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S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.1210b) 300.1210d)3) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on record review and interview the facility failed to provide adequate nutrition and hydration to prevent dehydration for 1 of 2 residents (R2) reviewed for nutrition and hydration in the sample	S9999		

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S9999	Continued From page 2 of 12. This failure resulted in R2 being readmitted to the hospital in Acute Renal Failure with Dehydration and a Urinary Tract Infection. Findings include: R2's 03/15/18 Minimum Data Set (MDS) shows that R2 was admitted to the facility on 03/08/18 with a feeding tube, a weight of 75 pounds and diet orders of NPO. The MDS documents R2 was unable to complete the Brief Interview for Mental Status (BIMS) which indicates R2 is severely cognitively impaired. The MDS also documents R2 has unclear speech, usually understands and is usually understood. The Facility's Admission Nursing Assessment per V4 (Licensed Practical Nurse) states R2 arrived at the facility on 03/08/16 at 5:00pm with a weight of 86 pounds. The Facility Weights List Report, per V10, documents R2's weight of 75 pounds on 03/10/18. The MAR documents a weight of 75 pounds on 03/12/18. The 03/13/18 and 03/14/18 Daily Skilled Nurse's Notes documents a weight of 84 pounds. On 03/15/18, V27 wrote a new order for daily weights x 7 days to begin 03/15/18. There are no weights recorded on 03/15/18 or 03/16/18 for R2. On 03/27/18 at 9:33am, V29 (Hospital Nurse) stated the hospital records document R2 weighed 42.5 kilograms (kg) (93 pounds) on 03/05/18 and 42.4 kg (93 pounds) on 03/16/18. R2's 03/08/18 Inpatient Discharge Summary states R2 was discharged to the Long Term Care Facility (LTCF) with diagnoses including; in part, Physical Deconditioning, Acute Renal Failure, Aspiration Pneumonia, Urinary Tract Infection, Alzheimer's Dementia and Dysphasia with a Percutaneous Endoscopic Gastrostomy Tube	S9999		

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(PEG/G-Tube) placed on 03/05/18. The records state R2 was sent to the LTCF for Physical Therapy, Occupational Therapy, Speech Therapy and Intravenous (IV) therapy.

The 03/08/18 Discharge Medications and Instructions documents R2 is to be on a Continuous Tube Feeding of Jevity 1.2 at an initial rate of 10ml (milliliters)/hour with a goal rate of 50ml/hour, Tube Feeding water flush of 20ml every 2 hours, Check Residual every 4 hours, if less than 30ml, increase by 10ml until goal of 50ml/hour is achieved. The records state R2 is on an Adult NPO (Nothing Per Os) Diet.

On 03/20/18 at 11:30am, V2 (Regional Clinical Director) stated R2 was admitted to the facility on 03/08/18 with orders for a continuous tube feeding and was NPO. V2 stated he called V9 (Registered Dietician) on 03/09/18 to inform V9 of a new admit with a tube feeding because it is protocol. V2 stated V9 increased the tube feeding at that time and V27 (Physician) approved the order.

On 03/22/18 at 1:46pm, V9 (Registered Dietician) stated she was notified of R2's admission by V2, who asked if the Jevity tube feeding could be changed to Glucerna, because the facility did not have Jevity available at that time. V9 stated she did not have a problem with this and recalculated the rate for the Glucerna and the flushes to provide adequate nutritional needs. (Glucerna 1.5 at 10ml/hour, increase by 10ml every 6 hours until goal of 35ml/hour continuous obtained.) V9 stated the initial flush order for R2 was "too low" and she also adjusted the free water flushes. V9 stated she was not provided R2's height and weight at this time, she was just asked by V2 if Glucerna could be used in place of Jevity. V9 stated she

