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	145868	A. BUILDING _____ B. WING _____	C 5/24/04

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F9999	FINAL OBSERVATIONS Surveyor: 14208 300.1010(h) 300.1210(a) 300.1210(b)(3) 300.1220(b)(3) 300.3240(a) 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. 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. 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	F9999		

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F9999	Continued From page 36 personal care needs of the resident. 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. The DON shall supervise and oversee the nursing services of the facility, including: 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. 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. An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These requirements are not met as evidenced by: Based on record review, and interview the facility:: 1. Failed to contact the physician to notify him regarding changes in resident's mental status, the color and amount of urine output, food and fluid intake. 2. Neglected to respond to resident's behavior of screaming and yelling for help from 3/10/04 through 4/7/04, wanting to go to the washroom, and wanting a bedpan, respond to documented changes in the color of urine and amount of output between 3/11/04 - 4/7/04, respond when food intake was low and fluid intake did not meet the	F9999		

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F9999	Continued From page 37 estimated daily needs in March and April 2004. 3. Failed to follow the care plan and respond to signs and symptoms of UTI, changes in the urine color and decreased output. 4. Failed to follow the care plan to record intake of fluids in the month of March, 2004, follow the hydration policy and procedure to routinely monitor resident for signs of dehydration, and have a hydration plan for R3 according to assessed fluid needs. This is for one resident (R3) out of the sample of seven. These failures resulted in R3 being admitted to the local hospital on 4/7/04 with Coma, Hypernatremia, Urinary Tract Infection, Hypoxia, and Hypoventilation. R3 expired at the hospital on 4/7/04 pm due to Sepsis and Dehydration. The findings include: 1) R3 was 88 years old who was readmitted to the facility on 3/9/04. R3 had diagnoses of Status Post (S/P) fracture of tibia and fibula, S/P Urinary Tract infection (UTI), Hypertension, Generalized Weakness and Dementia according to R3's Face Sheet 2) R3's nurses notes from 11/28/04 (the original date of admission) through 2/4/04 were reviewed. The nurses notes documented that R3 was treated with antibiotics for UTI from 11/29/04 to 2/4/04 intermittently. R3's nurses notes from 3/9/04 through 4/7/04 were reviewed On readmission R3 had a long leg cast to her right leg. R3 also had an indwelling catheter which was draining dark amber urine. On 3/10/04 at 6:30 am the indwelling catheter was	F9999		

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F9999	Continued From page 38 discontinued. On 3/10/04 at 1:00 pm the indwelling catheter was re-inserted as R3 was unable to void. From 3/10/04 at 8:31 pm to 4/6/04 R3 had thirty-nine documented episodes of screaming and yelling for help and/or wanting to go to the washroom and/or wanting a bedpan. Some examples are as follows: 3/10/04 8:31 pm " ... keeps screaming and yelling saying Help me, I need to go to the bathroom ..." 3/12/04 7:00 am " ... confused with episode of Hollering, ... noted resident (R3) stripping off her night gown ... constantly asking to go to the washroom ..." 3/15/04 1:30 pm " ... keeps screaming/yelling wants to go to the washroom ..." 3/16/04 1:40 pm "... keeps telling to the residents and people passing by that she (R3) wanted to go to the bathroom ..." 3/19/04 7:35 pm "Resident with yelling and screaming episode. ... Obsessed in the bathroom … Roommates daughter complaint that resident was very disruptive and smelling …" 3/23/04 6:00 am "Awake mostly during the night calling out for bedpan all the time ..." 3/23/04 10:00 pm "... Alert with confusion with episodes of screaming/yelling wants to go to the bathroom all the time ..." 3/30/04 1:45 pm " ... yelling/screaming episode with confusion and disorientation ..." 4/2/04 7:00 am "Slept at intervals with episodes of screaming and yelling ..." 4/6/04 6:30 am "Slept at intervals, with episodes of yelling/screaming ..." R3's nurses notes from 3/9/04 to 4/7/04 were reviewed. The nurses notes document the following: 4/2/04 at 1:00 pm documents that a message was	F9999		

