STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 09/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST BANK CENTER, LLC	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

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F9999	Continued From page 11 LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 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 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: 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the	F9999		

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F9999	Continued From page 12 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. Section 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) These requirements are not met as evidenced by: Based on interview and record review the facility failed to follow their policy and procedure for preventing neglect by not providing nursing care to avoid physical harm. The facility neglected to ensure that a resident identified by the facility as being at high risk for dehydration received the amount of fluid assessed by the dietitian (1800 cc per day). The facility failed to develop and implement interim approaches to prevent dehydration when the resident failed to meet estimated fluid needs. This neglect occurred over an 8 day period beginning with R1's admission to the facility on 8/5/08 until R1's discharge to the hospital on 8/14/08. This neglect contributed to R1 being admitted to the hospital on 8/14/08 in shock, related to profound fluid volume depletion and with elevated (BUN- blood urea nitrogen) and Creatinine levels.	F9999		

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F9999	Continued From page 13 R1 expired at the hospital on 8/15/08. This applies to 1 of 3 residents identified by the facility as being at high risk for dehydration (R1). Findings include: R1 was admitted to the facility from the hospital on 8/5/08. R1 has diagnoses of Dysphagia, Parkinson's Disease, Congestive Heart Failure, Atrial Fibrillation, Gastroesophageal Reflux Disease, Depression, Anal Rectal Cancer, Urinary Tract Infection, and Methicillin Resistant Staph Aureus (MRSA) per the Physician's Order Sheet for August 2008. The facility's (ADL) Activity of Daily Living and Condition Assessment dated 8/5/08 shows that R1 was alert, oriented, and cooperative. R1 was depressed and exhibited a slow comprehension. R1's Dehydration Evaluation dated 8/5/08 shows that R1 was assessed by the facility as being at high risk for dehydration. A Chemistry Profile dated 8/4/08, one day prior to R1's admission to the facility, shows that R1's BUN was 23 mg/dl (normal range 6 - 20 mg/dl) and her Creatinine was 1.4 mg/dl (normal range 0.5 - 1.4 mg/dl). The Initial/Quarterly/Annual Nutritional Assessment dated 8/6/08 documents that the dietitian assessed R1 as needing 1800 cc of fluid per day. The report also shows that R1 did not like the nectar thickened liquids but did understand why she needed them. R1's Physician's Orders for August 2008 documents that R1 was receiving Lasix 40mg by mouth every day.	F9999		

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F9999	Continued From page 14 The Intake/Output Record for August 2008 showed that R1 did not consume 1800 cc of fluid per day as recommended by the dietitian while at the facility. From 8/5/08 to 8/14/08 R1's highest intake in a 24 hour period was 1210cc. The least amount of fluids consumed was 840cc in a 24 hour period. The Intake/Output Record further documented that 5 out of 8 days R1 consumed less than 1000cc per day. R1's Interim Plan of Care dated 8/8/08 failed to address R1's increased risk for dehydration. There were no approaches/interventions from 8/5/08 to 8/14/08 to ensure R1's estimated fluid requirements, as assessed by the dietitian, were met or to increase R1's fluid intake to prevent dehydration. Progress Notes dated 8/14/08 at 9:06 AM, state, "Temperature 98.5, Respirations 18, Blood Pressure 110/60, Oxygen Saturation 95% on room air. Called to room by CNA. Patient leaning in her chair to the right. Right eye droopy. Patient has pale clammy skin. Patient drooling. Patient has occasional crackles bilateral upper lobes. Periods of tachypnea. Pulse is irregular.... " The Emergency Department Record dated 8/14/08 documents, "Patient unable to give any history, per paramedics patient was found unresponsive leaning to one side. Pale dusky and mottled. Patient is not responding to verbal stimuli, mouth dry, white and gray blue in color, very dusky. Patient has multiple contusions and bruising with poor tissue turgor.... " The Cardiology Consultation Report dated 8/14/08 documents that R1 was on thickened	F9999		

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F9999	Continued From page 15	F9999		

liquids because of her swallowing disorder secondary to Parkinson's Disease. "Accordingly, she has been getting very little in the way of fluid intake at the nursing home. She has been reportedly complaining of thirst to her daughter but has not been given regular liquids because of the necessary restrictions because of the swallowing problem."

The Cardiology Consult Report dated 8/14/08 states, "It now appears there was not an ST-elevation MI (Myocardial Infarction). The primary problem it appears is that the patient was profoundly volume depleted, based on her intracardiac hemodynamics and supported by her BUN and creatinine that have come back substantially elevated. Accordingly, the patient will need volume resuscitation ... "

The Cathlab Prep Admission/Holding Nursing Record dated 8/14/08 shows that R1's BUN was 76 and her creatinine was 4.6.

The Cardiac Care Admission/Post Intervention Orders dated 8/14/08 documents R1's diagnosis as "Volume Depletion Shock."

On 8/29/08 at 8:30 AM, Z1 (Cardiologist) stated, "The initial left ventricular pressure when we started the procedure was 4. After we gave her fluids we were able to raise her left ventricular pressure to 12 and her blood pressure did improve. It was very clear once we were able to get cardiac measurements that her shock state was not cardiogenic in nature. She was in shock related to her significant fluid volume depletion. Even though we were able to push intravenous fluids the metabolic process was well underway. (R1) was in profound acidosis and her blood

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F9999	Continued From page 16 gasses were low. (R1) had very high lactic acid levels and we just could not turn it around. (R1) did have physical findings of dehydration in the emergency room. Physical findings are not always definitive for dehydration. Intra cardiac measurements are the gold standard for fluid volume determination. (R1's) BUN and creatinine were relatively normal when she was discharged from the hospital. Her BUN and creatinine were elevated when she came back to the hospital. This process did not happen overnight. This process would have developed over the 9 days she was at the facility. The data we obtained during the cardiac catheterization is a very telling statement of what happened." The facility's Abuse/Neglect Prevention Policy and Procedure revised 2005 defines abuse/neglect as a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The facility's Policy and Procedure titled, "Nutrition and Hydration to Maintain Skin Integrity" states, "Ensure that the resident's intake of fluid is sufficient. 'sufficient fluid' means the amount of fluid needed to prevent dehydration and maintain health." (A)	F9999		