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NOKOMIS GOLDEN MANOR	**505 STEVENS STREET NOKOMIS, IL 62075**

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{F 327}	Continued From page 23 noted to be on the hallways. However, staff are not recording R10s' intake. Nor do her intake sheets indicate she is receiving any fluids other than at mealtime and IV therapy. Interview with E3, ADON, on 12/30/05 at 9:50am indicated that the hydration program cart is only done one time daily Monday thru Friday and not daily as indicated in the POC. The facility failed to identify R10's hydration needs following her readmission, failed to offer adequate fluids throughout the day between meals and at care and failed to care plan her hydration needs according to her needs to ensure adequate fluids are offered.	{F 327}		
F 354 SS=E	483.30(b) NURSING SERVICES - REGISTERED NURSE Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by : Based on interviews and record review, the facility failed to ensure that the facility had the services of a registered nurse (RN) for at least 8	F 354		

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F 354	Continued From page 24 consecutive hours a day, 7 days per week. Findings include: 1) Review of the licensed nurse staffing on 12/29/05 indicated that the facility did not have RN coverage 7 days per week in November and December. The November schedule reflects 16 days where no RN was scheduled to work . Those dates include 11/4, 11/7, 11/12-11/14, 11/17-11/18, 11/21-111/28 and 11/30/05. December schedule reflects 4 days with no RN coverage. December dates include 12/2/05, 12/5/05, 12/9/05 and 12/26/05. The average facility census daily is 65 residents. Interview on 12/30/05 with E2, DON (Director of Nurses) indicates she was in the building and was considered the RN coverage. However, interview also revealed that she did not work as a nurse during those times.	F 354		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.1210b)4 300.3220f) 300.3240a) 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 psychological well-being of the resident, in accordance with each resident's comprehensive assessment and	F9999		

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F9999	Continued From page 25 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: 4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following: Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview and record review, the facility failed to have a system in place to ensure that 1 of 9 sampled residents, R 1, be assessed and monitored for change in condition. The facility failed to have an interim care plan in place to ensure R1's needs are being met. The Facility failed to confirm Physician orders and failed to obtain reports from hospital when R1 was readmitted to the facility. This resulted in R1 not being given fluids or food from 12-24-05 to 12-27-05.	F9999		

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F9999	Continued From page 26 Findings include: R1 was observed on 12-27-05 throughout the day to be lying in bed. R1 would look when spoken to and would follow with his eyes when Surveyor was in his room. E4 and E5, Certified Nurse Aides (CNA's) were observed to reposition R1 in bed at 10:55 A.M. E4 attempted to give oral care with a swab and R1 was noted to clamp his mouth shut. Record review of DOCTOR'S PROGRESS NOTE of 12-9-05 states that R1 had a significant weight loss of approximately 24 pounds in 2 weeks. Stating Periactin could be tried. Family did not want a feeding tube. Record review of R1 's Physician Order Sheet (POS) dated 12-24-05 shows that R1 was readmitted to the facility from the hospital on 12-24-05 with an order NPO (nothing by mouth). R1 also had an order for Hospice care. POS stated diagnosis of dehydration. E2, Director of Nursing, (DON) stated on 12-27-05 at 2:30 P.M. that R1 is NPO and does not receive a tube feeding and confirmed that food and fluids have been withheld for the past 3 days since R1 was readmitted to the facility. E2 stated the doctor made R1 NPO because R1 was not taking anything in at the hospital. E3, Assistant Director of Nursing/Care Plan Coordinator, stated that the discharge planner from the hospital stated they were sending R1 back to the facility in a couple of days and would be doing a swallow evaluation prior to discharge from the hospital. E 3 stated that they called back a couple days later and stated that R1 would be NPO and on Hospice. Both E2 and E3 stated they did not know the results of the swallow evaluation. Surveyor requested that a copy of the evaluation	F9999		

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F9999	Continued From page 27 be obtained from the hospital. At 2:45 P.M., E2 provided the Speech Evaluation and Hospital History and Physical which she obtained from the hospital per Surveyor request. R1's Clinical Swallow Evaluation of 12-22-05 states, "Pt. (patient) was sitting in recliner. Nurse stated that he has not been responding to anything placed in mouth. Pt. first stimulated orally with moist spongette. Swallow was facilitated - weak. Puree - small amount was given. Pt. didn't round lips on spoon. Puree was placed on tongue however pt. used his lips & spit the puree out. Pt. refused to take puree. MD phoned with results. Pt. unsafe to eat orally due to decreased responsiveness & response orally. With increased responsiveness may try small bites puree with thickened liquids to Honey. Contact SLP (Speech Language Pathologist) when status improves." Record review shows that the facility Consultant Dietitian assessed R1 on 12-27-05 and did not question why R1 was NPO. Assessment states, "Resident readmitted from Hospital. Now on Hospice care. Diet: NPO. Stage 4 coccyx pain meds given no other medication given. Hypoactive bowel sounds. Wound & weight loss unavoidable secondary medical condition." During interview with Z2 (R1's Power of Attorney/Son) and Z3 (R1's Son) on 12-27-05 at 3:00 P.M., Z2 stated that R1 is more alert than when in hospital. Z2 stated R1 slept the whole time while he was in the hospital. Z2 stated R1 had IV's when in the hospital but receiving nothing by mouth. Z2 stated that he was told that R1 was unable to swallow. Z2 stated R1 is now more alert and if he can take food and fluids he wants R1 to get it. Z3 confirmed that R1 is much	F9999		

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F9999	Continued From page 28	F9999		

more responsive than when he was in the hospital. He looks around now and will move his lips. Both Z2 and Z3 stated they wanted R1 to have fluids and food if able.

