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	145363	A. BUILDING _____ B. WING _____	C 07/20/2006

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MANORCARE AT OAK LAWN/KOSTNER	**9401 SOUTH KOSTNER AVENUE OAK LAWN, IL 60453**

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F 309	Continued From page 14 the 24 hour reports for resident decline in condition and documentation of that decline. Quality Assurance Monitoring - All identified trends will be reviewed by the QA Committee until resolution of these issues, monthly for three months. Completion Date: 7/19/06 While the Immediate Jeopardy was removed as of 7/11/06 the facility remains out of compliance at level 2.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210a) 300.1210b)3) 300.1210b)5) 300.1220b)2) 300.1220b)7) 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 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 personbal 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	F9999		

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F9999	Continued From page 15 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. 5) A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 7) Coordinating the care and services provided to residents in the nursing facility. 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).	F9999		

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F9999	Continued From page 16 These requirements are not met as evidenced by : Based on record review and interview the facility failed to ensure that 1 resident (R3) was free from neglect as evidenced by the failure to provide the necessary care and services related to: 1) The care and maintenance of an indwelling urinary catheter which resulted in Urosepsis, Dehydration and Renal Failure; 2) The assessment, monitoring and documentation of the status of a resident (R3) who was demonstrating a decline in condition; 3) The assessment, treatment and documentation of the status of a wound; 4) Provision of adequate care and treatment of pressure sores. Findings include: R3 was an 81 year old resident who was admitted to the facility on 3/10/06. Her diagnoses included Cancer of the Vulva (Status/Post Surgery). Prior to surgery she had been living at home, but she was no longer able to care for herself. While at the facility, the resident was noted to be alert and able to feed herself. She depended on staff for all other care. She was hospitalized on 7/3/06 with diagnoses of Sepsis Syndrome with Pneumonia, UTI, Inguinal Abscess, Dehydration, Renal Failure, Hyperkalemia ane Respiratory Failure. She expired on 7/4/06 and according to the death certificate, the cause of death was "Sepsis Syndrome." 1) At the time of admission to the facility on 3/10/	F9999		

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F9999	Continued From page 17 06, the resident did not have an indwelling urinary catheter. On 5/21/06 the resident was sent to the emergency room for evaluation after a fall. During her time in the emergency room an indwelling catheter was inserted. She returned to the facility with the catheter. There were no physician orders in the resident's record for insertion, care or monitoring of an indwelling catheter. The nurses notes for R3 did not address the presence of an indwelling catheter. The resident's Minimum Data Set dated 6/23/06 was scored to indicate that the resident did not have an indwelling catheter. There was no documentation by the nursing staff regarding output, urine status or condition of the catheter. In an interview on 7/18/06 Z1 (Nurse Practitioner) stated that she was aware that R3 had an indwelling catheter, but she was not aware that there were no orders for the catheter. She further stated that it is the responsibility of the nurses to notify the physician (or Nurse Practitioner) when orders are needed. R3 was also receiving Hospice Services. While the Hospice notes (nurse and CNA) sometimes commented on the presence of the indwelling catheter, there was no documentation on the urinary status of the resident. On 7/3/06, at 4:00 am R3 was sent to the emergency room due to a change in status. The resident was no longer alert, she was febrile (103.6 axillary) and she had chest congestion. Upon arrival at the emergency room, the indwelling catheter was removed. In an interview on 7/5/06 Z2 (emergency room nurse) stated that when R3 arrived in the emergency room there was no urine in the bag attached to the indwelling catheter. The catheter was not patent and when it was removed, R3, " dumped" 500ccs thick urine immediately (from the urethra) - urine was "pure pus." Z2 further	F9999		

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F9999	Continued From page 18	F9999		

stated that, "The catheter was disgusting." R3 was hospitalized with diagnoses that included Urosepsis, Dehydration and Renal Failure; these were not part of her previous diagnoses. The laboratory values at the time of admission included the following: White Blood Cell Count - 20.3 (4.2 - 11.0), Blood Urea Nitrogen (BUN) - 68 (10 - 20), Creatinine - 4.0 (0.6 - 1.1). According to the consultation done by Z3 (Physician) on 7/3/06, her assessment was stated as, "Respiratory failure, primarily hypoxic with severe metabolic acidosis secondary to sepsis which primary source is urinary tract infection as well as pneumonia." Renal failure, likely all prerenal as prior BUN and creatinine on 5/21/06 were normal."

