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
	IL6009930	A. BUILDING: ______ B. WING ______	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF WESTMONT	6501 SOUTH CASS WESTMONT, IL 60559

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2178392/IL140196	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)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 a) Comprehensive Resident Care Plan. A	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1	S9999		

facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

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S9999	Continued From page 2	S9999		

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 300.3240 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 regulations are not met as evidenced by:

Based on interview and record review, the facility failed to monitor dialysis catheter access site according to plan of care and the facility failed to communicate changes in the dialysis site between a facility based outside dialysis provider and nursing staff in the facility, for one of 3 residents (R1) reviewed for dialysis catheter access site.

This failure resulted in a resident's (R1) death due to undetected infection and sepsis from the dialysis catheter access site.

Findings include:

R1's face sheet showed that R1was originally admitted to the facility on 8/18/2020. R1's multiple diagnoses included diabetes mellitus (DM), dependence on renal dialysis, end stage renal disease (ESRD, dementia, unspecified psychosis, major depressive condition, anxiety disorder, absence of left leg below knee, anemia in chronic

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S9999	Continued From page 3	S9999		

kidney disease, hypertensive chronic kidney disease with stage 5, peripheral vascular disease, secondary hyperparathyroidism of renal origin, and acquired absence of right great toe and other right toe.

R1's POS (Physician Order Sheet) for the month of November 2021 showed a physician order dated 7/13/2021 for "dialysis: check access site dressing dry and intact, right chest every shift; DIALYSIS: ACCESS SITE LOACATION/TYPE; CVC (Central Venous Catheter) to right chest."

R1's care plan dated 8/19/2000 with a review date on 12/3/2020 showed: "Dialysis; (R1) has potential for impaired renal function secondary to ESRD (End Stage Renal Disease) and receiving dialysis." The intervention was to "Observe access site for s/s (signs and symptoms) of infection: redness, drainage, swelling, pain and displacement every shift."

On 11/15/2021 at 11:15 AM, V8 (Dialysis Nurse) stated that R1 was on dialysis treatment 3 times a week scheduled Mondays, Wednesdays and Fridays at 5:30 AM. V8 said that R1's dialysis access site was a central venous catheter on the intra jugular vein unto the right chest area. V8 added that on 11/5/2021, during the dialysis treatment, R1 was observed with some redness, dry and flaky skin of the surrounding site of the dialysis access site. V8 added that she thinks it might be a skin irritation and so she decided to change the dressing to Betadine ointment instead of the standard cleansing with Chlor Prep solution. V8 also said that the facility onsite dialysis center was the one changing the dialysis dressing. V8 further added that she did not inform and communicate to V5 (staff nurse/floor nurse) regarding R1's skin irritation and treatment was

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S9999	Continued From page 4	S9999		

changed to the dialysis access site. V8 added that the access site will be checked again for the next dialysis treatment which would be 11/8/2021. As V8 continued to state, the dressing was only change during dialysis treatment. V8 said the access site was covered with pieces of gauze and secured with square type gauze tape.

On 11/17/2021 at 12:49 PM, V5 (Registered Nurse) stated that she did not check and visualize R1's dialyis catheter insertion site. V5 also said that when she sent R1 to the hopsital on 11/8/2021, R1 was "very lethargic and barely responsive. V5 added that she was not informed by V8 nor other nurses report to inspect the dialyis insertion site for possible infection.

The Telehealth Notes dated "11/7/2021 18:56 (6:56 PM) telehealth evaluation Date of Service: 11/07/2021 4:26 PM CT
Primary Chief Complaint: Altered Mental Status
History of Present Illness: (R1)with ESRD, DM2, HTN (hypertension), hyperparathyroidism secondary to ESRD. Patient has been lethargic for the past 2 days. (R1) is also not eating well. (R1) has cough with coarse breath sounds, temperature was 99.9, given Tylenol. (R1) HR (Heart rate) elevated at 107."

The physician progress notes dated "11/8/2021 at 11:40; Physician's Note Text: (R1)with PMH (Past Medical History) of ESRD (End Stage Renal Disease), DM (Diabetes Mellitus), PAD (Peripheral Arterial Disease), Seizure disorder who was seen at the hospital from 3/7 to 3/9/2021 for chest pain that radiated to her thoracic back with some N/V (nausea/vomiting). EGD (Esophagogastroduodenoscopy) showed acute pancreatitis and cholelithiasis....Currently on HD (hemodialysis) 3 x/week. Patient seen today for

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S9999	Continued From page 5	S9999		

follow up. According to nurse reports, (R1) was not able to get dialysis today, due to clogged port. Patient is not responding to verbal or tactile stimuli at this time. Ordered to send pt. (patient) out to ER(emergency room) for further evaluation; pt. is full code...VS (Vital Signs): BP (Blood pressure): 116/70 mmHg (millimenters of mercury) Temperature: 99.6 F Pulse: 100 bpm (beats per minute) Respirations: 19 Breaths/min O2 (oxygen): 97...Slowness and poor responsiveness. ER evaluation; nurse, MD and DON (Director of Nursing) at facility notified."

The EHR (Electronic Health Record) dated from 11/5-8/2021 showed no documentation that the dialysis catheter access site was monitored and visually checked for signs of infection.

