STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001002	A. BUILDING: _____ B. WING _____	C 01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

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S 000	Initial Comments Complaint Investigation: # 2170018/IL129884	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210)b) 300.1220b)2) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 REQUIREMENTS WERE NOT MET EVIDENCDED BY: Based on interview, and record review, the facility failed to have a system in place to ensure a newly	S9999		

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S9999	Continued From page 2 admitted resident received dialysis treatments and failed to follow their policy to initiate and provide dialysis services for a resident. As a result of this failure, R4 required emergency room admission at the local hospital due to not receiving four dialysis treatments between 12/23/2020 and 12/31/2020. This applies to 1 of 5 residents (R4) reviewed for dialysis services in a sample of 14. The findings include: On 01/13/2021 at 8:46 AM, V16 (Admissions Coordinator) said the facility was accepting new residents including residents who required dialysis. On 01/13/2021 at 8:49 AM, V13 (Dialysis Center Registered Nurse) said the facility's in-house dialysis unit services were provided by (dialysis company) and currently had 14 dialysis residents. V13 said the dialysis unit had eight chairs which could accommodate dialysis residents three days a week on Mondays, Wednesdays, and Fridays in three shifts for a total of 24 dialysis residents. According to the Electronic Health Record (EHR) R4 was admitted to the facility on 12/22/2020 with diagnoses including sepsis, morbid obesity, thrombocytopenia, diabetes, hyperparathyroidism, chronic congestive heart failure, pulmonary hypertension, acute kidney failure, and end stage renal disease. The incomplete Minimum Data Set (MDS) dated 12/29/2020 showed R4 needed extensive assistance of two people for bed mobility, dressing, and toilet use; and was totally	S9999		

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S9999	Continued From page 3 dependent on two people for transfers. The MDS showed R4's cognition was intact. The Physician Order Sheet (POS) did not have orders for R4 to receive dialysis until 01/05/2021, fourteen days after being admitted to the facility. R4 did not have a care plan for dialysis initiated on admission until 01/05/2021. The Hospital Records Nurse to Nurse Report dated 12/22/2020 showed R4 had received dialysis in the hospital on 12/21/2020. The Hospital Physician Notes dated 12/21/2020 at 11:08 PM showed R4 had acute renal failure with hemodialysis per nephrology orders. The Nephrology Consult dated 12/21/2020 showed R4 had end-stage renal disease (ESRD) continue hemodialysis Monday, Wednesday, and Friday. On 01/12/2021 at 9:31 AM, V6 (Medical Doctor [MD] Nephrology) said "Luckily for (R4) he must still have some kidney function left. Most dialysis patients would die or get fluid overload then die. I have had people miss one dialysis treatment and die from missing just one." V6 said R4's BUN (Blood Urea Nitrogen) level in the emergency room on 12/31/2020 was very high at 92 which indicates inadequate kidney functioning. According to V6, missing dialysis is harmful for the resident and has a risk of hyperkalemia and death. V6 said nobody from the facility had reached out to him regarding the situation. V6 said there has to be better communication between the floor nurses and the dialysis staff for a dialysis resident. Laboratory results dated 12/31/2020 showed R4 had: a BUN level of 92 milligrams per deciliter (mg/dl)	S9999		

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S9999	Continued From page 4 [normal BUN range level is 5.0 to 28.0]; a Creatinine level of 3.0 mg/dl [normal Creatinine range level is 0.70 to 1.30]; and an alkaline phosphatase level of 291 units/liter [normal alkaline phosphatase level is 34-104]. On 01/04/2021 at 12:54 PM, V3 (Nurse Practitioner [NP] Nephrology) stated she was informed by V19 (the facility's Nurse Practitioner) on 12/31/2020 at 7:35 AM, R4 had not received dialysis since admission to the facility on 12/22/2020, nine days earlier. V3 said R4 should have been receiving dialysis three times a week on Monday, Wednesday, and Friday, missing four dialysis treatments, which prompted sending him to the hospital emergency room to receive dialysis. V3 said if a resident doesn't receive dialysis, they have the potential for elevated Potassium from which they can die. V3 said the resident could also have a buildup of fluid in the lungs and heart resulting in pneumonia or possibly respiratory arrest. On 01/11/2021 at 4:10 PM, V21 (Dialysis Company VP National of Compliance and Education dialysis) said R4 must have had substantial residual kidney function or had been receiving dialysis for less than six months or the outcome would have been more severe and possibly death. V21 said typically the facility admissions person or a nurse should notify the dialysis staff when the resident was admitted to the facility in order for them to start dialysis. According to V21, the dialysis center sends a list of the residents receiving dialysis to each nurse's station in the facility. The nurse should be responsible for contacting the dialysis center and asking why the person was not on the schedule. On 01/05/2021 at 2:43 PM, V19 (NP) said on	S9999		

