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HELIA HEALTHCARE OF BELLEVILLE	**40 NORTH 64TH STREET BELLEVILLE, IL 62223**

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F 353	Continued From page 16 head rounds...We are also starting an evening administrator program Department heads will take turns working late to monitor ...the halls and to address any issues that arise. 5/23/13 documents, Call lights going unanswered, facility response documents We are conducting random spot checks on off hours to address the calls. 6/12/13 documents, Call lights not being answered, facility response documents on 6/12/13, Call light audits started by administrative staff. 7/9/13 documents, Call light still unanswered. Record review of facility Call Light's Policy and Procedure documents: Policy: Call lights will be answered promptly.	F 353		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)3) 300.1810h) 300.1220b)2)3 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy	F9999		

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F9999	Continued From page 17 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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 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.	F9999		

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F9999	Continued From page 18 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 300.1810 Resident Record Requirements h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output. 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	F9999		

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F9999	Continued From page 19 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 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 neglected to provide adequate hydration, and monitoring of intake and output. The facility also failed to follow their policy for Monitoring Intake and Output and Physician Notification, for one of four residents (R2) reviewed for hydration and physician notification in the sample of four. This failure resulted in R2 being hospitalized with a diagnosis of acute renal failure.	F9999		

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F9999	Continued From page 20 Findings include; On 3/26/12, Z2, Registered dietician documented in the admission assessment that R2's estimated nutritional needs require 2324 calories and 2490 cc of fluids per per day. Review of Facility Weekly intake and output records for the months of March and April 2012, document per 24 hour period that, on 3/23/12 R2 had 3's intake, Output is not measured, 3/24-840 cc intake; output not measured, 3/25-840 cc's intake, output not measured; 3/26/-220 cc's intake, output not measured; 3/27-320 cc's intake output not measured, 3/28-880 cc's intake, output not measured, 3/29-100 cc's intake, output not measured, 3/30-860 cc's intake, output not measured, 3/31-360 cc' s' intake, output not measured. For the month of April no intake and output was monitored until 4/6/12. On 4/6- there was 940 cc's intake and 600 cc's output, 4/7-960 cc's intake 410 cc's output, 4/8-720 cc's intake, 500 cc's output, 4/9-120 cc's intake, 850 cc's output, 4/10-700 cc's intake,1100 cc's output, 4/11-890 cc's intake 500 cc's output, 4/12-740 cc's intake, 400 cc's output, 4/13-60 cc's intake 800 cc's output, 4/14-120 cc's intake, 300 cc's output, 4/15-320 cc's intake 200 cc's output. There is no documentation of vomiting that occurred on 4/2 and 4/15 or the intravenous fluids that were given on 4/6/12. None of the daily intake totals meet the required fluid needs documented by the dietician. During an interview with Z1, R2's physician, on 7/17/13 at 11:15 PM, he stated he would expect 30-40 cc's per hour of urine output or 620-860 cc's per 24 hours. None of the output measurements come close to those requirements.	F9999		

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On 4/6/12 R2's BUN had increased to 64 (7-27 milligrams/deciliter) (mg/dc) and the Creatinine had increased to 2.5 (normal 0.5-1. 5mg/dc) Z1, MD, ordered Normal Saline 1 liter 1,000 cc's) to be given intravenously (IV). R2 received the IV fluids and a repeat laboratory test was ordered for 4/9/12.

On 4/10/13, Z1 was notified of the BUN result 61, and Creatinine result of 89. A daily nurses note dated 4/10/12 documents that Z1 ordered monitoring (R2) for now, and call him with any changes. There is no documentation that Z1 was ever notified of R2's ongoing, poor intake and output.

There are no narrative nurses notes in the chart for review between 4/6/12 and 4/16/12. There is no documentation of any nursing notes for 4/12 or 4/14, and no communication between nursing staff and Z1 between 4/10/12 and 4/16/12. Daily nurses notes and Speech Therapy notes for 4/1-4/15/12 document that R2 ate 50% one day, but regularly consumed less than 25% orally.

On 4/15/12 per the Daily Ventilator Documentation Record it is noted that R2's breathing treatment was held on day shift due to vomiting. There is no notation of this in the daily nurses note or on the intake and output record. There is no documentation in the medical record indicating the Physician was notified of vomiting or decreased intake/output over an extended period of time.

Per the Admission Face sheet, R2, has diagnoses which include, Acute-Chronic Respiratory Failure, Tracheostomy, Malignant Neoplasm of the lung, Anxiety, Malnutrition and

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Depression. The Minimum Data Set, dated 3/30/12 documents that R2 requires extensive assistance for all activities of daily living, including eating, and has an indwelling urinary catheter. Review of R2's Plan of Care dated 4/6/12 under the problem area titled, "Potential for alteration in Nutrition," intervention #3 is Monitor Intake and Output, #5 is Monitor for signs and symptoms of dehydration, #6 Monitor labs as ordered.

On 3/26/12, Z2, Registered dietician documented in the admission assessment that R2's estimated nutritional needs require 2324 calories and 2490 cc of fluids per per day.

On 4/3/12 Z3, Speech and Language therapist documented in a note that she discussed concerns with nursing "regarding intake less than 25 % consistently this week, patient breathing heavy and becomes easily fatigued...expressed to nurse concerns with adequate nutritional intake impacted by respiratory decline." Z3 also documented that nursing stated she was, " awaiting test results and she would see if patient could have a supplement." Ongoing Speech Therapy documentation for the week of 6/11/12 documents that R2 never took in more that 50% of her diet, only took sips of fluids and took in only 25% most of the week. Review of current Physicians orders dated 4/2012 has an order dated 4/5/12 to encourage oral fluids. There is no order noted for any dietary supplement.

