STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 01/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD HEALTHCARE CENTER	**6125 SOUTH KENWOOD CHICAGO, IL 60637**

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F9999	Continued From page 6	F9999		
F9999	FINAL OBSERVATIONS	F9999		

Licensure Violations
Licensure Violations

300.1010(h)
300.1210(a)
300.1210(b)(2)
300.1210(b)(3)
300.3220(f)
300.3240(a)

The facility shall notify the resident's physician of any significant change in a resident's condition that threatens the health, safety or welfare of a resident.

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.

General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
-All treatments and procedures shall be administered as ordered by the physician.

-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

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F9999	Continued From page 7 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of Nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act). An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. (Section 2-107 of the Act). These requirements were not met as evidenced by: Based on record reviews, staff interviews and interview with Z2 the facility neglected to provide R3 with needed care and failed to: (A) Provide sufficient hydration to R3 for several days. (B) Identify the signs and symptoms of dehydration. (C) Provide appropriate interventions or measures that would prevent R3 from being severely dehydrated, and follow physician orders. (D) Seek medical care in a timely manner for one resident (R3) who was cognitively impaired, at risk for dehydration, previously hospitalized for dehydration, had not eaten or drank fluids for several days and was sent to the emergency room . (E) Detect a critical change in condition. (F) Monitor fluid intakes/output changes in R3 that would trigger dehydration.	F9999		

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F9999	Continued From page 8 As a result R3 was readmitted to the hospital in acute renal failure, obtunded, hypotensive, severely dehydrated, in kidney failure. Four days later R3 died. Findings include: Upon R3's original admission to the facility on 11-11-05 the initial nutritional assessment stated that he appeared thin and underweight. It also indicated that he was at high risk for nutritional deficits. R3 is cognitively impaired and requires complete assistance from staff for drinking and eating. His RAP dated 11-17-05 indicated that he had good skin turgor and oral mucosa is good, " He takes liquids liberally." On 12-02-05 R3 was readmitted to the facility after a brief hospital stay for a diagnosis which included dehydration, lethargy, and difficulty swallowing. Review of his Minimum Data Set (MDS) reentry data reports that R3 was readmitted to the facility after a hospital stay after staff noted R3 to be lethargic, have a slow response, have difficulty swallowing and have an elevated temperature. The MDS also states, "Appetite remains poor. Needs assistance with all ADL's staff to monitor consumption of meal." On 12-05-05 Z1, (MD) wrote an order for facility to initiate bowel and bladder program and monitor the amount of intake and output. Review of the bowel and bladder tracking forms states	F9999		

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F9999	Continued From page 9	F9999		

that this process requires staff to "Provide fluids between meals, monitor the residents intake and output each shift while on B& B tracking." There is no evidence that intake and output was being done by each shift or that the resident was eating or drinking . Review of R3's records indicate that there was no monitoring being done for R3's intake or output.

E6 (CNA) stated that since R3's readmission he was "not eating." She further stated that she took care of him for 3 or 4 days and he wouldn't eat. " He would hold the food in his mouth. " "I took care of him a lot. I reported to the nurses that he would not eat and they would write it down. Nurses are supposed to do the calorie count, not us. I was told not to force him to eat. He couldn't drink either. He was not looking good."

On 12-07-05, Z1 was in the facility and was informed by E5 (evening nurse) that R3 was not eating. Z1 was asked by E5 if he (Z1) would see him (R3). On 12-7-05 Z1 (MD) ordered labs and a calorie count. There is no evidence that a calorie count was initiated or completed by staff. The facility staff failed to to do a calorie count for R3 after the physician ordered a calorie count to be done 12-07-05.

Review of labs for R3 dated 12-08-05 showed, Na of 144 (high normal), BUN 33 (high), Potassium 3.6 and Chloride 108 (High normal).

There was no evidence that facility staff monitored R3's condition for a change of status. There are no accurate records that the resident was being offered fluids or was voiding. There is no evidence that facility staff monitored R3's

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F9999	Continued From page 10 food, or fluid intake as the doctor ordered. On 12-12-05 R3 was assessed by E4 to have a poor cognitive response, his oral mucosa membranes were dry, his mouth and lips were dry and he was obtunded. E4 stated " He didn't look good, he was not able to drink. His mouth was pasty." E4 was instructed to send R3 to one hospital, but records indicated that due to R3's quickly deteriorating condition of hypotension (82/50), heart rate of 143, respirations of 38 according to the emergency room records, he had to be diverted to a closer hospital. Upon arrival in the Emergency room R3's labs showed the following. Sodium 169 (131-145), Potassium 5.4 (3.5-5.1), CO 16 (28), BUN 165 (33) , Creat 9.4 (0.5-1.4) 92% oxygen saturation. These are critical lab values showing signs of severe dehydration and acute renal failure. Emergency records further indicate that R3 presented with no gag reflex and no withdrawal from pain. Z2 (MD) stated that he was informed that the resident had not eaten for a couple of days however upon arrival to the hospital, R3 was severely dehydrated and in clinical renal failure. "He was emaciated and obtunded" upon arrival to the emergency room. These records further stated that after the placement of a urinary catheter there was "no urine return in the catheter." After R3 received over 3 liters of fluid in the emergency room, records indicated that he was able to express only 12 cc's of urine.	F9999		

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F9999	Continued From page 11 Z2 (ER-MD) stated "Based on his labs (upon arrival) he was in acute kidney failure due to low blood flow, which leads to a critical non flow of urine. He should have an average of 50 cc's per hour or 200-300 cc per day. "	F9999		