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F 327	Continued From page 22 Administrator; E2, Director of Nursing; E3, Certified Nurse Aide (CNA); E7, Regional Director; E8 and E9, Licensed Practical Nurse (LPN); and E10, E11, E12, E13, and E14, CNA's, and review of the facility policy and procedure and in-service records, it was determined the facility took the following actions to remove the Immediate Jeopardy: 1. All residents were assessed for signs and symptoms of dehydration. Completed 3/15/13 with dietitian review. 2. All Direct Care staff were inserviced on 3/13/13 in regards to intake and output, signs of dehydration, physician notification, meal intake, and provision of hydration. 3. All staff were inserviced 4/1/13 for hydration, signs and symptoms of dehydration, measures to take to ensure hydration, communication regarding residents at risk for dehydration, and monitoring residents with poor intake.	F 327		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and	F9999		

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F9999	Continued From page 23 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. Section 300.1010 Medical Care Policies h) The facility 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	F9999		

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F9999	Continued From page 24 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. Restorative measures shall include, at a minimum, the following procedures: 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: 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. (Section 2-107 of the Act) These Regulations were not met as evidenced	F9999		

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by:

Based on record review, interview and observation the facility failed to assess, monitor and provide sufficient fluid to maintain proper hydration for 5 of 8 residents (R1, R4, R2, R6, R8) reviewed for dehydration. This failure resulted in R2 being hospitalized for dehydration and expiring.

The findings include:

1. R2 was admitted to the facility on 2/20/13 with diagnoses, in part, of depression, Alzheimer's, pneumonia, and muscle weakness. The lab values on 2/20/13 were documented as Blood Urea Nitrogen (BUN) at 11 (7-25 mg (milligrams)/dL (decaliter), creatinine at 0.9 (0.6-1.3 mg/dL, and sodium 137 (135-145 mEq (milliequivalents)/L (liter).

The "Admission Assessment" dated 2/20/13 documented "Good" for "Turgor". The assessment also documented R2 had to be "Fed" and was oriented "To person". The hospital "Physician's Orders at Time of Transfer" on the "Nursing Home Transfer Form" dated 2/20/13 documented for R2 "Assist (with) meals" and "Between Meal nourishment".

The nurses notes on 2/20/13 at 4:15 PM documented "Good skin turgor", "needs help (with) eating", "Appears in a pleasant mood. quiet-alert x 1 to person. noted some confusion". The nurses notes dated 2/20/13 documented R2 "needs help with eating". On 2/24/13 the nurses notes documented "fed by staff". On 2/27/13,

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F9999	Continued From page 26 "needs to be fed/assist". On 2/28/13 "Staff fed meals". The Care Plan dated 3/1/13 identified R2 as at risk for dehydration due to cognitive impairment, decreased thirst perception, lack of awareness of need to drink and inability to communicate. The care plan documented as interventions: Assess skin turgor over sternum or inner thigh, as aging skin loses elasticity; Assess urine for color, consistency , and odor, as frequent, clear urine is an indicator of hydration; Be alert for symptoms of dehydration: change in mental status/confusion, constipation/fecal impaction, dizziness/drop in blood pressure from baseline, fatigue/lethargy; Explain the importance of hydration to (R2): Staff to offer fluids frequently and explain the importance of drinking fluids; Encourage her to drink and offer assistance at each encounter or on a routine basis; and Staff to feed (R2) as needed. On 2/23/13, Z3, R2's Primary Physician, came to the facility to see R2 and ordered lab work to be completed on 2/27/13. The lab results on 2/27/13 documented BUN at 20 mg/dL, creatinine at 1.1 mg/dL, and sodium 147 mEq /L. There was no other documentation that the physician was notified after 2/27/13 until 3/3/13. On 2/25/13 the nurses notes documented at 11:00 PM that R2 had a "Lg (large) emesis x 2 undigested food". The next nurses note on 2/27/13 at 12:00 AM documented "loose stools x 2". Lab work was drawn and reported on 2/27/12 at 5:00 AM. At 2:30 PM the nurses notes documented "multiple loose stools-no emesis. Alert to person (with) confusion poor PO intake".	F9999		

