Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: ______ B. WING ______	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

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S 000	Initial Comments Complaint Investigation: 2215537/IL149038	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2 300.1210d)3 300.1810a) 300.1810b) 300.1810c)3 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 well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a 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 300.1810 Resident Record Requirements

a) Each facility shall have a medical record system that retrieves information regarding individual residents.

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.
c) Record entries shall meet the following requirements:
3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical

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record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.

These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to ensure a resident with end stage renal disease (R3) received dialysis treatments, failed to document the missed dialysis treatments, failed to get orders for dialysis, and failed to develop a dialysis care plan. The facility also failed to notify the resident's physician and family of missed dialysis appointments and failed to monitor 2 of 2 residents (R3 and R6) reviewed for dialysis in the sample of 8.

This failure resulted in R3 being sent to a local hospital on 6/8/22 with a diagnosis of hyperkalemia (critical high potassium level) due to missed hemodialysis treatments and R3 being admitted to the intensive care unit for immediate hemodialysis treatment.

The findings include:

1. R3's Admission Record showed she was admitted to the facility on 5/5/22 with diagnoses including hypertensive chronic kidney disease with dependence on renal dialysis, schizoaffective disorder, chronic obstructive pulmonary disease, type 2 diabetes mellitus and major depressive disorder.

On 7/18/22 at 3:26 PM, V18 (R3's Power of Attorney-POA) said R3 missed dialysis appointments on 6/3/22, 6/6/22 and 6/8/22. V18 said he did not find out about the missed dialysis

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appointments until 6/8/22 when R3 was sent out to the hospital.

On 7/19/22 at 2:21 PM, V6 (Scheduler) said she has been scheduling transportation for about four and a half to five months for the facility. V6 said R3 was scheduled to go to dialysis every Monday, Wednesday and Friday. V6 said R3's appointments and transportation was already set up. V6 said she set these back up when R3 returned from the hospital on 6/2/22. V6 said she believed R3 declined the dialysis on 6/3/22 and the transport company did not show up for some of the appointments.

On 7/20/22 at 9:31 AM, V8 ((Licensed Practical Nurse-LPN) said she had not taken care of R3 prior to 6/3/22.
V8 said she was was not sure which days R3 was scheduled for dialysis because R3's paperwork and orders did not show anything about her dialysis. V8 said she got her information from other nurses and V2 (Director of Nursing-DON). V8 said she was the nurse for R3 on 6/3/22, 6/6/22 and 6/8/22. V8 said R3 did not refuse to go to dialysis on any of these three dates. V8 said R3 was dressed and ready to go. V8 said she believes all three missed appointments were due to transportation issues. V8 said on 6/8/22, she noticed R3 getting "puffier" and she was not as alert as she usually was. V8 said she called V19 (Nurse Practitioner). V8 said V19 informed her that they cannot wait for transportation and gave orders to send R3 to the hospital for dialysis. V8 said she did not document the missed dialysis appointments for R3. V8 said she thinks she spoke with V12 (R3's Mother) about transportation. V8 said she did not document in R3's chart about speaking with V12. V8 said she knows she spoke with V12 on 6/8/22, when the

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S9999	Continued From page 4 facility sent R3 to the hospital for dialysis. There was no evidence in R3's medical record showing V8 notified V2 (DON) or V19 (Nurse Practitioner) until 6/8/22, when R3 was sent to a local hospital. On 7/20/22 at 11:51 AM, V12 (R3's Mother) said she did not receive any calls from the facility informing her about any missed dialysis appointments on 6/3/22, 6/6/22 or 6/8/22. V12 said she received a call saying they were sending R3 to the hospital. On 7/20/22 at 10:08 AM, V2 said she believes one of R3's missed dialysis appointments was due to R3 refusing and the other two were due to transportation issues. V2 said the residents on dialysis, should have orders showing when and where the resident receives dialysis, as well as where the dialysis access site is on the resident, and what staff need to monitor the resident for. On 7/20/22 at 11:04 AM, V11 (Manager for local dialysis center) said R3 was scheduled for 6 treatments in June of 2022. V11 said the dialysis center did not treat R3 at all for the month of June 2022. V11 said the only time we receive a call from the facility is if there are concerns. V11 said there was nothing documented in R3's dialysis charting showing the facility calling to cancel missed appointments. V11 said dialysis is very important for someone with kidney disease. One missed treatment increases their chance of death. V11 said most patients receive dialysis for 12 hours a week whereas normal kidneys function 24 hours, 7 days a week. V11 said without the needed dialysis it will increase the patient's potassium levels and increase their risk of death. On 7/20/22 at 4:28 PM, V2 (Director of Nursing)	S9999		

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said when a resident misses a dialysis treatment, the doctor and the residents family should be notified and it should be documented in the resident's progress notes that the doctor and the resident's family was notified about the missed dialysis treatment. When asked if the facility had a communicaton binder for dialysis communications, V2 said the facility does not have a dialysis communication binder. V2 said the dialysis communication information could be found in the miscellaneous tab of the resident's electronic charting. R3's miscellaneous tab did not contain any communication documentation between the facility and the dialysis center. V2 said she does not recall seeing any dialysis communication forms for R3.

R3's Order Summary Report, printed by the facility on 7/19/22 showed orders on 5/5/22 of Dialysis access site care done at dialysis center. Dialysis access site: Shunt right arm. Dialysis days and times M/W/F 11:15 to 3:15. Dialysis location: no location listed. Dialysis: Check access site for bruit and thrill daily on return shift. The Order Summary Report showed these orders were discontinued. R3's Physician Order Sheet from her readmission on 6/2/22 showed no orders for dialysis, no shunt access site location, no location of dialysis center, the orders did not show the type of dialysis R3 received, or what staff should monitor for.

