DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A357	A. BUILDING ______ B. WING ______	09/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE SQUARE	620 NORTH OTTAWA AVENUE DIXON, IL 61021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Certification Survey	F 000		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to s cite the date and source of information when completing the resident Care Area Assessment Summary and the resident Care Area Assessments.

This is for 10 of 10 residents (R9, 20, 23, 1, 17, 25, 6, 11, 24, & 26) whose annual Minimum Data Sets were reviewed for accuracy and resident assessments in the sample of 10.

The findings include:

The Annual and/or Significant Change Minimum Data Sets (MDS) for 10 residents (R9, 20, 23, 1, 17, 25, 6, 11, 24, & 26) were reviewed for accuracy of assessment. None of the resident's Care Area Assessment (CAA) Summary sheets or Care Area Assessments had documentation to show where resident assessment information was obtained and why the care area triggered a concern.

The CAA Summary sheet states in the directions, "Indicate in the Location and Date of CAA information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area."

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F 272	Continued From page 2 On 9/6/2011 at 10:30 AM, E2 (Director of Nursing) was asked why the CAA's did not contain dates and places where resident information could be found regarding complicating factors, risks and referrals. E2 said, "What's a Care Area Assessment?"	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement individualized plans of care for residents with behaviors that place them at risk for being abused or being abusive to others.	F 279		10/9/11

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This applies to 3 residents, (R1, R6, & R25) of 10 reviewed for behaviors in the sample of 10.

The findings include:

1. R1 is a 62 year old male resident with diagnoses to include Cerebral Vascular Accident (CVA) with Left sided paralysis, Hypertension (HTN), Anxiety, Depression, Hypernatremia, Diabetes Mellitus (DM), Hypothyroidism, Bipolar and Liver Transplant (2001) according to the Physician Order Sheet (POS) 9/11.

E2 (Director of Nursing) presented the current working care plans for R1. The care plans do not include any specific interventions to address R1's potential for being abused, nor does it address how to deal with R1's behaviors when abusive to others. The care plan identifies problems of:
4/24/11 "Makes inappropriate comments-UNPREDICTABLE MOOD SWINGS FROM BOISTEROUS TO TOTAL WITHDRAWAL."
The goal listed is that R1 will "understand behavior is inappropriate."
The approaches listed include:
Explain sexual remarks inappropriate;
Have 2 Certified Nursing Assistants, (CNA's), buddy with care;
Inform resident trying to help and assist;
Provide 1:1 visits;
Medications;
Encourage Activities.

4/12/11 "Verbalizes lude, inappropriate sexual suggestions, asking aides to position his "Balls"

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repeatedly. Attention seeking behavior.

The goal listed is that R1 will have no display of inappropriate sexual behavior by next review; and will have no injury to self or others by next review.

The approaches listed include:
Set up conference with aides and nurses to discuss respectful, dignified care;
Assign staff R1 is familiar with. Educate staff on care expectations/approaches.

Nursing Notes dated between 7/2/11 and 8/25/11 document the following behaviors:
"I can't! The G** D*** Nurse is too busy!"
"Resident snapping at CNA's today when verbalizing what he wants them to do."
"Continues to use call light frequently. Yesterday used call light 26 times during shift. Today he used call light 25 times."
"Demanding of CNA's to 'do it right!'"
"On call light less tonight, 19 times."
"Multiple call light uses for several different complaints."
"Frequent call light use in AM . . .demanding staff do all of care for him. Argued with meds both passes."
"Increase of Seroquel seems to have brought some improvement to attitude."
"Is on call light frequently and is argumentative at times. Continues to have mood swings."
Refusing cares.
"Frequently changing mind regarding medications. Demanding and arguing."
"Snapping at CNA and cussing at him as well."

