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F 387	Continued From page 39 until 5/23/10, (greater than 5 months after admission). R11 has not been seen since 5/23/10. 10. The facility face sheet identified R12 was admitted to the facility on 4/23/10. R12 is an 80 year old male resident with diagnoses to include Occlusion of Cerebral Artery, Cerebrovascular Disease, Mixed Receptive-Expressive D/O, Facial Weakness, Mental Retardation, Emotional D/O and Hx of Cerumen Impaction according to the facility face sheet. The facility showed R12 was seen on 5/23/10, (1 month after admission). R11 has not been seen since 5/23/10. On 9/24/10 at 9:10 AM, E2 (Director of Nursing) stated she was not aware of the physicians visits not being made in a timely manner. E2 verified this was not acceptable and that new approaches would need to be adopted by the facility to ensure all residents are seen as required.	F 387		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1220b)2) 300.1220b)3) 300.3240a) 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 psychological	F9999		

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F9999	Continued From page 40 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	F9999		

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F9999	Continued From page 41 resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to notify a resident's physician when a resident was drinking 75% or less of all her fluids for over 1 month. The facility failed to ensure R1's fluid needs were met according to assessed needs. The facility failed to have a system in place to identify residents at risk for dehydration and develop hydration plans showing how they will meet the fluid requirements for their residents. This failure contributed to R1 being admitted to a local hospital for Aspiration Pneumonia, Difficulty in Swallowing, Significant Dehydration, Electrolyte Abnormalcies, and Hemoconcentration. R2 was admitted to a local hospital with diagnoses of Urinary Tract Infection, Substantial Dehydration, and Hypokalemia secondary to Dehydration. The facility failed to have a plan to monitor residents at risk for dehydration which includes: 1. An initial screening for residents at risk for dehydration risk 2. A proactive hydration program to assure that resident fluid needs are met. This applies to 58 of the 84 residents residing in the facility (R1, 3&4, 7 & 8, 10. 12, 13-17, 19-27, 29-32, 36, 38, 40-42, 44, 45, 48 & 49, 50, 52-54, 56-58, 60-72, 74, 75, 77, 79 & R80). The examples include:	F9999		

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F9999	Continued From page 42 R1's Minimum Data set (MDS) of 8/10/2010 shows that the resident has severe cognitive impairment and requires total assistance from the staff for mobility, dressing, eating, and hygiene. The MDS shows that the resident's methods of communication are by signs, gestures, and sounds. The MDS documents that the resident is rarely or never understood. R1's diagnoses include Down's Syndrome, Dementia, and Non-Speaking, according to the 9/2010 Physician Order Sheet (POS). On 9/21/2010 at 9:00 AM, R1 was observed seated in a geriatric chair, in her room. The surveyor attempted to communicate with the resident, but received no verbal response or eye contact. A feeding pump with formula was observed next to the resident's chair. On 9/20/2010 at 10:15 AM, Z1 said that R1 came into the GI (Gastrointestinal) Lab on 9/9/2010 for PEG tube placement, as an outpatient. Z1 said that when the resident presented to the lab, the resident was observed to be very "dry." She said that R1's tongue was stuck to her teeth. She said that the resident was given mouth care. The inside of her mouth had ulcers. Z1 said that her tongue looked like "cobblestones." It had very deep grooves. Z1 said that she called the facility and spoke with E5 (Licensed Practical Nurse) who said she did not know how long the resident had not had any water. She said that the resident had not had anything to eat since September 3, 2010 (9/3-9/8/2010). Z1 said she took the resident to see Z4 (physician) at which time the resident appeared to be in respiratory distress with Oxygen saturations in the 80's (Normal is 95-100% - MayoClinic.com). Z1 said that the resident's legs were mottled and she was	F9999		

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F9999	Continued From page 43 not responsive. Z1 said that the resident is mute. On 9/22/2010 at 3:30 PM, Z4 said, "When we first saw (R1) her mucous membranes were very dry and she was having difficulty breathing. She was too unstable to do the PEG (Percutaneous Endoscopic Gastrostomy) tube procedure. I ordered lab tests and she was admitted to the hospital. We found that her Na (sodium) level was high, she was severely dehydrated, and her blood was hemoconcentrated. She had gone some time without fluids. We needed to correct her Na and rehydrate her. She would have been better off if she would have gotten in for the procedure sooner." Z4's consultation report of 9/9/2010 states, "...When I went to see her, she was extremely dehydrated and was having difficulty breathing...Her Oxygen saturation is about 75% on room air and on a nonrebreather mask it is around 90%...Mucous membranes are extremely dry...." Z4's recommendations are, "1. the patient needs a correction of her electrolytes and volume status. 2. She needs correction of her respiratory status as well. 3. After she has been stabilized, we will proceed with an upper endoscopy with placement of a PEG tube." Z4's Discharge Summary of 9/13/2010 states, "...While in the GI suite, she was found to be quite dehydrated and she became hypoxic...When she came in, she was very dehydrated and she was also given oral care while here." The Discharge Summary shows the resident's principal diagnoses included Aspiration Pneumonia, Difficulty in swallowing, significant Dehydration, electrolyte abnormalcies, and Hemoconcentration.	F9999		

