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F 327	Continued From page 43 few inches of his 1/2 full urinal on the bed side stand. E4 LPN was asked whether he had had breakfast and she stated he had refused. His tray was removed from the room with no fluids left at bedside. The urinal and partial carton of milk remained on the bedside stand. At 10:15am, and 11:07am, R9 still had no water at bedside. E1, Adm was informed of him not having a fluid at bedside and at 11:45am, R9 was observed to have a water pitcher of ice water on his overbed table taking a drink when he was observed. At 12:55pm, R9 was fed his lunch meal. He had coffee and juice on his tray. At 1:20pm, R9's tray was removed by E5 LPN with no encouragement and/or cueing to drink more. He had eaten 100% of his meal but only consumed 1/3 of the 180cc of juice and no coffee. On 9/17/13 at 2:03pm, E18 Speech Therapist stated often residents do not have water pitchers or water at bedside.	F 327		
F9999	FINAL OBSERVATIONS Licensure VIOLATIONS: 300.610a) 300.1010h) 300.1210a) 300.1210b)4) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and	F9999		

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procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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

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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.

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

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.

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, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

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Based on interviews and record review, the facility neglected to follow their policy/procedure for monitoring, treating and evaluating pressure ulcers and failed to assess and monitor fluid intake adequate hydration for 2 of 3 residents, (R4, R8) reviewed for pressure ulcers and dehydration in a sample of 10. This neglect resulted in a signfication decline in R4's coccyx pressure ulcer which increased greatly in size showing signs of infections. R4 was hospitalized with a diagnosis of sepsis related to a pressure ulcer.. The facility neglected to assess R8 for risks of dehydration, neglected to monitor his intake following an order for thickened liquids and neglected to identify signs/symptoms of dehydration in a timely manner to avoid hospitalization for acute renal failure from severe dehydration.

Findings include:

1. According to weekly wound report completed by E8, Licensed Practical Nurse (LPN) dated 7/5/13, R4's right buttock was identified an "unstageable" having 100% necrotic tissue present with light purulent drainage measuring 3.5cm x 2.5cm x 1cm deep. E8 documented that the primary physician was notified but not the family. On 9/5/13 at 8:30am, E8 Licensed Practical Nurse stated she thought R4 needed to be seen by the wound clinic because her wound kept getting worse. E8 stated she did not document that anywhere but made the appointment for R4 on 7/10/13 to see a wound specialist.

On 7/10/13, R4 was seen by Z2, Wound Physician at the wound clinic. Wound notes from

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the clinic dated 7/10/13 document under History "the best that we can ascertain from the records that were sent with her, she has had a pressure ulcer since April." The report identifies the initial evaluation of R4's pressure ulcer measured "4.3c, x 5cm x 2.5cm with a significant amount of necrotic material throughout the entire base of the wound and along the upper surface of the wound." The report documents that "an extensive excisional debridement was performed using a scalpel. This removed skin, subcutaneous tissue and a copious amount of muscle." It continued to state "the wound was improved. The patient tolerated the procedure well. The size of the wound after debridement was significantly larger than that predebridement." Plans were to have Santyl Dressings and pressure offloading done and to see R4 again in a week.

On 7/17/13, R4 went to the wound clinic. Documentation dated 7/17/13 from the clinic states "last week in clinic, we performed a significant debridement which included skin, subcutaneous tissue and muscle. We removed a fair amount of necrotic tissue. We were able to get back to essentially viable tissue around the entirety of the wound. The patient was to be getting pressure offloading and Santyl dressings changes daily. The patient today was accompanied by her family. There was no report given to us that her wound had at all deteriorated." Physical examination recorded at the time documented R4's pressure ulcer 7 x 8.5 x 1 with copious necrotic tissue throughout the patient's right side of her buttock. She has a new area of skin necrosis, which extends over into the left buttock as well as inferiorly along the right." The Wound Physician, Z2 again debrided the

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area to both buttock to remove an "an extensive amount of tissue. This was in excess of 20 square cm." The report documents R4 was sent from the wound clinic directly to the hospital emergency room for likely admission.