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F9999	Continued From page 27 On 2/28/13 the nurses notes documented at 12:55 PM "N+V+D (nausea, vomiting, diarrhea) noted today PO fluids enc. (encouraged)". The nurses notes documented "loose stool x 1" on 3/1/13. On 3/2/13 the nurses notes documented "cont. (continue) to have loose stool. (No N/V (nausea/vomiting). Good appetite. Feeds self". At 3:15 PM the nurses notes documented "Did (not) get up for meals today". On 3/3/13 at 1:05 AM it documented "loose stools x 2". The temperature was 100 and Tylenol was given for increased temperature. At 5:00 AM on 3/3/13 the nurses notes documented "Respirations rapid and shallow-(left) leg mottled. The physician was notified (Z3) and "TO (telephone order) received to send to the hospital". The nurses notes documented that R2 expired at 11:30 AM at the hospital. There was no documentation in the nurses notes regarding monitoring and assessing skin turgor, urine, and indicators of dehydration according to the Care Plan. E2, Director of Nursing stated in an interview on 3/13/13 at 1:35 PM that the nursing staff would chart in the nurses notes any assessment for urine or skin turgor. E2 stated there was no intake and output documentation for R2. E2 stated there has been a lot of residents with the flu in the building. The hospital History and Physical dated 3/3/13 by Z2, Hospital Physician, documented R2's lab results on admission was BUN at 60, Creatinine 4.4, and Sodium was 179. R2 was admitted with chief complaint of altered mental status and respiratory distress. The History and Physical documented R2 was normally alert but not	F9999		

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oriented appeared septic and was experiencing "Cheyne-stokes breathing pattern. Due to the patients critical condition she was admitted for palliative care. Z2 documented R2 had very poor skin turgor and "The patients oral mucous membrane appears dry with food particles and significant dry thick green exudates covering over the paraoral cavities as well as the tongue". Intravenous hydration was started due to "significant hypernatremia with sodium of 172, suspected for lack of oral intake or oral feeding from the nursing facility". R2 expired shortly after her arrival to the medical floor of the hospital.

The hospital "Discharge Summary" dated 3/3/13 documented the final diagnoses as Sepsis, acute cardiopulmonary arrest, acute pulmonary failure, acute renal failure, multisystem organ failure, hypovolemic, hyperosmolar hypernatremia secondary to the severe volume depletion with dehydration and anemia of chronic disease.

Z2 stated in an interview on 3/13/13 at 10:36 AM that R2 had a severely high sodium level that was "incompatible with life". Z2 stated the severe dehydration and hypernatremia was the cause of death which caused the organ failure. Z2 stated R2 could not have been given fluids or fed.

Z3, Physician, stated in an interview on 3/26/13 at 9:35 AM, that the facility did not call him except on 2/27/13 to discontinue therapy. Z3 stated he was at the facility on 2/23/13. Z3 stated he was not aware there was any problems until the sister of R2 called him the day after she died to tell him. Z3 stated no one called him to tell him of her loose stools or decline. Z3 stated he was in town that weekend and was not sure why they didn't

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F9999	Continued From page 29 call him. Z3 stated it was a "Sad case" with what transpired in a week. Z3 stated they should have called him to help alleviate her problems. 2. R1 was identified in the Care Plan dated 12/28/12 as at risk for Dehydration due to cognitive impairment. The interventions included "Assess skin turgor over sternum or inner thigh, as aging skin loses elasticity", Assess urine for color, consistency, and odor, as frequent clear urine is an indicator of hydration", Be alert for symptoms of dehydration: change in mental status/confusion, constipation/fecal impaction, dizziness/drop in blood pressure from baseline, fatigue/lethargy", and "Explain the importance of hydration to (R1): and clarify the relationship of fluids and incontinence". The Care Plan dated 12/28/12 also identified R1 with "Cognitive Loss/Dementia", "Disordered Thinking, Mental function varies", and Disordered Thinking, Easily Distracted". The facility Nurses Notes dated 2/28/13 at 1:25 AM documented R1 "continues to have loose stools x 3-fluids encouraged". On 2/28/13 at 3:00 PM the nurses notes documented "loose stools x 4 today" and "poor PO (passing orally) intake". On 3/1/13 at noon the nurses notes documented the physician was "notified of current condition loose stools x 2". A Z-Pack was ordered. On 3/2/13 at 12:30 PM, the nurses notes documented R1 refused liquids and refused to get out of bed. On 3/3/13, the nurses notes documented fluids were encouraged and "will monitor". The physician was not notified again until 3/3/13 at 12:30 PM due to hypoxia with oxygen saturation levels at 80%. The nurses note also documented poor oral intake and poor	F9999		

