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	146001	A. BUILDING _____ B. WING _____	C 08/01/2008

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F 490	Continued From page 16 care of the dialysis resident. Completed by the DON and monitored by the Administrator. (Completed 7/31/08). 5. Nursing staff was in-serviced on the care, observation, and monitoring of vascular access sites. This was completed by Z2 (RN VP of the dialysis center). Monitored by Administrator. Inservices will be conducted every 3 months. (Completed 7/2/08). 6. Random chart audits will be completed 2-3x per week to ensure nursing documentation contains documentation of the access site. The Director of Nursing will present a report to the QA committee monthly including all dialysis residents and any identified problems. This will increase or decrease in frequency contingent upon the outcomes. This will be monitored by the Administrator. (Completed 7/31/08) 7. An addendum will be added to the Post Dialysis Monitoring and Observation to include Central Venous. This will be completed by the Nursing Consultant and monitored by the Administrator.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)3) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 17 a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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 psychological 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. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	F9999		

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F9999	Continued From page 18 Section 300.1220 Supervision of Nursing Services b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview, clinical record and policy review, the facility failed to ensure that appropriate care and services were provided by not assessing competently the dialysis access which led to bleeding for 1 of 22 residents receiving dialysis (R6). R6 is an 86 year-old male with diagnoses including End Stage Renal Disease with Hemodialysis, Status Post Cerebrovascular Accident, Tracheostomy, Percutaneous Endoscopic Gastrostomy Tube (PEG-tube), Seizure Disorder, Deep Vein Thrombosis and History of Hepatitis C. R6 receives hemodialysis at the facility. He has a	F9999		

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F9999	Continued From page 19 central venous catheter in the left internal jugular vein. On 6/29/08 during the morning shift, R6 was found lying in blood from an unclamped and uncapped catheter lumen. He was sent to the emergency room and was admitted due to left lung collapse. He was re-admitted to the facility on 7/3/08. The situation was determined to have begun when R6 was found with dialysis access unclamped, uncapped and resident was bleeding. Findings include: The Nurse's Notes dated 6/29/08 (9:00AM) documented, "Resident found lying in blood. Dialysis Quentin catheter c/(with) gauze noted c/ blood. Both ports noted to be intact. Red port c/ injection site in place. Blue port found without injection site & line unclamped. Pt (Patient) c/ eyes fixed." It documented that the blue port was then clamped and capped. The nurse who discovered the resident bleeding was no longer employed at the facility for interview. R6 was sent to the hospital for evaluation on 6/29/08 and was admitted for Left Lung Collapse and Rule Out Mucus Plug. He was re-admitted to the facility on 7/3/08. On 7/8/08 at 3:30 PM, interview with Z2 (Dialysis Company Vice-Pres./ Coordinator) stated that the use of access ports was discouraged except for dialysis. Z2 stated that after dialysis, the ports are clamped and capped. They are wrapped with 4 x 4 gauze and taped to the external limb to ensure they are securely attached. Z2 stated she had not seen port caps coming off in years. On 7/9/08 at 11:50 AM in the dialysis room, Z2 stated that it	F9999		

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F9999	Continued From page 20 was not possible for the clamp to open and for the port cap to come off from the way it was secured after dialysis without someone manually taking off the dressing. Interview with E3 (Nurse) on 7/8/08 at 12:45 PM, stated that the catheter dressing was changed in dialysis but it was the responsibility of the facility nurse to check the access area every shift. E3 stated the catheter care should be initialed in the Medication Administration Record (MAR) and sometimes the nurses document in the nurse's notes. E3 stated the nurse was suppose to check both catheter ports. She stated that R6 was unable to pull his tubings due to his condition and had not witnessed him to pull on any of his tubings. It was documented in the Dialysis Flowsheets that R6 had hemodialysis Mondays, Wednesdays and Fridays. There was no consistent documentation found in the nurses notes that nursing assessment of the vascular access was monitored. As an example, on 5/30/08, R6 was dialyzed and it was documented in the dialysis flowsheet that report was given to the facility nurse. No documentation was found in the facility nurses' notes for 5/30/08. The initialed MAR for June 2008 documented to "monitor dialysis access device to left subclavian area every shift and as needed." The central venous catheter placement was placed in the left internal jugular vein (per dialysis flowsheet) and not in the subclavian. Since R6 was re-admitted to the facility on 7/3/08, he resumed dialysis and still no documentation was found to indicate the access was being monitored. This was, even though inservice was provided on 7/2/08 on Dialysis Vascular Access -Care, Observation and	F9999		

