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fluid needs is 1200cc related to the diagnosis of Congestive Heart Failure and the resident's fluid restriction from the physician.

The 5/9/06 MDS has only a nutritional RAP sheet . The RAP shows that R5 leaves 25% or more of her food uneaten, has chewing and swallowing problems, and a reduced ability to feed herself. The dietary manager recommends Resource 2.0, 60cc twice daily with medication.

There was no Care Plan for R5 addressing the resident's nutritional needs and there was no Hydration Care Plan to address how R5's 1500 cc fluid restriction over 24 hours would be allocated and monitored.

On 6/22/06 at 11:00 AM, E10 (CNA) said she did not know what R5's fluid restriction limits were. She was aware that R5 was on a fluid restriction but she would have to look up the actual amount.

On 6/22/06 at 11:00 AM, E11 (CNA) said she had been on maternity leave and she has only been back 3 days. In April R5 was on a 1500cc fluid restriction. E11 (CNA) stated "I'm not sure not sure now(what the restriction is)".

R5's CNA tracking sheet for May 2006 was incomplete for 22 of 93 shifts during the 31 days reviewed. No totals were calculated for the entire 31 days in May. No CNA tracking sheet was available for June. A Nurse Hydration Monitoring tool was reviewed. The sheet did not have a date or a resident name on it. E2 (DON) placed R5's name on the sheet and stated it was the sheet for June 2006. E2 (DON) was unable to produce the fluid documentation for R5 prior to

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F 327	Continued From page 28 June 2006.	F 327		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1010h) 300.1210a) 300.1210b)3) 300.1210b)5) Section 300.1010 Medical Care Policies h) Facility staff 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 a) 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 personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

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F9999	Continued From page 29 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These regulations were not met based on interview and record review which determined that the facility failed to: [1] Reasonably monitor and utilize their objective observations to recognize a resident's (R1) declining condition then use appropriate interventions. [A] Monitor R1's vital signs on the evening shift of 5/25/06 and report R1's abnormal temperatures to Z10 (physician). [B] Assess and recognize a resident (R1)who was in declining health. [C] Assess and manage the pain of R1. [D] Stop administering a stool softener when R1 was having diarrhea stools. The facility failed to notify R1's physician of ongoing diarrhea in May 2006. [E] Recognize and act upon a resident (R1) displaying signs and symptoms of Septic Shock.	F9999		

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[2] Notify the physician of abnormal blood pressure readings and abnormal temperatures. The physician was not notified of frequent diarrhea, abdominal pain, nausea and vomiting.
[A] Follow up on Z6's (Nurse Practitioner) order to call Z10 (physician) with a condition update the morning of 5/25/06.

[3] Monitor the skin integrity and condition of a resident (R1) at high risk for breakdown.
[A] Identify and treat newly developed wounds on the sacral and scrotal areas.

[4] Have a means of communication with the facility doing R1's Hemodialysis.

This is for 1 (R1) of the 5 residents in the sample.

R1 was, according to the ambulance report, transferred via ambulance on 5/25/06 at 7:15PM to a local hospital. R1 was diagnosed as in septic shock, with possible Necrotizing Fasciitis, and Fournier's Gangrene of the Scrotum. According to Z8's (Local Hospital Emergency Department Physician) documentation (dated 5/25/05), R1 was in need of immediate surgical intervention. R1 was airlifted to a regional hospital for surgery and admission to the Intensive Care Unit. At 2:00AM on 5/26/06 the Regional Hospital Intensive Care Nurse's initial assessment states "Patient has large Coccyx wound stage III with green drainage. Wound to scrotum also." The surgical procedure revealed a fistula from the rectum to the scrotum. R1 also had the right Testicle and 3/4 of the Scrotum excised, extensive dissection of the Peritoneum, removal of the anus, and placement of a diverting

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Colostomy. The admitting diagnoses to the Intensive Care Unit of the regional hospital were Sepsis, Necrotizing Fasciitis and Fournier's Gangrene. On the hospital progress notes, dated 5/26/06 and written by Z9 (physician), document " Sepsis - Decubitus and Scrotal Gangrene."