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F9999	Continued From page 39 left at physician's office regarding the daughter's (Z4) concern of R3's poor appetite and poor fluid intake. 4/2/04 - 9:00 pm documents that the daughter was notified about the physician not calling back. 4/5/04 - 9:30 pm "Daughter came to see the resident (R3). Brought some food for dinner. Do not even dare to touch anything. Refused to eat nor drink. Spoke with the daughter that there is a possibility that resident (R3) is going up. Nobody knows probably due to diagnosis of dementia. Daughter requesting to change to new doctor ... the daughter wants to speak to him (physician) and probably wants some blood works, IVs and even the possibility of tube feeding ..." 4/6/04 - 10:00 am "Received a call from the resident's daughter (Z4) requesting to change doctor, told her that Dr... will be coming today from vacation. Not sure if he will come today. Told her (Z4) to call his office ..." The review of the nurses notes does not indicate any follow up to try and contact the physician. 4/7/04 - 6:00 am "Slept intermittently during the night. Less agitated. Noted less screaming ... oral fluids refused ...urine output in small amount and concentrated ..." 4/7/04 - 9:00 am "... refused to drink water, eat or take the medication. Kept removing all her clothes ..." 4/7/04 - 11:30 am "Offered lunch, resident (R3) refused ... offered liquids not taking anything." 4/7/04 - 2:00 pm "Called by the CNA noted SOB (Shortness of Breath) but able to push all the tray and broke all dishes on the floor ... Will monitor." 4/7/04 - 4:00 pm "Attempt to give the pm (evening) medications. Resident (R3) noted with apnea and	F9999		

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F9999	Continued From page 40 hardly opens her eyes. Put oxygen at 3 LPM (liters/minute) via NC (nasal cannula). Given fluids via sponge. Paged Dr.___, updated resident (R3) condition and informed that resident (R3) is a DNR but MD stated ... okay to send resident (R3) to the ___ ER for evaluation. 4/7/04 - 5:45 pm "___ ambulance came to pick up the resident (R3). Resident's daughter (Z4) came and accompanied the resident to the hospital ..." R3's nurses notes from 3/9/04 to 4/6/04 were reviewed. The nurses notes documents that on 4/6/04 at 6:30 am R3's indwelling catheter was draining dark tea colored urine. It further documents that on 4/2/04 at 1:00 pm a message was left at physician's office regarding the daughter's (Z4) concern of R3's poor appetite and poor fluid intake. It also documents that on 4/2/04 - 9:00 pm daughter (Z4) was notified about the physician not calling back. The review of the nurses notes does not indicate any follow up to try and contact the physician. A review nurses notes from 3/9/04 documents the following: a. On 3/11/04 at 6:00 am and 3:00 pm the color of the urine was dark amber. b. On 3/29/04 at 9:00 pm the color of the urine was dark amber. c. On 4/3/04 at 6:40 am the color of the urine was dark amber. d. On 4/4/04 at 12:15 am the indwelling catheter was draining concentrated urine. e. On 4/4/04 at 1:30 pm the indwelling catheter was draining concentrated urine. f. On 4/6/04 at 6:30 am the indwelling catheter was draining dark tea colored urine g. On 4/7/04 at 6:00 am the indwelling catheter	F9999		

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F9999	Continued From page 41 was draining small amount of concentrated urine. 3) R3's elimination care plan dated 3/16/04 documents " ... Assess for signs and symptoms of UTI such as burning sensation on urination, cloudy and foul smelling urine, increased confusion, elevated temperature, weakness, urinary frequency or retention. Notify MD as necessary ... Monitor intake and record ." 4) R3's Intake and Output sheets were reviewed. The review indicated that there were no intake documented for the month of March 2004. There were seventeen days where the total output was below 1000 cc. R3's Intake and Output sheets for April 2004 documents the following:	F9999		