On 9/8/11 at 1:35 PM, E7 (Registered Nurse) stated due to R1's behaviors, she would identify him as at risk to be abused. E7 acknowledged

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F 279	Continued From page 5 R1 has times when he is verbally abusive to staff. E7 stated interventions include to rotate staff as needed, have 2 people enter the room to attend to care needs and remind R1 that behaviors are inappropriate. 2. R6 is a 95 year old male resident with diagnosis to include Rhabdomyolysis with Dehydration, History of Dehydration, DM Type II, Congestive Heart Failure (CHF), Acute Renal Insufficiency, HTN, and History of Multiple Decubitus Ulcers according to the POS dated 9/11. A nursing note dated 7/10/11 documents the following: "Increased aggressive behavior this month and/or negative remarks. 6/11/11 - to CNA while giving care 'I was going to kill you,' 6/24/11 grabbed activities staff and also grabbed basin of water and threw it at her. 6/25/11 resident pinned CNA to wall with walker. Actions discussed with resident. Hourly checks for behavior done for 24-48 hours post." On 8/31/11 a document written by E1 (Administrator) documents R6 with "limited cooperation" and "antagonist personality." R1's current care plan presented by E2 showed the following concern: 6/10/09 Behavior (aggressive/sexual advances toward caregivers); Will strike out at aides. Behavior disturbance as evidenced by agitation/anxiety. 1-9-11 Spits in water glass. Goals listed are: R6 will reduce behavioral outburst episodes of behavior or sexual inappropriateness toward staff. Behavior will	F 279		

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improve within 90 days.

Interventions/Approaches include: monitor for signs and symptoms of agitation, provide opportunity to talk, provide calm environment, encourage activities, 2 staff assistance when providing hands on care, encourage to vent feelings, anticipate needs, maintain rigid routine with cares, redirect behavior, and provide choices. All these approaches are dated 2009. New approaches added have been: 1/19/11 - offer (tissues), 7/13/11 - check for Urinary Tract Infection, 8/1/11 - provide medication as ordered (medication Discontinued 8/29/11)and 8/1/11 -provide 1:1 while confused and reposition.

On 9/8/11 at 1:35 PM, E7 (Registered Nurse) stated she would consider R6 at risk for abuse and acknowledged he has aggressive behaviors towards staff.

The interventions show there are no specific approaches to protect the resident from being abused and others from being abused by him.
3 . R25's care plan identifies the problem of: easily agitated-striking out, biting, scratching employees. At risk of injury. The approaches include,
' Explain to resident what you are doing.
Give resident time to process the info.. Give resident space
Assist with redirecting negativity
Anticipate needs with care
Administer Ativan 0.5mg.'

R25's care plan identifies the problem of: 'Risk for self or other directed violence as evidenced by hitting, striking out, yelling, verbally

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abusive, impatient. Resident is at risk for abuse R/T her behaviors. When anxious gets in/out of bed setting off alarms.'
Approaches include:
'Assess behavior pattern, ability to control behavior and express needs and feelings.
Provide non-threatening and non-judgmental environment.
Provide exercises
Notify MD if behavior changes
Order received to increase Remeron to 30mg QHS
Ativan 0.5mg po BID, Administer Ativan as ordered
Assign familiar staff, whom she trusts
Introduce yourself when entering resident's room
Administer Remeron as prescribed by physician
Monitor her safety through walk by's each shift
On night shift, offer snacks in room or bring out where staff is to eat snacks around familiar employees
Assist with redirecting any anxiety behaviors
Reminisce\Take for w/c rides
Visit SC friend.'

On 9/8/2011 at 9 AM E7 (Registered Nurse) stated, "(R25's) hitting and biting, and scratching of staff can occur anytime. (R25's) behavior usually revolves around going to and coming from the dining room. (R25) wants to lay in her bed. " E7 confirmed the facility's failure to identify approaches on the plan of care that directly relate to R25's aggressive combative behavior towards staff. The care plan approaches are not proactive (revolving around meal time),and include only the administration of psychoactive medication to directly address the aggressive, combative behavior.

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F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327		10/9/11

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility failed to ensure R6 and R23 consumed fluids sufficient to meet their daily fluid needs. This failure contributed to a R6's admission to the hospital with a diagnosis of dehydration.