On 9/4/13 at 2pm, Z2 stated in interview that he very well recalled R4 and remembered her coming into the clinic. Z2 stated when he saw her the first time, he did an extensive debridement to "good healthy tissue" and sent her back to the facility for daily dressing changes. Z2 stated when she returned a week later, she had a fair amount of necrotic tissue, "the whole wound actually," then stated "NO WAY they could have done dressing changes daily and not noticed the decline." Z2 stated he would have expected the facility to notify him on the first sign of decline and he would have seen her again adding that there was "NO WAY this decline was an overnight thing.' When asked if he felt this was neglect, Z2 stated "Yes, I would." Z2 stated R4 was transferred to the hospital then expired at home with family. The death certificate signed by Z2 identified the date of death as 7/30/13 with cause of death listed as Sepsis, decubitus ulcer and pneumonia/Dementia.

According to the Treatment Administration Record, (TAR)'s for July 2013, R4's treatments were initialed as done by E15, LPN from 7/12/13 thru 7/14/13. On 9/6/13 at 10:10am in interview, E15 stated when R4 first came into the facility, she had very superficial pressure ulcers to her coccyx. E15 stated the wounds just kept "getting worse." E15 stated before R4 went to the wound clinic, the wound bed was covered with black eschar. After the wound clinic visit, E15 stated the wound bed was beefy red and was a deep

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hole but "by the 2nd or 3rd day, it had an odor, little patches of yellow slough in it." E15 also stated it appeared to be spreading toward the left side. Asked if she notified the wound physician or nurse of the decline, stated "no" she "would only notify them if she felt the decline or change was significant." E15 identified herself as a staff nurse and does treatments on third floor now.

The facility skin report dated 7/13/13 completed by E8, Licensed Practical Nurse, (LPN) identifies R4's ulcer as measuring 4.3 x 5 x 2.5 with 100% necrotic tissue, odor present three days after the debridement was done. In interview with E8 on 9/5/13 at 8:30am stated she had seen R4's wound the day after it had been debrided and that it appeared as a hole the size of a golf ball to tennis ball. At that time, E8 stated it was mostly beefy red with bloody drainage and 25% black tissue present in it. E8 stated it had "really bloody drainage." E8 was asked about the measurements documented on 7/13/13 and stated she did not measure the wound herself, but took the measurements off of the Wound Clinics report from 7/10/13. (These were measurements done prior to the debridement.) E8 stated she thought the wound had deteriorated on 7/13/13 but when asked if she notified the wound Doctor, stated "No, I figured it was being followed by the wound clinic Doctor" and would be seeing her weekly. E8 stated R4's pressure ulcer had odor on 7/13/13. When asked if E8 had ever seen R4 without a dressing to her coccyx, stated "Yes, one time." E8 identified herself as the floor manager of R4's floor at the time and was responsible to do the weekly assessments on all residents with pressure ulcers although she stated she has had no training in Pressure ulcers. The weekly wound report dated

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7/13/13 does not document the physician or family as notified and nurses notes from 7/12/13 thru discharge are missing and are unable to be located according to E1, Administrator in interview on 9/6/13 at 10am.

The TAR for 7/15/13 thru 7/17/13 have no initials present on 7/15/13 and 7/16/13 and E8's initials on 7/17/13 and there are no nurses notes documenting her decline in condition from 7/12/13 thru 7/17/13 when she went to the wound clinic and did not return.

On 9/4/13 at 12:30pm, Z3, R4's niece, in interview stated she was aware that R4 had a pressure ulcer on her coccyx and three weeks before 7/10/13 clinic visit, the nurse told her the pressure wound was "out of control." She stated staff did not give her details but would tell her it was not healing, getting worse toward the end but she had no idea that it was as bed as it was. Z3 stated she did not attend the first wound clinic visit with R4 but was called by the clinic and asked to be with R4 on her second visit 7/17/13. Z3 stated while waiting in the reception area at the clinic, she thought R4 had soiled herself because the odor was so bad. Z3 stated she was in the room when Z2 removed the dressing and that she could tell he was shocked at what he saw stating "I can't tell you how it got this bad." Z3 stated she observed the area and was shocked as well. Z3 stated Z2 sent R4 to the hospital then she took her home on Hospice where she expired on 7/30/13. Z2 stated the Wound Physician signed the death certificate since she died from the sepsis from the pressure ulcer.