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then recalculated the rate of the Glucerna based off the hospital admission order. V9 stated she gave a verbal order to V2 to increase the water flushes to 240ml every 4 hours, but V2 is saying V9 wrote down 40ml every 4 hours. V9 stated the usual flush order to maintain hydration is over 100ml every 6 hours, adding she would not order 40ml flushes every 4 hours. V9 stated she did not make a note of this conversation. V9 stated she saw R2 for the first time in the facility on 03/12/18 and at that time met with V26 (Surrogate) who did not want R2 "tied down to the tube the entire day" so she recommended nocturnal feedings. V9 stated she informed V2 of this recommendation and that an email with the recommendation would be sent to V3 (Director of Nurses) and V10 (Dietary Manager). V9 stated when she evaluated R2, there was no weight documented and she asked for R2 to be weighed while she was at the facility. V9 stated R2 was weighed and a weight of 75 pounds was recorded. V9 stated she calculated the nutritional value needed to run the Glucerna at night to include the free water flushes. V9 stated she emailed this assessment of R2 on 03/12/18 along with the recommendations to V3 and V10. V9 stated when she returned to the facility on 03/19/18 she was informed by a floor nurse that R2 had been admitted to the hospital. V9 stated in this discussion she found out the nurse was not aware of the nocturnal tube feeding recommendation and she again sent the email to V3 and V10. V9 stated, "I believe I made my effort to make that change. They had the email."

On 03/22/18 at 3:30pm, V2 stated the facility did not receive an email with any dietary recommendations from V9. V2 stated V3 (Director of Nurses) was off from 03/09/18 to 03/20/18 and is not available at this time to check

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her emails. V2 stated V10's last day at the facility was today (03/22/18) and already left. At this time, V2 went to V8 (Dietary Manager as of 03/22/18) and had her check the emails. V8 did find an email from V9 that was sent to V10 on 03/12/18 and again on 03/15/18 with the dietary recommendations.

V9's Dietary Recommendation for R2 dated 03/12/18 states: Recommendations: Add/Change: 1. Switch to nocturnal TF (Tube Feed) to allow Resident less time connected to feeding tube. 2. 10 hour nocturnal TF from 2000-0600. 3. Glucerna 1.5 via PEG at goal rate of 85ml/hour. 4. 220 ml free water flushes every 6 hours.

The 03/09/18 Nutritional Assessment per V10 has no height or weight documented. The document has only R2's admission date, date of birth, diagnosis and food allergies noted with "NPO" and "Feeding Tube" notations hand written with a note stating V9 has been notified. The Assessment is grossly incomplete.

The 03/12/18 Facility's Nutrition Assessment per V9 states R2's Ideal Body Weight (IBW): 52.2 kg (115 pounds) with a Body Mass Index (BMI) of 13.3. "Resident significantly underwt (underweight). Significant protrusion of clavicle, minimal adipose underlying triceps with fingers overlapping, moderate orbital and temple depression."

On 03/27/18 at 9:20am, V8 stated V10 did give her a copy of the Nutritional Assessment that she is to do on every new admission, adding V10 highlighted the areas that need assessed/filled out. At this time, V10 showed this surveyor the highlighted Nutritional Assessment which details;

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S9999	Continued From page 6 in part, height, weight, IBW, diet order/tube feed order, food allergies, chewing/swallowing assessment and feeding assessment. The 03/08/18 Medication Administration Record (MAR) documents R2's admitting Jevity 1.2 order is 10ml and increase to goal of 50ml, flush every 2 hours with 20ml water. The first notation on the MAR of the Jevity infusion is on 03/09/18 with no time indicated. (Per the Admission Nursing Assessment, R2 was admitted on 03/08/18 at 5:00pm). The MAR documents on 03/09/18 the Jevity was discontinued and a new order was received for Glucerna 1.5 at 10ml/hour, increase by 10ml every 6 hours until goal of 35ml/hour continuous obtained. On 03/27/18 at 1:25pm, a phone interview was conducted with V22 (Registered Nurse-RN). V22 stated she worked on 03/08/18 from 6:00am to 6:00pm. V22 stated when she came to work at 6:00pm, V4 was completing all of the admitting paper work and prepared the MAR and sent the orders to the pharmacy. V22 stated she recalls R2 did have a PEG tube, but no tube feeding was started during her shift and she did not flush the PEG tube because she did not have the MAR when she was passing medications and was not aware of a flush order. V22 added she does not recall if R2 was NPO. On 03/27/18 at 1:30pm, V2 stated he started the Glucerna at 10:00am on 03/09/18 as stated on the MAR and he mistakenly signed out the Jevity on 03/09/18, adding the Jevity was never started. There is no documentation on R2's MAR that indicates R2 received any water flushes until 03/09/18 at 8:00am. The MAR documents V27's 03/09/18 gradual increase to achieve the goal	S9999		