This applies to 2 residents (R6 & R23) of 10 reviewed for hydration in the sample of 10.

The findings include:

1. R6 is a 95 year old male resident with diagnosis to include Rhabdomyolysis with Dehydration, History of Dehydration, Diabetes Mellitus Type II, Congestive Heart Failure (CHF), Acute Renal Insuffiencey, Hypertension (HTN), and History of Multiple Decubitus Ulcers according to the Physician Order Sheet (POS) dated 9/11.

The POS of 9/11 also showed R6 has orders for Lasix 20 mg (Diuretic), Ditropan 5 mg (used for overactive/neurogenic bladder) and Colace 100 mg (stool softener) daily. According to the Nursing Drug Handbook 2011, side effects of Lasix and Ditropan include:
dry mouth
dry skin

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anorexia
constipation
abdominal discomfort

In addition, the Nursing Drug Handbook showed additional side effects of Lasix to be "volume depletion and dehydration." The side effects listed for Colace include Electrolyte Disorders, Throat Irritation and Abdominal Discomfort.

On 9/8/11 at 1:35 PM, E7 (Registered Nurse) stated the nurses are responsible for documentation of a residents' Intake and Output. E7 verified the following information:
R6 had gone to the hospital July 28, 2011 for a fractured hip and returned to the facility on August 1, 2011. R6 was in the facility from August 1, 2011 until August 16, 2011 at which time he was re-admitted to the hospital with a diagnosis of Dehydration and Urinary Tract Infection (UTI).
R6 had no Hydration Plan for August 1, 2011 and August 16, 2011.

E7 said the nurse on duty is to total the fluids consumed for their shift and document the amount on the Intake and Output Record. At the end of the day, the fluid consumption should be totaled. E7 verified the Intake and Output record for August 1, 2011 through August 14, 2011 was incomplete and not totaled. E7 stated "there shouldn't be all those blanks." E7 stated the intake/output sheets and/or "hourly check sheets" are given to the Director of Nursing (DON) at the end of the day. E7 stated, "what happens after that I don't know." E7 explained the hourly check sheet documents the nursing intervention of offering food and/or fluids to residents with poor

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intakes. E7 stated R6 was not on hourly checks between 8/1/11 and 8/16/11. E7 stated the amounts documented on the intake/output record for R6, dated 8/1/11 to 8/14/11, would account for his "total consumption" on those days.

The Intake and Output Record for August 1, 2011 to August 14, 2011 documents R6 consumed between 420-1510 cc's of fluid daily. The documented titled "Sheltered Care Nutritional Assessment/Dietary Assessment," dated 8/5/11, signed by the Registered Dietitian, showed R6 requires 2290 cc's of fluid daily to meet his needs.

The hospital admission face sheet dated 8/16/2011 documents the reason for admission as UTI/Dehydration. The August 18, 2011 Hospital History and Physical, (H&P), documents, "In the emergency room, the patient was evaluated and found to have mild to moderate dehydration . . .started on gentle hydration. Overnight, I was called with urine results which did suggest infection . . ." The H&P also showed under the "Assessment/Plan" portion, "The patient does have evidence suggestive of significant dehydration and his Lasix has been put on hold." Review of the facility Medication Administration Records for R6 dated 8/1/11 to 8/16/11 showed no medications were placed on hold until he was hospitalized on 8/16/11.

R6's Laboratory Results dated 8/16/11 from the hospital showed the following values:

	8/16/11	8/17/11	8/18/11	Normal Values
Sodium	153 High	155 High	149 High	137-145 mmol/L
Chloride	116 High	117 High	113 High	

