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	145914	A. BUILDING _____ B. WING _____	C 08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HTS NURSING HOME	**1010 WEST 95TH STREET CHICAGO, IL 60643**

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F 309	Continued From page 8 residents get transported to dialysis. The facility took the following steps to remove the Immediate Jeopardy: 1. All dialysis residents charts were audited to make sure that all were in compliance. All residents were receiving dialysis as scheduled. 2. Scheduled days for all dialysis residents were placed on the Medication Administration Record. 3. Sheet with dialysis center, telephone number, name of transportation company, telephone number of transportation company and time and day of that resident appointment was placed in front of each resident's Medication Administration Record. 4. All nurses were in-serviced on this procedure. 5. The above procedure is monitored by Nursing supervisor to make sure that all nurses are in compliance with this procedure. A dialysis book has been placed at each nurse's station with all information for each resident on dialysis; a master copy is located in the Director of Nursing's office. Although the Immediate Jeopardy was removed on 7/31/06, the facility remains out of compliance at a severity level 2 to allow for implementation of all of the above responses, as well as having time to monitor dialysis residents and evaluate the effectiveness of these interventions.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 9 300.1210a) 300.1210b)2) 300.1220b)1) 300.1220b)6) 300.1220b)8) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b)2) All treatments & procedures shall be administered as ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and	F9999		

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F9999	Continued From page 10 restorative/rehabilitative nursing techniques through out-of-facility training programs. This person may conduct these programs personally or see that they are carried out. These Rules and Regulations are not met based on medical record review and staff & other interviews, which determined that the facility failed to: 1) Consistently monitor and assess the dialysis shunt for 1 dialysis resident (R2); 2) Completely assess R2's lower body when re-admitted from the hospital; 3) Ensure that newly oriented staff obtained supervisory assistance with tasks new to the orientee, specifically in this case, completing the admission assessment and review of orders; and, 4) Track dialysis appointments for R2 in order to insure that he was transported to 3 of his scheduled dialysis visits during a 1 week time period. These failures resulted in R2 missing 3 consecutive dialysis treatments, causing R2 to develop respiratory distress requiring hospitalization in an Intensive Care Unit due to fluid overload and hyperkalemia. Findings include: Review of R2's medical record reflects that R2 is 68-years old, with multiple diagnoses including Renal Failure, End-stage renal disease and a history of Congestive Heart Failure. R2's record reflects a long-standing physician's order, from 11/04/05, for dialysis three times a week on Mondays, Wednesdays and Fridays. Review of R2's 05/19/06 comprehensive assessment reflects that R2 scores a "2" for cognition, indicating that R2 is moderately impaired for	F9999		

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F9999	Continued From page 11 decision-making, requiring cues and supervision. This comprehensive assessment also reflects that R2's mental function varies over the course of the day. Upon R2's readmission 6/14/06, neither E4's Admit/Readmission Assessment form or E4's nursing note refers to R2's dialysis shunt or that R2 was a dialysis resident. E4 did not identify that R2 was a dialysis patient or document an assessment of his shunt. This Admit/ Readmission Assessment form documents"... resident is tired and moody, uncooperative at times..." There is no documentation of any monitoring or assessment of R2's dialysis shunt between 06/14 and his admission to the hospital on 06/25. R2's next dialysis treatment should have been on Friday, 06/16. Review of nursing notes reflect that on Friday 06/16, R2 was not transported to the dialysis center because the ambulance company did not arrive to pick him up. According to the record and staff interview of E5 (LPN), when this was discovered on 06/16, E5 attempted to send R2 to dialysis. However, because the dialysis center could only hold his chair open for so long, R2 could not receive treatment that day. E5 scheduled R2 for a treatment the next day. This 06/17 appointment was kept, and was his last dialysis appointment until his hospitalization on 06/25. Review of R2's record reflects that R2 was not transported to his regularly scheduled dialysis appointments on Monday 06/19, Wednesday 06/21, or Friday 06/ 23. Nursing notes reflect that on 06/25, R2 complained of shortness of breath, and oxygen was started. R2's respirations became more labored, despite oxygen being increased. R2's	F9999		

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F9999	Continued From page 12 physician was called and gave orders for R2 to be sent to the Emergency Room for evaluation. R2 was admitted to the hospital from 06/25 until 07/02. Review of hospital records from R2's 06/25 hospitalization reflects that R2 was admitted to the Intensive Care Unit with diagnoses including fluid volume overload and hyperkalemia (increased potassium), and that he required emergency hemodialysis. During interview with E2 (ADON) on 07/24, E2 stated that she became aware of a problem with R2's transport to dialysis after his hospitalization. When she began to investigate, she learned that a fairly new nurse (E4-LPN) had been caring for R2 on several of the days his appointment had been missed. E2 also stated that E4 had been the nurse who re-admitted R2 back from the hospital on 06/14. This nurse, E4, had just come off of orientation. E4 told E2 that she was not aware that R2 was a dialysis resident. E2 also stated that R2 usually leaves for his dialysis appointment at about 2:30pm. E2 went on to explain that dialysis residents have a standing appointment for their transport with an ambulance company, and that this transport schedule gets put on hold when a resident gets hospitalized. E2 stated that it is the responsibility of the nurse who either readmits a dialysis resident or discharges the resident to the hospital to notify the ambulance company regarding the resident's transport; if a resident is discharged, the nurse is to tell the transport company to put the resident's dialysis transport schedule on hold until further notification, and when the resident gets readmitted to the facility, the admitting nurse is to call and tell the transport company that the resident is back in the building and to resume their regular transport schedule. E2 stated that	F9999		

