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	146075	A. BUILDING ______ B. WING ______	C 07/30/2012

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GRANITE NURSING & REHABILITATION	**3500 CENTURY DRIVE GRANITE CITY, IL 62040**

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F9999	FINAL OBSERVATIONS	F9999		

LICENSURE VIOLATIONS:

300.1210b)
300.1220b)3)
300.3240a)

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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.

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on record review and interview, the facility failed to provide timely laboratory services, treatment, and sufficient fluids for 2 of 3 residents (R2, R3) reviewed for urinary tract infection in a sample of 3. This failure resulted in R2 and R3 becoming dehydrated and required hospitalization for treatment. R3 expired on 7/20/12.

The findings include:

1. R2 was admitted to the facility on 8/5/11 with diagnoses, in part, of Alzheimer's, Diabetes Mellitus, Pressure Sore on the heel, and peripheral vascular disease. R2 had a history of recurrent urinary tract infections with laboratory reports and the Care Plan documenting a positive urinalysis on 11/11/11, 12/18/11, 2/6/12, 2/27/12, 4/4/12, and 4/26/12.

The Care Plan dated 8/5/11 identified R2 with recurrent urinary tract infections with the approach to "Monitor for adverse effects", "Report to physician/nurse practitioner" and "Encourage Fluids". The Care Plan also identified R2 at risk for dehydration with the goal to be well hydrated. The approaches include, in part, "Observe and document food and fluid intake" and "Encourage

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F9999	Continued From page 21 consumption of food". R2 was assessed on the "Assessment of Dehydration Risk" on 5/7/12 as low risk. On 6/25/12 at 10:00 PM, nurses notes documented the physician was contacted and orders for a urinalysis and culture and sensitivity was obtained. The nurses note documents R2 was "being sluggish this evening and c/o (complained of) UTI (urinary tract infection) possible". The lab report for the urinalysis documented the urine was "Collected" on 6/26/12 at 7:00 PM and "Received" on 6/28/12 at 4:28 AM. The laboratory (lab) report documented the urinalysis was "Reported" on 6/28/12 at 10:34 AM to the facility. The lab report documented "TNTC" (too numerous to count) for white blood cells and a culture was indicated. The culture lab report documented the culture was "Received" on 6/28/12 1:48 PM and "Reported" to the facility on 6/30/12 at 10:22 AM. The culture lab report documented greater than "100,000 CFU/ML (colonies forming units/milliliter)" of Proteus mirabilis. The lab report documented the physician was not contacted with the results until 7/1/12 at 12:10 AM and Augmentin 500 milligrams three times per day for 10 days was ordered. The nurses notes dated 7/1/12 at 3:51 AM also documented the physician was notified and Augmentin 500 milligrams three times per day for 10 days was ordered. According to the June and July, 2012 Medication Administration Record the facility did not give the first dose of antibiotic until 7/1/12 at 8:00 AM. The urinalysis was ordered on 6/25/12 at 10:00 PM with the first dose of antibiotic not given until 7/1/12 at 8:00 AM.	F9999		

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E2, Director of Nursing (DON), stated in an interview on 7/19/12 at 9:25 AM that the lab takes two days from when the urinalysis results are obtained to do the culture. E2 stated they had problems getting a sample from R2 and when they did the lab did not pick the sample up until the next day. E2 stated the lab will not do stat urinalysis so they have to wait until the sample is picked up. E2 stated the antibiotic was given early in the morning on 7/1/12. The MAR documented it was given at 8:00 AM.

The "Quarterly Nutritional Re-Evaluation" dated 5/4/12 documented R2's weight was 132.6 pounds with fluid needs at 1800 milliliters per day. According to the nurses notes dated 6/21/12, R2 weighed 139 pounds. The "Nutritional Assessment" dated 8/8/11 documented normal fluid needs at 30 cubic centimeters (cc) per kilogram (kg) of body weight and increases the fluid needs to 35 cc per kg for urinary tract infection or dehydration. According to the Nurses Notes dated 6/28/12 at 2:34 PM, E8, Registered Dietitian, assessed R2 for normal fluid needs of 1860 cc's per day based on a weight of 135.6 pounds. The note did not address that R2's fluid needs would increase due to the urinalysis reported to the facility on 6/28/12 at 10:34 AM. Based on the "Nutritional Assessment" calculations and R2's weight of 135.6 pounds, R2's fluid needs would be 1849 cc's (weight in kg x 30 cc's) for normal needs and increase to 2157 cc's (weight in kg x 35 cc's) with a urinary tract infection.