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appetite. R1 was admitted to the hospital for dehydration and bronchitis. There was no documentation in the nurses notes regarding monitoring and assessing skin turgor, urine, and indicators of dehydration according to the Care Plan.

E2, Director of Nursing stated in an interview on 3/13/13 at 1:35 PM that the nursing staff would chart in the nurses notes any assessment for urine or skin turgor.

The hospital History and Physical dated 3/3/13 documented R1 was "positive for mental status changes, increased confusion". According to the History and Physical, "Per family, one week ago patient was able to communicate and understand and know his family. He was able to stand and was eating good". R1 was admitted with diagnoses of "Dehydration, bronchitis, leukocytosis and hyperkalemia". R1's lab results were: Blood Urea Nitrogen 65 , creatinine 1.2 , Sodium 151. R1 was readmitted to the facility on 3/8/13.

Z2, Hospital Physician, stated in an interview on 3/13/13 at 10:36 AM that R1 was dehydrated on admission to the hospital with sodium levels in the 150's. Z2 stated R1 received hydration and that was corrected.

3. R8's Care Plan dated 1/11/13 identified R8 as at risk for dehydration due to cognitive impairment, dysphagia, fluid restriction and restricting fluids to avoid incontinence episodes. The interventions were: "Assess skin turgor over sternum or inner thigh, as skin in the elderly loses elasticity", Assess urine for color, consistency,

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and odor, as frequent clear urine is an indicator of hydration", Be alert for symptoms of dehydration: change in mental status/confusion, constipation/fecal impaction, dizziness/drop in blood pressure from baseline, fatigue/lethargy", and "Explain the importance of hydration to (R8): and clarify the relationship of fluids and incontinence".

There are no nurses notes from 2/8/13 to 3/12/13. On 3/12/13 the nurses notes documented R8 had an 8 pound weight loss and "eats fair to good each meal". The note also states "Plan to have Dietitian review this weight loss". The last Dietitian documentation was on 10/18/12.

On 3/12/13 at the noon meal, R8 was observed to eat only 75% of his ice cream with no other food or fluids taken. On 3/13/13 at the noon meal, R8 was observed to drink 4 ounces of water only. E3, Certified Nurse Aide (CNA), confirmed R8 only drank 4 ounces of water in an interview on 3/13/13 at 1:50 PM.

The Food Intake Record for R8 documented R8 as "Fair" or that he ate and drank 50-75% of his food and fluids at the noon meal on 3/12/13 and 3/13/13. E2, DON, was informed of the intake observation for R8 at the noon meals and the documentation in the Food Intake Record. E2 stated in an interview on 3/13/13 at 2:00 PM that she asked E3 why the Food Intake Record was marked as Fair. E2 stated E3 told her she had told E6, CNA, that R8 had 0% intake and was not sure why she marked it that way.

At 2:10 PM, the Director of Nursing was observed

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to check R8's skin turgor by pulling the skin up on his chest and arms. The skin on the arm was slow to go back but did not tent when pulled up. E2 stated the turgor was 'not good, not bad, not tenting". E2 stated she was not aware R8 had only had 4 ounces of water at lunch and told the staff R8 has to drink. E2 stated she told the charge nurse to make sure it was documented in the shift report. E2 stated R2 would be put on intake and output sheets.

