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F 441	Continued From page 49 replace handwashing."	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210d)5 300.1220b)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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection,	F9999		

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F9999	Continued From page 50 and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 WERE NOT MET AS EVIDENCED BY: Based on observation, record review and interview, the facility failed to monitor resident's skin, prevent development of new pressure ulcers, promote healing of facility acquired pressure ulcers, ensure dietary recommendations are implemented for residents with new pressure ulcers and failed to provide	F9999		

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assistance with feedings to residents at risk for pressure ulcers.

This failure resulted in 2 of 14 residents (R3,R9) acquiring stage II pressure ulcers in a sample of 27.

Findings include:
1. R3's diagnoses includes Depression and Dementia. R3's Minimum Data Set (MDS) dated 11/19/12 assessed R3 as requiring extensive assistance in all activities of daily living and incontinent of bladder and bowel. R3's Norton Risk Assessment Scale dated 2/3/13 assessed R3 as at risk for pressure ulcers.

Facility's pressure ulcer report for February 2013 identified R3 as having two acquired stage II pressure ulcers to the left and right buttock on 2/4/13. Initial measurements of the right buttock wound was 1.0 centimeter (cm) x 0.5 cm x 0.2 cm and measurements to the left buttock was 1.5 cm x 1.0 cm x 0.2 cm. Treatment orders for the right and left buttock dated 2/4/13, included cleanse with normal saline, apply hydrogel gauze, cover with foam dressing daily and prn (as necessary) till healed. Documentation on the treatment sheet indicates that R3's physician and dietary staff were notified of wounds on 2/4/13.

Weekly pressure ulcer report dated 2/18/13 documented that the measurement of the stage II pressure ulcer on the left buttocks was 1.5 cm x 1.0 cm x 0.1 cm and the stage II pressure ulcer on the right buttocks was 0.7 cm x 0.5 cm x 0.1 cm. On 2/21/13 the treatment order for R3's wounds were changed. The new order was to apply saline moistened collagen pad, cover with

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border foam dressing daily and prn. On 3/5/13 at around 11:00 am E26 (wound care nurse) stated the treatment was changed to promote healing to wounds.

On 2/26/13 during the noon meal, R3 did not receive assistance. Staff was assisting her tablemate. R3's 2 jellied sandwiches were still wrapped in wax paper. Facility's weight sheets indicate R3 had a 5.39% weight loss in 1 month from January -February 2013.

Dietary notes dated 2/22/13 written by Z4 (Registered Dietician) documents R3 is on regular diet with thin liquids and receiving resource 120 cc three times a day, Zinc, Multi-vitamins and Iron and Vit C daily.
A recommendation for Prostat 30 cc daily until healed was written on dietary notes. R3's February 2013 Medication Administration Record (MAR) and Physician Order Sheet (POS) lacked documentation that the recommendation was followed. POS dated 2/26/13 documents the Prostat was finally ordered on 2/26/13.

E2 (DON) stated when new or multiple pressure ulcer are discovered, the dietary manager is notified by the treatment nurse or nursing staff.

E28 (Food Service Supervisor) stated on 3/5/13 at around 11:00 am, she is notified of pressure ulcers by the wound nurse and receives weekly wound sheet. E28 stated she e-mails wound report to Z4 weekly and /or calls and leaves message. When E28 was asked if there is a time frame for Z4 to see resident admitted with wounds or new wounds, E28 stated it usually does not take that long. E28 stated Z4's dietary

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recommendations are sent to ADON (E3). E3 stated on 3/5/13 at around 11:45 am, she did not receive the dietary recommendation for R3.

On 2/26/13 at 11:30 AM, Z4 was reviewing records. Z4 was informed that R3 did not receive the Prostat as recommended on 2/22/13. Z4 responded " I don't have time to follow up on recommendations."