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rate of the new Glucerna order was not recorded as being completed by the nursing staff. The MAR documents the nursing staff continued with sporadic signing out of the Glucerna increase each day from 03/09/18 - 03/16/18 with multiple areas on the MAR being blank. V9's 03/09/18 flush order increase of 240ml every 4 hours and 03/12/18 change to 220ml every 6 hours is not documented on the MAR. (Only the 40ml/hr every 4 hours free water flushes are signed out on the MAR from 03/09/18 to 03/16/18.) The inconsistent and incomplete recording on the MAR by the nursing staff does not provide the information needed to calculate R2's nutritional or hydration intake.

There is no documentation in R2's medical records indicating V27 was notified of V9's 03/12/18 dietary recommendation. Further, there is no documentation of Intake and Output monitoring or if gastric residuals were monitored at any time from 03/08/18 to 03/16/18.

On 3-20-18 at 11:30 a.m., V2 stated R2 was readmitted to the hospital on 03/16/18 due to an abnormal chest x-ray and electrocardiogram.

The 03/16/18 2:03pm Emergency Department (ED) History and Physical documents R2 was sent to the ED following a routine chest x-ray and found to have right lower lobe infiltrates and abnormal laboratory readings. The records document in part: Blood Urea Nitrogen (BUN) 59 (7-17 mg (milligrams)/dL (deciliters)), Creatinine 1.6 (0.5-1.1mg/dL), Albumin 3.1 (3.5-5.0 grams/dL), Uric Acid 6.5 (2.5-6.2 mg/dL), Urine Leukocyte Esterase Large (Negative). The records state R2 was admitted to the hospital with Acute Renal Failure, Dehydration, Urinary Tract

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Infection and Lactic Acidosis. "Is cachectic has increased skin turgor and dry mucous membranes. It appears she has an acute renal insufficiency which I think is due to dehydration. I do think her leukocytosis is also from dehydration based on her clinical assessment." The records state R2 is admitted for observation of the dehydration. The 03/16/18 Hospitalist History and Physical per V28 (Hospital Physician) documents R2 is a poor historian, but answers with short phrases and yes/no, appears distressed, sick looking, dehydration, cachectic, thin. PEG tube in place and an indwelling urinary catheter. V28 further documents, "Dehydrated though she has a PEG tube. Questioning why she was not given enough fluids via the PEG tube. Dry skin, contraction metabolic alkalosis, high uric acid and high BUN going with dehydration." V28 documents R2 has muscle atrophy and failure to thrive with an adult BMI (Body Mass Index) less than 19 kilograms/square meters.

On 03/28/18 at 8:20am, V28 (Hospital Physician) stated he did not provide R2's care prior to her readmission to the hospital on 03/16/18. V28 stated when R2 presented to the hospital on 03/16/18 she appeared distressed, sick looking, dehydrated, cachectic and thin as his medical records document. V28 stated R2 was in Acute Renal Failure, Dehydrated and had a Urinary Tract Infection, adding R2 was "totally out of it, lethargic and not responding." V28 stated R2 had a swallowing problem and was not taking water orally and was NPO. V28 stated water must be provided and is the most important. V28 stated even if the facility did not get the tube feeding started until the next day (03/09/18), a patient who is not eating still needs to drink. V28 stated R2 did have the markers of dehydration with a

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S9999	Continued From page 9 high Uric Acid, high BUN and was in metablolic alkalosis. V28 stated regardless of R2's water flush order being 20ml of water every 2 hours or 40ml every 4 hours, the specific orders should be changed based on the daily needs of the patient. V28 stated the order is "not permanent" and the facility has the liberty to change the fluid intake as needed. V28 stated if a patient has dehydration issues, the water intake needs to be increased. V28 stated R2's condition was not critical and was able to be reversed. V28 added the issue here is more of awareness by the facility, not negligence. The Facility's (Adapted/Revised 2015) Enteral Nutrition policy states in part, "5. The Dietitian will monitor residents who are receiving enteral feedings, and will make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings." "7. Residents receiving enteral nutrition will be periodically reassessed for the continued appropriateness and necessity of the feeding tube. Results of these assessments will be documented and any changes will be made to the care plan....." (B)	S9999		