At 3:20 PM R8 was observed still in the hallway in his geri chair. R8's eyes were sunken. When asked what the hydration plan for R8 was E2 stated they had made a new sheet to monitor fluid intake. E2 was not aware if R8 had any fluids since lunch. E2 confirmed in an interview on 3/14/13 at 10:30 AM that the physician was not notified of the low intake until the evening of 3/13/13. E2 stated he ordered R8 to be monitored on an intake and output record and start weekly weight monitoring.

4. R6 was admitted to the facility on 11/14/12 with diagnoses, in part, of Alzheimer's, Parkinson's disease, Depression. The Care Plan dated 11/25/12 and 2/22/13 documented "Dehydration, at risk for, potentially related to diuretic medication and dependency. Risk factor: cognitive impairment." The interventions listed on the 2/22/13 Care Plan documented "Assess skin turgor over sternum or inner thigh, as aging skin loses elasticity.", Assess urine for color, consistency, and odor, as frequent, clear urine is an indicator of hydration", and "Be alert for symptoms of dehydration: change in mental status/confusion, constipation/fecal impaction, dizziness/drop in blood pressure from baseline,

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fatigue/lethargy". On 3/13/13 the following interventions were added: "offer fluids throughout the day and night", assist with all meals", "labs as ordered".

On 12/3/12 the physician ordered lab work and to "push water". The lab work was not completed until 12/5/12 at 10:20 AM and reported to the facility at 10:30 PM on 12/5/12. E5, Licensed Practical Nurse (LPN), documented on the lab report "MD (Medical Doctor) Notified 12/5/12".

The lab results were BUN 57, Creatinine 1.0, Sodium 178. The sodium level was designated as "RCH" or "Repeat Critical High". Z4, Lab technician, stated in an interview on 3/27/13 at 9:15 AM that the repeat critical high means it has been repeated to ensure the correct results.

R6's intake was documented as below the estimated fluid requirement for R6. Fluid needs were calculated by the Registered Dietitian as 1458 cc's (cubic centimeters) per day on the 1/17/13 "Nutritional Assessment". This is for normal fluid needs at 30 cc's per kilogram of body weight. The Nutritional Assessment documented fluid needs for "UTI (urinary tract infection), HX (history) Dehydration" is 35 cc's per kilogram of body weight. This would increase R6's fluid needs to 1701 cc's of fluid per day. The "Physician Orders" documented R6 was started on Lasix 20 mg twice a day on 11/14/12.

The Intake and Output documentation for R6 noted her daily fluid intake was below fluid requirements. On 11/29/12-480 cc's; 11/30/12-690 cc; 12/1/12-530 cc; 12/2/12-550 cc; 12/3/12-190 cc's; 12/4/12-260 cc's; and,

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12/5/12-560 cc's. There is no documentation the low fluid intake was reported to the physician. There is no documentation in the nurses notes from 12/1/12 through 12/6/12 regarding skin turgor or urine assessment for dehydration. E2, Director of Nursing stated in an interview on 3/13/13 at 1:35 PM that the nursing staff would chart in the nurses notes any assessment for urine or skin turgor.

E5 stated in an interview on 3/13/13 at 3:10 PM that she would usually call the physician if the lab was critical and usually the lab call to tell us. E5 stated she could not recall that far back. On 3/14/13, E2 provided a written documentation by E5 of the 12/5/12 incident. There was no date on the documentation.

E5 documented "On 12/5/12 I notified (Z1) about labs on R6. Unable to recall the specific details of this event. I do not recall a telephone conversation with the lab on this night. I do recall checking our facility fax between 8 PM and 10 P med pass. It was during this time I received the fax and notified (Z1)".

E2 stated in an interview on 3/14/13 at 10:30 AM that E5 told her she had called the physician about R6 and he had told her to call the family. E2 stated E5 could not recall if she had. E2 stated the next morning on 12/6/13 they did call the family and told them if she wasn't sent to the hospital she would die. E2 stated she was not sure why they had not sent her out the evening of 12/5/12.