	Intake	Output
4/1/04	250 cc	300 cc
4/2/04	400 cc	625 cc
4/3/04	390 cc	650 cc
4/4/04	400 cc	600 cc
4/5/04	140 cc	220 cc
4/6/04	180 cc	600 cc
4/7/04	None	150 cc

R3 was sent to the local Emergency Room on 4/7/04 at around 5:45 pm.
R3's Intake and Output sheets for April 2004 shows intake ranged from 400 cc on 4/2/04 to None on 4/7/04. The output ranged from 600 cc to 150 cc in 24 hours

5) A review of R3's Nutritional Assessment dated 3/16/04 indicates that R3's estimated fluid needs were 1770 cc.

R3's nurses notes documents the following about the fluid intake:
4/2/04 7:00 am "... requested for water, offered per

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F9999	Continued From page 42 request took small amount of water ..." 4/3/04 6:45 am " ... offered oral fluid (water) per request, took only some sips of water ..." 4/3/04 9:45 pm "... keep encouraging to drink water but resident (R3) refused to take it. Then afterwards keeps yelling for water, cold water but takes a sip only ..." A review of R3's nutritional care plan dated 3/16/04 documents "Encourage increased fluids." R3's care plan did not have a specific hydration plan to assure that R3's fluid needs are met. 6) R3's meal monitoring sheets from March 10th 2004 to 4/7/04 were reviewed. A review of R3's meal monitoring sheet from 3/10/04 to 3/19/04 indicates that there was only one meal that R3 had consumed 75%. A review of R3's meal monitoring sheet from 3/20/04 to 3/31/04 indicates that out of the 36 meals R3 consumed 25% for 18 meals and 0% (None) for 18 meals. R3's meal monitoring sheet for April 2004 documents the following: Breakfast % Lunch% Dinner% 4/1/04 50% 25% None 4/2/04 25% 25% None 4/3/04 None None None 4/4/04 25% None None 4/5/04 None None None 4/6/04 None None None 4/7/04 HOSPITAL R3's meal monitoring sheet for April 2004	F9999		

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F9999	Continued From page 43 documents from lunch on 4/1/04 to 4/7/04 Zero to 25% consumption with no food consumed since noon of 4/4/04. 7) E4 (CNA) was interviewed on 5/6/04 at 3:00 pm. E4 stated that he took care of R3 only twice after the readmission. E4 further stated that the second time he took care of her, R3's urine color was dark yellow, she refused to drink fluids and was yelling every 15 minutes to go to the washroom. 8) E6 (CNA) was interviewed on 5/11/04 at 10:50 am. E6 stated that few days before 4/7/04 the color of R3's urine was dark brown and the amount of urine was scant. E6 further stated that during the last one week of R3's stay at the facility R3 was not drinking anything. E6 said that R3 was pleasantly confused prior to the readmission. After the readmission R3 screamed everyday "Help, Help, I want to go to the washroom". E6 also said that R3 screamed everyday from the 3/9/04 until one week prior to 4/7/04. E6 stated that on 4/7/04 at 2:00 pm R3 was not responding to tactile and verbal stimuli. E6 also stated R3 was lethargic and seemed to be in deep sleep 9) Z4 (Family) was interviewed on 5/10/04 at 3:55 pm. Z4 stated that she visited R3 everyday. Z4 further stated that towards the end of March the color of the urine in the bag was dark yellow. Z4 said that that around March 25th whenever R3 saw her she would "Can you get me some water" and by the end of March Z4 had to force her to drink and R3 would hardly take a small sip and that she noticed small amount of urine in the drainage bag when she visited. Z4 also said that R3 was pleasantly confused and ambulated with a walker	F9999		

