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	145712	A. BUILDING _____ B. WING _____	C 06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREST NURSING PAVILION	**515 NORTH MAIN SANDWICH, IL 60548**

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F 309	Continued From page 21 physician, family and Director of Nursing will be notified immediately. F. On 6/1/11 bus drivers and the 2 nurses involved in this incident were counseled. G. On 6/1/11 all nurses were inserviced on the transportation policy, hemodialysis policy and the care of the hemodialysis resident. H. On 6/1/2011 dialysis residents care plans were reviewed to ensure they contained all details related to dialysis. I. Met with family and discussed incident in detail and the facility's plan of action.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1035a)4)5) 300.1210a) 300.1210b)3) 300.3210o) 300.3220f) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time	F9999		

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of notification.

Section 300.1035 Life-Sustaining Treatments

a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:
4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;
5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

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.

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

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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 300.3210 General

o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.

Section 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on interview and record review the facility

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neglected to have/follow their policies on dialysis transportation to ensure a resident R1 had transportation to receive a dialysis treatment on 5/20/11. As a result R1 developed fluid overload and Congestive Heart Failure on 5/23/11.

This applies to 1 of 2 residents requiring kidney dialysis at a treatment center outside the facility. (R1).

The findings include:

The Physician Order Sheet for May 2011 lists R1's diagnoses to include Chronic Renal Failure, Hypertension, and Congestive Heart Failure. R1 is prescribed to receive kidney dialysis on Monday, Wednesday and Friday at the Dialysis Center (According to Mapquest, it is 11 miles from the facility).

On 5/31/11 at 1:50 PM, E4 Licensed Practical Nurse (LPN) stated, "Around 2:00 AM (on Friday 5/20/11), I observed that the facility transport van was not in the parking lot at the facility. R1 leaves for her dialysis treatment at 6:00 AM. I called the van driver (Z1) when I noticed the van missing and left a message for him to call and confirm how R1 was going to her appointment. I did not know the van was out of service. After 6:00 AM, when the driver had not returned my call and and the van was not here, I called the dialysis center and told them she would not be able to have dialysis." E4 stated, "Usually if the van is unavailable they pass it on to us, but I didn't know. I told R1 the van was not available and her dialysis appointment was cancelled. I did not discuss any other options for transportation with her. I did not call the doctor

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or the family. I guess I should have."

On 5/31/11 at 10:20 AM, E3 Registered Nurse - (RN) confirmed she was working the day shift on 5/20/11. E3 stated the night nurse (E4) reported to her the van needed service and was not available and R1 would not be going to dialysis that day. E4 stated she was not aware of any alternative transportation options that were available if the van was broken. E4 stated, "The (Senior Service Van) refuses to go out of town and would not go as far as the dialysis center. The ambulance service would not be an option because this would have been a non-emergent case." E4 stated she had not talked with the resident, family, physician or administrative staff about the cancelled appointment and other transportation methods available. E4 stated, "Usually residents are taken in the facility van. Nursing coordinates the transportation. The drivers and their phone numbers are posted and we call them. I did not know the van was broken till the night nurse told me."

On 5/31/11 at 12:30 PM, E5 (Director of Maintenance) stated, "I didn't know the resident (R1) did not go to her appointment on Friday (5/20) until Monday (5/23). Nothing was wrong with the van, they worked on the lift hydraulics. It still worked, it just had to be used manually. In fact, Tuesday (5/17) is when we identified the problem. We used the van until Thursday (5/19) and then I took it in for service. The nursing staff did not let us know R1 had to go to dialysis. The transportation log is missing. When a resident is scheduled to go to an appointment every week, the driver puts it in the log book. The one time appointments go onto the schedule at the nursing

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desk. Then the driver checks the schedule and puts everything into the log book." E5 continued, "In fact, the facility van was returned that Friday around 8:30 AM. I was not aware anyone was waiting to go out." E5 stated, "The (Senior Service Van) would have taken the resident to the dialysis center, it is approximately 15 miles away. They won't go more than 25 miles from town. It is nursing's responsibility to schedule the residents' appointments and put it on the schedule." E5 commented, "Nursing knew the van was going in for service. The DON knew on Thursday (5/19) the van was going to be out for service."