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F 327	Continued From page 11 98-107 mmol/L BUN 48.5 High 40.7 High 37.6 High 7.0-25.0 Creatinine 1.30 High 1.40 High 1.25 (Normal) 0.66-1.25 mg/dL BUN/Creatine Ratio: 37.30 High 29.07 High 30.08 High Values over 23 indicate dehydration 8/17/11 Laboratory Results for R6's urine showed the following abnormal results: Color = Dark Yellow with Cloudy appearance. Large amount of blood and Trace Leukocytes. The urine contained 5-10 White Blood Cells, 21-50 Red Blood Cells and Few Bacteria. The current care plan provided by E2 (DON) on 9/7/11 for Fluid Volume Deficit is dated 1/17/11. The care plan identified no specific interventions or parameters on how to meet R6's dietary recommended hydration needs, (2290 cc's daily). The problem identified on the care plan is "Nausea and vomiting and loose stools." E7 verified on 9/8/11 during the 1:35 PM interview, she was not aware of R6 having vomiting and loose stools during the 8/1/11 to 8/16/11 time frame. E7 said R6 "wasn't himself after returning from the hospital with the broken hip. He just wasn't eating or drinking." The goals listed on the care plan included: 1. R6 will receive adequate fluid intake; 2. R6 will receive adequate fluid intake within 90 days. Interventions listed are: Staff to encourage R6 to drink; Staff to monitor for signs and symptoms of edema;	F 327		

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F 327	Continued From page 12 Staff to offer fluids at activities and as needed; Monitor; Notify MD; Send to ER (emergency room) for evaluation and treatment; Watch for fluid volume overload. On 8/10/11 at 10:36 AM, E2 acknowledged she reviews the intake sheets and hourly check sheets daily. E2 stated if she identifies a resident with a poor intake she will go talk to the nurses to see if the sheets are accurate. E2 said her inventions include talking with the nurses and "possibly call the Doctor for new orders." E2 could not explain why R6 went more than 14 days with less than required intake and no inventions implemented. Nursing notes for 8/1/11 through 8/16/11 were reviewed with no assessments documented regarding R6's hydration status. No hydration assessments for R6 were presented by the facility during the survey. The facility Policy and Procedure for Hydration and Nutrition, (undated), mentions hydration in the following context: Baseline nutrition and hydration information is obtained by a registered nurse on admission; Fluid is available to residents at all times; Assessment for signs of dehydration (dry mouth, poor skin turgor) Special attention is given to the hydration status of each resident when the environmental temperature rises. Additional fluid is given to each resident every two hours when awake; vital signs are taken and recorded on each shift and as needed; and skin turgor and oral moisture are	F 327		

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observed.

Surveyor: Konstant, Vicki
2. Review of R23's Physician's Order sheet dated 9/2011 shows an order for a 1500 fluid restriction. The Comprehensive Care Plan identifies a problem dated 4/5/2011 of 'on Dialysis 3 times a weekly'.
R23's September 2011 order sheet, shows an order for 1500cc fluid restriction, and an order for Gatorade 20 oz. (600cc) of fluid daily.
On 9/8/2011 at 10:51 AM, E7 (Registered Nurse) stated, "We haven't served Gatorade to (R23) since March of this year. (R23's) favorite flavor was lemon/lime, but we gave her what ever she wanted, but it got so she would not drink any of it. She is drinking (lemon-lime soda) instead now. We really don't do intake on (R23) since she eats down stairs."
On 9/6/2011 at 2:23 PM, E8 (Registered Nurse) confirmed that R23's intake was poor, and stated, "We do not have a hydration plan for R23 to ensure adequate fluid intake."
On 9/7/2011 at 2:30 PM, R23 stated, "I got so tired of Gatorade, I couldn't drink it any more. I drink (lemon-lime soda) now."
During the interview a 4 oz cup that R23 identified as containing (lemon-lime soda) , was observed on the table in front of the window. The cup of (lemon-lime soda) remained untouched during the 45 minute interview. R23 stated, "I just don't drink enough."
Review of the Intake & Output Records for July, August and Sept. 6, 2011 shows only three days of the 68 days did R23 consumed the ordered 1500cc of fluid. The Intake and Output record shows R23's intake has been calculated as low as 480cc to a one time high of 1530 with the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 327	Continued From page 14 average of 1017 cc per day. On 9/7/2011 at 2:30 PM, R23 stated, "Last night the staff came and talked to me and told me that I'm not drinking enough fluids. I'm not doing well in dialysis either. The people at dialysis told me I need to drink more."	F 327		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		9/25/11

