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	145006	A. BUILDING _____ B. WING _____	C 06/18/2012

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F 364	Continued From page 6 potato fries a pan of polish sausages in water and a small pan of carrots in water. When asked, E18 (Dietary Aide) admitted the steam table should have had water in the bottom for keeping foods warm. When asked why there wasn't water in the bottom of the table, E18 replied staff had been running late and staff didn't have time to add water to the steam table. The surveyor was able to place her bare hands into the area of the table where the water should have been. The metal was cold when touched and when checked, it was observed while the table had been plugged into an electrical outlet, the controls/knobs were in the off position indicating that the table had not been turned on. This was verified by E18. When asked E 19 (cook) tested the food temps on the steam table, but initially failed to calibrate the thermometer before using it until prompted by the surveyor. Prior to calibration, the thermometer temp was more than 100 degrees. When tested it was noted that the temp of the fries was 74.3 degrees and the carrots were 121.6 degrees. E1 (Administrator) was present during this observation.	F 364		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.690a) 300.1210a) 300.1210b) 300.1210d)3)	F9999		

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F9999	Continued From page 7 300.3240a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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 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	F9999		

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F9999	Continued From page 8 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. d) Pursuant to subsection (a), 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 300.3240 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) Based on record review and interview the facility failed to provide the necessary care and treatment to one of three individuals (R2) in the sample when they failed to recognize and address changes in intake and output and overall health. This failure resulted in a decline in physical	F9999		

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F9999	Continued From page 9 condition for R2 and subsequent hospitalization during which R2 expired. FINDINGS INCLUDE: R2 is deceased and the resident's closed record was reviewed. On February 13, 2012 R2 was admitted from an acute care hospital to the facility with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure, Anxiety, Chronic Pain and Depression. The resident had an order for a No Added Salt diet. Review of Nurses Notes indicated that R2 was admitted to the facility with complaints of pain in the chest, back and legs. The resident chronically complained of pain and received Norco for the pain from 3/17/12 through and until 4/5/12. R2 received the Lidocaine patches from 3/17/12 through 4/5/12. On 2/15/12 R2 was assessed by Z1 (physician) for pain control and a new pain medication (Fentanyl Patch) was ordered. On 3/7/12 R2 refused the ordered Lidocaine patch (given for pain), stating that the patch wasn't effective in relieving her pain. On 3/14/12 R2 complained of a migraine headache. Z2 (physician) was notified and ordered Imetrix for the pain. R2 received Imetrix multiple times between 3/14/12 and transfer to the hospital on 4/11/12. On 4/10/12 R2 is documented as having complained of blurred vision, continued pain and staff documented that the resident appeared to	F9999		

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be weak. There is documentation on 4/12/12 that verifies the allegation that the resident wanted to go to the hospital. There was also a documented decrease in bowel sounds (staff had difficulty hearing bowel sounds in the left lower quadrant). The resident was documented as crying in pain. Norco one tab was given and resident response was monitored. At 5:00PM R2 stated that she hadn't had any relief from pain. The resident was "reassured" and Z3 (physician) was paged, but didn't answer. Staff paged Z3 several times,but he didn't answer; Z4 (Medical Director) was contacted, informed of situation and transferred R2 to the hospital. Staff also documents that R2's family member was contacted regarding the transfer.

It isn't until 4/3/12 that staff documents a decrease in R2's appetite. On 4/3/12 staff documented the dinner intake as 25%, down from 100% on previous days. On 4/4/12 and 4/5/12 staff do not document R2's meal/liquid intake at all and on 4/6/12 staff documents that the resident ate 50% of her dinner. On 4/7/12 and 4/9/12 staff doesn't document the resident's meal intake at all. On 4/8/12 staff documents that R2 eats more than 1/2 of meals.

On 4/10/12 R2 is documented as eating 25% at dinner and the appetite "remains poor..states her vision is so blurry... Resident appears weak." Staff continued on to document "No diarrhea this shift even though resident states that she is still having it." There isn't any verification of any physician or family having been notified of the resident's blurred vision or apparent weakness. There is not any documentation of a physician being notified of R2's decreased appetite until

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4/11/12 when Megace (an appetite stimulant) was ordered. Nor is there any indication that staff notified Z8 (Registered Dietician) of a decline in appetite. April 11 2012, R2 was transferred to the hospital.

When asked to provide all Nutritional Assessments conducted for R2 between her admission to the facility on 2/21/12 and discharge 4/11/12 the facility provided a Nutrition Note for R2 dated 2/21/12 which assessed that the diet as served met 76-100% of her estimated needs, that the resident was eating well, and a Nutrition Risk Assessment for R2 that was dated 5/4/12. This date is dated three (3) weeks after R2 died. The information on the Risk Assessment is the same information as documented on the Dietary Assessment Note of 2/21/12 and fails to mention/assess the resident's poor oral intake and unplanned weight loss of 6.7 pounds between February,2012 admission and April 11, 2012 discharge to the hospital.

When the surveyor asked to speak with Z8, the facility stated that Z8 was no longer employed at the facility, that Z7 was the new Registered Dietician for the facility.

When interviewed 6/1/12, Z7 Registered Dietician, stated that she would expect staff to notify her regarding a resident with diarrhea, that sometimes the diarrhea may be medication related or dietary related. Z7 stated that she would interview the resident. Z7 stated that the caloric and fluid requirements would need to be calculated and if the resident has diarrhea they As stated by Z9 "R2 was brought to the ER due to a change in mental status and was found to have

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severe hypotension requiring pressors (to increase blood pressure) support...found to have a creat of 12.5...had quite significant diarrhea for the last few weeks and not eating well. Over last night only had 100 ml urine...virtually anuric on pressors." Z9's impression was 1). Acute Renal Failure most likely prerenal, however anuric and on pressors. 2). Hypokalemia 3). Metabolic Acidosis most likely secondary to severe diarrhea 4). Septic Shock. Attachment 4.

Mosby's Clinical Nursing, 3rd Edition, page 130, states that metabolic acidosis (decrease in PH and decrease in bicarbonate levels) is caused by either the increase of fixed metabolic acids or through the loss of bicarbonate in the body fluids and lists persistent diarrhea as a cause of bicarbonate loss. Page 900 addressed Acute Renal Failure and indicated that one category of renal failure is prerenal and listed one cause as dehydration.

On 4/11/12 at 2340 R2 was admitted to the Intensive Care Unit (ICU) with diagnoses of Renal Failure and Metabolic Acidosis. The resident was receiving intravenous (IV) fluids of D5W with 3 amps of NaHCO3 (sodium bicarbonate).

The Physician Progress Note dated 4/11/12 at 11:55PM verified Z9's assessment of R2 and additionally added that the Severe Metabolic Acidosis was due to the Acute Renal Failure and the hypotension was due to dehydration, and the physician verified that R2 had had recurrent diarrhea.

On 4/13/12 at 10:15PM the ER Attending physician was asked to assess R2. The Attending

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F9999	Continued From page 13 physician pronounced R2 dead. The Death Certificate for R2 listed the initial cause of death as Acute Renal Failure due to Sepsis and Advanced Chronic Obstructive Pulmonary Disease. (B)	F9999		