STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145593	A. BUILDING ______ B. WING ______	C 01/09/2013

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MANORCARE OF LIBERTYVILLE	1500 SOUTH MILWAUKEE AVENUE LIBERTYVILLE, IL 60048

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F 327	Continued From page 7 The facility failed to document the assessments after dehydration was suspected.	F 327		
F9999	FINAL OBSERVATIONS LICENSURE Violations 300.1210b) 300.1210d)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. 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	F9999		

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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 WERE NOT MET AS EVIDENCED BY:

Based on observation, interview and record review, the facility failed to ensure three residents (R4, R16 and R20) of five reviewed (R2, R4, R8, R16, R20) for Hydration needs, had his fluid requirements met to prevent the development of severe dehydration and the associated complications that resulted from this. Failed to notify the doctor, assess and follow their hydration policy.

As a result of this failure, R20 was admitted to the hospital with severe dehydration, R4 and R16 became symptomatic of hydration issues.

Findings include:

R20 was admitted to the facility on 6/28/12 for rehab therapy after suffering a CVA (cardiovascular accident) earlier in the month. R20 had left sided weakness, aphasia, and dysphagia identified on admission.

The initial nurse's note 6/28/12 at 3:36 am, documented R20 as alert and oriented with some facial drooping on the left...unable to help with moving in bed when turning to the right side. Skin intact, SO2 93% on room air, HR 63. The following note documents "slurred speech... .(but) makes needs known."

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F9999	Continued From page 9 The nutritional assessment of the same date (6/28/12) assessed R20 as a high nutritional risk. The assessment showed oral intake of food meets only 26-75% of estimated needs; oral intake of fluids 1000-1499 cc/day. The dietician's assessment identified needs of 2313-2775 cal/kg for oral intake with a total protein need of 93 grams. Fluid needs were 2775 cc/day. R20 was ordered a mechanical soft diet with nectar thickened liquids. The Respiratory assessment of 6/28/12 noted normal vital signs with diminished breath sounds in the left lower lung. A recommendation was made for an incentive spirometer to be placed at the bedside, to be used four times daily. There was no documentation to support this was ever used by the resident. The history and physical dated 6/28/12 by Z1 (primary physician) documented normal vitals, "aphasia although speech is discernable." Z1s next note dated 7/3/12 again noted normal vitals and "doing reasonably well." R20 's status appears to have changed according to nurses' notes as early as 7/5/12 when the note timed 19:06 documented "...speech slurred, pocketing food...appetite poor." The notes dated 7/6 and 7/8 are brief and showed no followup of the concerns on 7/5. A review of the note of 7/9 at 13:08, by Speech Therapy, stated: " Video swallow canceled secondary to change in status." No further details are given in the note. At 15:43 another note read: "unable to verbalize	F9999		

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F9999	Continued From page 10 needs, pockets meds, all AM meds held MD/NP (nurse practioner) notified. Asked NP to see pt. SBAR done. Vital signs 114/62, 99.2, 97-94% on RA. Tylenol suppository given, T 98.4 at 2:45pm. STAT CBC/CMP done. Endorsed to next shift re UA/CS. Given ice chips ." The results of the labs drawn were relayed to the physician according to note timed at 22:04 on 7/9/12. Telephone order 7/9/12 at 7pm gives an order for starting an IV of 0.45% NS (normal saline) 2L then recheck CMP. At this time the SO2 dropped to 79%. O2 at 2L/min via nasal cannula was started. Nursing documentation did not indicate that the IV fluids were started by the nursing staff any time before the ambulance team arrived for transport. The ambulance report documents: "24 gauge IV put in pt's L wrist. access with saline fluids." This is timed at 06:52 on 7/10/12. No documentation exists about who or when an IV was started. The hospital medical records showed when R20 was admitted to the hospital on 7/10/12, he was dehydrated. The note dictated by Z2 (nephrologist) notes: "Hypernatremia. He does have an estimated fluid deficit of approximately 5 liters, with a sodium of 154. I suspect this Hypernatremia is due to a combination of decreased free water as well as insensible losses...elevated BUN (70mg/dL) and creatinine(1.80mg/dL)." Notes by Z3 (pulmonologist) confirm R20 was hypoxic and chest CT (Cat Scan) showed bibasilar infiltrates. Z3 attributed this to "hypoxic	F9999		

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F9999	Continued From page 11 respiratory failure due to pneumonia...at risk for aspiration." Z3 also referred to the "acute kidney injury, most likely due to dehydration." As part of his plan, R20 required placement of an NG (Nasal Gastric) tube for 300ml of free water flushes every 4 hours and supplemental IVF (Intravenous fluid) of 80ml/hour of 0.45% normal saline" to achieve rehydration. R20 showed evidence of left leg DVT (Deep Vein Thrombosis) requiring placement of an IVF filter, aspiration that required placement of a PEG (Percutaneous Endoscopic Gastrostomy) tube. On admission R20 "had sinus tachycardia (153 bpm) from dehydration" and was described as "He was extremely debilitated." This was per Z4's note. Z4 (cardiologist) listed R20's discharge diagnoses as : "aspiration pneumonia, severe protein calorie malnutrition, SVT (supraventricular tachacardia) secondary to dehydration, and acute renal failure with Hypernatremia. The facility staff was asked to provide any monitoring of the intake of R20. E3 (director of nursing) stated that intake and outputs were not done routinely even though a resident has been identified as high risk for dehydration and had a significant change of condition. Any policy to this effect was requested but one was not provided. The nurse aides document percentages of meals consumed only. Review of R20's record shows an average consumption of 75% from 6/27 -7/3. Then the consumption starts to decline to 50% or less. On 7/7/12 documentation showed 25%, 0%, 100% for the three meals, on 7/8 it was 0%, and refused. Only two meals documented. Again on 7/9/12 only two meals are documented at 25% and 25%.	F9999		