On 5/31/11 at 1:40 PM, E6 Administrator stated, "The facility van is the primary method of transportation for the residents. If there is a problem, the floor nurse will call the Director of Nurses or Administrator. They could have notified the (Senior Service Van) or the family as alternate methods of transportation for R1." E6 stated the facility did not have a transportation program/policy until this incident occurred.

On 5/31/11 at 11:20 AM, Z1 (R1's son) stated, "If we had known they cancelled the appointment because the van was broken down, we would have found a way to get her there. I can get her in and out of the chair, and I know I could get her out of my car."

On 5/31/11 at 11:10 AM R1 stated, "The bus was down, they told me that morning (5/20) that I wasn't going (to dialysis)." R1 stated no one discussed alternate methods of transportation with her. R1 stated, "I don't understand, I go home in the car for family visits, I need help but

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the dialysis staff could have helped get me out of the car."

On 5/31/11 at 1:20 PM, E1 Director of Nurses (DON) stated, "The 11-7 nurse realized the van was not at the facility; she was not aware it was being repaired. The nurse assumed it was OK to cancel the appointment. I was not here on Friday (5/20/11). There are alternative services available, she just didn't know that. The van driver is the transportation coordinator. He checks the appointment schedule and calendar. He did not make any contact with nursing about the van being in for service. No alternate plans were made."

The Physician Consultation report on 5/23/11 from (Facility B) documents the following: "She missed her dialysis on Friday and no one was notified that she could or would not come. No alternate plans made because no one knew what was going on with her....Exactly why she did not call and schedule alternate dialysis is unclear at this point."

The monthly nursing summary for R1 dated 5/15/11 states, "Alert and orientated times 3. Is a one person assist to partial assist with activities of daily living, and is a 2 person transfer. Is a dialysis resident, goes on M, W, F to (outside facility) early on those days. Family is involved with personal needs and appointments."

The nurses' note dated 5/20/11, 5:00 AM states, "Called Dialysis Center about no transportation related to wheelchair van being repaired." There were no additional nurses' notes or resident assessments documented until 5/23/11 at 1:30

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AM.

R1's care plan dated 5/16/11 states the resident receives dialysis 3 times per week on Monday, Wednesday and Friday. The interventions include to send the resident to dialysis as scheduled. The method of transportation is not listed.

The Minimum Data Set dated 4/8/11 documents R1 does not have any cognitive deficits, or any problems with short and long term memory.

The facility policy dated 12/2010 on Care of a Dialysis Resident states to follow the hemodialysis access site assessment policy, to place dialysis information (i.e. site, days, time) in the resident's chart, to document dialysis transportation information in the resident's chart, and to follow the Physician and Family Notification: Missed or Delayed Appointment policy if a dialysis appointment will be delayed or missed.

The policy does not address resident assessment or monitoring the resident will receive when a dialysis treatment must be delayed or cancelled.

The facility policy dated 1/2009 on Physician and Family Notification: Missed or Delayed Appointment policy states: 1. Upon determining that a resident's significant appointment will be delayed or missed do the following: a. Call the attending physician and notify the physician of the significant appointment that will be delayed or missed. b. Follow any orders given by the physician. c. Call the family and notify them of

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F9999	Continued From page 29 the significant appointment that will be delayed or missed. d. Notify the DON or ADON. 2. Document all the above in the nursing notes. On 5/31/11, E6 (Administrator) was requested to provide the facility transportation program/policy for residents requiring transportation to and from medical appointments. E6 provided a policy, "Transportation of Hemodialysis Patients." E6 stated they just wrote this policy as a result of this incident. On 5/31/11 at 2:45 PM, E6 Administrator was informed of R1 missing her dialysis treatment on 5/20/11 related to lack of transportation. (A)	F9999		