On 11/15/2021 at 10:54 A.M., V2 (Director of Nursing) was asked to make a chronological timeline regarding R1's dialysis catheter concern. The timeline showed:
"-11/5/21, (R1) was sent to Dialysis. Dressing was changed and slight redness noted at site. Dialysis RN (V8) noted that (R1) had behavior of excessively touching site. No note of signs of infection. Dialysis was uneventful.
-11/7/21, (R1) was noted as excessively sleeping since 11/6 and with altered mental status on 11/7 with abnormal vitals. Resident Temp 99 degrees. Heart rate 107. Change of condition initiated. ...MD notified. Labs ordered.
-11/8/21 at 2:55 am resident was noted with cough and respiratory symptoms. ... MD notified. Labs relayed.
-11/8/21 at 5:30 am during dialysis session the dialysis nurse is unable to access (R1's) port. Follows their protocol and uses Cathflo (drug used to restore patency to dialysis catheters) to clear catheter. No note of dressing stain or

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S9999	Continued From page 6	S9999		

discoloration. Sent back to room for Cathflo to begin to work.
-11/8/21 at 11:40 am NP (Nurse Practitioner) saw (R1) in room and recommended to send out due to altered mental status.
-11/9/11; Hospital staff notified (facility staff) that they needed clarification about the catheter (dialysis access catheter/port). Facility responded by placing (V8) in contact with the hospital social worker."

On 11/15/2021 at 10:54, V2 stated that V1 (Administrator) had received a call from V14 (Hospital Social worker) on 11/9/2021 asking about the dialysis catheter and that V1 asked her to communicate with V14. V2 said that V14 had informed her of "inappropriate nursing care due to infected dialysis catheter that was full of pus and "will not missed it if it was monitored." V2 also said that the dressing was not removed to check the insertion site of the dialysis catheter since it is the dialysis nurse who change the dressing. V2 added that since R1's dialysis treatment was M-W-F, R1's catheter insertion site was not visualized and check for signs of infection since 11/5/2021. V2 added that the insertion site of the dialysis catheter was not visible because it was covered with gauzes and tape. V2 further said that staff nurse only look at the dressing but was not able to visualize the insertion site if there were signs of impending infection.

On 11/15/2021, V6 (dialysis technician) stated that he had changed R1's dressing of the dialysis catheter on 11/8/2021 in the morning around 5:30 AM. V6 said he did not see signs of infection.

On 11/15/2021 at 2:35 PM, V14 stated that she informed the facility on 11/9/2021 that R1's dialysis catheter on the right chest area was full

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S9999	Continued From page 7	S9999		

of pus and was infected and "there was no way that it was missed if they were monitoring it."

On 11/16/2021 at 5:30 P.M., V12 (Nephrologist) stated that "standard of practice was for the dialysis nurse to change the dressing of the dialysis catheter during treatment. However, if there was a sign of skin irritation that could also most likely be an impending sign of skin/bacterial infection. The expectation was to open the dressing and visualize the dialysis insertion site for monitoring and check signs of infections before the situation become grave. The Cathflo, which is to clear clogged catheter will not backflow from the tunneled catheter and it will not backflow or seep through from the insertion site. If ER (Emergency Room) had documented that purulent drainage from the insertion site, meaning there was pus around the insertion site. They (facility) should have monitor the insertion site by opening the dressing and visualizing the insertion site. The infection would not suddenly develop in few hours, but should the access site should have been monitored to provide prompt treatment."

On 11/16/2021 at 6:10 PM, V13 (R1's Attending Physician) stated that she had followed R1 for care at the hospital. V13 stated that R1 had expired on 11/16/2021 due to sepsis and infection from the dialysis catheter. V13 also added that the dialysis catheter was sent to laboratory after it was removed for culture and determine microorganisms on 11/8/2021. V13 added that the dialysis catheter culture result had matched R1's microorganism found on R1's blood result. V13 added that "when it was identified on 11/5/2021, (R1's) skin irritation /dry/flaky around the dialysis catheter insertion site, there was already an impending skin infection building up that went through (R1's) dialysis catheter. I was

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S9999	Continued From page 8	S9999		

not informed about the (R1's) skin irritation around the insertion site of her dialysis catheter, otherwise I would have ordered treatment such as antibiotic or send her out to the hospital."

The ER documentation dated 11/8/2021 showed " (R1) on arrival, febrile (with fever), tachycardia (elevated heart beat), and tachypneic (fast breathing). Septic work up initiated. She does have purulent drainage around the dialysis catheter site."

The hospital record showed that R1 had expired at 3:16 A.M. on 11/16/2021.

V14, hospital social worker notes dated 11/9/2021 showed a call from V1 (Facility Administrator) and stated "we do not deal with HD (Hemodialysis) catheter, this is managed by the dialysis nurse who are technically with a different company. V14 noted surely the bedside nurses at facility could keep an eye on catheter site and identify possible infection. (V1) stated they should be doing this but cited nursing shortage. V14 noted HD catheter very infected and looks like this was not address for some time."

Facility policy for Dialysis revised September 9, 20021 documents,
"The dialysis site will be checked every shift for signs and symptoms of infection or bleeding."
Under resident care the policy documents, "Assessing, observing and documenting care of access site".

Under the section "Resident Care Facility Specific Guidelines" documents, "Assess, observing and documenting care of access site.

Under the section "Shared Communication

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S9999	Continued From page 9 between the facility and Dialysis Facility" the policy documents, "The care of the resident receiving dialysis services will reflect ongoing communication, coordination between facility and dialysis staff. The communication process includes how the communication will occur, who is responsible for communicating, and where the responses will be documented in the medical record, including but not limited to... Dialysis adverse reactions/complications and/or concerns related to the vascular access site/PD (peritoneal dialysis) catheter." (A)	S9999		