STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

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S9999	Final Observations Statement of Licensure Violations Section 300.690 Incidents and Accidents 300.690 a) b) c) a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This requirement is not met as evidence by: Based on record review and interview the facility failed to report a resident's serious injury and death as required by the state agency. This	S9999		

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failure applies to two of twelve residents in a sample of twelve.
Findings include:
1. R7's electronic medical record diagnosis included but not limited to end stage renal Fistula Arteriovenous Left Forearm, Renal disease, and renal dialysis M-W-F (Monday, Wednesday and Friday). According to the facility ' s incident report dated 8/01/2014 R7 was found on the floor with blood present. R7 was sent to the hospital for treatment.
On 8/20/14 at 11:03am, E15 CNA (Certified Nurse ' s Aide) on 7/31/14 when she came on duty for the 11pm to 7am shift (R7) was already asleep and (R7) did not require much help. E15 further stated she saw (R7) but at 5:25am when (R7) called for the light to be turned off after she (E15) had finished caring for (R7) ' s roommate.
On 9/2/14 at 3:12pm, E5 (Nurse) acknowledged that when he came on duty on 7/31/2014 he saw (R7) at 11:10pm and (R7) was sleeping. E5 further stated he checked on (R7). E5 did not state or acknowledged he did a physical check of (R7) ' s AV-Fistula for patency (thrill and bruit). E5 further stated at 5:30am, he found (R7) on the floor in the room bleeding from the dialysis site (AV-Fistula)with about 200-300ml (Milliliters) of blood on the floor and the AV Fistula dressing was off. E5 reported the time span between the last time he checked on R7 and the time R7 was found on the floor with the blood was about 5 minutes. E5 reported he used 4 x 4 gauze and applied pressure.
On 8/19/14 at 10:45am, Z3 (Nephrologists) reported he was present at the hospital when R7 came in for treatment. Z3 confirmed the bleeding was from R7's AV-Fistula. When R7 came into the emergency room the bleeding was stopped and a compression bandage was in placed.
R7's hospital record dated (8/01/2014)

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documented R7 received 10 liters of replacement blood. R7's death certificate listed hemorrhage from a renal access as the cause of death. The facility did not provide evidence of the date and time of the regional office notication of R7's death.
2.On 7/21/14 at 11:53am, E3 DON (Director of Nurses) stated on 4/03/14 R1 went out on pass sustain a fall went to emergency room for care and the X-ray done at the time was negative for fracture, after returning to the facility R1 started complaining of pain and was sent to the local hospital for MRI (Magnetic Resonance Imaging) on 4/08/14.
R1's electronic medical progress note dated 4/4/14 3:43pm by E7 (Registered Nurse) documented she was informed to get ortho doctor ' s appointment because R1 had a mild fracture on the left fibular head. This information was endorsed to the supervisor and all shift (referring to staff). Documentation in the progress note indicated the result faxed to the facility on 4/10/14 at 11:03am. The State Agency was not notified until 4/11/14 at 5:39pm.
On 9/08/14 at 4:27pm, E3 DON (Director of Nurses) acknowledged Z11 (physician) on 4/04/14 called the facility to inform them of R1 x-ray result showing the fracture of the left fibular head.

(B)
Statement of Licensure Violations
300.610a)
300.1210b)
300.1220b)3)
300.3240a)
Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall

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S9999	Continued From page 3 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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: Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as	S9999		

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S9999	Continued From page 4 indicated by the resident's condition. The plan shall be reviewed at least every three months Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on interview and record review, the facility failed to have a formal agreement or method for communicating with the dialysis staff regarding the care and services for four of four residents (R1, R7, R8 and R9) reviewed for dialysis, in a sample 15. As a result, a dialysis resident (R7) with a known behavior of manipulating a renal access (AV-Fistula site), bled out and died, when the facility failed to follow their policy for monitoring the site. And put interventions in place to prevent the negative behavior. Findings include: R7 ' s electronic medical record diagnosis includes but not limited to Fistula Arteriovenous Left Forearm, Renal disease, and renal dialysis M-W-F (Monday, Wednesday and Friday). On 8/13/14 at 9:29a.m, Z2 (daughter) stated she called the facility on 8/1/14 around 5:05 am to check up on (R7) because she sensed something going wrong with (R7). Z2 stated when she called no one picked up the phone, she called again and E12 (night nurse supervisor) picked up, E12 told to her that she will go up to R7 ' s floor to ask E5 (Nurse) to pick up the phone. Z2 stated she was on hold till E5 picked phone. Z2 stated that E5 informed her that R7 was " fine. " Z2 stated in part that the next call she will get was from the local hospital emergency doctor who called her to inform her that (R7) is in the hospital for emergency care of the dialysis access line and	S9999		

