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	145142	A. BUILDING _____ B. WING _____	C 04/17/2006

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ALDEN ALMA NELSON MANOR	**550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108**

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F 327	Continued From page 19 The facility's policy and procedure for Intake and Output monitoring showed, "Intake and Output will be recorded for all residents on intravenous fluids, dialysis, restricted intake and for others as ordered by physician or assessed as needed by an RN, LPN. Output recorded for residents with an indwelling or suprapubic catheter."	F 327		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610 a) 300.1010 h) 300.1210 a) 300.1210 b) 300.1210 b)1) 300.1210 b)2) 300.1210 b)3) 300.3240 a) Section 300.610 Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999		

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F9999	Continued From page 20 Section 300.1010 Medical Care Policies h) Facility staff shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident ' s comprehensive assessment and plan of care. 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. Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1-120 of the Act)	F9999		

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F9999	Continued From page 21 b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous, and imtramuscular shall be properly administered. 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by interview and record review which revealed that the facility failed to start R1's intravenous (IV) access and give IV fluids as ordered by the physician on 4/4/06. On 4/5/05 R1 was transported to the closest Emergency Room (ER) for treatment. R1 expired in the ER, on 4/5/05, due to hyperkalemia (secondary to dehydration) which put her heart in an abnormal rhythm, Pulseless Electrical Activity (PEA). This is for 1 of 13 residents at risk for dehydration on the sub-acute care unit (R1). The findings include:	F9999		

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F9999	Continued From page 22 The hospital transfer sheet dated 3/3/06 for R1 showed, "Primary Diagnosis - Acute Renal Failure with Chronic Renal Insufficiency; Secondary Diagnoses - Atrial Fibrillation, Electrolyte Disturbances and Malnutrition. Encourage oral fluid intake." R1's nephrology consultation dated 3/20/06 showed, "Recent acute renal failure, due to volume depletion." R1's Minimum Data Set (MDS) dated 3/24/06 showed no impairment of long term and short term memory; a height of 60 inches and a weight of 93 pounds. R1's nurses notes from 3/8/06 through 4/3/06 showed R1 "refused" meals or would eat only "10%" of a meal, "had a few sips of water," was " alert to person and place (3/14/06 at 9:15am) at times, or was "alert with confusion" (starting 3/17/06) and had "difficulty swallowing" on 4/3/06 . R1's nurses notes dated 4/4/06 showed, "6:00pm - Alert with confusion...went out the dining room for breakfast. R1 not able to (eat) by herself. Will start to eat in room...fed by certified nursing assistant (CNA). At 2:00 R1 slid forward out of chair.... Approximately 1/2 an hour later R1 was sleeping and not as alert. Called doctor. Orders were for lactated ringers at 75ml per hour for 2 days, a urinalysis with culture and sensitivity along with a complete blood count.... Searched sub-acute and long term care area (for lactated ringers) unsuccessful. Called doctor back and received orders for D5NS at 75ml per hour. All intravenous (IV) medication left for E4 (Licensed Practical Nurse - LPN) and E7 (Registered Nurse	F9999		

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F9999	Continued From page 23 - RN) to start. IV medications on nurses cart. Went to 400 (hall) and told E7 that the IV needed to be started on R1.... 9:30pm - R1 is lethargic.... RN at bedside to start IV. 4/5/06 2:35am - RN again at bedside to start IV site and was unable to start line. 5:15am - Call placed to doctor's answering service. Awaiting call back to inform him of R1's increasing lethargy and unsuccessful attempts to start IV fluids. Blood pressure 80/42, temperature 96.4, heart rate 59, respiratory rate 24, oxygen on at 2 liters per nasal cannula, oxygen saturation 83%. Feet cold to touch. 5:30am - Order received to send to hospital (west side) for evaluation. Ambulance called.... 6:10am - Ambulance here, state they will take R1 to hospital (east side hospital/closest hospital)." On 4/6/06 at 4:20pm, E4 stated, "I got report from E8 (LPN) and was told R1 was to have an IV. Only RN's can start IV's and E7 was the only RN. So E8 told him R1 needed an IV so E7 would start it. It was about 6-6:15pm. It was about 9:00 pm or 9:30pm before E7 got there. I don't know how many times he attempted the IV. Later during the night at 2:35am I asked E7 again (to start R1's IV), he said he would be there. I don't know how many times he tried. I went into the room and the equipment was still there." I called the doctor about 5:15am because the IV was not started and R1's blood pressure was 80/40." E4 was asked what R1's vital signs were when her first assessment of R1 showed that the resident was lethargic. E4 stated that they were within normal limits but could not state what they were. E4 was asked if there was a supervisor on duty and E4 replied that she thought there might have been on the long term care side but that there was no supervisor on this side (sub-acute area).	F9999		