Review of facility laboratory test results, narrative and daily nurses notes document that starting on 4/2/12 R2 had a change in condition requiring the Physician to be contacted. Z1, the treating Physician for R2 responded and ordered

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baseline laboratory tests to be drawn immediately. The tests included a blood urea nitrogen (BUN), and creatinine (CREAT) level both of which monitor kidney function. Per the laboratory result documentation the normal range for these tests is BUN-7-27 milligrams /deciliter, MG/Dl. The normal creatinine range is 0.5-1.5 MG/Dl. On 4/2/12 the results for R2 were BUN 38 and Creatinine-2.2, both of which are slightly elevated. On 4/5/12 nurses notes document that R2 had cloudy and red tinged urine. The physician was notified and ordered a repeat blood test to recheck the BUN and Creatinine. Z1 also ordered to increase fluid intake for R2. On 4/6/12 Z1, MD was notified of the test results. The BUN had increased to 64 and the Creatinine had increased to 2.5. No documentation of intake and output tracking is available until the 6th for the month of April 2012. When Z1, MD, was given the 4/6/12 lab test results he ordered Normal Saline 1 liter 1,000 cc's) to be given intravenously (IV). R2 received the IV fluids and a repeat laboratory test was ordered for 4/9/12. Z1 was notified on 4/10 that the BUN result was 61, and Creatinine result was 89. A daily nurses note dated 4/10/12 documents that Z1 stated to monitor (R2) for now, and if R2's condition changes, to call.

There are no narrative nurses notes for review between 4/6/12 and 4/16/12. There is no documentation of communication between nursing staff and Z1 between 4/10/12 and 4/16/12, when R2 was noted to have increased respirations and was diaphoretic and pale. Family requested the resident be transferred to the hospital.

On 4/15/12 per the Daily Ventilator

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Documentation Record it is noted that R2's breathing treatment was held on day shift due to vomiting. There is no notation of this in the daily nurses note or on the intake and output record. A Narrative Nurses note for 4/16 also indicates vomiting.

Review of Facility Weekly intake and output records for the months of March and April 2012, document per 24 hour period that, on 3/23/12 R2 had 360cc'c intake, Output is not measured, 3/24-840cc intake; output not measured, 3/25-840 cc's intake, output not measured; 3/26/ -220 cc's intake, output not measured; 3/27-320 cc's intake output not measured, 3/28-880 cc's intake, output not measured, 3/29-100 cc's intake, output not measured, 3/30-860 cc's intake, output not measured, 3/31-360cc's intake, output not measured. For the month of April no intake and output was monitored until 4/6/12. On 4/6- there was 940 cc's intake and 600'cc's output, 4/7-960'cc's intake 410 cc's output, 4/8-720 cc's intake, 500 cc's output, 4/9-120 cc's intake, 850cc's output, 4/10-700'cc's intake,1100'cc's output, 4/11-890 cc's intake 500 cc's output, 4/12-740 cc's intake, 400 cc;s output, 4/13-60 cc's intake 800 cc's output, 4/14-120 cc's intake, 300 cc's output, 4/15-320 cc's intake 200 cc's output. There is no indication on the Intake -Output record of the Intravenous fluids given to R2 on 4/6/12. There is no documentation in the medical record indicating the Physician was notified of vomiting or decreased intake/output.

Review of the Hospital Emergency Department Summary where R2 was treated on 4/16/12 documents that R2 had, " very elevated Creatinine and BUN. Patient appears dry this is likely prerenal failure will hydrate and admit for

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this. Review of the History and Physical from the intensive care unit dated 4/16/12, documents thats R2 had a BUN level of 171-normal range(8-25), her Creatinine was 7.4-normal range (0.60-1.10). R2 was admitted to the medical intensive care unit for treatment of acute renal failure.

Review of the facility policy titled Intake and Output states, "It is the policy of this facility to ensure that an accurate intake and output is maintained and recorded on all residents who have 1) Foley Catheter
2) Intravenous Fluids..... Under the area marked procedure is documented that the Certified Nurses Aide will empty the indwelling catheter bag at the end of each 8 hour shift and the nurse is responsible for maintaining the record and recording the findings on the output form.

During an interview with E1, Administrator on 7/15/13 at 2:30 PM she stated, "If there is no documentation on the intake and output sheet for certain days or shifts I would say (R2) either didn't have any or it did not get measured. I found some additional documentation from the Certified Nurses Aids shift report sheets but I realize there are still many areas on the sheet without any documentation.

During an interview with E2, Registered Nurse, Director of Nurses on 7/30/13 at 1:30 PM she stated, If there is no documentation on the narrative notes or daily nurses notes I would say the nurses didn't document on those days. I checked with medical records and they say everything we have on (R2) was in the medical file you have here."

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F9999	Continued From page 26 During and interview with Z1 Medical Doctor (MD) on 7/17/13 at 11:15 AM he stated, " I would have expected the nurses to let me know the intake, urine output and vital signs for (R2). If any changes or decrease had occurred. I would want to see 30-40 CC's per hour of urine output. It is hard to recall but if there was poor intake and output, I would have given additional IV fluids. I did that once and the labs improved slightly, I would have tried that again or repeated the labs. I count on them to let me know if changes occur. (B)	F9999		