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
	IL6014963	A. BUILDING: ______ B. WING ______	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR NORTH SHORE	2773 SKOKIE VALLEY ROAD HIGHLAND PARK, IL 60035

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S 000	Initial Comments	S 000		

Complaint Investigation
#1817893 / IL107811

Statement of Licensure Violations

S9999	Final Observations	S9999		

300.610a)
300.1210b)
300.1210d)6)
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 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

Attachment A
Statement of Licensure Violations

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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:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 indicated by the resident's condition.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements were not met as evidenced by:

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Based on interview and record review the facility failed to monitor a cognitively impaired resident with a known behavior of manipulating her dialysis access site. On July 3, 2018 R2 was discovered deceased due to hemorrhage and fatal blood loss.

This applies to 1 of 3 residents (R2) reviewed for death in the sample of 3. This past noncompliance occurred on July 3, 2018.

The findings include:

R2's computerized face sheet showed R2 had diagnoses including dementia, atrial fibrillation, heart disease, and end stage renal disease. R2's Physician Order Sheet (POS) dated June 1st to July 4th 2018 showed an order for hemodialysis 3 times weekly every day shift Tuesday, Thursday, and Saturday and an AV fistula (dialysis access site) located on the left upper extremity. The POS showed an order to monitor bilateral upper extremities for signs and symptoms of infection and bleeding every shift. The POS showed an order to monitor the site for circulation, motion, and sensation of extremity distal to AV fistula every shift.

R2's POS also showed orders for aspirin 81 milligrams daily for congestive heart failure- hold if rectal bleeding occurs, and Eliquis (Apixiban) 2.5 milligrams two times daily for blood thinner. Both medications had start dates in February 2018.

R2's MDS (Minimum Data Set) dated June 11, 2018 showed R2 was severely cognitively impaired with long and short term memory problems. The MDS showed R2 required total staff assistance for transfers, locomotion, and

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S9999	Continued From page 3 toilet use. The MDS showed R2 required extensive staff assistance with bed mobility, dressing, eating and personal hygiene. The MDS also showed R2 had no upper extremity impairment. R2's progress note dated April 4, 2018 at 21:54 (9:54 PM) stated "CNA called this writer to come see pt (patient) quickly. Upon entering room found pt lying in ________. This writer removed fistula dressing and saw fistula oozing very little. Sheets full of coagulated blood, also sheets were hardened and brownish in color (indicative of dried blood)" .....A second note on the same evening stated "called to see pt this writer went to room and pt bood (blood) moderate amounts all over sheets looked at fistula sit (site) and was bleeding from there pressure dressing applied ....." R2's progress note dated May 21, 2018 at 21:35 (9:35 PM) LATE ENTRY stated .....called by caregiver on 5/18/18 with concern of a new wound proximal to her LUE (left upper extremity) graft. Caregiver states that AM, she found (R2) ace wrap to the LUE loosened. (R2) is known to scratch at her chest and other areas ..... R2's progress note dated July 3, 2018 at 6:06 am LATE ENTRY stated ....."around 11 pm went to resident room. Hand was relocated away from left anticubital due to scratching the site. AV fistula to left arm intact with bruit and thrill appreciated. Covered resident with warm blanket. Around midnight resident seen sleeping comfortably and covered with warm blanket. No sign of distress noted. Around 3 am, resident seen sleeping comfortably and covered with warm blanket with no signs of distress. At 4:12 am while doing round, resident was noted unresponsive with no	S9999		

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vital signs and with blood on the floor, the source of blood was later noted to derive from AV fistula on left arm and scattered blood on the bed and walls behind her. At 4:17 am (V9-RN) confirmed vital signs not appreciated, pupils dilated, upper body cold to touch, not responsive to stimulus. RN continue to search for source of bleeding and vital signs until 4:20 am and then paramedics arrived and took over. Page (V10-physican) and made aware of resident's death ....."

