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	IL6002778	A. BUILDING: _____ B. WING _____	C 09/10/2024

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BRIA OF ALTON	3523 WICKENHAUSER ALTON, IL 62002

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S 000	Initial Comments Complaint Investigation: 2447154/IL177687	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 1	S9999		

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.

These Regulations are not met as evidenced by:

Based on interview and record review the facility failed to arrange a medically necessary appointment transport for 1 of 3 (R16) residents reviewed for dialysis in the sample of 18. This failure resulted in R16 missing his appointment to treat a clogged dialysis shunt, which in turn created ineffective dialysis procedures.

Findings include:

R16's Care Plan, dated 9/30/2022, documents Dialysis: Resident has potential for impaired renal function secondary to Dialysis due to ESRD (End Stage Renal Disease); Assist with arranging transportation to and from dialysis center, check arteriovenous fistula/shunt for bruit and thrill to assess for arterial blood flow every shift, inspect access site dressing after dialysis and apply pressure if bleeding occurs. If bleeding does not stop or restarts, contact MD (Medical Doctor) and/or dialysis clinic, Notify MD and/or dialysis clinic PRN (as needed) of complications, Notify MD of weight gain, and/or fluid volume excess (sudden, weight gain, increased BP(blood pressure), full bounding pulse, jugular vein distention, SOB (shortness of breath), moist cough, abnormal breath sounds, and edema), Observe access site for s/s (signs/symptoms) of infection: redness, drainage, swelling, pain and

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S9999	Continued From page 2	S9999		

displacement every shift. Report changes in neurological status (E.g.: altered LOC (level of consciousness), headache, visual or pupillary changes, restlessness, seizures), Review post treatment sheets.

R16's Minimum Data Set, dated 7/2/2024, documents that R16 is cognitively intact.

R16's Dialysis progress note, dated 8/5/2024 at 9:11 AM, documents AVF (arteriovenous fistula) RUA (right upper arm)- primary cannulation without difficulties/issues. Secondary & Tertiary cannulation, both times there was a flash, blood moved down the line by itself, unable to push or pull, needles were readjusted without success. RN (registered nurse) called Vascular Institute, advised that access be rested and try again tomorrow, if no success will have to come in, possible re-insert CVC (Central Venous Catheter).

R16's Progress Note, dated 8/8/2024 at 10:22 AM, documents "Nurses Notes Note Text: resident has an appointment at (Regional hospital) with the vascular unit at 8am tomorrow to have his fistula unclogged. transportation is aware.

R16's Progress Note, created date 9/9/2024 at 1:10 PM and effective date 8/9/2024 1:08 PM, documents "Nurses Notes Late Entry: Note Text: Resident attended appointment at Vascular Institute at (Regional Hospital) New cath (catheter) put in due to infiltration of fistula. Waiting for the edema to subside and will have a fistulagram on 09/13/2024 to see if it has remedied itself.

R16's (Regional Hospital) History and Physical,

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S9999	Continued From page 3	S9999		

dated 8/30/2024, documents reason for admission: Pt (patient) is a 58-year-old who has a past medical history of Anemia, Chronic obstructive pulmonary disease, Cognitive communication deficit, ESRD (end stage renal disease) on dialysis, ESRD on dialysis, Essential hypertension, and Hyperlipidemia was transferred from (local hospital) for evaluation by vascular surgery for his non-working dialysis AV fistula. He gets his dialysis daily except Saturday. He had his full dialysis on Wednesday. Yesterday when he was having his dialysis his AV fistula stopped working and he couldn't complete his dialysis. As per Dialysis nurse his fistula was clotted. For which he went to (local) ER (emergency room) for evaluation today and was transferred to (hospital).

R16's Progress Note, dated 9/4/2024 at 9:07 PM, documents "Nurses Notes Note Text: Resident was re-admitted to the facility at 7:30 pm. from (Regional Hospital). Arrived via stretcher and accompanied by 2 EMT (Emergency Medical Technicians). Returned to room. Resident is alert and oriented and able to make needs known. No respiratory distress noted. Assessed resident and noted his new fistula in his RUE. No s/sx (signs and symptoms) of pain or discomfort. No irritation noted. Resident is afebrile.
(140/70-97.9-86-18-96% RA (room air). Resident able to move about independently. Resting at this time.

R16's Progress Note, dated 9/5/2024 at 12:17 PM, documents "Nurses Notes Note Text: pt (patient) appt (appointment) by dialysis nurse at (Vascular Clinic) will be rescheduled. pt being sent out to (local hospital) NPO (nothing by mouth) for eval of lt (left) chest fistula for an eval and possible intervention to function properly. pt

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S9999	Continued From page 4	S9999		

up ad lib, 144/86 last bp (blood pressure) at noon. picked up via (local hospital) ambulance to (local hospital) via x2 staff members. pt took his phone charger and his wallet with him.

R16's Progress Note, dated 9/5/2024 at 4:40 PM, documents "Nurses Notes Note Text: Resident returned to the facility in good spirits. No c/o (Complaints of) voiced, denies pain. Resident had lab work while there. Looks like he has some up and coming appointments.