The findings include:

R1 is a 64 year old male resident who was re-admitted to the facility from a local hospital with the discharge diagnoses of dehydration and weakness (according to the Long Term Admission Order Sheet dated 5/1/06). Other diagnoses, according to the hospital History and Physical report dated 4/28/06, are Prostate Cancer, Insulin Dependent Diabetes Mellitus, Morbid Obesity, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, and End-Stage Renal Disease. The resident undergoes Renal Dialysis 3 times a week, Monday, Wednesday, and Friday (according to 4/28/2006 Nephrology Consultation Report).

R1 had been readmitted to the facility with a discharge diagnosis of weakness and dehydration (per the hospital history and physical dated 4/28/06). According to nursing documentation he had multiple significant symptoms. From 5/3/06 to 5/25/06 there were 23 episodes of diarrhea stools documented. The only communication with R1's physician regarding the loose stools is on 5/2/06 at which time an order for Imodium (anti-diarrheal agent) was obtained. On 5/14/06 an order for a stool culture for C-difficile was obtained by the on-call physician. The resident also had a daily order for Colace (stool softener). The Colace was given

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daily except on 5/13, 5/14, 5/15, and 5/16.

From R1's admission date of 5/1/06 through 5/25/06 generalized edema was documented in the Nurse's Notes on 13 days.

On 5/3/06 R1 began complaining of abdominal pain. He complained of pain on 6 different occasions in 23 days (5/3, 5/6, 5/21, 5/23, 5/24, 5/25). R1 had an order for Vicodin (5/1/06 admission orders). This was given to the resident on 5/23/05 and 5/24/05. All other complaints of pain were not assessed or not treated with pain medication. The Nurse Practitioner was notified on 5/24/06 and the physician was notified on 5/25/06 at which time orders to transfer the resident were received.

R1 complained of nausea and emesis 7 times from 5/3/06 through 5/22/06. On 5/2/06 an order was obtained for Tigan, 1 tablet by mouth for nausea and emesis. According to Nursing Notes R1 received the Tigan for nausea and vomiting on 5/5/06 and 5/23/06. There were no assessments completed and the physician was not notified of the nausea and vomiting.

Since admission (5/1/06) R1 had varying blood pressure readings ranging from 67/36 to 150/125. R1's physician was only notified 2 times of his significant blood pressure readings. On 5/19/06 (not timed) the facility received an order to hydrate and hold the resident's blood pressure medications for the day. On 5/24/06 (not timed) the facility received orders to push fluids and call Z 10 in the morning. There is no documentation on the 6AM-2PM shift on 5/25/06 that Z10 was

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called with a condition report regarding R1. R1 had abnormal temperatures less than 97 degrees Fahrenheit 9 times beginning on 5/3/06 through 5/25/06.

The Care Card dated 5/1/06 documents that R1 is cooperative. On 5/7/06 (6AM-2PM shift) nursing documentation shows that R1 is lethargic and uncooperative. From 5/6/06 through 5/25/06 there are multiple entries in the nursing documentation showing R1 as being uncooperative and non compliant. R1 often refused to change positions. In an interview on 6/21/06 at 9:00AM, Z3 (Enterstomal Therapist) stated "I would never have thought of him (R1) as uncooperative, just very sick. He had to be on his back with the head of the bed elevated because of his difficulty with breathing." Beginning on 5/9/06 documentation states that the facility staff assists R1 with all movement. On 6/21/06 at 5:00 PM E1 (Administrator) said "I think we were focusing on his (R1) non-compliance. We may have overlooked the medical issues and the reasons for the non-compliance."

On 5/23/06 it is documented that R1 was "sleepy ." He was given Vicodin for complaints of "sharp abdominal pain".