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F9999	Continued From page 44 and that R3 had previous history of UTIs. Z4 also stated that every time R3 saw her she would state that she wanted to go to the washroom. Z4 further stated that whenever she called the nurse to check on her mother's condition, the nurse would report to her that R3 was yelling all night and morning to go to the washroom. Z4 stated that around March 24th, R3 was eating little breakfast, no lunch, no dinner, she was drinking sips of water and juice. Z4 stated that she went to the nurses' desk and spoke to E5 and asked her to please tell the physician to call her when he comes in, as she wanted feeding tube, and IV. Z4 stated that everyday R3 ate very little. Around April 1st R3 started to take her night gown off and that her breast were exposed. Z4 said that on April 2nd or 5th around 9:00 am she called E5 and suggested that R3 should be transported to the hospital. E5 transferred her call to the Director of Nurses (DON), she told her concerns to the DON, and the DON stated that she will call her back after checking on these concerns. Z4 also said that the DON called her back four hours later and told her that her mother was fine. Z4 stated that when reached the facility that night she saw that R3 was very confused, not eating and not drinking. Z4 stated that on April 5th around 5:30 pm there was little urine in the bag and it was dark yellow, she went to E5 and asked if the physician was coming. E5 stated to Z4 that they were calling and nobody has come to see R3. Z4 also stated that on April 7th around 5:30 pm E5 came to her and told her that she had called the ambulance as R3 was having trouble breathing. Z4 stated that when she entered R3's room, the ambulance attendants were transferring her from the bed to the gurney and that R3 was not responding to anything, R3 was comatosed. Z4 stated that she	F9999		

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F9999	Continued From page 45 followed the ambulance to the hospital. Z4 further stated that the ER Physician (Z2) told her that R3 was in coma, and she was having difficulty breathing and wanted to know what extend she wanted to go with the treatment. Z4 said that she told Z2 that she wanted blood works, brain scan, chest x-ray and EKG because she wanted to rule out pneumonia, blood clots, stroke, and heart attack. Z4 also stated that all these test were negative. Z4 further stated that Z2 told her that they will pump R3 with fluids for dehydration, give antibiotics for UTI and admit R3 to the Intensive Care Unit (ICU). Z4 stated that she went home to change her clothes and the phone rang it was the physician from the ICU (Z3), Z3 told her that R3's kidneys were failing and asked her how long it will take for her to reach the hospital. Z4 stated that by the time she reached the hospital R3 had expired. 10) E2 (DON) was interviewed on 5/6/04 at 3:45 pm. E2 stated that they did not have a tool to assess dehydration. E2 stated that R3's intake for March should have been documented because R3 was refusing to eat. After reviewing the intake and output sheets for April E2 stated that R3 did not have enough output and R3 needed Intravenous (IV) fluids. E2 said that after a day or two of R3 not eating the physician should be notified. E2 confirmed that R3's behavior of yelling and screaming should have signaled a change in R3's mental status probably due to UTI. When the color of urine was dark amber the physician should be notified. E2 confirmed that there was no follow up with the physician. E2 said that the staff failed to identify R3's signs and symptoms for dehydration, UTI and failed to notify the physician and failed to intervene to reverse dehydration.	F9999		

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F9999	Continued From page 46 11) E9 (Nurse) was interviewed on 5/20/04 at 2:44 pm. E9 stated that few days before transferring the R3 out to the hospital R3's urine was becoming dark in color, tea colored. E9 said that R3 was dehydrated because she was not drinking. E9 when asked why the physician was not notified about the tea colored urine stated "I should have paged the doctor but I just endorsed it to the 7-3 Nurse and asked her to update the physician." 12) E5 (Nurse) was interviewed on 5/10/04 at 1:30 pm. E5 stated that the color of R3's urine was dark (unsure of the date). E5 also stated that she was aware of the tea colored urine. E5 said that the R3's output was low for a long time. E5 said that after the readmission to the facility R3 was more confused, kept yelling and saying that she wanted to go to the bathroom. E5 stated that on 4/7/04 at 4:00 pm R3 was not responding to verbal, tactile and painful stimuli. E5 when asked why she did not call other physician when R3's attending physician (Z1) did not respond, E5 when asked to clarify what she meant by the possibility of R3 going up, E5 stated that R3's condition was going down because every day R3 was drinking less and eating less. E5 also stated that the daughter (Z4) was afraid that her mother (R3) will die and wanted lab works, IVs and even the possibility of tube feeding. E5 stated that "I cannot make the decision of who to call. ADON was notified about Dr___ (Z1) not returning the call ...I was not aware that I had to contact the Medical Director ..." . When asked by the surveyor why she did not contact the physician on 4/7/04 at 2:00 pm, E5 stated "I did not get a change to call the doctor. I have no reason to tell you." The surveyor asked E5 why she did not notify the physician before 4/7/04, E5 replied "I cannont give you a reason	F9999		

