficile (C-Diff) and parasite laboratory testing. R11's physician order sheet (POS) dated 7/28/24 at 3:11 PM documents order for lab test and that lab sample was obtained and sent to laboratory. R11's lab results report log dated 8/20/24 fails to document that sample was tested . Medical record failed to document follow up with laboratory.</p> <p>8.) R12's nursing notes dated 7/28/24 at 1:44PM, documents gastrointestinal symptoms and physician order to obtain stool for clostridium difficile (C-Diff) and parasite laboratory testing. R12's physician order sheet (POS) dated 8/20/24 fails to document order for lab test or that lab sample was obtained and sent to laboratory. R12's lab results report log dated 8/20/24 fails to document that sample was tested . Medical record failed to document follow up with laboratory.</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 - Many</p>	<p>On 8/20/24 at 9:15 AM V2 confirmed there were no lab results for R9 and R10. V2 states that after initial symptoms, both residents' symptoms had resolved, and no sample was ever received. V2 states that the laboratory stated they threw out all samples that had a date older than 4 days. Lab stated that any samples not tested would have a result entered labeled rejected. V2 does not provide any information regarding the status of labs for R11 and R12.</p> <p>Facility 802 document dated 8/20/24 lists 69 total residents with 68 currently in house and 1 in hospital.</p>		