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F 356	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to post nurse staffing that included the number of hours each discipline (Certified Nursing Assistant, Licensed Practical Nurse, Registered Nurse) worked per shift and the resident census. This has the potential to affect all 25 (residents residing in the certified unit). The findings include: The Resident Census and Conditions form, presented by the facility on 9/6/2011 shows that 25 residents reside in the certified unit. On 9/6/2011 at 4:00 PM, the Nurse Staff posting was located behind the nurse's desk, on a door, not within public view. The posting did not contain the resident census for the day. The posting also did not have how many CNA's, RN's, or LPN's worked each shift and the total number of hours worked by each discipline for the shift. On 9/7/2011 at 3:50 PM, E1 (Administrator) verified that is the way the staffing is always posted.	F 356		
F 363 SS=F	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National	F 363		9/28/11

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F 363	Continued From page 16 Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide the amount of protein as stated on the menu/recipe for the noon meal on 9/6/11. This applies to 25 of 25 residents in the facility. The findings include: The Federal form 672 identifies the certified bed census as 25 residents. The menu for 9/6/2011 shows the noon meal was chicken and noodles, beets, peaches, cookie, and soup. On 9/6/2011 at 11 AM E4(Food service Supervisor) stated, "We have substituted turkey for chicken, so we are serving turkey and noodles. The substitute for the noodle dish will be a hot dog on a bun. The recipe for chicken and noodles shows that one serving would yielded 3 oz. of chicken (turkey). " On 9/6/2011 at 11 AM with E4 (Food Service Supervisor) present, one serving of the noodle turkey dish was weighed. One serving of turkey weighed 2.7 oz., short .3 oz. The substitute of the turkey-noodle dish was one hot dog. On 9/6/2011 at 11:20 AM with E4 present, one serving of hot dog was weighed, and found to be short .6 ounces. E4 confirmed that both the noodle and turkey dish	F 363		

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F 363	Continued From page 17 and the hot dog when weighed were short on protein. E4 stated at the time of the observation, the residents should be served 3 oz. of protein at the noon meal today. I will have to adjust all the menus, weighing the meat after it's cooked to ensure we serve the correct amount of protein."	F 363		
F 366 SS=F	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide substitutes for vegetables and the main entree for the noon meal. This applies to 25 of 25 residents in the facility. The Federal form 672 identifies a census of 25 residents in the facility. The findings include: Review of the 7 day menu for week 2 shows on 9/6/2011 residents were to be served, vegetable soup, chicken and noodles, Harvard beets, fresh fruit cup/ hot dog/bun, cookies. On 9/6/2011 at the noon meal (12:20 PM), 22 residents were observed in the dining room on the second floor, 1 resident ate in the main first floor dining room, and 2 residents ate in their rooms. Most residents in the dining room were observed sitting and consuming only small amounts of the noon meal 9/6/11. After the food was served, only one resident was asked if he would like to	F 366		9/28/11

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F 366	Continued From page 18 have a hot-dog, of which the reply was yes. Over half, 13 residents did not eat the beets, and 11 residents did not eat the turkey-noodle dish. On 9/6/2011 at 2:10 PM E4 (Food Service Supervisor) stated, "We did not have a substitute for the beets. I don't know why we didn't. We offer the substitutes when we first serve the residents their food".	F 366		
F9999	FINAL OBSERVATIONS 300.610a) 300.1210a) 300.1210b)4) 300.1210c) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	F9999		

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F9999	Continued From page 19 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. c) Each direct care-givicng staff shall review and be knowledgeable about his or her residents' respective resident care plan.	F9999		

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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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on interview, observation and record review, the facility failed to ensure R6 and R23 consumed fluids sufficient to meet their daily fluid needs. This failure contributed to a R6's admission to the hospital with a diagnosis of dehydration.

This applies to 2 residents (R6 & R23) of 10 reviewed for hydration in the sample of 10.