R3's care plan for pressure ulcers dated 11/28/12 was not updated regarding R3's acquired pressure ulcers until 2/21/13 documenting R3 had stage II decubitus ulcers to left and right buttock and is a risk for additional breakdown due to decreased mobility and incontinence. R3's care plan interventions includes observe for adequate hydration and nutrition.

2. R9's diagnosis includes Cerebral Vascular Accident with left hemiplegia, Diabetes Mellitus. R9's Minimum Data Set dated 11/29/12 assessed R9 as requiring extensive assistance in all activities of daily living and incontinent of bowel and bladder.

R9's Norton Risk Assessment Scale dated 1/21/13 assessed R9 as at risk for pressure ulcers.

During the initial tour on 2/25/13 at 10:30 AM, R9 was observed lying in bed on his buttocks.

On 2/26/13 at 11:45 AM R9 was again observed lying in bed on his buttocks. During an skin and incontinence check with E16, CNA at 11:50 AM, R9 diaper was soiled with stool and an opened area was observed to R9's left ischial area. E16

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stated she did not notice the opened area earlier. E21 (RN) was asked to observe R9's buttocks and stated she was unaware of the open area. E26 (wound care nurse) was notified of observation on 2/26/13 and assessed the wound as a Stage II measuring 0.5 centimeters (length) (cm) x 0.3 cm (width) < (less) 0.1 in depth. R9's physician was notified and an order was obtained to apply Xenaderm to peri/rectal area every shift and prn (as necessary) until healed.

On 2/25/13 at 6:17 PM during the evening meal, R9 ate only 25% of his meal and received only intermittent assistance. On 2/26/13 at 8:45AM, R9 received only minimal assistance with his meal. Facility's weight records documents R9 had a significant weight loss of 10% in the last 3 months.

R9's current care plan for skin breakdown includes: assist resident as he needs to turn and reposition at least every two hours and prn when in bed-able to turn to left side using siderail: minimize friction or shearing by proper postioning, transferring and turning: provide incontinence care after each incontinent episode and apply Baza creme to buttocks every shift, and skin check daily. R3's care plan interventions also include observe for adequate nutrition and proper hydration.

(B)

300.1210a)
300.1210b)
300.3240a)

Section 300.1210 General Requirements for

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F9999	Continued From page 55 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 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. 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 WERE NOT MET AS EVIDENCED BY:	F9999		

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Based on observation, interview and record review the facility failed to identify and respond to significant and insidious weight losses, failed to ensure that nutritionally high risk residents received assistance with meals, failed to respond to dietary recommendations, failed to complete nutrition assessments, and failed to have care plans in place for nutritionally high risk residents and residents with weight loss.

This applies to 16 of 16 residents reviewed for weight loss (R6, R15, R21, R19, R16, R14, R9, R18, R7, R12, R10, R23, R13, R17, R4, R25) in the sample of 27, and 34 residents (R43, R44, R45, R47, R48, R49, R50, R51, R52, R53, R28, R87, R30, R54, R41, R46 R73, R33, R89, R88, R90, R91, R92, R93, R94, R95, R96, R97, R98, R99, R100, R102, R103, R104) in the supplemental sample.

The findings include:

A total of 26 residents had significant weight losses in January 2013 and February 2013 based on data calculated from the facility's "Weight Report Form for 2/1/12 - 2/11/13." The following residents had a significant weight loss of 5% or greater in 1 month: R43, R15, R44, R45, R21, R47, R19, R48, R49, R50, R51, R16, R52, R53, R28, R87, R30, R54, R41, and R14. The following residents had a significant weight loss of 7.5% or greater in 3 months: R46 and R9. The following residents had a significant weight loss of 10% or greater in 6 months: R7, R73, R12, and R33. This represents 14.5 % of residents residing in the facility with significant weight loss.

Additionally, there are 20 residents with insidious

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weight loss over the past 6 months - 1 year based on data calculated from the facility's "Weight Report Form for 2/1/12 - 2/11/13." These residents are: R10, R89, R88, R90, R91, R92, R93, R94, R95, R23, R6, R96, R97, R98, R99, R100, R102, R103, R13, and R104.

