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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and 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 b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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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:

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:
Based on observation, interview and record reveiw the facility failed to notify the physician of decreased oral intake, numerous episodes of emesis and montior and act on signs and symptoms of dehydration for two residents out of seven (R62 and R34) reviewed for dehydrations from a total sample of 14.
As a result of this deficent practice, R62 and R34 requried hospitalization and treatment for dehydration.
Findings include:
1) According to the facilities profile information, R62 has been a resident at facility on and off for almost six years with most recent re-admission on 1/27/15. According to R62 ' s January 2015 Physician Order Sheet, R62 has the following diagnosis: hypokalemia, neck strain, full failure to ambulate, hypertension, Gastroesophageal Reflux Disease, Osteoarthritis, hypothyroidism, constipation, Alzheimer ' s Dementia and Depression.
According to hospital record, R62 was admitted to the hospital on 1/22/15 with diagnosis of acute

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volume depletion (dehydration), acute metabolic encephalopathy, hypernatremia (high sodium), poor oral intake, acute renal failure and hypokalemia (low potassium).
According to R62 ' s medical document dated 1/22/15 titled Laboratory Report, the following abnormal labs were noted: Sodium 159 CH (Critical High) (Normal 131-145), Glucose= 136 H (High) (Normal 64-112), BUN-Blood Urea Nitrogen=41 H (Normal 5.0-28.0), Creatinin; Serum=1.4 H (Normal 0.6-1.2), BUN/Crea Ration=29.3 H (Normal 12-20), Calcium 11.2 H (Normal 8.4-10.2).
According to R62 MAR (Medical Administration Record) for January 2015, R62 is to receive the diuretic Lasix 80 milligrams by mouth two times a day. R62 ' s nurse ' s note dated 1/17/15, documents, " appetite continues to be poor. Emesis noted several times this week. None noted this shift. MD (doctor) aware and seen yesterday(1-16-15), no new orders noted. No appetite for lunch. Resident slept through meal and possibly due to new medication Seroquel. Will continue to monitor. " No additional nursing notes were noted in the medical record concerning R62's oral intake and episodes of vomitting. No nurse ' s notes or other documentation indicating that R62 was having any type of emesis or vomiting or that the doctor was notified of these multiple episodes of emesis. On 1/21/15 another nurses note states " Resident noted with emesis x1 during dinner. Was not able to eat dinner ". No additional documentation was noted concerning notification of the physician of emesis and or poor oral intake. Nurses note dated 1/22/15 states " Resident being admitted (to hospital) for dehydration, hypernatremia, renal insufficiency and elevated troponin. "
R62s meal intake record for January 1, 2015 to

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January 22, 2015 has resident with 3 episodes of refusing meals.
Seven episodes where no meal intake was documented.
Intake of 0-25% happened 38 times.
Intake of 26-50% happened 8 times.
Intake of 51-75% happened 6 times.
Intake of 76-100% happened 3 times in this time frame.
No documentation was found or provided by facility regarding snacks. No documentation was found making the doctor aware of poor meal intake until 1/21/15. Meal intake record from 1/12/15 to 1/21/15 has resident eating less than 25% or refusing meals for every meal except for 1 on 1/14/15 at the am in which she consumed 76-100%
On 2/19/15 Z2(R62 ' s Primary Care Physician) stated he could not recall that he was ever made aware that R62 was not eating or drinking until the day before she entered the hospital (1/22/15).
On 2/19/15 Z2 stated that if he had been made aware of the multiple episodes of emesis that was documented by the nurse on 1/17/15 sooner, when they actually occurred, the resident treatment plan could have been adjusted. Z2 also stated that R62 could have received intravenous fluids at the facility, fluids could have been encouraged sooner to attempt to increase R62 ' s oral intake. Z2 continued to state that a possible change in diuretic medication could have been made. Z2 stated that R62 ' s hospitalization on 1/22/15 and resulting dehydration and other diagnosis could have been avoided had the facility notified him of R62 ' s decline.
On 2/19/15, Z2 stated that dehydration is a very serious condition and verified that R62's lab values were critical upon admission to the hospital. Z2 stated that nursing staff should be