On December 12, 2018 at 10:45 AM, V6 (dialysis registered nurse) stated R2 received dialysis at the in-house dialysis center three times per week since the time of admission to the facility (2017). V6 said R2 was alert, but confused. V6 said R2 could easily move her arms and legs. V6 said R2 would scratch and itch at her left arm and it possibly was due to the itching of the dialysis tape. At 1:30 PM, V6 said R2 was routinely scheduled for dialysis sessions before 6 AM and facility staff typically got her out of bed around 4 or 5 AM.

On December 12, 2018 at 11:30 AM, V3 (Assistant Director of Nurses) stated R2 "had an incident on the night shift and her fistula bled out". V3 said she routinely cared for R2, generally five times per week, and R2 would scratch at the fistula site.

On December 12, 2018 at 12:35 PM, V7 (Certified Nurse Aide-night) stated he remembered R2 very well and cared for her often. V7 said R2 was confused most of the time and "many times she would scratch and pull at her dialysis thing" (fistula). V7 said he was working the night shift on July 3, 2018 when an "incident" occurred. V7 said he checked in on R2 every two hours and found her sleeping soundly. V7 said

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R2's arms were covered under her blanket and he did not remove or check her body underneath the bedding during rounds. V7 said sometime in the early morning, before 5:00 AM, he heard the floor nurse calling out for help. V7 said he entered R2's room and saw blood on the bedding and the dressing that covered her left arm was off. V7 said he had no idea what caused the bleeding. V7 said R2 was found covered with blood after the floor nurse entered her room to prepare her for her scheduled 5AM dialysis session.

On December 12, 2018 at 2:20 PM, V9 (Registered Nurse-night) stated he was working the third floor night shift on July 3, 2018 when he was called to the second floor for a resident "issue". V9 stated he entered R2's room and saw blood "all over her body". V9 said R2 was "covered from head to toe in blood". V9 said R2's blanket was wet from blood and her bed sheet was completely saturated. V9 said there was blood on the floor under her bed. V9 said R2 had passed away by the time he arrived to her room.

During the course of this survey, the second floor night nurse on duty July 3, 2018 was attempted to be interviewed, but no longer works at the facility.

On December 13, 2018 at 11:15 AM, V10 (R2's physician) stated R2 was known to scratch at her fistula site and died due to prolonged bleeding at that site. V10 said something should have been done to reduce the scratching, such as increased monitoring. V10 said the fistula was a direct connection to an open artery which can bleed out within five to ten minutes, regardless of blood thinner use or not. V10 said R2's daily blood thinner use would cause longer bleeding.

R2's State of Illinois Certificate of Death

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Worksheet was reviewed and showed a date of death of July 3, 2018 and occurring at the subject facility. The death certificate showed the cause of death due to: Exsanguination (loss of blood to a degree sufficient to cause death).

R2's hemodialysis care plan and end stage renal disease care plans (both initiated dated March 1, 2017) were reviewed. Both care plans showed interventions put in place on March 1, 2017 but no new interventions addressing R2's April or May 2018 AV fistula scratching.

The facility's Hemodialysis Policy reviewed dated November 1, 2017 states: It is the policy of the facility to ensure that appropriate care for resident on hemodialysis is provided by facility staff.

On December 20, 2018, the surveyor confirmed through observation, interview, and record review that the facility took the following actions:

1. Audits were performed twice weekly to identify dialysis residents with behaviors.
2. The Behavior Management Policy was updated on July 3, 2018 to instruction staff to respond to cognitively impaired dialysis residents displaying a behavior of scratching, picking, touching or manipulating the dialysis access site immediately. The resident will immediately be redirected and monitored. Staff will immediately report the behavior, reassessments will occur, and care plans will be updated.
3. An IDT will be involved in reporting and intervening when the behavior is identified.
4. Dialysis patients will be assessed for cognitive impairment at admission and on an ongoing basis.
5. All licensed nursing staff have been individually in-serviced on the care of

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S9999	Continued From page 7 hemodialysis patients, behavior specific to dialysis residents manipulating access sites, and emergency response to access site bleeding. Completed July 3, 2018. (A)	S9999		