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Continued From page 12

R20's careplan for maintaining adequate hydration is the same as that of R2 and R8. Approaches included obtaining lab results as ordered and notifying physician, report changes related to signs of fluid deficit (tongue furrows, dry mouth, etc.), therapy eval and treat as ordered, thickened liquids as ordered. These approaches did not address preventive measures but only identifying dehydration once symptoms are present such as the dry mouth and furrowed tongue.
Preventive interventions such as detailed monitoring of fluids consumed or encouraging fluid consumption were not considered in the plan. This lack of preventive measures contributed to R20 developing severe dehydration and subsequent organ system failures.

Review of R16's medical record on 1/8/13, showed that E6 wrote a nutritional note on 11/29/12 that noted a 13.6% weight loss in a two month period. The last physician note was dated 10/20/12. On 12/18/12 R16's diet was changed to regular-enhanced with health shakes bid and magic cup everyday and multivitamin everyday. Nurses notes show R16 was lethargic and refusing breakfast and lunch. This was repeated several times in the next few weeks. on 1/3/13 the nurse's note documented lethargic, refused breakfast and lunch, unable to swallow some meds...dry cough.
Labs were ordered and obtained on 1/4/13. Results of the labs showed an elevated H/H of 15.7/47.1 and a BUN of 76 and Creatinine of 2.5, both outside of the normal range of 8-28 for BUN and 0.4-1.6 for Creatinine. A critical level of 2.8 for potassium was also noted. The low potassium level was addressed but there was

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F9999	Continued From page 13 nothing acknowledging the elevated BUN and Creatinine. R16 was identified as at risk for dehydration on assessment and is also on multiple diuretics (Lasix and Hydrochlorothiazide). When observed on 1/6/13, R16 was in bed, pale, with no fluids available at bedside. On 1/6/13 a new red area was identified on R16's buttock. There is no documentation that indicated that the facility hydration plan was being followed for this resident or the other abnormal labs were being evaluated based on R16's overall condition. R4's Physician's Order Sheet (POS) for January 2013 documented admitting diagnoses including Esophapharyngeal dysphagia. Diovan 160 milligrams was ordered to be given daily. On 01/06/13 at 10:20am R4 was lying in bed with her eyes closed. She did not verbally respond and her movements were slow. On 01/06/13 at 02:00pm E9, Certified Nursing Assistant (CNA) was interviewed regarding oral intake. E9 stated, "R4's appetite varied; however , she does better with her family. R4 had dry lips. We used Vaseline and swabbed R4's mouth. The Nurses were aware of these symptoms. R4 only ate about 25% of her noon tray today." E10, Nurse, was interviewed on 01/06/13 at 10:20am. E10 stated, "R4 was dehydrated. She had a poor appetite. The physician was faxed and phoned last night. There has been no response at this time. R4 had dry cracked lips and her mucous membranes were dry." At 12pm on 01/06/13 at 12:00pm E10 added, "I called and faxed the physician on 01/04/13. The	F9999		

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F9999	Continued From page 14 message had not been responded to at this time. On 01/05/13 I learned that the physician was on vacation. I did not feel that it was an emergency to reach the physician." (It was brought to the facility's attention that the resident had a change in condition and there was a delay of two days without the physician being notified.) (The facility then contacted the physician and received orders for Intravenous Hydration.) On 04/21/12 R4 was evaluated as a high nutritional risk. R4's lab dated 11/02/12 had a blood urea nitrogen (BUN) level of 46. (reference range was 8-28) R4's Nursing notes dated 11/03/12 documented Intravenous Hydration was ordered. On 12/26/12 R4's BUN level was 31. R4's Nursing Notes dated 01/04/06 at 10:56pm documented,"...Patient's family translated that patient feels too weak to open mouth to chew, eat or take in fluids. "Physician" faxed at this time for lab orders Follow up needed." There are no further assessments, monitoring prior to the note written on 01/06/13. R4's Hydration Care Plan initiated on 09/06/12 addressed hydration with an intervention of reporting changes in fluid deficit... The facility's care plan for dehydration included assessing mental status. If there was an acute mental status change notify the physician immediately. The resident is to be managed in the facility with options that included monitor vital signs and urine output every 4-8 hours. Offer small frequent fluids 2-4 ounces every 2 hours.	F9999		

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F9999	Continued From page 15 The facility failed to document the assessments after dehydration was suspected. On 01/08/13 at or about 11:00am. R4 was lying in bed. A visitor, who stated she was a Nurse Practioner, was at bedside. R4 was more alert than she was for the past two days. (Hydration Therapy was in progress.) The visitor added," R4's urine is clear today and she has about 240 milliliters in the indwelling urine catheter bag since 06:00am. This was in normal range. R4 periodically became dehydrated and needed Hydration therapy to correct this problem" (B)	F9999		