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R1's initial laboratory results of 9/9/2010 shows the following:

WBC (white blood cell)	12.10 -	High	(Norm 4.5 - 11.0)
Hemoglobin	17.9 -	High	(Norm 12.7 - 14.7)
Hematocrit	53.8 -	High	(Norm 36 - 44.9)
Glucose	159 -	High	(Norm 74-106)
BUN	32 -	High	(Norm 7-22)
Potassium	3.6 -	Low	(Norm 3.8-5.1)

The Merck Manual of Geriatrics, 3rd edition states under dehydration and volume depletion (page 562 - 568) an increased Hematocrit and BUN (Blood Urea Nitrogen), Hypernatremia, and Hyperkalemia are indicative of dehydration and decreased water intake.

A Web MD (www.webmd.com) article, Potassium in Blood, states, "Potassium levels often change with sodium (Na) levels. When Na levels go up, potassium levels go down...other conditions that can cause low blood potassium levels include...dehydration...."

The 4/21/2010 RD (Registered Dietician) documents that R1's fluid requirements are 1650 cc's in a 24 hours period.

R1's diet Care plan of 8/13/2010 shows that the resident has a problem with chewing and swallowing related to dysphagia. The problem list shows that on 4/13/2010 the resident choked on pureed food. Interventions included are to offer fluids to meet hydration needs and monitor

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F9999	Continued From page 45 and record intake at all meals. There are no specific interventions on how the facility plans to meet the RD's recommendation of fluid needs for R1. R1's Meal Intake Record for 8/2010 and 9/1 through 9/8/2010 shows that out of 117 meals there is no documentation of fluid intake for 34 meals. For 42 of 83 meals documented the resident consumed less than 75% of her fluids. The fluids were not measured. Staff based the fluid intakes on percentages. On 9/21/2010 at 9:30 AM, E4 (Licensed Practical Nurse - LPN) said that the nurse aides fill out the intake records in the dining room. She said that if there is a problem they let the nurse know. The nurses don't review the intake records unless a problem is brought to their attention. A swallow study was conducted by Z5 (Speech Therapist) on 9/3/2010 documented a recommendation was made to make the resident NPO (nothing by mouth). On 9/21/2010 at 2:50 PM, Z3 (Nurse Practitioner) said that she saw R1 on 9/8/2010. Z3 said that the resident's mouth appeared dry. Z3 said, "I did not know that a swallow study had been done on 9/3/2010 and that there was a recommendation for the resident to be NPO. I was not made aware of that until 9/7/2010 (at which time Z3 signed the Speech Therapy order) She went from 9/3 to 9/8/2010, before the NPO order was carried out." Z3 was shown R1's intake records. She said, "I had not been made aware of (R1's) poor intake for August through September 7, 2010. I would have acted sooner if I'd have known."	F9999		

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F9999	Continued From page 46 The Long Term Care Legal Desk Reference HCPro. MA. 2006, states, "...Resident who are at high risk for dehydration must be identified...Contributing factors to inadequate hydration: fever, infection, dysphagia, nausea, vomiting, diarrhea, malabsorption, edema, inability to consume fluids or refuses fluids...Signs and symptoms of dehydration: sunken cheeks, sunken eyeballs, dry tongue and membranes, dry, inelastic skin, weight loss, hypotension, increased pulse, weakness, mental confusion, constipation and impaction, abnormal laboratory values (elevated hemoglobin/hematocrit...BUN...Sadly by the time signs and symptoms appear and are evident to staff most residents are already quite dehydrated, making the need for aggressive interventions essential...Chapter 12, Nutrition, pages 195-198 states, "...Interventions have been evaluated repeatedly and periodically and modified according to the resident's responses to the intervention...Evaluate I&O over at least one week, compare with dietitians's calculations of the resident's minimum daily fluid requirements..." The American Medical Directors Association (AMDS), Dehydration and Fluid Maintenance-Clinical Practice Guideline (www.amda.com.2001) states, "...The facility's health care practitioners and staff must know how to recognize, assess, treat, monitor, and reduce the risk of dehydration or fluid/electrolyte imbalance...Because dehydration is both common among frail older persons and yet under recognized and under treated, all long-term care providers must be vigilant at identifying patients who have or are at risk for dehydration or other	F9999		