On 5/24/06, on the 6PM to 10PM shift (exact time not documented), R1 complained of increasing pain; R1 was given Vicodin for complaints of abdominal pain. The nurse documented that R1 's face was red and his skin was hot and dry to the touch. R1's Vital signs were (unknown time): Temperature 100.9 degrees Fahrenheit, Heart rate 106, Respiration 24; Blood Pressure 76/36,

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F9999	Continued From page 34 and Oxygen Saturations were 90% on 2 liters of Oxygen. Z6 (Nurse Practitioner) was contacted regarding the resident's condition. Orders (not timed) were received to gradually increase the Oxygen until Oxygen Saturation is 92% or greater. Give Tylenol 325mg, 2 tablets by mouth every 4 hours for a temperature greater than 99 degrees Fahrenheit. Push fluids related to the low blood pressure and report in the morning to Z 10 (physician). Nursing Notes of 5/25/06 show no evidence that Z10 was called the next morning with an update on R1's condition. On 5/25/06 at 6:30PM it is documented in the nurse's notes that R1 "is complaining of severe pain all over. ...Moaning...Color more pale now... rolled over noted extreme Scrotal swelling and grayish painful area to back of scrotum. Resident is also seeping liquid (stool)...Wife wants R1 sent to the Emergency Department for Care." There are no Vital Signs documented. R1 was transferred to the local Emergency Department at 7:00 PM on 5/25/06 (per nursing documentation). On 6/22/06 at 4:00PM E3 (Assistant Director of Nursing, LPN) said she took care of R1 on the evening shift of 5/24/06. E2 (ADON) felt that R1 needed to be sent to the Emergency Department, however, Z6 (Nurse Practitioner) did not give an order to send the resident to the Emergency Department. On 6/22/06 at 10:00AM E1 (Administrator) said that they do not have a policy stating that if a resident becomes very ill the facility staff can send them to the Emergency Department. However, that is what is done.	F9999		

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F9999	Continued From page 35 On 6/19/06 E7 (Certified Nursing Assistant -CNA) at 2:15PM said that R1 had a reddened area on his buttocks. She also said she observed that on 5/25/06 (day shift) R1 was really quiet, he wasn't his usual self. E7 (CNA) said she reported to the nurse that he (R1) wasn't acting right. The only documentation on 5/25/06 for the 6AM-2PM shift is "Refused breakfast stated he didn't feel like eating it." On 6/19/06 at 2:30PM E6 (Registered Nurse - RN) said she worked the evening shift on 5/25/06 . She observed that R1 was experiencing a lot of pain. "Even when I laid my hand on his abdomen " created pain. His scrotal area was very edematous and painful. R1 was oozing stool. I noticed the bottom of his scrotum was a gray color. She stated that she had noticed R1's condition declining since his last hospitalization in a local hospital (stay was from 4/27/06 to 5/1/06, dates per hospital discharge summary sheet). On 6/19/06 at 4:00PM E2 (DON) said she was called back to the facility on the evening of 5/25/06 due to R1's condition change. She noted that R1's scrotal area was gray in color and moist appearing. She said the resident was in a lot of pain.E2 later stated, on 6/22/06 at 10:20AM, that the nursing staff understood that if a nurse judges that a resident needs to go the Emergency Department for evaluation, the resident is transferred out and the physician order is obtained later. E2 (DON) said she was not contacted on 5/24/06 on the evening shift regarding R1's condition change. E2 also verified that the medical director was not contacted. E2 said if the medical director would have been contacted he would have given an	F9999		

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order to transfer the resident to the emergency department based on nursing judgment.

On 6/21/06 at 9:20AM Z1 (physician) said that for gangrene to develop there would have had to been an open area in the skin and that the gangrene was probably secondary to a cellulitis of the area. It would take a minimum of 2-3 days of underlying infection for R1 to have presented with Fournier's Gangrene of the scrotum and Necrotizing Fasciitis. Necrotizing Fasciitis is preventable with recognition of an open area, proper wound care, and antibiotic therapy. The staff should have recognized his deteriorating condition and the symptoms of Septic Shock.

Z2 (physician), 0n 6/21/06 at 10:30AM said that the sepsis did not happen in a matter of hours, it would have taken days to develop. The resident's emergent condition occurred on 5/24/06, he should have been transferred out at that time.

Z3's (Enterstomal Therapist) progress notes dated 6/26/06 at 9:00AM state "Initial visit to evaluate skin integrity. Patient with multiple problems. The greatest being the scrotum necrotic tissue with possible tract to bowels. Feces coming from opening above scrotum verses feces flowing into opening...there is a linear opening just over the coccyx 3.0 cm x 0.5 cm."

