STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. BUILDING _____ B. WING _____	C 06/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	**715 EAST RAYMOND ROAD WATSEKA, IL 60970**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation: 1662966/IL85887- no deficiencies 1662977/IL85897- F157, F309	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the physician of residents dialysis status for two of five residents (R2 and R3) reviewed for hemodialysis in a sample of eight. This resulted in R2 and R3 being admitted to the intensive care unit with fluid overload. Findings include: 1. R2's Physicians Order Sheet (POS) dated 5/18/2016 documents a diagnosis of End Stage Renal Disease with Hemodialysis, History of Respiratory Failure, Hypertension, Anxiety Disorder, Atrial Fibrillation and Diabetics Mellitus. The POS also documents R2 is to receive hemodialysis five days a week (Monday through Friday). R2's progress note dated 5/16/2016 at 9:00 PM, documents R2 complained of shortness of breath, nebulizer treatment given as ordered with little relief. At 9:45PM, R2 was transferred to the local hospital via ambulance. No other documented notes present in R2's medical record for 5/16/2016. R2's "Early Termination of Hemodialysis" form dated 5/16/2016 is not signed by R2. The signature line is blank. On 6/8/2016, Z1 (Nephrologist) stated R2 was admitted to the intensive care unit on 5/16/2016 for fluid overload due to not receiving dialysis on 5/16/2016. Z1 further stated "I was not informed that R2 had not received dialysis that day until (R2) arrived at the hospital. (R2) was dialyzed	F 157		

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F 157	Continued From page 2	F 157		

and 3 liters of fluid were removed at that time. If I had been notified I would have checked weight fluctuation since last dialysis day 5/13/2016, had electrolyte laboratory draw completed and asked about residents respiratory status. After laboratory results were back I would have had the facility transfer (R2) to the emergency room if laboratory result were significant and have arranged for (R2) to have dialysis elsewhere. Since I was not informed, none of the monitoring was completed and (R2) ended up in intensive Care (ICU). It was critical the facility inform me immediately of the missed dialysis for (R2) since that was three days in a row that (R2) was not dialyzed. (R2) typically receives dialysis five days a week Monday through Friday. (R2) would not have had the severe breathing difficulty or ended up in the hospital for three days if I had been informed. I should have been informed of (R2) not receiving dialysis on 5/16/2016 PERIOD!"

2. R3 's Physicians Order Sheet dated 5/18/2016 documents a diagnosis of Renal Failure with Hemodialysis, Hypertension, Anemia, Chronic Kidney Disease stage Five, and Congestive Heart Failure. The POS also documents R3 is to receive hemodialysis five days a week (Monday through Friday).

R3's progress note dated 5/17/2016 at 2:00AM, documents R3 was complaining of shortness of breath with rapid respirations of 28. R3 was transported to the local hospital via ambulance at 2:20AM. No other progress noted document in the clinical record for R3 on 5/16/2016.

On 6/8/2016 at 10:00AM, Z1 (Nephrologist) stated "I was not informed that (R3) did not receive dialysis on 5/16/2016 until the 2:00AM

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admit to the hospital on 5/17/2016. (R3) was admitted to the intensive care unit with a diagnosis of Respiratory Failure secondary to Fluid Overload. Again I would have ordered laboratory tests, checked weight fluctuation and respiratory status. I would have had (R3) transferred to the Emergency Room and arranged for (R3) to be dialyzed. (R3) has never refused treatment before and is very aware of what will occur if (R3) does refuse. I was told the facility did not have a dialysis nurse that day so neither (R2 or R3) received dialysis. This again was an unnecessary hospitalization in (R3's) case Respiratory failure secondary to Fluid Overload. It is critical I am informed when a patient does not receive dialysis so this does not occur.(R3) ended up in intensive Care (ICU). It was critical the facility inform me immediately of the missed dialysis for (R3) since that was three days in a row that (R3) was not dialyzed. (R3) typically receives dialysis five days a week Monday through Friday. (R3) would not have had the severe breathing difficulty/ fluid overload if I had been notified."

On 6/8/2016 at 8:35AM, Z3 (Contractual Dialysis Nurse Case Manager) stated "I am to be notified any time a dialysis patient refused treatment, has a systolic blood pressure of less than 90, or if a patient has any issues in dialysis. I then notify the patient nephrologist of the given information and receive any new orders which are then faxed to the facility. I was not informed that anyone refused dialysis on 5/16/2016, therefore the nephrologist was not notified. I learned of (R2 and R3) not receiving dialysis on 5/16/2016 a couple of days later (5/18/2016)."