The total number of residents with weight loss (significant + insidious) is 27.9 %.

On 2/27/13 Z4 (Dietitian) stated that she is "not involved" in the facility's weight loss prevention program and does not attend any quality assurance meetings at the facility.

1. R14 is a 79 year old resident who had a significant weight loss of 6.6% in the last month (1/4/13 - 2/11/13) according to the facility's Weight Report Form dated 2/1-2/11/13. In November 2012 R14 also had a significant weight loss of 8.5% in 3 months. R14's current weight is 70 pounds (2/11/13). R14 has a current diet order for Pureed, No Concentrated Sweets, No Added Salt, Skim Milk at meals, and supplement orders for Resource 2.0, 120 milliliters (mL) 4 times a day, according to the February 2013 Physician's Order Sheet (POS). R14 has been on the same supplement of Resource 2.0 since 1/16/12, according to the POS. R14 has also been on Megace 40 mg (milligrams), an appetite stimulator, since 10/28/12, according to the POS. The Dietitian (Z4) made recommendations to discontinue R14's dietary restrictions of No Concentrated Sweets, No Added Salt and Skim milk on 10/25/12, 11/27/12, and 12/13/12 in order to "encourage intake" according to Nutrition Notes. These recommendations were not acted upon. No rational was documented regarding the

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reason that these recommendations were not initiated. There is no care plan that addresses R14's nutrition or weight loss, according to review of all care plans for R14.

R14 consumed 25 - 50% at most of her meals (75% of the time) from 12/30/12 - 2/2/13, according to review of the facility's Meal Intake Log.

On 2/25/13 R14 was sent to the hospital because of mental status changes and was diagnosed with AMS (Acute Mental Status) and UTI (Urinary Tract Infection), according to hospital records date 2/25/13. R14's BUN (blood urea nitrogen) was elevated at 32 (normal range 6-26), according to hospital lab records dated 2/25/13.

During an interview with Z4 (Dietitian) on 2/27/13, Z4 stated that she does not have time to follow-up on her dietary recommendations.

2. R12 is an 89 year old resident with diagnoses that include OBS (organic brain syndrome), dementia, and diabetes. R12 entered the facility in 2007 and had a gastrostomy tube placed 12/29/09. Review of R12's records show that over the last 12 months from 2/7/12 until 2/6/13 she has had a severe weight loss of 11% in 6 months, and a total of a 26 pound weight loss altogether.

R12 currently has orders for Jevity 1.5 cal at 50 ml / hr, to run for 14 hours. R12 also has orders for puree pleasure feedings. R12 is a total care resident that requires staff assistance for all activities of daily living such as feeding. R12's current tube feeding provides 1080 calories and

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46 grams of protein. R12 requires 1881 - 1950 calories according to the only two Nutrition Notes that estimate R12's calorie requirements (dated 2/16/11 and 5/20/11) , per review of notes dated 10/15/10 - 2/14/13. R12's protein requirements are not calculated at all per review of all Nutrition Notes.

On 2/16/12 the Dietitian (Z4) recommended decreasing R12's tube feeding from 80 cc/hr to 60 cc/hr, according to Nutrition Notes dated 2/1/12. No rational is given for this significant reduction. On 3/8/12, Z4 recommended a further reduction in tube feeding to 50 cc/hr because R12 was refusing to eat at meal. The 3/8/12 Nutrition Note documents that this was at the request of the Power of Attorney (POA). Subsequent Nutrition Notes continued to document that this reduction in tube feeding was at the request of the POA. R12's tube feeding remains at this level to the current date. This level of feeding only meets 57 % of R12's calorie requirements.

On 2/25/13 at 6:30 PM, during dinner observation on the second floor, R12 was not present in the dining room. E17 (Nurse Supervisor) was asked why R12 was not present and responded that she is only fed for breakfast and lunch because she has a tube feeding. There is no such restriction written into her physician's orders.