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Hospital Discharge records for R4 dated 7/22/13 document diagnoses as "Sepsis (secondary) to infected decubitus ulcer, pneumonia, UTI (Urinary Tract Infection), Dementia." Admitting diagnoses on 7/17/13 according to Emergency Room Department documents identify "infected decubitus ulcer, hypernatremia, dehydration

E1 Administrator/ Registered Nurse (RN) on 9/6/13 at 10am confirmed that the nurses notes for R4 from 7/12/13 thru 7/17/13 are missing. E1 stated he would have expected E8 or E15 to call both the wound physician and the primary physician with a decline in wound condition.

The facility's policy entitled "Pressure Ulcers/Skin breakdown - Clinical Protocol" (no date) documents that the nurse shall assess and document/report the following: b. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue and f. Current treatments, including support surfaces among others. The protocol documents under 4. The physician will help the staff define the type (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed, etc.) of ulceration. Under General guidelines for treatment, strategies will include assessing the resident and pressure ulcer, managing tissue loads, pressure ulcer care, managing bacterial colonization and infection, operative repair of pressure ulcers and education and quality improvement.

The facility's policy entitled "Change in a Resident's Condition or Status" documents the facility "shall promptly notify the resident, his or her attending physiucan and representative of

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change in the residents medical/mental condition and/or status. The policy documents "significant change" of condition is a decline or improvement in condition in the resident's status that will not normally resolve itself without intervention. The policy also indicate the Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

2. According to the Admission Nursing Assessment dated 8/22/13, R8 was described as continent, gait assist of one staff with transfers, could help himself turn in bed and was alert with periods of confusion. The assessment continues to document that he answered questions appropriately and was oriented to facility, family and staff. The physician's order sheet for August indicated R8 received Lasix 20mg daily among other drugs and had no swallow deficits identified. The diet ordered on admission was regular with thin liquids.

Admitting nurses notes dated 8/22/13 at 5pm, documented that R8 arrived in w/c (wheelchair) from the hospital with a diagnosis of R (Right) sided weakness from CVA (cerebral Vascular Accident). Minimum Data Set (MDS) dated 8/29/13 assessed R8 to require extensive assist of one staff for all other activities of daily living including eating.

E20, Registered Dietician, (RD), assessment dated 8/26/13 documents that R8's estimated daily fluids needs would be 2455cc/24 hours and that at the time of the assessment, R8 consumes approximately 1000-1499cc/day. On 9/4/13, a

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speech evaluation was completed and R8's diet was changed to mechancial soft with nectar thick liquids. The Interim Care Plan dated 8/22/13 neglects to identify R8 risk for dehydratioin due to the use of diuretics, thickened liquids and insufficient fluids consumed as identified by the RD.

Nurses Notes and Skilled Nursing Flow Sheets from 8/22/13 thru 9/7/13, document R8 to be alert and responsive and able to verbalize needs. On 9/8/13 at 10:55am, the nurse documented R8's appetite as being poor but "drinks lots of fluids." On 9/9/13 at 1:45pm, the nurse documented that R8 takes his medications whole, appetite continued to be poor but fluid intake good. R8 was documented as going out to a physician's appointment.

On 9/10/13 at 1:30pm, E11, Licensed Practical Nurse (LPN) documented "called (Z5 - R8's primary physician) office "re: (regarding) tremors. Spoke to nurse (Z6), et MD (medical doctor) wasn't to see res. (resident) before referring to neurology as per niece request." There is no further information on the tremors R8 was documented as having. At 7pm, the nurse documented R8 "appetite poor. Did drink some of his ensure. Body twitches at times." The nurse further documented that fluids were offered and taken.