The facility dialysis policy "Adverse Occurrence

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F 157	Continued From page 4 Reporting" dated 2015 documents the case manager is to be promptly notified of any unexpected event that is inconsistent with the routine operation."	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed monitor and provide physician ordered hemodialysis to residents with end stage renal disease. This applies to two of five resident (R2 and R3) reviewed for dialysis treatment in a sample of eight. This resulted in R2 and R3 being hospitalized in intensive care for fluid overload. Finding include: 1. R2's Physicians Order Sheet (POS) dated 5/18/2016 documents a diagnosis of End Stage Renal Disease with Hemodialysis, History of Respiratory Failure, Hypertension, Anxiety Disorder, Atrial Fibrillation and Diabetics Mellitus. The POS also documents R2 is to receive hemodialysis five days a week (Monday through Friday), is a full code status and is on a 1500 cubic centimeter fluid restriction.	F 309		

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F 309	Continued From page 5 The Minimum Data Set (MDS) dated 5/5/2016 documents R2 is cognitively intact. On 6/7/16 at 1:30pm, R2 stated, "I didn't refuse treatment but there was no nurse so I didn't get dialysis on 5/16/16. I was hospitalized for three days because of it." R2's progress note dated 5/16/2016 at 9:00 PM, documents R2 complained of shortness of breath, nebulizer treatment given as ordered with little relief. At 9:45PM, R2 was transferred to the local hospital via ambulance. There was no documentation of R2 not receiving dialysis or monitoring of R2's medical condition after dialysis not received on 5/16/2016 in R2's clinical record. R2's "Early Termination of Hemodialysis form dated 5/16/2016 is not signed by R2. The signature line is blank. R2's Emergency Room Documentation documents "Vital signs: Blood Pressure-198/78, Pulse-78, and Respiratory Rate- 30." R2 states R2 is short of breath and has been since this morning, with shortness of breath worsening with movement. The onset of symptoms was sudden and constant this morning lasting all day with no alleviating or exacerbating factors." R2 also stated "I did not receive my scheduled dialysis today." "Critical Care: The high probability of sudden, clinically significant, or life threatening deterioration required my full and direct attention, intervention and personal management while R2 was critical. R2 was admitted to intensive care." R2's hospital History and Physical dated 5/16/2016 documents (R2) did not receive dialysis as scheduled on 5/16/2016. R2	F 309		

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subsequently began having significant shortness of breath. R2 was admitted to the intensive care unit with significant bilateral crackles (to lungs), Hyperkalemia and possible Reactive Luekocytosis. R2 was dialyzed and three liters (3000 cubic centimeters) of fluid was removed.

On 6/8/2016, Z1 (Nephrologist) stated R2 was admitted to the intensive care unit on 5/16/2016 for fluid overload due to not receiving dialysis on 5/16/2016. Z1 further stated "I was not informed that (R2) had not received dialysis that day until (R2) arrived at the hospital. (R2) was dialyzed and 3 liters of fluid were removed at that time. If I had been notified I would have checked weight fluctuation since last dialysis day 5/13/2016, had electrolyte laboratory draw completed and asked about residents respiratory status. After laboratory results were back I would have had the facility transfer (R2) to the emergency room if laboratory result were significant and have arranged for (R2) to have dialysis elsewhere. Since I was not informed, none of the monitoring was completed and (R2) ended up in intensive Care (ICU). It was critical the facility inform me immediately of the missed dialysis for (R2) since that was three days in a row that (R2) was not dialyzed. (R2) typically receives dialysis five days a week Monday through Friday. (R2) would not have had the severe breathing difficulty or ended up in the hospital for three days if I had been informed. I should have been informed of (R2) not receiving dialysis on 5/16/2016 PERIOD!"

2. R3 's Physicians Order Sheet dated 5/18/2016 documents a diagnosis of Renal Failure with Hemodialysis, Hypertension, Anemia, Chronic Kidney Disease stage Five, and Congestive heart Failure. The POS also documents R3 is to

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receive hemodialysis five days a week (Monday through Friday).