On 2/26/13, the lunch meal on the second floor was observed. It was noted that R12 was seated at the table with two other residents, all of whom needed to be fed. R12 was seated at the table since shortly after noon. At 12:25 PM, R12 was served her pureed diet. The food was placed on the table, the milk carton was opened, and staff

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left the table. Not until 12:50 PM did anyone sit down with R12 to attempt to feed her or encourage her to eat. The food was not reheated after waiting all this time. R12 took several spoonful then seemed to not want the food.

Z4 was interviewed by phone on 2/28/13. When asked about the statement regarding the POA, Z4 admitted that she has not talked to the POA ever. Z4 said that this was conveyed to her by nursing staff. Z4 said she never conducted a calorie count on R12 to assess the amount of food she was taking in by mouth.

On interview, Z5 (POA) stated that she was not aware of the severity of R12's weight loss, that no one had called to inform her from the facility. Z5 said that she had expressed concern about her mother (R12) gaining a lot of weight in 2011. At that time R12 had gone over 150 lbs. Z5 said that there had been no further discussion since that time.

3. R9 is a 90 year old resident who has had a significant weight loss over the past 3 months according to the facility's Significant Weight Change reports dated January 2013. R9 did not have a current weight loss or nutrition care plan in place, according to review of all care plans.

R9 was not receiving any assistance with his dinner meal on 2/25/13 when observed at 6:13 PM, 6:32 PM, and 6:57 PM in the 2nd floor main dining room. R9 ate 25% of his meal. R9 was not receiving any assistance with his breakfast on 2/26/13 when observed at 8:45 AM, and 8:53 AM.

R9 was observed on 2/26/13 with a new Stage II

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F9999	Continued From page 61 pressure ulcer on his left peri-rectal area. 4. R10 was initially admitted to the facility on 10/31/12 weighing 162.5 pounds according to the facility's weight report. R10 was hospitalized and re-admitted twice (12/8/12 and 1/6/13) according to the weight report. R10 lost 10 pounds upon his readmission on 1/6/13 (153 pounds), and an additional 2 pounds by 2/6/13 (151). The last nutrition note is dated 12/13/12. The dietitian did not evaluate R10's weight loss or make any recommendations to prevent further weight loss. R10's Nutrition Status Care Area Assessment (not dated) for ARD (Assessment Reference Date) 11/10/12 states "May need to add fortified foods and/or supplements if intake and weights start to decline. Proceed to care plans." There was no nutrition or weight loss care plan in the medical record. On 2/26/13 at 3:04 PM, E23 (Care Plan Coordinator) stated that there was no nutrition or weight loss care plan developed for R10. On 2/27/13, Z4 (Dietitian) said she didn't see R10 when he was readmitted from the hospital on 1/6/13. Z4 stated "I only see people who are readmitted if I have the time." Z4 also said "Sometimes I have to skip seeing residents because I don't have enough time." 5. R4 is a 79 year resident with dementia, history of gastrointestinal problems, and Parkinson's disease. R4 was admitted to the facility in 2009. Review of facility Weight Report records show that since 2/7/12, R4 has lost 34 lbs. Review of his clinical record shows that there was no care plan to address R4's nutritional status, eating or	F9999		

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weight loss. The Kardex only indicates "independent after set up."

On 2/26/13 the lunch meal was observed on the second floor. R4 was eating his desert and drinking his milk from the carton with it spilling out of his mouth onto his clothing protector as he drank. No one offered him assistance or encouragement. The entree of ground meat and potato and spinach, was not touched by R4 except for about 1 spoonful of meat. After sitting there for more than 1/2 hour, R4 left the table. No staff intervention was ever initiated.