According to nurses notes written on 9/11/13 at 9:35pm, "res ate evening meal in bed and was fed by staff." The nurses notes do not document that Z5, R8's primary physician, was notified of this decline in ADL's and no indication any further assessment was done regarding a causative factor of this decline.

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On 9/13/13, the nurses notes written at 3am document incontinent care was given. At 1145am, the nurse documents R8 "appears tired - but does answer yes/no questions fed per staff. Update to MD." At 1pm, the nurse documents that R8's medications were crushed, and he was again fed per staff." The note also indicates R8 "conts (continues) to rest c eyes closed." An additional nurses note written (no time) on 9/13/13 documents R8 going to see Z5, MD, "slumping over in his chair, not as alert as usual." At 1600 (4pm), the nurses notes written by E11, LPN documents that she received a call from Z6, Z5's nurse regarding R8 being transferred to the emergency room as resident was slumped over in chair and may be having a heart attack.

The History and Physical from the hospital dated 9/13/13 documented "(R8) is a 78 year old patient seen in our office yesterday. After talking to the nurses in the nursing home, they said that he was fine this morning or yesterday, although, he was having some twitching in his left upper extremely. The paramedics were called, and the patient was taken by ambulance to the ER (emergency room). In ER, he was found to be severely dehydrated with acute on chronic renal failure." Hospital Lab results dated 9/13/13 document R8's BUN as 191 (normal 6-22), Sodium 146 (normal 133-142), urine was unremarkable.

Interview with Z6, Z5's nurse, on 9/17/13 at 12pm indicates when R8 was brought into the building by the van driver (E21), he was slumped over, couldn't sit upright, was ashen in color and could barely respond when spoken to. Z6 stated the driver indicated that he was like this when he picked him up at the facility and that he talked

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE AND REHAB CENTER	**555 WEST CARPENTER SPRINGFIELD, IL 62702**

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with the nurses about taking him to a doctors appointment in this condition but was told to take him anyway. Z6 stated she recalled having a conversation with the facility nurses a few days prior to 9/13 and said they had told her they thought he was having another stroke with tremors and weakness. Z6 stated she was not told of his over decline and lethargy. Z6 stated R8's oxygen saturation in the office that day was 80% and it took three firefighters to transfer him to a gurney in order to transport him to the hospital via the ambulance. Z6 stated Z5, MD commented at the time that it was neglectful of the facility to bring R8 to the office in the condition he was in. Z6 stated Z5 was not informed of any condition change except the tremors and would have wanted to know about his overall general weakness, lethargy and inability to help himself as he had when he entered the nursing home a few weeks prior. Z6 stated another physician (foot doctor) in the practice had seen R8 on 9/9/13 and what they saw on 9/13/13, was a completely different person.

On 9/17/13 at 3:30pm, Z7, R8's Power of Attorney, (POA), was interviewed and stated she noted a huge decline in the last 1 and 1/2 weeks he was at the facility and that she was at the facility when the nurse called the physician a few days before his appointment on 9/13/13. Z7 stated she was told by the nurse R8 was possibly having another stroke. Z7 said she told them she didn't want him to go to the hospital only to be returned back to the facility if that was the case. Z7 stated she is not in the medical field and relied on the nurse to assess R8 appropriately. Z7 stated she was never told R8 was put on thickened liquids and that she never saw a water pitcher or glass of water at bedside or in his room

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during his entire stay at the facility except a couple on his meal trays. Z7 stated she had seen him on 9/5 or 9/6 and he seemed to be doing okay then did not come in until 9/9 or 9/10 and he was "jerking." Z7 stated she came again on 9/11/13, and called the nurse, E11 LPN to his room because he was again jerking and was sitting with his head down. Z7 stated she thought he was having seizures and didn't see him again until 9/13/13 when the van driver wheeled him into the physician's office in his wheelchair. Z7 stated he was slumped over in this chair and the driver had to hold him back to prevent him from falling. Z7 stated the driver told her he didn't want to bring him like that but that the nurse insisted he did. Z7 stated she was shocked that R8 was in as bad of shape as he was.