The "Meal Report" documented the following fluid amounts at meals for R2: 6/25/12-2040 cc's,

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6/26/12- 1800 cc's, 6/27/12-1080 cc's, 6/28/12-960 cc' s', 6/29/12-1560 cc's, 6/30/12-incomplete, 7/1/12-incomplete, 7/2/12-1540, and 7/3/12-incomplete. The average amount of fluid taken in by R2 in June on the "Meal Report" was 1530 cc's per day as calculated by the facility. R2 had a lab report on 4/3/12 with the blood urea nitrogen (BUN) at 33 (8-19) and creatinine of 1.2 (0.66-1.25).

The facility provided fluid intake amounts on 7/19/12 that included the "Meal Report", medication pass fluids and Prostat supplement for R2 as follows: 6/25/12-2490 cc's; 6/26/12-2250 cc's; 6/27/12-1530 cc's; 6/28/12-1830 cc's; 6/29/12-2010 cc's; 6/30/12-breakfast and lunch fluids not charted; 7/1/12-breakfast and lunch fluids not charted; 7/2/12-1990 cc's; 7/3/12-admitted to hospital at 2:52 PM-1020 cc's prior to admission.

According to the lab report routine ordered labs were done on 7/2/12. On 7/3/12 at 12:32 PM, the lab reported that the BUN (Blood Urea Nitrogen) was 114 (9-23) and the creatinine was 2.9 (0.5-1.1). Sodium and potassium levels were within normal limits. According to the lab report, the BUN and creatinine were at "critical high" levels. According to the nurses notes dated 7/3/12 at 2:52 PM, the Physician, Z1, was notified and R2 was sent to the hospital due to "critical high labs".

According to the History and Physical dated 7/3/12, R2 was admitted to the hospital on 7/3/12 with "Reason for Admission" as "Dehydration and acute urinary tract infection". The History and Physical documented the family "reports her

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F9999	Continued From page 24 mother has been lethargic and is normally alert. Fatigued, easily exhausted and not participating in minimal activities of daily living". The "Assessment" documented dehydration, acute renal insufficiency on chronic kidney disease, stage 4, metabolic encephalopathy, acute urinary tract infection, Diabetes type 2, sacral decubitus ulcer and hypertension. R2 was discharged from the hospital on 7/6/12 with final diagnoses as acute kidney injury secondary to volume, chronic kidney disease, stage 3, Depletion, prerenal azotemia, dehydration, fecal impaction, urinary tract infection, Diabetes type 2, hypertension, and encephalopathy secondary to urinary tract infection. R2's blood urea nitrogen on discharge was 36 (9-23) with a creatinine of 1.11 (0.5-1.1). Z1, Physician and Medical Director, stated in an interview on 7/18/12 at 1:20 PM that R2 was hospitalized with acute dehydration due to low intake. Z1 was provided the fluid intake amounts from the "Meal Intake" sheet which only listed meal fluid amounts. Z1 stated there was a correlation between the low fluid intake, urinary tract infection and impaction. Z1 stated the impaction goes hand in hand with low fluids and then the urinary tract infection makes it even more difficult. Z1 stated the kidneys were impaired due to low fluid intake and then the infection would increase the difficulty. Z1 stated if R2's BUN and creatinine went back to normal baseline after hospitalization then she was dehydrated. Z1 stated it is hard to see "day to day" and the only thing that would have helped if someone was paying attention to the numbers. Z1 stated someone has to monitor the intake	F9999		

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daily.