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F9999	Continued From page 24 E4 stated that she thought E7 (RN) would call the supervisor. On 4/6/06 at 2:40pm, E5 (Director of Clinical Services/Registered Nurse) stated, "E4 told me that they attempted an IV and couldn't get it. If they can't get the IV then they should call whoever is on call. I don't know why they didn't." When E5 was asked why R1 was sent to the closest hospital she replied, "Because R1 wasn't doing well." On 4/6/06 at 2:50pm, E6 (Director of Nursing - DON) stated, "The RN attempted the IV a couple of times and was not able to get it. That just really concerned me. Why didn't the nurse get me? I was here after 6:00pm and there were other RN's here until 10:00pm. If we can't get a resident's IV, we send them out (to the hospital). E6 was asked why there was such a gap in time from when the order for R1's IV fluids was obtained to the several unsuccessful attempts at an IV (9:30pm on 4/4/06 and 2:35am on 4/5/06)? E6 stated, "I don't have an answer for that. I wondered about that myself." E6 then stated that she was concerned that there were vital signs in the beginning (E4's 1st assessment) and then at the end (last assessment before leaving the facility) but nothing in the middle (between assessments) for R1. E6 stated that R1's physician called her to ask what had happened. E6 stated she read the chart to the physician. When E6 was asked what R1's physician said to her she replied, "He asked me if it was documented anywhere that R1 was agonal. It wasn't (documented)." On 4/7/06 at 10:00am, Z1 (Physician) stated, "	F9999		

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F9999	Continued From page 25 The facility did call about a week ago stating R1 was not eating or drinking well. Another physician was on call and gave the order for the IV for hydration. On Wednesday (4/5/06) I called the facility to see what had happened. There are a lot of notes that don't coincide with her condition. The facility gave glowing reports as to R1's condition but I didn't believe it as accurate. I don't believe the vital signs that were documented and I don't believe R1 was talking. R1's condition was markedly worse than what was reported. R1 was near death when the ambulance pulled up. R1 had minimal signs of life. When the ambulance arrived they were delayed significantly because they could not get the papers for R1's transfer. R1 was in marked trouble and the transfer papers should have been ready to go. If the facility could not start the IV and had called the doctor earlier this could have saved her life. From a long standpoint of view she would have died but not that day. R1 had diagnoses including renal failure and needed hemodialysis. R1's cause of death was hyperkalemia. With appropriate care she would not have died at this time. Even if R1 could have gotten to the emergency room (ER) a little earlier they could have saved her. R1's death could have been prevented at this time." On 4/6/06 at 11:00, Z2 (ER Charge Nurse) stated, "R1 was a full code upon arrival to the ER . Z3 was the ER nurse but there were several people in the room. R1 was dead upon arrival." On 4/6/06 at 4:18pm, Z3 (ER Registered Nurse) stated, "I don't know what the ambulance report said but the ER technician yelled that she needed a nurse in the room. When I walked by R1	F9999		

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F9999	Continued From page 26	F9999		

looked dead. I called for the doctor and went into the room right away. R1 had a few agonal respirations and then nothing. The cardiac monitor showed pulseless electrical activity (PEA) on the monitor. We coded R1 but could not bring her back. When Z4 (ER physician) checked R1's corneal reflex when she arrived and there wasn't one. R1 had no vital signs when she arrived or an IV. The only time we had any vital signs were because of the epinephrine and cardiopulmonary resuscitation (CPR)."

On 4/7/07 at 5:30pm, Z4 (ER physician) stated, " R1 should have come in earlier. R1's pupils were fixed and dilated when she came in. R1 had agonal respirations, weak pulse and unobtainable blood pressure. R1 was in PEA on the cardiac monitor and we initiated CPR. The possible cause of R1's death is hyperkalemia. The hyperkalemia can cause the PEA rhythm. This is evident by the peaked T waves and widened QRS complexes (for R1) on the cardiac monitor. R1 looked cachetic. R1 was most definitely dehydrated. Dehydration can cause hyperkalemia and the hyperkalemia can cause PEA."

The facility's policy and procedure, "Resident's Condition or Status/Change In" showed, "Policy: The facility will promptly notify the resident, his or her attending physician and responsible party of any changes in the resident's condition and/or status. Procedure: The nurse will notify the resident's attending physician when: b. there is a significant change in the resident's physical, mental or psychosocial status; f. deemed necessary or appropriate in the best interest of the resident; g. changes occur that affect the

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F9999	Continued From page 27 residents current level of care...." The Physician Order Sheet (POS) dated 3/3/06 for R1 showed, "Encourage oral (PO) fluid intake. The POS showed diagnoses including Malnutrition, Hypotension, Acute Renal Failure and Chron's Disease status post Ileostomy." R1's care plan dated 3/3/06 for malnutrition showed, "Monitor food/fluid intake and document if below 75%. Monitor for muscle wasting, dehydration, persistent areas of redness, change in level of consciousness and cognition, weight loss." The facility's Intake and Output policy showed, "Intake and output will be recorded for all residents on intravenous fluids, dialysis, and restricted intake and for others as ordered by physician or assessed as needed by an RN, LPN." R1's treatment order sheets dated 3/3/06 showed, "Encourage oral (PO) fluid intake - for your information (FYI)." There was no documentation showing monitoring of R1's fluid intake. On 4/6/06 at 12:28pm E1 confirmed that all of R1's records had been given to the surveyor. When E1 was asked if the intake and output record for R1 was also with R1's closed record? E1 replied, "Yes, but we can check the CNA book." E1 and the surveyor went and checked the CNA book. E1 stated, "They are not there so they must be in the record (R1's closed chart)."	F9999		