STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. BUILDING _____ B. WING _____	C 10/27/2010

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PEKIN MANOR	**1520 EL CAMINO DRIVE PEKIN, IL 61554**

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F 000	INITIAL COMMENTS Complaint #1024065/IL50062 - F327 Complaint #1023985/49970--No deficiencies	F 000		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION 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 observation, record review, and interview, the facility failed to develop and implement individualized approaches for 2 of 4 sampled residents at risk for dehydration. The facility also failed to analyze the results of fluid intake monitoring for R1 and R2. Findings include: 1. R1's care plan dated 07/19/10 documents R1 is at risk for urinary tract infection (UTI) due to recent hospitalization with diagnoses of UTI and receiving antibiotic therapy. The approaches documented are to "Report signs of dehydration/dizziness; confusion/mental status change; decreased urine output; concentrated urine; decreased skin turgor; dry mucus membranes; sunken eyes; constipation; fever; infection and fluid and electrolyte imbalance. The care plan does not address to monitor Input/Output nor does it address R1's fluid needs. The care plan dated 07/19/10, also documents R1 had a recent hospitalization that included a	F 327		

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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F 327	Continued From page 1	F 327		

diagnosis of dehydration and that R1 has a risk of dehydration related to diuretic (Lasix) therapy. There are no specific approaches on the care plan related to monitoring R1's intake and output. R1's September and October, 2010 nursing notes do not document nursing staff are assessing/monitoring R1's actual daily fluid intake or R1's output nor is there any documentation assessing R1 for signs of dehydration such as skin turgor or urine color, urine odor, urine consistency or number of times R1 is urinating.

The registered Dietitian's Enteral/Parenteral Nutrition assessment record dated 07/12/10, documents R1's baseline fluid needs are 2010 cc's (cubic centimeters) of fluid daily. R1's daily intake records for September 1st to September 30, 2010 indicate R1 is received an average of 1039 cc's of fluid daily and the October 1, 2010 to October 4, 2010 daily intake records show R1 is received an average of 1380 cc's fluid (below the recommended daily fluid intake). There are 12 days during this time period, that the third shift that do not record R1's fluid intake.

Nursing notes document that on 09/19/10, R1 is displayed increased confusion. A urinalysis was done showing R1 was negative for urinary tract infection. On 09/22/10, R1 was started on Lasix 40 mg (milligrams). On 09/28/10 and 09/29/10, R1 is documents as having a hard time with swallowing her medications. On 09/30/10 nursing notes, R1 is having problems with sleeping and is frequently calling out in Spanish and part of R1's speech is in English, as well.

On 09/30/10, R1 was NPO (nothing by mouth) after midnight and scheduled for a CT

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F 327	Continued From page 2 (Computerized Tomography) scan of the brain on 09/30/10. On 10/01/10 nursing notes, R1 was lethargic and quickly fell back to sleep after R1's medications were given. Physician orders and nursing notes dated 10/04/10, documented R1 received an evaluation by Speech Therapy related to difficulty with swallowing and R1's diet was changed to a Pureed diet. On 10/05/10 hospital lab reports, R1's BUN was 66.0 (elevated). The hospital reports shows the normal BUN is 7.0 to 22.0 mg/dl. E3 (Nurse Manager) stated on 10/25/10 at 1:45 that R1 had some altered mental status when admitted but the altered mental status had increased after the Lasix was started on 09/22/10. Urinalysis were done and R1 did not have a urine infection. E3 stated R1 was able to speak in English but as the confusion worsened, R1 started speaking more in Spanish. E3 stated that R1 was sent into the emergency room on 10/04/10 for increased lethargy, per nursing judgement, and was diagnosed in the emergency room with dehydration on 10/05/10. E3 stated that prior to 09/21/10, R1 was drinking her fluids well; especially her coffee. E3 stated staff would bring R1 hot water because R1 liked to make her own instant coffee. However, R1's intake records and nursing notes do not reflect increased fluid intake. E3 stated R1's fluid intake was monitored daily by Certified Aides and that the CNA manager (E8), recorded and kept track of R1's fluid intake daily. Despite the fluid intake records, there is no documented analysis of the intake versus estimated needs. E3 and E8 stated that R1's fluid output was not recorded because R1 was voiding without any difficulty and did not have a catheter. E3 could not verify	F 327		

