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F 309	Continued From page 16 support the assessment, findings and action taken. According to the policy what to do asses after a fall, denotes in the event a resident has a fall the nursing staff is to assess the resident and provide for emergency care as needed. The procedure denotes to ask the resident if they have pain assess the resident prior to moving them. Get base vital and neuro signs. Assess for any changes in range of motion. Assess the resident using the following guideline. Observe for bruises, lacerations, skin tears, and abrasions. Note if there is any pain or deformity in the extremities, particularly the hip, arm, leg, or lumbar sacral spine. Assess the blood pressure lying down, and sitting down. According to the hospital records dated 9/29/10 radiology report findings include an oblique fracture of the right femur with sperolateral displacement. 10/1/10 R4 under went the partial right hip replacement surgery.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.3240a) Section 300.610 Resident Care Policies 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	F9999		

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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.

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 Requirements were not met as evidenced by:

Based on interviews, record review, review of hospital records, and review of medical examiner's report, the facility failed to provide adequate monitoring for one resident (R1) in the sample of three residents receiving dialysis. R1 had an AV (Arteriovenous) Fistula that was used

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F9999	Continued From page 18 for Dialysis. R1 had a history of spontaneous bleeding from that site and did not receive on-going monitoring to that site in order to detect potential problems. The last evidence that facility staff had monitored R1's AV fistula site was dated 04/24/09. The facility failed to have a dialysis policy for staff to follow when caring for residents, as well as, the facility failed to have a monitoring tool for staff to use when caring for Dialysis residents. On 10/18/10 at 5:10am, R1 was found in bed bleeding from left shunt/fistula and laying in a puddle of blood. R1 was transferred to a local hospital where R1 was later intubated. R1 expired in the emergency room of this local hospital at 7:27am (less than 2 hours after transfer from the nursing home). Review of the Medical Examiner's Autopsy report indicates that "R1's AV fistula showed a thrombus (blood clot)1.5cm in diameter with 0.3 cm erosion of the intima" (inside). R1's death is ascribed to "Hemorrhage due to erosion of AV fistula. Review of dialysis data (a part of R1's care plan) from Midwest kidney center under section A-3 indicates that a blood clot can be detected by checking the dialysis access at least twice daily and listening for certain sounds (called the thrill and bruit). The last evidence that was provided to surveyor indicated that the facility staff had not checked/monitored R1's AV fistula site since 04/24/09. Findings Include: 1. R1 is an 80 year old resident who was admitted to the facility originally on 06/01/07 with	F9999		

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diagnosis including End stage Renal disease, Renal disease and Bilateral below knee amputation. R1 has a left Arteriovenous fistula through which she recieves hemodialysis 3 times a week (Tuesday, Thursday, and Saturday) at a local hospital dialysis unit.

During phone interview Z1 (family of R1), Z1 stated, "I really don't think they (staff) check on R1 at night, they don't answer call lights." Upon further interview Z1 added, "That's not the first time R1 had bleeding from that shunt, but they've (facility staff) always been able to stop it. Z1 continued, "I guess this time they hadn't seen R1 all night, so when They saw R1 it was too late, R1 probably had been bleeding all night!"

Nurses notes dated 10/18/10 at 5:10am document the following, "Upon passing medication R1 told E10 (nurse) that she was bleeding . E10 discovered a puddle of blood on sheets, R1 was bleeding from the left arm shunt. Pressure was applied, 911 was called." Documentation continues 5:30am, "Ambulance came and
took R1 to hospital."

E10 could not be reached for interview, however there was no documentation on this day (10/18/10) prior to R1 being found bleeding at 5:10am. The last documentation for R1 was dated 10/17/10 (late entry) at 600am. Further review of R1's closed clinical record indicated there had been no documentation with regard to the condition of R1's AV fistula since 04/24/09.

R1 has a care plan that indicates that staff will monitor graft site for redness, swelling and pain every shift. Also noted was a form titled,

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"checking bloodflow in your access" that was included in R1's clinical record along with the care plan that staff was to follow. This form included instructions for staff including in part: "you should check the access twice a day to make sure it is open, Clotting is one of 3 main problems that can happen with access. To help prevent clotting, check access at least twice a day to be sure it is open----" There was no documentation that this was being done since 04/24/09.