On 12-27-05 at 3:40 P.M., E2 was informed of concern that facility was withholding food and fluids from R1. E2 confirmed that facility was not aware of results of Speech evaluation which was done at the hospital on 12-22-05. E2 stated she is not aware of any staff calling Z1 (R1's Physician) to confirm NPO orders. E2 stated R1 came back from the hospital with these orders. E 2 agreed that R1 is now more responsive and alert than when first readmitted to the facility. E2 stated she had not called Z1 to notify him that R1 was more alert and responsive and was not aware of any staff calling Z1.

Record review of R1's Nurses Notes shows that E2 called Z1 and obtained an order for pureed diet with honey thickened liquids on 12-27-05 at 3:45 P.M., this was after Surveyor expressed concerns. Nurses note states family requested "wouldn't mind having resident try to eat, he's more responsive here."

Nurses notes of 12-26-05 at 0230 state R1 is NPO as per MD orders...Responds to stimuli... Nurses note at 1050 states R1 appeared restless . Sub Q Ativan given...Resting in bed eyes open. There is nothing in R1's nurses notes that states R1 is more responsive than when first admitted on 12-24-05.

Record review showed that there was no interim Care Plan for R1 to address his current needs. Record review of R1's most recent Care Plan of 5-27-05 show that on 12-24-05 update was written that R1 is NPO and Hospice. Care Plan objectives and approaches were unchanged, for example, R1 is at risk for

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F9999	Continued From page 29 dehydration with approaches, in part, Keep fresh water by bedside at all times. Offer him a drink whenever doing his turns and repositioning. Encourage participation in activities where food and fluids. CNA CARE PLAN REFERENCE SHEET that is undated states to assist with transfers, fed by staff, chew/drinks/swallows, pureed diet. Interview with E2 and E3 on 12-28-05 at 11: 30 A.M. confirmed there was no interim care plan for R1 since readmission from the hospital. E3 confirmed that CNA CARE PLAN REFERENCE SHEET was not updated to address R1's current needs. E2 confirmed they did not have a Care Plan for R1 from Hospice. Record of Residents IMMEDIATE NEEDS CARE PLAN shows that Care Plan was started on R1 12-27-05, after Surveyor expressed concerns, which identifies eating - swallowing problem. Approaches include to document how R 1 eats pureed diet with honey liquids and to notify MD with daily update or status. On 12-28-05 at 12:05 P.M., E6 CNA stated she fed R1 at noon meal using a baby spoon. R1 took 2 bites and let the 3rd roll out of his mouth. E6 stated she fed R1 2 bites of honey thick liquids and R1 let the 3rd run out of his mouth and started coughing. On 12-29-05 at 9:50 A.M., E3 stated that R1 only takes a couple of bites and they have noticed that R1 is coughing more when taking fluids. Surveyor asked if they have gotten a Swallowing evaluation by Speech Therapy. E3 stated she hadn't thought of that. E3 stated Hospice has their own, but the facility Speech Therapist would be in today. E3 stated she would call Hospice and see if she can evaluate him. Record review of R1's Physician Orders	F9999		

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F9999	Continued From page 30 show that E3 did get the order for Swallow evaluation. On 12-28-05 at 2:00 P.M., Z1 (R1's Physician) stated R1 was NPO at the hospital and receiving IV's. Z1 stated he was not aware that R1 was discharged from the hospital NPO. R1 was nonresponsive in the hospital. Z1 stated he does not remember anyone calling him and confirming NPO order. Z1 stated he was not notified that R1 was more alert and responsive. Z1 stated that R 1's family did not want G tube. Z1 stated he is not opposed to R1 receiving food and fluids if able and that he didn't want R1 to feel thirst. Z1 stated he would have expected to be contacted when R1 became more alert. If alertness persists then R1 should try to eat. E9, Registered Nurse (RN), on 12-29-05 at 11 :10 A.M. stated that he was involved with R1's admission. E9 stated he transcribed R1's admission orders and transcribed orders from Hospital Discharge Summary. E9 stated he filled out Physician Telephone Order slips but did not call to confirm orders with the physician. E9 stated E10 was also involved with R1's admission. E10, Licensed Practical Nurse (LPN) was interviewed on 12-29-05 at 11:15 P.M. E10 stated she filled out the Admission Nursing Assessment. E10 stated R1 was sent back to the facility without orders and she called the hospital and they faxed Hospital Discharge Summary. E10 was told that R1 was Hospice and NPO. E10 stated she did not confirm orders with R1's Physician stating she thought Hospice would take care of things. Facility Policy and Procedures of 6/99 for ADMISSION ORDERS states, "Orders are verified with attending physician for accuracy and completeness... Orders must be dated and co-signed by nurse."	F9999		