On interview on 7/6/06, E2 (Corporate Nurse) stated that the facility does not have a protocol for the care and monitoring of indwelling catheters. He further stated that it is the policy of the facility that in regard to indwelling catheters, only noted problems are documented. The facility currently has 14 residents with indwelling catheters with no protocol for the care and monitoring of indwelling catheters.

2) Review of the clinical record for R3 indicated that there were no nursing notes by the facility nurses to describe the resident's condition since before 6/14/06. There are several hospice notes between 6/14/06 and 6/27/06 but they do not provide a detailed discussion of the resident's status. The hospice note on 6/27/06 stated that the resident was up in the chair and in a pleasant mood and that the wound care was done by staff.

The next note was dated 7/2/06 at 8:30am and documented a change in condition for R3. The

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F9999	Continued From page 19	F9999		

note stated, "Pt. lethargic and weak. Difficult to arouse. Blood Pressure 94/60." The note went on to say that the resident had a difficult time taking her morning medications and that hospice was contacted. At 9:00am it was documented that the physician was notified and orders were received. At 10:00am it was documented that the IV had been inserted and the IV was running at 80cc per hour (as ordered).

There was no further documentation of monitoring for R3 for 15 hours. According to the physician order, the IV order was for 1 liter at 80 cc/hour until finished and the physician was to be notified with the status of the resident at that time . Based on that order and the time that the IV was started, the physician should have been notified at 10:30pm. There is no documentation to indicate that the physician was notified or on the status of the IV.

The note at 12:45am on 7/3/06 stated, "Received patient in bed responsive to touch and name. Vital Signs: 94/62, 102, 22, 103.6 (Ax)." According to the note, Acetaminophen was administered for the increased temperature. The next note is at 2:10am indicating that the physician was called. There was a note at 3:00 am stating that a physician was reached and gave the order to send the resident to the hospital. The nurses notes indicate that "911" was not called for another hour - at 4:00am. The report from the ambulance that responded, documented her oxygen saturation (pulse oximetry) at 75%. According to the emergency room record, the resident was placed on a non-rebreather mask with oxygen at 15 liters and her oxygen saturation was still in the 70% range.

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F9999	Continued From page 20 3) R3 had a diagnosis of Vulvar Cancer. When admitted to the facility on 3/10/06 it was noted that she had an abscesses in the right groin. She received several courses of antibiotic therapy and she had orders for warm moist packs to the area every 4 hours while awake and dressing changes . She was evaluated for an Incision and Drainage and on 5/19/06 (according to the Physician's Progress Notes) the hospice physician recommended that the procedure should not be done because there was, "no erythema, minimal drainage" and the right groin abscess was, "much improved." The resident's primary physician stated that she was in agreement with the hospice physician. There were no further descriptions of the abscesses by the physicians. The nurse practitioner referred to the abscesses but without descriptive detail. The "Ongoing Skin Alteration Report" for R3 included 4 notes related to the abscesses in the right groin . 4/4/06 - "Small open area 0.2 X 0.2cm with hard, round raised areas around." 4/5/06 - " Large amounts foul smelling pus extracted." 4/12 /06 - "Small open and 0.2 X 0.2 with hard raised areas." 5/2/06 - 0.2 X0.2cm open area with hard, round raised area around." On this note the drainage was described as, "Heavy Purulent - creamy white to yellow." There were no notes by the nursing staff to describe the status of the right groin abscesses after 5/2/06. On interview on 7/ 17/06, Z5 and Z6 (Advocate Hospice) stated that Z7 (Hospice Nurse) saw the resident on 6/22/06, she spoke to the nurse practitioner (Z1) and requested a wound care evaluation. On review of the resident's clinical record, there was no order and no evaluation. E1 (Administrator) was asked on 7/17/06 if the evaluation was ever done . She faxed a copy of the telephone order dated 6/22/06, however she stated that there was no	F9999		

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F9999	Continued From page 21 evaluation. When R3 was admitted to the emergency room on 7/3/06 the abscesses were described as ranging in size from 2 inches to grape and pea size. According to the note by Z4 (emergency room physician) the incision and drainage was performed and a "significant amount of purulent drainage obtained." 4) R3 was noted to have pressure sores to both heels. She had orders for daily dressing changes . When R3 was sent to the emergency room on 7/3/06, according to Z2 (ER nurse), the dressings on her heels were dated 6/29/06. Review of the Treatment Administration Record for July 2006 indicated that there were no dressing changes done on 7/1/06 and 7/2/06. Also upon arrival at the emergency room, it was noted that R3 had no dressing over the pressure sore on the sacrum. (A)	F9999		