6. R15 is a 78 year old resident with multiple diagnoses, including renal insufficiency according to the Minimum Data Sets (MDS) dated 12/26/12. R15 is assessed to be independent with eating according to the MDS. R15 lost 33 pounds between January and February 2013 according to the facility's Weight Report Form for 2/1-2/11/3. R15 had no weight loss care plan and no new orders to address her weight loss. Additionally, R15 was not assessed by the Dietitian following her weight loss.

R15 was observed during dinner on 2/25/13 between 5:56 PM - 6:30 PM in the 2nd floor dining room. R15 ate 25% of her dinner meal. R15 did not receive any staff encouragement to eat. R15 was observed during breakfast on 2/26/13 between 8:40 AM - 9:10 AM. R15 ate 25% of her meal. R15 did not receive any encouragement to eat.

Direct care staff were not aware of R15's significant weight loss. On 2/27/13 at 2:15 PM, E17 (Nurse Supervisor) stated that R15 is

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independent with eating. E17 said she was not aware that R15 lost 33 pounds over the past 30 days.

On 2/27/13 Z4 (Dietitian) stated that she did not assess R15 for her significant weight loss because she doesn't have enough time to see everybody. Z4 said she has to "prioritize her time."

7. R17 is an 81 year old resident with dementia, depression, hx of gout and Vit B12 and Vit D deficiency, and DJD (degenerative joint disease). R17 has an order for a regular diet with thin liquids and a supplement of Resource 2.0, 60 cc three times a day.

On 2/28/13 at 8:50 am, R17 was observed being assisted by the nurse. R17 ate about 25% of the cereal and refused more. The annual nutritional assessment dated 1/12/12, identifies R17 as high risk nutritionally. The January 2013 nursing summary also identifies R17 as being at risk for skin breakdown. Recent labs of 2/25/13 show R17's Blood Urea Nitrogen to Creatinine ratio was 24 (reference range 12-20).

The most recent note by the dietician is from 7/19/12, and the most recent annual nutritional assessment was from 1/12/12. No current nutritional care plans or interventions were in place for R17.

8. R18, 93 years old has a hx of Gastrointestinal problems, and is on a pureed diet with thin liquids. Review of the clinical record shows that the most recent annual nutritional assessment was done 7/28/11 and indicated that at that time

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F9999	Continued From page 64 R18 was at high risk nutritionally. The last dietary note was 7/26/12. 9. R13 was admitted to the facility on 12/2/12. Since admission R13 has lost 10 lbs. R13 is on a mechanical soft diet currently . The nutritional assessment form dated 12/27/12 identifies R13 as high risk. There are no other notes acknowledging the weight loss or its cause. There has been no care plan developed or interventions to address the weight loss. 10. R25 was an 87 year old resident who was admitted to the facility 9/29/12 and discharged to the hospital on 1/10/13. Nursing notes of 1/6/13 document a diminished consumption for meals. Review of the clinical record shows no dietary assessment, no dietary notes, no care plan for eating, or nutritional needs. Only one weight, that of admission, is in the record. The facility's Weight Monitoring for Gradual Weight Loss (2010) states that the facility will monitor the nutritional status of all residents, and will track "gradual and insidious weight loss." (B) 300.1210a) 300.1210b) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 65 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 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. 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 WERE NOT MET AS EVIDENCED BY: Based on observation, interview and record	F9999		

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review the facility failed to assess for dehydration, failed to monitor fluid intake, and failed to develop a dehydration care plan.

These failures resulted in R14 being sent to the hospital on 2/25/13 and diagnosed with acute mental status changes and urinary tract infection.

This applies to 3 of 12 residents (R14, R5, R7) reviewed for hydration in the sample of 27.

The findings include:

1. R14 has multiple diagnoses, including heart failure and non-Alzheimer's Dementia according to most recent Minimum Data Sets (MDS) dated 12/9/12. R14 requires extensive, 1-person assist with eating/drinking according to the MDS. R14 has physician orders for Lasix 20 mg at 6:00 AM daily, according to the Physician's Order Sheet (POS). R14 has been receiving Lasix since January 2012 according to the POS. R14 did not have a Care Area Assessment for dehydration with her last MDS dated 12/9/12. There was no dehydration assessment in the medical record. R14's Dehydration care plan dated 12/19/12 states "observe fluid intake during meals..." There is no documentation of R14's fluid intake in the medical record.