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that R7 has lost a lot of blood.
On 7/22/14, E3 stated in part during interview that R7 was previously noted picking on her AV-fistula (dialysis Access site) before incident of 8/1/14.
On 8/18/14 at 12:55pm, Z4 RN (Registered Nurse) dialysis nurse, Z9 and Z10 (Dialysis Technicians) in the home dialysis unit stated R7 has been known to remove her AV-Fistula access site dressing prior to incident of 8/1/14. Z4, Z9 and Z10 were unable to present any documentation that communicate this behavior to the nurses on the floor, resulting in lack of assessment and appropriate monitoring of cause for R7 picking on the AV-Fistula site. Z4 stated in part that everyone is aware of this, Z4 turned to Z9 and Z10 (Dialysis Technicians) to corroborate her statement stating " Isn ' t that so. " And both Z9 and Z10 replied " yes. "
On 8/19/14 at 10:45am, Z3 (Nephrologists) stated in part that it is not advisable to allow R7 to either pick or remove her Av-Fistula by self because since (R7) was not trained to perform this task and if much pressure is applied when removing the dressing or picking at the site can result in hemorrhage (bleeding).
On 8/20/14 at 11:56am, E13 (Social services Director) stated in part that she was not aware of (R7) ' s behavior of removing or picking on the AV-Fistula site. At 12:08pm, E14 (Social Services Aide) assigned to R7 also stated he was not notified of this behavior.
On 8/20/14 at 1:25p.m., E3 DON (Director of Nurses) stated in part that it was reported to him that R7 was scratching the AV-Fistula sight and removing the dressing at the Av-Fistula site but it was not treated as a behavior.
On 8/20/14 at 11:03am, E15 CNA (Certified Nurse ' s Aide) stated in part that on 7/31/14 when she came on duty for 11pm to 7am shift (R7) was already asleep and (R7) did not require

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much help. E15 further stated in part that she saw (R7) but at 5:25am when (R7) called for the light to be turned off after (E15) left it on after caring for (R7) ' s roommate.
On 9/2/14 at 3:12pm, E5 (Nurse) acknowledged that when he came on duty he saw (R7) at 11:10pm and (R7) was sleeping. E5 further stated he did not physically check on (R7) ' s AV-Fistula for patency (thrill and bruit). E5 also stated at 5:30am, he found (R7) on the floor in the room bleeding from the dialysis site (AV-Fistula)with about 200-300ml (Milliliters) of blood on the floor and the AV Fistula dressing was off.
On 9/3/14 at 11:55am, E1 stated in part that the picking of the dressing or removing her dressing is not considered behavior because that is R7 ' s preference. At 12:00pm, E3 acknowledged being informed of the issue with R7 tampering with the Av-Fistula dressing prior to incident of 8/1/14 stating "We did not treat that as behavior and that does not need to be documented. "
R7 ' s care plan presented by the facility with problem date of 7/24/14 and edited date of 8/5/14 is not individualized to R7, no mention of checking for patency of Av-Fistula line, no care plan developed to address the picking or removing of Av-fistula line dressing.
The facility " Behavior Symptom Evaluation policy " presented with no date under the title definition indicated that any behavior including but not limited to removing of bandages and tapes " should be considered for behavior coding and interventions if they become consistent, that is part of the individual ' s repertoire. "
The facility " behavior symptom Evaluation policy " presented further indicated under documentation " Documentation shall occur according to the facility ' s policy. This includes a " Special behavior Symptom Evaluation " within the appropriated time parameters and

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S9999	Continued From page 7 subsequent follow up documentation. A care plan addressing the behavior symptoms and interventions is recommended. This policy was not followed. Review of the electronic record of R1, R7, R8, and R9 had no form of two way communication between the dialysis staff and the facility staff. On 8/18/14 at 12:55pm, Z4 stated any information about the resident is communicated to the floor nurses verbally. On 8/20/14 at 11:56am, E13 (Social services Director) stated in part that she was not aware of (R7) ' s behavior of removing or picking on the AV-Fistula site. At 12:08pm, E14 (Social Services Aide) assigned to R7 also stated he was not notified of this behavior. On 8/22/14 at 10:00am, E3 stated " communication between dialysis staff and floor nurses are done verbally by telephone calls. The facility dialysis contract indicated " The personnel shall maintain communication with the facility ' s Director of Nursing during the dialysis treatments and shall immediately inform the facility ' s nursing staff of any change in the patient condition requiring immediate nursing or medical attention. (A)	S9999		