On 6/20/06 Z4 (Enterstomal Therapist) said that it is highly unlikely that R1 could have progressed from not having open areas of the coccyx and scrotum at the facility to having a stage III wound with green drainage on the coccyx 7 hours later (

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F9999	Continued From page 37 upon admission to the Intensive Care Unit). On 6/22/06 at 4:15 PM Z7 (physician) said that R 1 had a very large, gangrenous ulcer on his scrotum upon admission to the Intensive Care Unit of the regional hospital. The wound was very odorous. His scrotum was greenish/black in color and it was oozing green fluid. A wound like this would take days to develop. The gangrenous wound could not have developed over a period of 7 hours (from discharge from the facility to admission to the Intensive Care Unit). The Fournier's Gangrene and the Necrotizing Fasciitis are a result of the facility not identifying and treating an open wound. Z7 (Physician) documented on 5/26/06 "...The patient was in his usual state of health until two days prior to admission, when he began to experience fevers and chills. He was noted to have become a little bit more confused and complaining of increasing pain in his scrotum. On the day prior to admission, it was noted that the patient's scrotum was quite swollen and there was an ulcer on the posterior aspect of the scrotum which appeared to be draining purulent foul-smelling material." The facility policy, Change In Condition, defines a significant change as a "deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications." The policy states under the Procedure Heading that Licensed Nursing staff will obtain a complete set of vital signs at the onset of the condition change and at 4 hour intervals for the first 24 hours. According to the documentation provided	F9999		

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in the nurse's notes from 5/1/06 through 5/25/06 this policy was not followed when R1 displayed symptoms of a condition change.

The book "Nursing Care of Older Adults", second edition (author Carol A. Miller, copyright 1995) shows that normal body temperature decreases with increased age (page 368). It states that "the febrile response of older adults may be impaired by diminished renal function...In the presence of any risk factor, however, hypothermia or hyperthermia may develop in an older adult. (page 370)

Septic Shock (according to the book "Diseases, Nurse's Reference Library" (copyright 1984) lists the early stage symptoms as nausea, vomiting, and diarrhea. The late stages of Septic Shock are apprehension, irritability, and hypotension. It states that Hypothermia is a common late sign.

The facility's Weekly Pressure Ulcer Tracking Report dated 5/2/06 shows R1 had 3 decubitus ulcers on the buttocks ranging in size from .3cm X .3 cm to .6cm X .6cm, all documented to be stage II wounds. The resident also had a decubitus ulcer on his left 5th toe 1.8 X 2.8 cm, staged at level IV. The wounds to the buttocks were receiving a Silvadene dressing and the wound on the toe was getting wet to dry dressings. The Daily Skin Assessment Wound sheet dated May 3, 2006 has the following comment, "3 open areas to buttock. Doctor notified, treatment received. Black Tissue fell off, Stage IV." On 5/16/06 E3 documented that R1's left buttock wounds were healed. There is no further documentation on the Daily Skin Assessment Sheet or the Weekly Pressure Ulcer

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F9999	Continued From page 39 Tracking Report for wounds other than the wound to the left 5th toe. On 6/19/06 at 2:00 PM, E3 said that she did a head to toe skin assessment daily on R1; she does daily head to toe assessments on all residents with current wounds or who have a history of having had a wound. After 5/16/06 there were no open areas to R1's buttocks or scrotum. The Nurse's Notes dated 5/20/06 at 9:00 PM states that R1's left outer heel is purplish in color with a fluid-filled blister 2 cm (centimeters) in size . This wound was not been identified on the May 2006 Daily Skin Assessment sheet. Review of R1's medical record showed no communication or verbal reports from the dialysis center where R1 received his Hemodialysis. On 6/20/06 at 2:05PM E2 (DON) said that they do not receive any form of communication from the Dialysis Center when a resident returns to the facility On 6/21/06 Z11 (Dialysis Center Manager) said that they do not send any form of communication to this facility or to any of the other Nursing Care Facility's they work with. (A)	F9999		