2. R3 was admitted to the facility on 7/12/12 with diagnoses, in part, of chronic obstructive pulmonary disease, atrial fibrillation, congestive heart failure, morbid obesity, and chronic kidney disease stage 3 with creatinine between 1.2 and 1.7, according to the history and physical dated 7/12/12. A lab report dated 7/12/12 documented R3's Blood Urea Nitrogen (BUN) at 42 (8-23) and creatinine 1.7 (0.5-1.1). The history and physical noted R3 had a "mild urinary tract infection" and Ciprofloxacin was ordered on discharge to the facility. There was no culture and sensitivity documented. The initial nurses notes from the facility documented R3 required assist of 1-2 staff and was alert and oriented times 3 and "Pleasant and cooperative, able to make needs known". A regular diet was ordered.

On 7/15/12 at 2:07 AM, R3 complained of nausea, vomiting and constipation. At 7:40 AM the nurses note documented R3 was nauseated and phenergan 25 milligrams three times per day was ordered. The nurses notes documented R3 "consumed 120 cc's all shift". R3 was "alert and oriented x 3".

The nurses notes dated 7/16/12 at 4:39 AM documented "Resident consumed 100 cc all shift". On 7/17/12 at 6:30 AM the nurses notes documented R3 started "yelling she can't breathe". The family called and stated R3 was more confused.

On 7/17/12 at 9:00 AM, a lab report documented R3's BUN at 96 and creatinine at 6.3. Both were documented as "CH" (critical high). On 7/17/12

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F9999	Continued From page 26 at 11:23 AM, Z2, Nurse Practitioner, saw R3 and ordered to hold Lasix, give Kayexalate 30 grams, recheck the labs and do a urinalysis with a culture and sensitivity as indicated on 7/18/12. Z2 documented as "Assessment/Plan" that "(elevated WBC (white blood count) CXR (chest Xray) UA (urinalysis) renal failure-diuretic use hold Lasix hyperkalemia-1 dose Kayexalate Hold K (Potassium)". In an interview on 7/24/12 at 9:00 AM, Z2 stated she was not aware of R3's low fluid intake. Z2 stated she does not have access to the fluid intake on the computer and staff have to inform her. Z2 stated she had thought R3 was in renal failure with Lasix use. Z2 stated R3 had a high white blood count and she had ordered a urinalysis for 7/18/12. Z2 stated R3 could stand when first admitted, according to Physical Therapy, but then declined. Z2 stated R3's fluid needs would have been 2000-2500 cc's per day based on her weight of 320 pounds. E2, Director of Nursing (DON), documented R3 received the following fluids from the "Meal Intake" sheet and medication pass: 7/13/12-1200 cc's, 7/14/12-1200 cc's, 7/15/12 1200 cc's, 7/16/12-1060 cc's, 7/17/12-840 cc's. E2 stated on 7/24/12 at 11:50 AM that the urinalysis was not obtained. E2 confirmed the urinalysis was ordered on 7/18/12 and R3 went to the hospital on 7/18/12. On 7/18/12 at 6:43 AM, the nurses notes documented R3 was "yelling now "Help Me" "Help Me" "I can't breathe". At 12:02 PM, E2 documented that she approached R3 and her	F9999		

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family and told them the physician had been contacted regarding her anxiety and lab results. E2 documented Z1 was going to be in the facility to examine R3. At 1:25 PM the nurses notes documented Z1 was in the facility with orders to send R3 to the hospital.

The History and Physical dated 7/18/12 documented R3 was admitted to the hospital with "Altered mental status". R3 was "confused, just moaning out loud". The history and physical documented the BUN at 126 and a creatinine of 6.8. The urine was noted as "Turbid, packed full of white cells and many bacteria". R3's white blood count was 19.3 (4.0-10.0). The "Assessment" documented 1. Encephalopathy. This is metabolic. Etiology uncertain at this time, but there are multiple factors. The patient is significantly dehydrated. 2. Acute renal failure. I suspect related to volume depletion. 3. Cardiac Arrhythmia, secondary to underlying metabolic problem. 4. Hypertension. The discharge summary dated 7/20/12 documented the final diagnosis as metabolic encephalopathy with secondary diagnosis as acute renal failure, electrolytes abnormality, urinary tract infection, Proteus, hyperkalemia, dehydration and Hypocoagulable state.

The Urine culture dated 7/19/12 documented R3 culture was greater than 100,00 of Proteus mirabilis which was resistant to Ciprofloxacin. R3 had received Ciprofloxacin on her admission to the facility on 7/12/12 for a urinary tract infection.

(B)