R3's progress note dated 6/8/22 at 10:53 AM, showed "Resident to be sent to (local hospital) for possible dialysis per (V19). vitals within normal limit although resident is not as alert as previous day...ambulance to transport. Emergency contact notified (Mother)." R3's Progress note of 6/8/22 at 2:00 PM showed "Writer called (local hospital) to follow up status of resident's dialysis. (Local

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S9999	Continued From page 6 hospital) nurse informed writer that resident was just moved to critical care to initiate dialysis... Critical care nurse informed this writer that the resident's potassium level is high, but will still initiate dialysis. R3's Progress note dated 6/9/22 at 12:12 AM showed the Critical Care Nurse at the local hospital was called and informed the facility nurse that they had to stop the dialysis early. The same note showed they were only able to do 233 milliliters of fluid due to R3's high potassium level. The Critical Care Nurse also informed the facility nurse that they will perform another dialysis in the hospital later that morning. R3's progress notes showed no documentation of the missed dialysis treatments on 6/3/22 or 6/6/22. R3's progress notes did not show V19 (Nurse Practitioner) or R3's physician being notified of the missed dialysis treatments until 6/8/22 when V8 (Licensed Practical Nurse-LPN) received orders to send R3 out to the hospital. On 7/20/22 at 9:07 AM, a message was left on V19's voice mail to please call this surveyor. Another call was placed to V19 at 2:57 PM. At 3:00 PM the facility was asked to assist with obtaining an interview with V19. No return call was received prior to exiting the facility on 7/21/22. R3's lab results dated 6/8/22 showed a critical high potassium level of 6.8 mg/dl (milligrams per deciliter), the normal range is between 3.6-5.0 mg/dl. The lab results showed R3 had a critical low sodium level of 104 mg/dl (normal range 138-147 mg/dl), and a critical creatinine level of 7.25 mg/dl (normal range 0.44-1.32 mg/dl). R3's care plans reviewed showing no dialysis care plan in place during her stay at the facility. The facility's Nursing Home Dialysis Transfer Agreement, provided by the facility on 7?20/22,	S9999		

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S9999	Continued From page 7 showed "4. Transportation of Designated Resident. Facility shall have the responsibility for arranging suitable transportation of the designated resident to and from center, including the selection of the mode of transportation, qualified personnel to accompany the designated resident and transportation equipment usually associated with this type of transfer including the use of appropriate life support measures in accordance with the applicable federal and state laws and regulations." The agreement showed the facility shall be responsible for all costs of transportation associated with the transfer of the designated resident to and from the center and the facility. R3's June 2022 Medication Administration Record and Treatment Administration Records were reviewed with no documentation of dialysis-related monitoring. R3's acute care hospital paperwork dated 6/8/22 showed, history of present illness:... Presenting from (the facility) due to missed HD (hemodialysis)...I spoke with her nurse and as per her, patient has missed a total of three HD sessions...At baseline she is alert, oriented x 1-2, screams with all care, but this morning, patient was obtunded and was difficult to arouse with sternal rub...I saw her in the emergency department and she is still currently obtunded but wakes up to sternal rub and starts moaning... 1. Principle problem: Hyperkalemia-due to missed hemodialysis. ..Plan: 1. Admit to medical ICU (intensive care unit). 2/ Patient already received hyperkalemia cocktail in the ED (emergency department)...3. Nephrology on board from ED. 4. Plan for stat (immediate) HD (hemodialysis)." The hospital paperwork showed R3 was admitted on 6/8/22 and discharged on 6/20/22.	S9999		

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S9999	Continued From page 8 The facility's policy and procedure titles Dialysis Care, with a revision date of 12/2021 showed, "5. An individual care plan should be developed and followed in coordination with the comprehensive assessment." 2. R6's face sheet showed she was admitted to the facility on 4/30/21 with diagnoses to include schizoaffective disorder, chronic kidney disease (Stage 5), Chronic Obstructive Pulmonary Disease, generalized anxiety disorder, hypertension secondary to endocrine disorders, and hypothyroidism. R6's July 2022 physician order sheet showed, "Dialysis M/W/F." R6's physician orders did not include the type of dialysis access, the location of the dialysis access, monitoring of the dialysis site, or where she would go to receive dialysis treatment. R6's July 2022 eMAR (electronic Medication Administration Record) and eTAR (electronic Treatment Administration Record) showed no documentation regarding dialysis. R6's Care Plan initiated on 3/5/2020 showed, "[R6] has renal insufficiency related to stage 5 kidney disease. [R6] has dialysis on Monday, Wednesday, Friday. She goes to [dialysis facility]. R6's care plan did not include what type of dialysis access she has, the location of the access site, monitoring of the access site, or communication with the dialysis facility. R6's medical record did not show any communication with the dialysis facility since February 2022. On 7/20/22 at 1:07 PM, V10 ADON (Assistant	S9999		

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S9999	Continued From page 9 Director of Nursing) said she was currently working on R6's hall. V10 said she does not know where R6 goes for dialysis treatment. V10 said she is not aware of any communication forms or paperwork that would go with R6 to dialysis and R6 does not bring anything back from dialysis. V10 said after dialysis it would be important to monitor the dialysis site for bleeding, leave the bandage in place for 24 hours, monitor the thrill and bruit at the dialysis access, and monitor for other signs and symptoms such as swelling and puffiness. (A)	S9999		