The nurses notes dated 12/5/12 documented at 4:00 PM and on 12/6/12 at 1:45 AM has no

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	146144	A. BUILDING _____ B. WING _____	C 04/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE SENIOR LIVING CENTER	**902 SOUTH MCLEANSBORO BENTON, IL 62812**

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documentation the physician was notified of the lab results. The next nurses note on 12/6/12 at 9:40 AM documented "Labs drawn came back critical. (Z1, Physician) notified. Orders to send to ER (emergency room) for IV (intravenous) fluids and evaluation".

Z1, Physician, stated in an interview on 4/1/13 at 11:30 AM that he could not recall if he was notified regarding R6's lab values dated 12/5/12. Z1 stated if they would have called that night on 12/5/12 about the sodium being 170 that he "hope you would have sent her in". Z1 stated a sodium of 170 was "sort of an emergency" and they "should have called me". Z1 stated a sodium of 155, 160, 170 was the "usual manifestation of not drinking".

According to the History and Physical dated 12/6/12, R6 was admitted to the hospital for severe hypernatremia, hyperchloremia, erythrocytosis, probably secondary to dehydration. R6 was admitted to the medical floor for IV fluid hydration. The history and physical documented R6's catheter was draining "dark amber urine". R6 was readmitted to the facility on 12/10/12.

5. R4 was admitted to the facility on 1/18/13 with diagnoses, in part, of mental retardation, possible psychosis, altered mental status. On 1/13/13, R4's bun was 18, creatinine 1.1 and sodium 147.

The nurses notes dated 3/1/13 documented R4 was having emesis and loose stools. Z1, Physician, was in the facility and documented in a progress note "One of the principal things is he is not eating and drinking enough and that does

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concern me. Today is Friday, CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel)next week along with pelvis and both hip X-rays. They must keep me posted about his eating".

The nurses notes dated 3/2/13 documented at 2:00 PM that R4 refused breakfast and lunch. The next nurses note was dated 3/3/13 at 2:45 AM when R4 was found on the floor non-responsive. R4 was sent to the hospital where he was admitted.

The History and Physical by Z2, dated 3/3/13, documented R4 was admitted due to fractured ribs, altered mental status, acute renal failure, hypovolemic, hyperosmolar, hypernatremia secondary to volume depletion, metabolic acidosis secondary to prerenal azotemia, and hyperglycemia. The History and Physical documented R4 had significant altered mental status with minimal withdrawal to pain. The History and physical documented R4 was "significantly volume depleted with perioral mucous membrane dryness with crack in the lips. The patient was found to have significant poor skin turgor with poor capillary refill...". The History and Physical documented R4's BUN at 38, creatinine at 1.2 and sodium at 162.

Z2 stated in an interview on 3/13/13 at 10:36 AM that R4 had been combative in the past and was unresponsive on admission. Z2 stated R4 had severe dehydration with cracked lips and dry mucous on the tongue. Z2 stated R4 was unkept and required IV fluids.

R4 was readmitted to the facility on 3/6/13. The

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nurses notes dated 3/6/13 documented "Plan: Encourage, persuade et insist 1-1 (with) this res. (resident) to consume food (and) fluids and to involve family to participate (with) eating or drinking".

6. The facility Policy and Procedure titled "Hydration-Clinical Protocol" states:

"The staff, with the physician's input, will identify individuals with signs and symptoms (for example, delirium, lethargy, increased thirst, etc) or lab test results (for example, hypernatremia, azotemia, etc.) that might reflect existing fluid and electrolyte imbalances".

"They will report this information promptly to the Attending Physician".

"The staff, with the physician's input, will identify individuals with a significant risk for subsequent fluid and electrolyte imbalance, for example, those with prolonged vomiting, diarrhea, or fever, or who are taking diuretics and/or ACE inhibitors and who are not eating or drinking well

"The Physician will manage significant fluid and electrolyte imbalances, and associated risks, appropriately and in a timely manner."

"The staff will provide supportive measures such as providing fluids and adjusting environmental temperature".

"The Physician will help monitor for the development, progression, or resolution of fluid and electrolyte imbalance in at-risk individuals".

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F9999	Continued From page 38 "The Physician will adjust treatments based on specific information (lab results, level of consciousness, etc.) relevant to the individual". (A)	F9999		