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using good nursing judgment and notifying him as needed and if resident had been having emesis for over a week he should have been made aware of this a lot earlier and a hospitalization and dehydration could have been prevented.
According to R62 ' s medical record on 1/13/15 she was referred to Z11 (psychiatrist) related to worsening memory and psychosis. On 2/19/15 Z11 (psychiatrist) stated that worsening memory, psychosis and lethargy could absolutely be indicators of dehydration. Z11 stated that nursing staff should be doing a better job of notifying the primary physician if he (primary physician) was not made aware of R62 not eating, drinking and having episodes of emesis/vomiting.
On 2/18/15 E9 (Certified Nurse ' s Aide) stated that R62 had not been eating, refusing meals, and had increased periods of sleeping for over 2 weeks. E9 stated she had worked with this resident for extended period and was familiar with her habits and that she had always been a picky eater but appetite had definitely declined since before Christmas. E9 also stated R62 required assistance with eating.
On 2/28/15 E10 RN (Registered Nurse) stated that she was familiar with R62 and resident had been gradually declining since the New Year and appetite had also decreased. E10 stated that if a resident was having emesis the nurse should send a fax or call him within twenty four hours to make him aware of problems or changes.
On 2/28/15 E26 (Certified Nurse ' s Aide) stated that she was familiar with R62 and resident had been declining for a while, probably since the New Year and she had always been a picky eater but she would usually eat something but lately had been refusing and simply wouldn ' t open her mouth at time to be assisted with feeding. E26 also stated that R26 had begun being more lethargic and would fall asleep in her wheelchair

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and lean forward in the wheelchair E26 stated R62 require help with meals.
According to R62 ' s Plan of Care with initiation date of 12/18/14 the resident has dehydration or potential fluid deficit related to diuretic use and the goal is the resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. Interventions include: Educate the resident/family/caregivers on importance of fluid intake; monitor/document/report PRN(as needed) for signs/symptoms of dehydration: decreased urine output, concentrated urine, strong odor, tenting skin, cracked lops, furrowed tongue, new onset confusion, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes; notify physician if: persistent symptoms of diarrhea, nausea/vomiting unresolved 48 hours; pristine output exceeding intake past 48 hours, abnormal labs.
On 2/19/15 E1(administrator) was unable to provide any documentation how R62 was being monitored for signs/symptoms of dehydration since start of plan of care on 12/18/14 to 1/22/15 when R62 was admitted to hospital with diagnosis of dehydration. E1(administrator) confirmed that R62 did not have a dehydration assessment done upon return from hospital on 1/27/15 and still had not been completed on 2-19-15.
On 2/18/15, E1 also could not find any documentation that E62 ' s fluid intake and output were being monitored until after her return from the hospital on 1/27/15.
2. According to R34 ' s facility face sheet/information sheet, she is 84 years old with her initial admission to facility on 7/9/10 and most recent re-admission on 2/8/15. R34 ' s diagnosis include: Anxiety, Depression, Chronic Pain, Osteoarthritis, Anemia, Hypertension, Transient Cerebral Ischemia, Osteoarthritis and Altered

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Mental Status, dysphagia and Reflux esophagitis.
On 2/4/15 R34 ' s nurse ' s note has at 5:30pm resident was brought to nurse unresponsive. Resident was clammy and pale. Resident was not breathing and had no pulse. Was unresponsive to sternum rub. Put resident on 10 liters via non re-breather. Resident started to regain consciousness as paramedics arrived. Blood Sugar: 148. Vital signs: 128/68, 75, 97.9. Sent out 911. Director of nursing/Power of Attorney notified.
According to R34 ' s Physicians Order Sheet for 1/2015 and 2/2015 under lab order section she is to have a complete blood count (CBC) and chemistry 6 every six month and is on diuretic Lasix 20 milligrams daily.
According to the documentation from the hospital with admission date of 2/4/15 for R34 from the hospital under History of present Illness: Under laboratory: " White blood count 12.0 H (High) (Normal 4.1-11.0), hemoglobin 23.2, (High) (normal 12.0-16.0), hematocrit 38.7(high) (normal 36-46), Albumin 2.7. (Low) (Normal 3.5-4.8), which is significantly low.
According to Hospital report dated 2/4/15 the admitting diagnosis for R34 was sepsis, early with urinary tract infection, pre-renal azotemia and volume depletion (dehydration) and part of the plan was to give antibiotics and fluids.
On 2/24/15 Z2 (primary care physician, stated he could not remember if staff had made him aware of multiple refusal of R34 ' s labs on 1/29/15. Z2 did state that if those labs (CBC, Chemistry 6, BUN/CREA, and electrolytes) would have been done per the order, that it could have shown abnormal values and would have been early indicators of possible problems with infection and dehydration. Z2 also stated that R34's hospitalization would not have been necessary because the problem could have been addressed