R14 consumed 50% or less at most of her meals (75% of the time) from 12/30/12 - 2/2/13, according to review of the facility's Meal Intake Log. R14 weighs 70 pounds (2/11/13) according to the weight report. R14 had a significant weight loss of 6.6% from January to February 2013, according to the facility's weight report.

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On 2/25/13 at 6:01 PM, R14 was in bed being assessed by E17 (Nurse Supervisor) and E24 (Nurse). R14 appeared frail, with sunken eyes. E17 stated that R14 had a change in mental status. R14 was sent out to the hospital and diagnosed with AMS (acute mental status) and UTI (urinary tract infection), according to the hospital records dated 2/25/13. R14 had 4+ bacteria and blood in her urine according to the Urinalysis report dated 2/25/13. R14's BUN (blood urea nitrogen) was elevated at 32 (normal range 6-26), according to hospital lab records dated 2/25/13.

On 2/28/13 at 9:15 am, E25 (Nurse) stated that there is no fluid monitoring done on R14. E25 stated "I guess we could start I's (intakes) and O's (outputs)." E25 said that R14 had lost weight a couple months ago, but regained it after Megace was started. E25 was not aware that R14 currently had poor food intake and that R14 had a significant weight loss in February 2013.

On 3/4/13 at 2:20 PM E2 (Director of Nursing) stated that a dehydration assessment had not been completed on R14.

2. R5 has a diagnosis of Dysphagia and has a diet order for nectar thick liquids, according to the MDS dated 12/13/12 and POS dated February 2013. R5 has no dehydration assessment and no dehydration care plan, according to review of the medical record. R5's most current nutrition notes dated 1/19/12 and 6/12/12 do not address her hydration risk. R5 had a urinary tract infection on 2/11/13, according to review of the medical record.

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R5 was in her room on 2/25/13 at approximately 10:30 AM sitting in her wheelchair. R5 was repeatedly asking for water. On 2/25/13 at 12:56 PM R5 was in the dining room asking for water. When staff directed her to her thickened water, R5 pushed it away and yelled "I want my water (explicative)." On 2/25/13 at 4:15 PM, R5 was sitting in her wheelchair in her room asking for water. R5 repeated "C'mon, C'mon, give me water...I want water." R5 was observed during breakfast on 2/26/13 at 9:00 AM. R5 did not drink any of her liquids. On 2/28/13 R5 was observed during breakfast. R5 did not drink any of her liquids.

On 2/28/13 at 10:21 AM, E23 (MDS/Care Plan Coordinator/Nurse) said that R5 did not have a dehydration care plan. E23 said that they only do a care plan if "they're on a diuretic and have an ongoing infection."

On 2/28/13 at 9:25 AM, E25 (Nurse) stated that R5 does not like thickened water. E25 said she "cries out and won't always take it." E25 said that there is no fluid intake monitoring sheet for R5. E25 said she probably doesn't like it because it's warm. E25 said "I tasted it warm, it's terrible." E25 said that when she gives R5 water, she puts ice in it and R5 accepts it better.

3. R17 is an 81 year old resident with dementia, hypertension, and a history of UTI (urinary tract infection). On 2/4/13 R17 had a UTI with greater than 50,000 colonies of escherichia coli as the infecting organism. Lab results dated 2/25/13 indicate an elevated BUN of 24 mg/dl. The only dietary documentation in the clinical record are the annual nutritional assessment dated 1/12/12

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F9999	Continued From page 69 and a note dated 7/19/12. The assessment identifies R17 as high risk nutritionally, but there are no care plans or interventions to address the hydration needs or the UTI's. (B)	F9999		