The MDS dated 6/1/2016 documents R3 has a Brief Interview for Mental Status (BIM's) score of 11 out of 15 with deficits in temporal orientation and recall.

On 6/7/16 at 12:40pm R3 stated, "I never refused dialysis. They have me sign all kinds of stuff that I can't read because I can't see."

R3's progress note dated 5/17/2016 at 2:00AM, documents R3 was complaining of shortness of breath with rapid respirations of 28. R3 was transported to the local hospital via ambulance at 2:20AM. There was no documentation of not receiving dialysis or monitoring of medical condition after refusal in R3's clinical record on 5/16/2016.

R3's Emergency Room Physicians Documentation report dated 5/17/2016 documents the following: "(R3) states that (R3) is short of breath. (R3) missed dialysis on Monday (5/16/2016) because there was no nurse that showed up at the dialysis center. This is the second patient I have had tonight like this requiring admission. Onset of symptoms sudden and progressive all day today since missing dialysis. factors. Critical Care: The high probability of sudden, clinically significant, or life threatening deterioration required my full and direct attention, intervention and personal management while (R3) was critical. (R3) was admitted to intensive care with condition serious."

R3's hospital History and Physical dated 5/17/2016 documents " The patient (R3) stated "I

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did not receive my scheduled dialysis on 5/16/2016. The patient (R3) was placed on 15 liters of oxygen via non-rebreather mask to maintain saturations above 90%. The patient was admitted to the intensive care unit for continued management. (R3's) blood pressure was also noted to be significantly elevated with a systolic blood pressure greater than 200."

On 6/8/2016 at 10:00AM, Z1 (Nephrologist) stated "I was not informed that (R3) did not receive dialysis on 5/16/2016 until the 2:00AM admit to the hospital on 5/17/2016. (R3) was admitted to the intensive care unit with a diagnosis of Respiratory Failure secondary to Fluid Overload. Again I would have ordered laboratory tests, checked weight fluctuation and respiratory status. I would have had (R3) transferred to the Emergency Room and arranged for (R3) to be dialyzed. (R3) has never refused treatment before and is very aware of what will occur if (R3) does refuse. I was told the facility did not have a dialysis nurse that day so neither (R2 or R3) received dialysis. This again was an unnecessary hospitalization in (R3's) case Respiratory failure secondary to Fluid Overload. It is critical I am informed when a patient does not receive dialysis so this does not occur. (R3) would not have had the severe breathing difficulty/ fluid overload if I had been notified."

On 6/8/2016 E2, (Director of Nursing) stated " I schedule the dialysis staff for the facility. I give the Administrator (E1) the days no nurse is scheduled. (E1) then faxes the contractual dialysis company for a nurse to work if none available at the facility per our back up plan, somehow this fell through the cracks and the contractual dialysis company was not notified until

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the morning of 5/16/2016. The contractual dialysis nurse (Z2) was at the facility at 9:00AM to train new staff for dialysis. (Z2) was told to run the dialysis unit as the nurse on 5/16/2016 by contractual dialysis company at 11:00 AM."

On 6/7/2016 at 11:00AM, Z2 stated "When I got to the facility on 5/16/2016 I was told (R2, R3 and R4) all refused their dialysis treatments before I arrived. I told the facility staff the "Early Termination of Hemodialysis Against Medical Advice" form must be signed by those patients per protocol. I did not talk to (R2, R3, or R4) myself. I did not call the doctor or case manager that day to inform them that (R2, R3 and R4) refused dialysis, since (R2, R3 and R4) all refused before I arrived. The facility should have notified the contractual dialysis Case Manager as per dialysis protocol."

On 6/8/2016 at 8:35AM, Z3 (Contractual Dialysis Nurse Case Manager) stated "I am to be notified any time a dialysis patient refused treatment, has a systolic blood pressure of less than 90, or if a patient has any issues in dialysis. I then notify the patient nephrologist of the given information and receive any new orders which are then faxed to the facility. I was not informed that anyone refused dialysis on 5/16/2016, therefore the nephrologist was not notified. I learned of (R2 and R3) not receiving dialysis on 5/16/2016 a couple of days later (5/18/2016)."

The facility dialysis policy "Adverse Occurrence Reporting" dated 2015 documents the case manager is to be promptly notified of any unexpected event that is inconsistent with the routine operation."