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sooner. Z2 also stated that the fact R34 was on a diuretic only made her more at risk for the resulting dehydration and the nursing staff need to be able to identify the signs and symptoms of dehydration. Z2 stated the labs were ordered in part due to the fact that the resident was on the diuretic Lasix and one of the risks with the use of this medication is dehydration and the BUN/CREA and electrolytes are usually where you can first identify possible problems.
According to R34 ' s identified current Care Plan there is an identified focus of " The resident has dehydration or potential fluid volume deficit related to poor intake, diuretic use with date of initiation as 12/19/14. Goal is " The resident will be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor. Interventions are: Monitor/document/report PRN(as needed) any signs/symptoms of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increase pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Notify physician if: Persistent symptom of diarrhea, nausea/vomiting unresolved past 48 hours: persistent output exceeds intake past 48 hours, abnormal labs. Obtain and monitor/diagnostic work as ordered. Report results to doctor and follow up as indicated.
On 2/24/15 E1 (administrator) or E2 (Director of Nursing) were unable to provide documentation on how R34 was being monitored for signs and symptoms of dehydration. They were also unable to provide documentation of a hydration assessment on R34 until re- admission from hospital to the facility on 2/9/15.
On 2/24/15 E1 (administrator) stated that the

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nursing staff had not done a very good job charting on R34 ' s medical record.
On 2/18/15 and 1/24/19 E1 (administrator) and E2 (Director of Nursing) were unable to provide how staff are monitoring identified persons at risk for dehydration per plan of care.
On 2/18/15 E1 stated R62 or R34 had no documentation on medication administration record or treatment administration record or nursing notes to show that nursing staff was regularly monitoring residents for any sign or symptoms of dehydration.
According to facilities Hydration Policy with revision date of 10/2010 states under General: This policy allows for each resident to provide with sufficient fluid intake to maintain proper hydration and health. Under Policy: 1.) Nursing will routinely monitor each resident for signs of dehydration such as cracked lips, dry oral mucosa, poor skin turgor and dark urine. If present they will be recorded in the medial records and the physician or nurse practitioner notified. 2.) Nursing will routinely observe the residents ' consumption to determine if individual residents have reduced fluid intake. Pertinent observations will be recorded in the resident ' s medical record. The fluid intake record may be used for this purpose.
According to the facilities Notification of change in Residents Health Status, states The facility will consult the residents physician, nurse practitioner or Medical Director and when indicated notify the residents legal representative or an interested family member when there is: (B) Acute illness or a significant change in the resident ' s physical, mental or psychosocial status (i.e. deterioration in health, mental, psychosocial status in either life-threatening condition or clinical complications). Criteria: Life threatening conditions such things as heart attack or

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S9999	Continued From page 9 respiratory distress. Clinical complications are such things as developing of a stage 2 pressure ulcer, onset or recurrent periods of delirium, urinary tract infection, a persistent decline in psychosocial status. Notification time: immediately. Definition of Immediate: As soon as possible no longer than 24 hours. Nursing judgment is an integral part of the skilled care provided in this facility; therefore, such judgment must be applied in a case by case basis in keeping with acceptable nursing practice According to the facility ' s policy titled: Documentation by Exception with revision 11/13 states under General: A resident is not generally documented on daily unless there is an unusual event or circumstance that requires frequent documentation. Under Policy: 2.) Documentation should include any unusual event or change of the resident. 3.) Any communication with the physician, nurse practitioner, consulting physician or family should also be documented. 4.) Medicare resident will be documented on daily either in narrative form or using the Daily Skilled Note on Pointclick Care. Other documentation is not required unless an unusual event occurs. 6.) New admission, change in condition, residents on antibiotics, and residents who have had an unusual occurrence should be documented on every (B)	S9999		