On 9/9/2024 at 9:40 AM V27, Registered Nurse, stated that R16 catheter was clogged and had been sent to the emergency room. V27 stated that there was an attempt to unclog without success. V27 stated at that time R16 was evaluated and an appointment was made with the vascular clinic. V27 stated that a week later R16 was sent back to the hospital because the facility did not have transportation to send him to his appointment that would have fixed the clog. V27 stated that the hospital could not do anything because R16 was not admitted. V27 stated that R16 was assessed and sent back to the facility. The catheter remained clogged. V27 stated that it is inappropriate to send a patient to the emergency room because you don't have transportation for his doctor's appointment. V27 stated that the facility sent the patient to the ER to handle it. V27 stated that this is R16's lifeline and not having appropriate dialysis can lead to his death. V27 stated that this is inappropriate level of care and neglectful.

On 9/9/2024 at 10:40 AM V25 stated that R16 is a dialysis patient of theirs. V25 stated that R16 has two access points, and both are compromised. V25 stated that this is a big concern because they can't dialyze R16

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S9999	Continued From page 5	S9999		

appropriately. V25 stated that R16 had an appointment at the vascular clinic and that appointment was missed due to transportation issues. V25 stated that R16's kidneys don't filter blood the way they should. As a result, wastes and toxins build up in his bloodstream. Dialysis removes waste products and excess fluid from the blood because his kidneys can't. V25 stated that this is a serious problem and can be life threatening.

On 9/9/2024 at 12:00 PM V4, Nurse Practitioner, stated that she was made aware of R16 access being clogged. V4 stated that they are able at this time to perform dialysis. V4 stated that they are not able to remove all of the fluid but believes that may be due to R16's blood pressure. V4 stated that it is important that R16 has his CVC fixed. V4 stated that she has informed V26 to continue to communicate with V4 about R16's dialysis and the facility is in the process of getting an appointment. V4 stated that the residents on dialysis have such a high acuity. V4 stated that she can't do much if they don't get them to the appointment.

On 9/9/2024 at 12:12 PM V2, Director of Nursing, stated that R16 was having some problems with his access. V2 stated that R16 had been out to the hospital and had a new catheter placed. V2 stated that at some point the dialysis staff made an appointment for R16 to be seen at clinic in Missouri. V2 stated that the dialysis staff did not communicate the appointment appropriately to the V23 so that transportation could be set up. V2 stated that when he became aware that R16 missed the appointment he notified V4 and R16 was sent to the hospital for evaluation. V2 stated that the appointment was cancelled due to transportation issue.

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S9999	Continued From page 6 On 9/9/2024 at 1:09 PM V24, dialysis Registered Nurse, stated that R16 is a patient of theirs. V24 stated that there have been issues with R16 missing appointments. V24 stated that currently R16's ability to remove waste and toxins from his body is compromised. V24 stated that R16 has a shunt in right arm that has been clogged and no access at this time. V24 stated that she is aware that R16 has gone to the hospital. V24 stated that the problem with that is the hospital will not do anything with the graft to the shunt. V24 stated that hospital prefer to leave that to those that specializes in this. V24 stated that so sending R16 to the hospital may not help. V24 stated that R16 has not been to the institute since 7/29/2024. V24 stated that R16 went to the hospital. V24 stated that they share the hospital but is a separate entity. V24 stated that R16 had catheter placed while there. V24 stated that they were informed by the dialysis that this is not working and that they are getting less and less results. V24 stated that this is a serious problem because this is his only lifeline. V24 stated the appointment was set for replacement and R16 did not show. V24 stated that this is a problem because if this continues R16 could die. On 9/10/2024 at 7:45 AM R16 stated that he is aware of the issues with his shunt site. R16 stated that it is blocked and can't be used. R16 stated that he was supposed to go to the clinic but was not able to because of transportation. R16 stated that V23 takes him if she doesn't have any appointments, or he goes by ambulance. R16 stated that the facility sent him to the hospital and the hospital did not do anything for him. R16 stated that he was told that this is a specialty and must be handled by the right people. R16 when he went to (Regional Hospital) they didn't address	S9999		

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S9999	Continued From page 7	S9999		

the clog at all. R16 stated that the put a line in him and told him this was temporary and that he has to get to the clinic to get his access fixed. R16 stated that when he was to go to his appointment the facility sent him to (local hospital) instead. R16 stated that they didn't do anything there either. R16 stated that the catheter that he has in now doesn't work well either.

On 9/10/2024 at 2:10 PM V26, Dialysis RN, stated that R16 previously had a CVC in his right chest for dialysis. V26 stated that CVCs are acute and temporary. V26 stated that they are not usually chronic because of the need to be changed. V26 stated that R16 then got a AV shunt in his right arm and the CVC in Right chest was removed. V26 stated that R16 started having problems with his shunt 8/6 and the shunt was clogged. V26 stated that this was communicated to the vascular institute, and they suggested a rest for the day and try the next day. V26 stated that they attempted to perform dialysis the following day and was not successful. V26 stated that on 8/12/2024 R16 had dialysis using the CVC to the left chest, which was newly placed. V26 stated that the problem is that the CVC to the left chest is not working correctly. V26 stated that this has been sometime. V26 stated that this is R16's only access at this time and it can be a medical emergency if it stops working all together. V26 stated that previously they were able to remove about 70 Liters but they are only able to remove about half of that maybe 30 to 35. CVC catheter so that R16 can be dialyzed appropriately. V26 stated that if R16 is not able to remove the toxins and waste in R16's blood it will build up and be life threatening.

On 9/10/2024 at 2:15 PM V28, dialysis Tech, stated that they have been having problems with

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S9999	Continued From page 8 it since it was placed. The facility did not provide a policy for appointment transportation. (A)	S9999		