The findings include:

1. R6 is a 95 year old male resident with diagnosis to include Rhabdomyolysis with Dehydration, History of Dehydration, Diabetes Mellitus Type II, Congestive Heart Failure (CHF), Acute Renal Insuffiencey, Hypertension (HTN), and History of Multiple Decubitus Ulcers according to the Physician Order Sheet (POS) dated 9/11.

The POS of 9/11 also showed R6 has orders for Lasix 20 mg (Diuretic), Ditropan 5 mg (used for

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F9999	Continued From page 21 overactive/neurogenic bladder) and Colace 100 mg (stool softener) daily. According to the Nursing Drug Handbook 2011, side effects of Lasix and Ditropan include: dry mouth dry skin anorexia constipation abdominal discomfort In addition, the Nursing Drug Handbook showed additional side effects of Lasix to be "volume depletion and dehydration." The side effects listed for Colace include Electrolyte Disorders, Throat Irritation and Abdominal Discomfort. On 9/8/11 at 1:35 PM, E7 (Registered Nurse) stated the nurses are responsible for documentation of a residents' Intake and Output. E7 verified the following information: R6 had gone to the hospital July 28, 2011 for a fractured hip and returned to the facility on August 1, 2011. R6 was in the facility from August 1, 2011 until August 16, 2011 at which time he was re-admitted to the hospital with a diagnosis of Dehydration and Urinary Tract Infection (UTI). R6 had no Hydration Plan for August 1, 2011 and August 16, 2011. E7 said the nurse on duty is to total the fluids consumed for their shift and document the amount on the Intake and Output Record. At the end of the day, the fluid consumption should be totaled. E7 verified the Intake and Output record for August 1, 2011 through August 14, 2011 was incomplete and not totaled. E7 stated "there shouldn't be all those blanks." E7 stated the	F9999		

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intake/output sheets and/or "hourly check sheets" are given to the Director of Nursing (DON) at the end of the day. E7 stated, "what happens after that I don't know." E7 explained the hourly check sheet documents the nursing intervention of offering food and/or fluids to residents with poor intakes. E7 stated R6 was not on hourly checks between 8/1/11 and 8/16/11. E7 stated the amounts documented on the intake/output record for R6, dated 8/1/11 to 8/14/11, would account for his "total consumption" on those days.

The Intake and Output Record for August 1, 2011 to August 14, 2011 documents R6 consumed between 420-1510 cc's of fluid daily. The documented titled "Sheltered Care Nutritional Assessment/Dietary Assessment," dated 8/5/11, signed by the Registered Dietitian, showed R6 requires 2290 cc's of fluid daily to meet his needs.

The hospital admission face sheet dated 8/16/2011 documents the reason for admission as UTI/Dehydration. The August 18, 2011 Hospital History and Physical, (H&P), documents, "In the emergency room, the patient was evaluated and found to have mild to moderate dehydration . . .started on gentle hydration. Overnight, I was called with urine results which did suggest infection . . ." The H&P also showed under the "Assessment/Plan" portion, "The patient does have evidence suggestive of significant dehydration and his Lasix has been put on hold." Review of the facility Medication Administration Records for R6 dated 8/1/11 to 8/16/11 showed no medications were placed on hold until he was hospitalized on 8/16/11.

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R6's Laboratory Results dated 8/16/11 from the hospital showed the following values:

	8/16/11	8/17/11	8/18/11	Normal Values
Sodium	153 High	155 High	149 High	137-145 mmol/L
Chloride	116 High	117 High	113 High	98-107 mmol/L
BUN	48.5 High	40.7 High	37.6 High	7.0-25.0
Creatinine	1.30 High	1.40 High	1.25 (Normal)	0.66-1.25 mg/dL
BUN/Creatine Ratio:	37.30 High	29.07 High	30.08 High	Values over 23 indicate dehydration

8/17/11 Laboratory Results for R6's urine showed the following abnormal results:
Color = Dark Yellow with Cloudy appearance.
Large amount of blood and Trace Leukocytes.
The urine contained 5-10 White Blood Cells, 21-50 Red Blood Cells and Few Bacteria.