On 9/17/13 at 2:03pm, E18, Speech Therapist recalled R8 well and responded "Yes, definitely" when asked in interview if she noted a significant decline in R8 in the last week or so he was at the facility. E18 stated R8 was able to feed himself when he first came in and could at times, complete a full sentence. E18 also stated he had a very good appetite when he first came and the last few days, she attempted to feed him lunch he wouldn't eat or drink anything. E18 stated she had changed his liquids to thickened liquids on 9/4/13 after an evaluation showed that he was having some difficulted with thin liquids. She stated she assumed the nurses were monitoring his intake and response but wasn't sure. E18 stated R8 would try to "mostly drink his drinks, but would get it about 1/2 way to his mouth and have a spasm then would give up." E18 state R8 "didn't drink anything all those last few days at lunch" when she attempted to feed him. E18 stated she discussed this with E16, LPN on

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several occasions.

On 9/17/13 at 1:45pm, E16, LPN, stated in interview that she was the nurse that sent R8 to the doctor on 9/13/13. E16 stated the first week R8 fed himself and slumped in the wheelchair some. E16 stated she had noticed a decline the prior week before he was sent to the doctors office and that she recalled calling Z5's office on 9/10/13 while R8's Power of Attorney (Z7) was at the facility. E16 stated she thought R8's decline was due to him having another stroke and that's what she told R8's POA.. E16 did not respond when asked if she did any further assessment and/or monitoring in a effort to determine the causative factor of R8's decline. E16 stated although R8's overall condition continued to deteriorate, she did not notifiy the physician again due to him having an appointment on 9/13/13. E16 was asked about R8's fluid intake and the thickened liquids and responded, they didn't keep track of intake. When showed intake records from mealtime, responed "Oh, I didn't know we did that." R16 had no idea how much fluids or how R8 tolerated the thickened liquids in the week before he went to the hospital.

According to the Intake records for meals only, R8 was recorded intake was as follows: 1320cc - 9/6/13, 900cc - 9/7, 1689cc - 9/8, 600cc - 9/9, 660cc - 9/10, 480cc - 9/12 with refusing at the lunch confirmed in interview with E18. and no intake recorded for 9/13 all three shifts even though he didn't go to his appt until 2pm on 9/13/13.

On 9/17/13, interview with E17 CNA at 1:20pm indicates that she cared for R8 the last few days he was here and stated she noticed a major

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F9999	Continued From page 59 decline adding that he could talk when he first came in and the last day or so, he "jibber jabbered" that you couldn't understand. She stated she was off the weekend prior and when she came back on Monday (9/9/13), "he seemed to have had a stroke" keeping his eyes closed, sleeping more, not eating or drinking. E17 was asked about thickened liquids and facility's process stated that they get fluids with snacks. B 300.1230 K) Section 300.1230 K) Direct Care Staffing Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. (Section 3-202.05(e) of the Act) This requirement was not met as evidenced by: Based on record review and interview, the facility failed to meet the minimum requirement for Registered Nurse (RN) staffing. Findings include: Interview with E2, Director of Nursing (DON) , on 9/6/13 at 11AM and documentation provided, the facility had a census of 162 residents on 8/20/13 with 60 residents requiring skilled care and 102	F9999		

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F9999	Continued From page 60 requiring intermediate care. E2 identified 41% staff worked on the 7-3 shift; 38% worked on the 3-11 shift; and 21% worked on the 11-7 shift. According to calculations for the Registered Nurse Time needed to provide 10% of the time for resident care, the facility should have a minimum of 5.5 (8 hour shifts) for RN's per day. Review of the facility working schedule for RN's for August 20, 2013 showed the facility had 2 RN's in a 24 hour period plus 1 RN as a floor manager. Interview with E2 on 9/6/13 at 12:20PM, E2 stated she would love to have 5.5 RN's a day. E2 stated she advertises but doesn't get any applications for RN's. NV	F9999		