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S9999	Continued From page 5 12/31/2020 at approximately 9:00 AM, R4 relayed that he had not been receiving dialysis since he was admitted to the facility nine days earlier. V19 consulted with V3 (nephrology nurse practitioner) and the decision was made to send R4 to the emergency room for dialysis. Nursing Progress Notes do not show any documentation of when R4 was sent to the hospital. The Hospital Emergency Department Notes showed R4 arrived at the hospital on 12/31/2020 at 11:52 AM. On 01/07/2021 at 3:44 PM, V18 (Licensed Practical Nurse [LPN] agency) said she had admitted R4 but had not received report from the transferring hospital. V18 said as an agency nurse she had never been trained to do an admission at the facility. V18 said she will look through the hospital paperwork, enter the medication orders into the computer, and do the resident assessments. V18 did not call the physician to verify orders for R4. V18 was not certain but said she may have asked the night nurse to call the physician to verify orders. V18 denied notifying the dialysis center because she did not know how to notify them and had assumed, they were aware of it during the admission process. On 01/08/2020 at 9:19 AM, V18 said she felt the facility should have a nursing manager or supervisor review the admission orders afterward or the next day to make sure all orders were entered correctly. On 01/06/2021 at 11:56 AM, V16 (facility Admissions Coordinator) said prior to admission she sends a referral to in-house dialysis center admissions department regarding any incoming	S9999		

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S9999	Continued From page 6	S9999		

dialysis residents. V16 said she sent the referral information to (dialysis company) for R4 prior to his admission. According to V16, once R4 was admitted, she just checks that he was in the building and the floor nurses are supposed to notify the dialysis department that the resident was in the building.

On 01/05/2021 at 12:55 PM, V5 (Acting Assistant Director of Nursing [ADON]) said with a newly admitted resident the nurse should enter the orders from the hospital and call the physician to verify the orders. V5 said usually the ADON will do an audit of the new resident orders. On 01/11/2021 at 11:58 AM, V5 stated she did the audit for R4's medications only. V5 said all dialysis residents should have orders for dialysis and the nurse should document the location of access site and the days of dialysis. V5 said when a resident comes in for dialysis, the nurses would assume care had been coordinated with the dialysis center by the admission coordinator. V5 said it was the Admissions Coordinator's responsibility to coordinate dialysis with (dialysis company), the in-house dialysis center. V5 did not know why R4 didn't get dialysis for two weeks, "I don't know what happened there honestly. No residents requiring dialysis will come into the building unless they are approved to receive treatments by the dialysis center." V5 said the dialysis nurse will send a list of any new dialysis residents to every station. V5 said the nurse had the responsibility to call the dialysis center when they noticed R4 was not being called for dialysis, notify the dialysis center he was admitted to the facility, and ask why he wasn't being dialyzed. V5 stated "I have no idea why none of the nurses picked up on it."

On 01/13/2021 at 11:04 AM, V23 (Acting Director

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S9999	Continued From page 7 of Nursing from corporate) said V2, the previous Acting Director of Nursing from corporate was "MIA (missing in action)" and V23 was the acting DON since Friday 01/08/2021. V23 said she was not aware of R4 not receiving dialysis for nine days and would need to further investigate what happened. The facility's undated Dialysis policy includes "All residents that are admitted to the facility with needs for hemodialysis will have coordination of services between the facility and the hemodialysis unit prior to admission. Dialysis services will be set up prior to admission...The facility will obtain orders from the physician for the resident dialysis days and be written on the physician order sheet." " A "	S9999		