Surveyor reviewed R1's clinical record again for monitoring of R1's access. Later this day (12/08/10), E2 was interviewed regarding staff monitoring of R1's access. E2 with surveyor reviewed R1's clinical record in search for documentation of staff monitoring R1's access since 04/24/09. Finally after a few minutes search E2 stated, "Its none here!" Upon further interview E2 stated, "The monitoring of R1's access should be documented here (referring to nurses notes), but I guess if its not documented it's not being done!" E2 added, "We don't have a dialysis monitoring tool for staff to use, but I'm going to work on developing one now." Later this day E2 approached surveyor, handed surveyor a form and stated, "This will be the new monitoring tool that staff will be using for all dialysis residents."

During daily status later this day, E1 (administrator) was unable to provide surveyor with a dialysis policy for staff to follow when caring for dialysis residents in the facility.

Review of hospital emergency room records on the day R1 was transferred (10/18/10) indicates that R1 arrived via 911 ambulance at

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F9999	Continued From page 21 approximately 5:53am bleeding from left dialysis shunt. At 6:35am, R1 who was unable to be stabilized went into cardiac arrest and was intubated. R1 expired at 7:27am (less than 2 hours after R1 arrived). Review of the Medical Examiner's Autopsy report indicates that "R1's AV fistula showed a thrombus (blood clot)1.5cm in diameter with 0.3 cm erosion of the intima" (inside). R1's death is ascribed to "Hemorrhage due to erosion of AV fistula." Z4 (nephrologist/ physician of R1) was interviewed via phone regarding R1's death diagnoses. Z4 stated, "When residents are on dialysis for a period of time, the constant needle sticks sometimes thin the wall of the fistula and cause it to erupt and bleeding, that's not uncommon." Upon further interview, Z4 acknowledge that R1 had a history of spontaneous bleeding from the AV site before and added, "That's not an uncommon occurrence with dialysis residents!" Z4 added, "Dialysis patient needs to be monitored more closely!!" During interview with E2 and E3 it was confirmed that R1 had a history of spontaneous bleeding from the AV fistula site, however, again E2 and E3 were unable to provide evidence of any staff monitoring or increased monitoring especially in view of R1's history of spontaneous bleeding. (AA) 300.615k) 300.625j)	F9999		

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300.625k)
300.625l)
300.3240a)

Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

k) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Criminal History Analysis Report is pending.

300.625 Identified Offenders

j) For current residents who are identified offenders, the facility shall review the security measures listed in the Criminal History Analysis Report provided by the Department.

k) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care.

l) The facility shall incorporate the Criminal History Analysis Report into the identified offender's care plan. (Section 2-201.6(f) of the Act)

300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee

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F9999	Continued From page 23 or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to conduct risk assessments/analysis for nine residents (R3, R5, R6, R7, R8, R9, R10, R11 and R12). During interview on 12/08/10, E1 (administrator) and E2 could not provide surveyor with risk assessments/criminal analysis for any of the nine identified offenders housed in the facility. E1 and E2 could not provide surveyor with documentation that the facility had ever requested risk assessments to be done by the Department of Public Health or state police. During record review R3 an identified offender had a physical altercation with R4 (his roommate) sending R4 to a local hospital with a laceration to the bridge of the nose. This laceration required 3 stitches to repair. R3 and R4 had a history of not getting along as roommates since 06/10 however were not separated by the staff until this incident that resulted in injury. R3 was incarcerated for 90 days in 1971 for Burglary. R3 also has criminal history as follows: Criminal damage to property, Aggravated Assault in 1967. There was a menial risk screening aggression done by the facility staff, however there was no risk assessment/criminal analysis done by the state police or the department, even though R3 had been in the facility since 06/24/08. There was also no treatment plan developed for R3.	F9999		

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Findings Include:

1. R3 was admitted to the facility on 06/24/08. His criminal background check indicated a conviction for Burglary, Aggravated Assault and Criminal damage to property. The resident was in the custody of the State of Illinois Department of Corrections in the year 1971. No risk assessment with a social evaluation from the Department Corrections nor a treatment plan was found in the R3's paper work. E1 (Administrator), E2 (Director of nurses), E4 and E5 (both psychiatric rehab aides) were interviewed on 2/08/10, in the first floor conference room concerning no risk assessment being done for any identified offender as well as R3. E1 stated "The SSD (social service Director) quit a couple weeks ago and currently we have E6 (SSD/consultant)". E2 (director of nurses) stated during interview "We were waiting for Public Health to come in and do the assessments." E2 added, "I really don't know why it wasn't done, I thought it was taken care of."