The current care plan provided by E2 (DON) on 9/7/11 for Fluid Volume Deficit is dated 1/17/11. The care plan identified no specific interventions or parameters on how to meet R6's dietary recommended hydration needs, (2290 cc's daily). The problem identified on the care plan is "Nausea and vomiting and loose stools." E7 verified on 9/8/11 during the 1:35 PM interview, she was not aware of R6 having vomiting and loose stools during the 8/1/11 to 8/16/11 time frame. E7 said R6 "wasn't himself after returning from the hospital with the broken hip. He just wasn't eating or drinking." The goals listed on the care plan included:

1. R6 will receive adequate fluid intake;

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2. R6 will receive adequate fluid intake within 90 days.
Interventions listed are:
Staff to encourage R6 to drink;
Staff to monitor for signs and symptoms of edema;
Staff to offer fluids at activities and as needed;
Monitor;
Notify MD;
Send to ER (emergency room) for evaluation and treatment;
Watch for fluid volume overload.

On 8/10/11 at 10:36 AM, E2 acknowledged she reviews the intake sheets and hourly check sheets daily. E2 stated if she identifies a resident with a poor intake she will go talk to the nurses to see if the sheets are accurate. E2 said her inventions include talking with the nurses and "possibly call the Doctor for new orders." E2 could not explain why R6 went more than 14 days with less than required intake and no inventions implemented.

Nursing notes for 8/1/11 through 8/16/11 were reviewed with no assessments documented regarding R6's hydration status.

No hydration assessments for R6 were presented by the facility during the survey. The facility Policy and Procedure for Hydration and Nutrition, (undated), mentions hydration in the following context:
Baseline nutrition and hydration information is obtained by a registered nurse on admission;
Fluid is available to residents at all times;
Assessment for signs of dehydration (dry mouth, poor skin turgor)

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F9999	Continued From page 25 Special attention is given to the hydration status of each resident when the environmental temperature rises. Additional fluid is given to each resident every two hours when awake; vital signs are taken and recorded on each shift and as needed; and skin turgor and oral moisture are observed. Surveyor: Konstant, Vicki 2. Review of R23's Physician's Order sheet dated 9/2011 shows an order for a 1500 fluid restriction. The Comprehensive Care Plan identifies a problem dated 4/5/2011 of 'on Dialysis 3 times a weekly'. R23's September 2011 order sheet, shows an order for 1500cc fluid restriction, and an order for Gatorade 20 oz. (600cc) of fluid daily. On 9/8/2011 at 10:51 AM, E7 (Registered Nurse) stated, "We haven't served Gatorade to (R23) since March of this year. (R23's) favorite flavor was lemon/lime, but we gave her what ever she wanted, but it got so she would not drink any of it. She is drinking (lemon-lime soda) instead now. We really don't do intake on (R23) since she eats down stairs." On 9/6/2011 at 2:23 PM, E8 (Registered Nurse) confirmed that R23's intake was poor, and stated, "We do not have a hydration plan for R23 to ensure adequate fluid intake." On 9/7/2011 at 2:30 PM, R23 stated, "I got so tired of Gatorade, I couldn't drink it any more. I drink (lemon-lime soda) now." During the interview a 4 oz cup that R23 identified as containing (lemon-lime soda) , was observed on the table in front of the window. The cup of (lemon-lime soda) remained untouched during the 45 minute interview. R23 stated, "I just don't	F9999		

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F9999	Continued From page 26 drink enough." Review of the Intake & Output Records for July, August and Sept. 6, 2011 shows only three days of the 68 days did R23 consumed the ordered 1500cc of fluid. The Intake and Output record shows R23's intake has been calculated as low as 480cc to a one time high of 1530 with the average of 1017 cc per day. On 9/7/2011 at 2:30 PM, R23 stated, "Last night the staff came and talked to me and told me that I'm not drinking enough fluids. I'm not doing well in dialysis either. The people at dialysis told me I need to drink more."	F9999		