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F9999	Continued From page 47 fluid/electrolyte imbalances...." Nursing Notes show that there is no mention of the resident's poor intake in the month of August, 2010. On 9/1/2010 at 7:51 PM, Nursing Notes state, "Resident refused to eat supper." On 9/2/2010 at 7:14 PM, Nursing Notes document, "...took only two bites of supper, would let food sit in mouth and not swallow...." The nursing documentation for 8/2010 and 9/2010 show that there were no hydration assessments done. The Second Edition of the Nursing Care of Older Adults Theory and Practice (page 204) states, "...In older adults, total body water may be further diminished by poor fluid intake secondary to age-related factors, such as diminished thirst sensation. Older adults must consume 1,500 to 2,000 mL (milliliters) of fluid daily to maintain adequate hydration... (page 527) Examination of the mucous membranes and skin turgor over the abdomen provide more accurate clues to dehydration...older people may have a diminished thirst response...A visual examination of urine concentration will provide some clues to hydration. When any indicators of...dehydration are identified, the next step is to determine whether the hydration...status can be improved adequately without removing the person from the setting. The role of the nurse can be especially important in assessing hydration...." The facility's Intake and Output (dated 2/04) policy and procedure states that the objective is to maintain an accurate record of the resident's fluids balance. The procedure lists that staff are to "check with resident to make sure that all fluid intake has been measured, including all fluids served between meals and total intake at the end	F9999		

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of each shift."

The facility's Hydration Assistance Policy and Procedure dated 7/08 states the purpose is "to provide adequate daily fluids to all residents to avoid dehydration."

On 9/21/2010 at 10:30 AM, E1 (Administrator), and E2 (9/24/2010 at 10:00 AM) verified that the facility does not have a hydration policy, risk assessment, nor guidelines to show the facility will ensure and meet a resident's required fluid intake.

The facility's Intake and Output policy and procedure (dated 2/04) states that the objective is to maintain an accurate record of the resident's fluids balance. The procedure lists that staff are to "check with resident to make sure that all fluid intake has been measured, including all fluids served between meals and total intake at the end of each shift."

The facility's Hydration Assistance Policy and Procedure dated 7/08 states the purpose is "to provide adequate daily fluids to all residents to avoid dehydration."

2. R2 is an 88 year old female resident admitted to the facility on 5/13/10 according to the facility face sheet. R2 has diagnoses to include Convulsions, Hypoxic-Ischemic Encephalopathy, Diabetes Mellitus Type II, Atrial Fibrillation, Congestive Heart Failure, and Cerebral Artery Occlusion according to the Physician Order Sheet (POS) dated 9/10. The POS showed R2 takes Lasix 80 mg daily (diuretic).

R2's Meal Intake Records dated June, July and

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F9999	Continued From page 49 August 2010 showed that of the 240 documented meals, R2's fluid intake was less than 50% of her required amounts for 103 meals. The Dietary Care Plan dated 5/19/10 identified R2's needs as 1750-1960 calories, 84-91 grams of protein and 1750-2450 ml. of fluid daily. This care plan stated R2's needs would be met if she (R2) consumed 80-85% of all her meals. The Dietary Care Plan dated 8/15/10 (3 months later) identified R2 as having an Oral Intake of 25-50%. On 9/24/10 at 9:10 AM, E2 (DON) verified the facility does not track specific amounts of fluid intakes (ml's/cc's). R2 had been treated for Urinary Tract Infections (UTI's) on four occasions since her admission (6/3/10, 7/15/10, 9/9/10 and 9/19/10). On 9/19/10, R2 was admitted to the hospital with diagnoses of Urinary Tract Infection, Substantial Dehydration and Hypokalemia secondary to Dehydration according to the Physician Admission Note. As a part of the plan of treatment, the physician admission note stated, "I am going to hold the Lasix and start her on IV fluids...The patient will be given extra potassium in the IV." R2's lab values dated 9/19/10 show: BUN 47 High (Normal 7-22 mg/dl) Creatinine 1.79 High (Normal 0.52-1.04 mg/dl) Potassium 3.7 Low (Normal 3.8-5.1 mEq/L) 3. On 9/21/2010 at 10:30 AM, E1 (Administrator), E3 (Licensed Practical Nurse - Restorative Nurse), and E6 (MDS Coordinator) said that the	F9999		

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F9999	Continued From page 50 facility does not do hydration assessments. E3 said that residents are considered at risk for dehydration if they have skin issues or if a resident is on diuretics. On 9/21/2010 at 3:30 PM, E1 presented a list of residents at risk for dehydration. The list included 58 of the 84 residents residing in the facility (R1, 3&4, 7 & 8, 10. 12, 13-17, 19-27, 29-32, 36, 38, 40-42, 44, 45, 48 & 49, 50, 52-54, 56-58, 60-72, 74, 75, 77, 79 & R80). The facility could not show how it determined that each of the residents was at risk for dehydration. The care plans for each of the residents were not specific and did not include the RD's fluid recommendations or how the facility was going to try to meet those requirements. On 9/21/2010 at 10:30 AM, E1 (Administrator), and E2 (9/24/2010 at 10:00 AM) verified that the facility does not have a hydration policy, risk assessment, nor guidelines to show the facility will ensure and meet a resident's required fluid intake. (A)	F9999		