Upon further interview E1 (administrator) and E2 could not provide surveyor with risk assessments/criminal analysis done by the Department of Public Health or the state police for any of the nine identified offenders housed in the facility. E1 and E2 could not provide surveyor with documentation that the facility had ever requested risk assessments to be done by the Department of Public Health or state police.

During record review with surveyor and later interview, E4 and E5 finally confirmed that there were no assessments nor treatment plans for any of the nine identified offenders including R3. E5

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added, ''We don't have treatment plans. I have care plans for all 9 residents except R8." E5 then provided surveyor with eight care plans. Upon review surveyor noted all care plans were developed on 11/26/10 which was months, and most cases years, after these residents entered the facility. Surveyor pointed this date out to E4 and E5. E4 added, "That's the only ones we have!"

The identified offenders had the following admission dates:
R3= 06/24/10, R5 = 08/18/04, R6 = 11/08/06, R7= 03/29/10, R8 = 09/15/10, R9 = 02/10/06, R10 = 12/19/08, R11 = 08/27/09, R12 = 08/12/10.

2. Record review of nurses notes dated 10/26/10 at 6:20pm indicates that R4 (roommate of R3) was noted in hallway yelling, ''Nurse, Nurse.'' Staff observed bright red blood dripping from R4's nose. R4 was sent to a local hospital with a nasal laceration and returned at 12:40am with 3 stitches to top of nose. It was explained/documented that R3 and R4 had been fighting.

Record review indicates that R3 had aggressive behaviors and history of not getting along with R4 prior to the incident of 10/26/10 as follows:

-Incident accident file dated 06/29/10 indicates that R3 had an altercation with roommate and "grabbed his collar because the resident said something R3 didn't like."

-nurses notes dated 08/04/10 indicate, "R3 displays aggressive behavior toward R13 by shoving a chair toward R13. R13 did nothing to

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provoke R3's actions."

- social service note, dated 10/22/10 (4 days before physical assault that sent R4 to hospital with an injury) indicates, "R3 does not get along with R4 because of the TV (television). The remote to the TV controls both TV, when R3 turns his TV it also controls R4's TV."

Surveyor noted that even though there were ongoing conflicts between R3 and R4 since 06/10 the facility staff did not move either resident to another room. R3 was moved to another room on 10/26/10 when an altercation between R3 and R4 sent R4 to a local hospital that required stitches to repair.

R3 is an identified offender but had no risk assessment/criminal analysis done nor a social evaluation from the department of correction obtained in order to develop a treatment plan and to determine the amount of staff supervision required for him.
Surveyor noted a mere check/circled risk assessment done by the facility staff. There was no comprehensive thorough analysis done by the department of Public Health or the state police.

Later this day, E1 stated to surveyor, "E6 was recently here, so everything should be there for the identified offenders." E1 then called E6 per telephone and handed the phone to surveyor. During interview per phone, E6 stated in part, "The facility has an aggression assessment for the identified offenders! Upon further interview, E6 had no explanation for the missing risk assessment/criminal analysis by the Department of Public or the State police or the missing social evaluation.

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F9999	Continued From page 27 (B) 300.695c) 300.695 Contacting Local Law Enforcement c) The facility shall develop and implement a policy concerning local law enforcement This requirement was not met as evidenced by: Based on interview and record review, the facility failed to have a policy on calling local law enforcement when a resident is found injured or dead. On 10/26/10 there was an altercation with R3 (identified offender) and R4 . R4 was sent to hospital with bleeding and a nasal laceration requiring 3 stitches to repair. The police were called following this incident, however the facility has no law enforcement policy. Findings Include: 1. Record review indicated that on 10/26/10, at approximately 6:20pm, R4 was noted in hallway yelling "Nurse, Nurse" staff observed bright red blood dripping from R4's nose. R4 was sent to a local hospital with a nasal laceration and returned at 12:40am with 3 stitches to top of nose. It was explained/documented that R3 (an identified offender) and R4 had been fighting. During further Record review and interview with E2 (Director of Nurses) it was confirmed that the police was called following the incident. Upon further interview with surveyor, E2 was not sure	F9999		