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F9999	Continued From page 21 Monitoring. The hand-out on vascular access documented on page 3 to "Pay close attention to the access post-treatment." Interview with Z2 on 7/11/08 stated that staff should document the condition of the catheter limbs. She stated that if the catheter is open, air will enter the body. Staff needed to contact the physician immediately. The ports have to be clamped and the resident has to be positioned on his left side and in the Trendelenburg position to prevent embolism in the brain. Z2 stated that even though the port is uncapped, there might not be bleeding but there is danger of air embolism. The dialysis company's policy on the care of fistula or graft documented that if the cap or clamp of the vascular catheter is exposed and open, the nephrologist and/or home program staff (ESRD) should be notified immediately. There was no documentation found this was done when R6 was found bleeding. The attending physician was paged but did not respond in a timely manner. On 7/8/08 at 11:50 AM, the facility's policy and procedure on the care of central venous catheter and vascular access was requested from E2 (Director of Nursing). E2 stated the facility uses the same policy and procedure as the (ESRD) end-stage renal dialysis company that was providing the service at the facility. E2 stated the facility has no separate policy and procedure on the care and management of residents receiving dialysis. Review of the ESRD's policy on central venous catheter only pertained while the resident was being dialyzed. Interview via phone with E1 (Administrator) on 7/11/08 at 10:20 AM confirmed the facility has no	F9999		

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F9999	Continued From page 22 separate policy and procedure for the residents receiving dialysis. She stated that the coordination of care with the dialysis staff was done via the flow sheet from dialysis after each treatment. However, review of the nurses' notes indicated inconsistent or lack of documentation on resident's condition after dialysis. She stated that there was no facility staff with specialized training in the care of dialysis residents but staff can seek help from the ESRD nurse. She stated staff receives yearly inservice in the care of dialysis residents. Interview with E7 (Nurse) on 7/9/08 in the afternoon stated she worked the 11PM - 7AM on 6/28/08. She stated that she administered an intravenous (IV) antibiotic medication on the morning of 6/29/08 at approximately 5:30 AM in R6's right arm IV site. She noticed the medication was dripping slower than normal even after several minutes. E7 stated she was not too familiar with the dialysis lines so she peaked at the dialysis ports at approximately 7:10 AM - 7:15 AM "to see if there was something she should do with the ports why things were not acting right." She stated the ports were dressed with 4 x 4's, were taped and clamped. They were wrapped with tape on top and bottom portion. She stated she did not take the gauze all the way off except the bottom part, pulled back the gauze a little and tucked it back in and re-taped it with the same tape. She stated the red port had a cap but the blue port did not have a cap. She stated she did not touch the clamp. No bleeding was noted. E7 stated she left the unit at approximately 7:30 AM. E7 stated she attended the dialysis inservice on 7/2/08 but did not take the written test. R6 was observed on 7/8/08 at 12:55 PM with E3	F9999		

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F9999	Continued From page 23 (Nurse) in bed with eyes closed and did not respond to greetings. R6 was on oxygen with high humidity via trache collar, had a gastrostomy tube feeding infusing, had a peripherally inserted central catheter (PICC) line on right arm and central venous catheter (CVC) limbs on left arm. On 7/9/08 at 11:50 AM, R6 was observed in the dialysis room being dialyzed with eyes closed. The Minimum Data Set dated 5/9/08 coded R6's range of motion as: neck had limitation both sides; arm, hand, leg, foot as 2/2 (limitation both sides/full loss). Interview with Z5 (Physician/Illinois Dept of Public Health) on 7/30/08 at 10:35 AM stated the unclamped and uncapped dialysis catheter placed the resident in danger of excessive bleeding, air embolism and infection. The hospital consultation report dated 6/30/08 indicated that R6 had severe anemia which could be caused by several sources of which one could possibly be secondary to bleeding from the dialysis access. While in the hospital the resident developed shortness of breath and went into respiratory distress. The Emergency Room nurses notes on 6/29/08, documented that the resident lost 2 1/2 cups of blood as reported by the nursing home staff. (A)	F9999		