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F9999	Continued From page 47 why the Doctor was nto called. I work there permanently so everybody waits for me to come, nobody else follow up. I am sorry." 13) E7 (QA Consultant) when interviewed on 5/6/04 at 3:10 pm stated that they do not have any special flow sheet to assess the residents for dehydration and that they used the Minimum Data Set (MDS) to assess the residents for dehydration. R3 had a significant change in status MDS done on 3/16/04, the area of dehydration was not triggered. 14) Z1 (R3's attending physician) was interviewed on 5/13/04 at 1:20 pm. Z1 stated that he has never seen R3, and that he has never received any calls about R3 from the facility . Z1 further stated that he was not on call when R3 was in the facility. 15) Z2 (ER Physician) was interviewed on 5/13/04 at 3:03 pm. Z2 stated that when he saw R3 she was unresponsive, had a coma score of 3 (it is the lowest possible score on the Glasgow coma scale). Z2 also stated that R3 had Dehydration and UTI. 16) Z3 (ICU Physician) was interviewed on 5/13/04 at 3:47 pm. Z3 stated that when he saw R3, she was thirty minutes from death. R3 was profoundly dehydrated, had acute renal failure and UTI. Z3 said R3's pupils were fixed and unresponsive. 17) R3's medical records from the local hospital was reviewed. a. The Emergency Service Record dated 4/7/04 documents that R3 was unresponsive, respirations were 8/minute, had Glasgow Coma Score of 3.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145868	A. BUILDING _____ B. WING _____	C 5/24/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON REHAB & LIVING CTR	**1666 CHECKER ROAD LONG GROVE, IL 60047**

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F9999	Continued From page 48 R3's diagnoses documented were Coma, Hypernatremia, Dehydration, UTI, Hypoxia and Hypoventilation. b. The Critical Care notes dated 4/7/04 documents that R3 was in deep coma, pupils were fixed, she was not responding to painful stimuli. It further documents " ... spoke to daughter by phone and explained that the situation is hopeless and death is imminent within minutes ..." c. R3's Chemistry Panels dated 4/7/04 documents the following: BUN 148 mg/dl (Normal 7- 22 mg/dl) Creatinine 4.3 mg/dl (Normal 0.7- 1.2 mg/dl) Sodium 164 mmol/l, (Normal 135 - 146 mmol/l), Sodium critical result given to the Registered Nurse. R3's Urinalysis dated 4/7/04 documents the following: Color Red, Appearance Turbid Blood 4+ (Normal - Negative) Bacteria 3+ (Normal - None) R3's Urine Culture report dated 4/8/04 (Urine was collected on 4/7/04) documents the following: 100,000 colonies/ml Escherichia Coli 100,000 colonies/ml Enterococcus 100,000 colonies/ml Alpha Hemolytic Streptococcus 18) A review of the hydration policy and procedure documents " ... Nursing will routinely monitor each resident for signs and symptoms of dehydration, such as cracked lips, dry oral mucosa, poor skin turgor and dark urine color. Pertinent observations shall be recorded in the residents' medical record. If signs and symptoms of dehydration occur, the	F9999		

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F9999	Continued From page 49 resident's physician will be notified ...". A review of the change in a resident's condition or status policy documents "... The unit nurse or nursing supervisor will notify the resident's attending physician when: ... there is a significant change in the resident's physical, mental or psychosocial status; ... the resident repeatedly refuses treatment ...".	F9999		