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F9999	Continued From page 13 prior to this incident, dialysis appointments were not tracked and documented on the MAR (medication administration record). According to E2, the only thing that was documented on the MAR with regards to dialysis was pre and post-dialysis weights. As a result of this incident, dialysis appointments are now documented in the MAR. On 07/26 at 10:00AM, E2 stated that if she or someone from management had found out about these missed appointments earlier, they could have called the physician and made arrangements for R2 to be sent to the emergency room for emergency dialysis. During interview with E4 on 07/25 at 10:55AM, E 4 stated that she was a new nurse at the facility, and had just completed orientation at the time R2 was re-admitted to the facility on 06/14. E4 stated that she was unaware that R2 was a dialysis resident during the week he missed his appointments. According to E4, prior to this incident with R2, no one had told her that upon readmission of a dialysis resident from the hospital, the admitting nurse was to notify the ambulance company to resume the resident's regular schedule of transportation to dialysis. E4 confirmed that she was the nurse who readmitted R2 back from the hospital on 06/14, and she stated that she did not call the ambulance company about resuming his dialysis pick-up schedule because she did not know of this practice, and did not realize he was on dialysis. E4 stated she became aware of the problem on 06/23, when the dialysis center called to ask why R2 had not been to dialysis that whole week. E4 stated that when she learned of the problem, she tried to arrange transport for R2 to go to dialysis on Friday, 06/23, but she could not get the transportation there in time, as the dialysis center	F9999		

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F9999	Continued From page 14	F9999		

could not accommodate him if he arrived there too late. E4 stated that in her discussion with the ambulance personnel they stated that they were unaware that R2 was back in the building, which is why they had not been there to pick him up all week. According to E4, since the dialysis center had no openings for Saturday, 06/24, he was to keep his regular Monday appointment for 06/26; however, R2 required hospitalization on 06/25. E 4 stated that she told a supervisor, E10, when she learned of the problem on 06/23.

During a second telephone interview on 08/02 at 2:45PM, E4 stated that she assessed R2's upper body at his readmission on 06/14, but she could not assess his lower body because he was uncooperative and would not allow her to remove his pants. Upon questioning, E4 stated that she did not go back and make another attempt at completing her assessment, as R2 was sleeping and she believed waking him up would make him more combative. E4 denied requesting help from a supervisor in completing her assessment, or making a supervisor aware of her inability to do a full assessment on R2. E4 also denied utilizing other staff that had been at the facility longer than she and who were familiar with R2, for help in obtaining R2's full body assessment. E4 also stated that at that point in time, she did not know what a dialysis shunt looked like. During telephone interview with E1 on 08/02, E1 stated that R2's dialysis shunt is currently in his right thigh.

During interview with E10 (LPN-3-11 supervisor) on 07/26 at 3:30PM, E10 stated that she learned of the problem from E4, but not until after R2 had been hospitalized. E10 also stated that she was aware that R2 was a dialysis resident and that

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F9999	Continued From page 15 she worked during the week that he missed his dialysis appointments. E10 stated that even when R2 is in the building, he spends much of his time in his room, so she did not notice that he had not gone for his dialysis appointments. During telephone interview with Z4 (Nurse Practitioner) on 07/26 at 2:30PM, Z4 stated that she was very familiar with R2, as she had been seeing him along with Z1 (R2's former physician). Z4 stated that Z1 was no longer available and no longer working out of the facility. Z4 stated that she was aware that R2 had missed some dialysis appointments and that he had required admission to the ICU (intensive care unit) with fluid overload as a result of him missing dialysis. Z4 stated that R2's mental status has deteriorated over the last year, and he would not be alert enough to remember his dialysis appointments. Z4 stated that missing dialysis treatments will cause hyperkalemia as well as fluid overload, and that receiving dialysis will help to lower the potassium level and remove excess fluid. During telephone interview with E1 on 08/03, E1 stated that the facility staff has the ultimate responsibility of making sure that their dialysis residents get transported to dialysis. During telephone interview with E1 on 08/02 at 1:30PM, E1 stated that the only responsibility the facility has with regards to dialysis shunts is to monitor them for bleeding or any problem, and report the problem to the doctor or the dialysis center. According to E1, if a nurse doing an admission assessment sees the shunt, she should note it. E1 stated that the facility is not routinely documenting monitoring or assessment of dialysis shunts.	F9999		