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F 327	Continued From page 3 that nursing staff were monitoring R1's daily total input and output. E8 (Certified Nursing aide Manager) stated on 10/25/10 at 1:00 p.m., that E8 keeps daily records of residents intake that is recorded on the daily intake records. According to E8, urine output is recorded by the certified aides at the end of each shift if the resident has a catheter. R1 did not have a catheter. E9 (Licensed Practical Nurse) stated on 10/25/10 at 10:00 a.m., that if a residents fluid intake is below 800 to 900 cc's in a 24 hour period, the computer automatically flags this to alert the nurse to monitor residents intake and output. E9 stated that the certified aides keep track of residents fluid intakes and output is kept on residents with catheters. E11 (Certified Nursing Aide) stated on 10/25/10 at 11:30 a.m., that residents fluid intake is recorded daily and fluid outputs are recorded for those that have catheters. E12 and E13 stated on 10/25/10 at 2:05 p.m., that residents intakes are recorded at the end of the shift and documented on the daily vitals record. If a resident has a catheter, then the urine output is recorded at the end of the shift. 2. R2's nursing notes and physician orders dated 09/15/10 and 10/13/10 document R2 started on antibiotic therapy related to a Urinary Tract Infection (UTI). R2's care plan dated 10/21/10 documents R2 has a history of UTI and requires extensive assistance with care by two staff. The	F 327		

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F 327	Continued From page 4 approaches are for staff to encourage and offer fluids frequently throughout the day to R2, assess for signs of fluid and electrolyte disturbances, reports signs of dehydration/dizziness, confusion/mental status change, decrease urine output, concentrated urine, decreased skin turgor, dry mucous membranes, sunken eyes, fever , infection and fluid and electrolyte imbalance. Report abnormal labs indicating of dehydration such as elevated hemoglobin and hematocrit, potassium, blood urea nitrogen (BUN), albumin, transferrin, or urine specific gravity greater than 1.030. Daily Intake records for October 1, 2010 through October 24, 2010 indicates R2's received an average daily fluid intake of 1133 cc's (millimeters). The Registered Dietitian's Recommendation dated 10/22/10 assessed R2 as requiring 2400 cc's fluids daily. R2's Resident Intake and Output record for October, 2010 shows fourteen (14) days not documented of R2's intake and 6 days in October, R2's output is not recorded. E9 (Licensed Practical Nurse) stated on 10/25/10 at 10:15 a.m., that R2's October Intake and Output record that is kept with the Medication Assessment Record (MARs is incomplete. E9 stated the Intake and Output record is kept on R2 because R2 currently has a catheter in place. E9 stated that when a resident's urine output is very low in a 24 hour period, that the computer flags this to warn nursing staff. E8 (Certified Nurses Aide Manager) stated on 10/25/10 at 2:30 p.m., that the certified Aides are to document each shift, residents intake and output and E8 gathers this information and	F 327		

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F 327	Continued From page 5 records it on an Intake/Output record. R2's intake and output record shows that from September 28 through October 24, 2010, R2's urine output is only being documented once a day except for October, 8, 1st and 19 where R2's urine output is document on two shifts. R2's daily urine output, according to the urine output record, shows R2's urine output averages 500-600 cc's daily. R2's care plan dated 10/21/10 documents R2 is at risk for impaired skin integrity related to incontinence, impaired decision making, decreased safety awareness, progressing Alzheimer's Disease, requires extensive assistance wit two person physical assist wit bed mobility. The approaches provided include to keep R2 hydrated by encouraging fluids through out the day-hydration passes, as well as during activities. The 10/21/10 are plan documents that R2 has an Indwelling catheter and that the catheter will remain patent and provide adequate drainage of urine with no signs and symptoms of UTI's (Urinary Tract Infection). The approaches include for staff to monitor and document intake and output every shift, monitor for signs and symptom of infection such as decrease in urinary output,concentrated urine, foul smelling urine, increased amount of sediment or mucous, urinary retention, increased temperature, and complaints of pain. R2's physician orders dated 09/15/10 and 10/14/10 document R2 received antibiotic medication for urinary tract infections. On 10/25/10 at 10:00 a.m., R2's water pitcher in R2's room was 3/4 full. At 11:30 a.m., in the main dining room, R2 was sitting in a wheelchair	F 327		

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F 327	Continued From page 6 at a dining room table. The urine in R2's catheter tubing was "milky" color. At 2:00 p.m., R2's water pitcher was warm to the touch and still 3/4 full. R2 was lying on a low bed and is unable to reach the water pitcher. E3 stated on 10/25/10 at 2:35 p.m., that the staff have to feed and provide fluids for R2 who is unable to feed himself. E3 stated that R2 was served juice at 10:00 a.m., but there is no documentation recording the fluid (juice) intake for 10/25/10. The first shift (days) intake and output record for R2, that the Certified Nursing Aides (CNA's) record intake and output on before leaving their shift, was blank (incomplete) after the first shift CNAs left for the day at 2:00 p.m..	F 327		