STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045339	A. BUILDING _____ B. WING _____	02/06/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATKINS NURSING AND REHABILITATION CENTER	605 NORTHWEST 7TH STREET ATKINS, AR 72823

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0327	**Give each resident enough fluids to keep them healthy and prevent dehydration.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to provide sufficient fluid intake to maintain proper hydration and health for Resident #1. The facility failed to conduct and document ongoing monitoring of the resident's hydration status and assess for increased fluid needs when the resident was diagnosed with [REDACTED].#1) of 2 (Residents #1 and #2) case mix residents who were at risk for dehydration. The failed practice resulted in actual harm for Resident #1, who was subsequently hospitalized with Severe Dehydration and Acute Kidney Injury, and had the potential to affect . 10 residents who were at risk for dehydration according to the Director of Nursing on 2/6/13 at 5:00 p.m. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/7/13 documented the resident had severely impaired cognitive skills for daily decision making per a Staff Assessment of Mental Status, had a feeding tube and was totally dependent on staff for nutrition. a. A Physician order [REDACTED]. b. The Plan of Care dated 1/18/13 documented, Nutrition/Hydration via PEG tube due to severe oropharyngeal dysphagia. Administer tube feeding and water flushes as ordered, monitor for tolerance. monitor for fluid and skin turgor. c. Nurse Notes dated from 1/17/13 through 1/20/13 documented the following: 1/17/13 at 12:15 a.m.: T (Temperature) 101.2, P (Pulse) 85, R (Respirations) 20, B/P (blood pressure) 131/78. O2 (oxygen) sat (saturation) 97% with O2 at 4 L/m (liters per minute). slight wheezing noted to bilateral upper lobes. (Physician) notified.1:30 a.m. - Recheck temp (temperature) 100.5. 3:30 a.m. - Temp 100.6. 1/18/13 at 12:30 a.m.: T 100.9. 3:40 a.m. - .T 100.8.Will continue to monitor. 1/18/13 at 7:00 p.m.: .O2 at 4L/m. able to answer question. Skin w/d (warm and dry) to touch. VS (vital signs) 139/82, 83, 24, 100.6. 1/19/13 at 5:15 p.m.: .Continues on [MEDICATION NAME] 500 mg.VS 160/100, 92, 100.7, 38, 96%. 1/20/13 at 12:30 a.m.: T 100.8, P 96, R 17, B/P 150/90. O2 sat 97% with O2 at 4 L/m. Lung sounds with ronchi to upper bilateral lobes, continues on antibiotic therapy for URI (upper respiratory infection). 1:30 a.m. - Recheck temp 100.2. 1/20/13 at 10:10 a.m.: VS 138/90, 98, 46, 100.2, 94%. O2 at 4L/min via NC (nasal cannula). skin warm and dry. [MEDICATION NAME] 5/325 given. will continue to observe. 2:45 p.m. - VS 135/91, 105, 44, 99.6, 94%. Send to (hospital) due to change of condition. d. Hospital Emergency Department documentation dated 1/20/13 documented, .presented to the Emergency Department at 1535 (3:35 p.m.). The patient was triaged at 1540 (3:40 p.m) with the following vital signs: T: 99.4 AX (axillary), P: 105 regular, R: 62 labored, BP: 124/85, SPO2: 97. Amt: 4L N.C. (nasal cannula). BUN (blood urea nitrogen) 74, Creatinine 1.4, Sodium 151. Clinical Impression: Severe Dehydration, Respiratory Distress, Nursing Home Neglect, Pneumonia. e. A hospital Laboratory Report dated 1/20/13 upon admission to the hospital documented, BUN (Blood Urea Nitrogen) 74 (reference units: 7-18), Creatinine 1.4 (reference units: 0.6-1.3), BUN/CR ratio 52.9 (reference units: 10-17), Sodium 151 (reference units: 136-145), Potassium 5.2 (3.5-5.1), Chloride 116 (reference units: 98-107). k. The hospital History and Physical dated 1/20/13 documented, .He was brought to the emergency room for worsening shortness of breath. Apparently patient was diagnosed with [REDACTED]. Today he was found to be severely dyspneic with a worsening cough and was unresponsive.There is also reported history of fever. Physical Examination. mucous membranes are dry. Assessment/Plan: .nursing home resident who came with severe dehydration. At this point we will perform aggressive IV (intravenous) hydration with consideration of patient's [MEDICAL CONDITION] status. l. The hospital Discharge Summary dated 1/25/13 documented, The patient came with acute hypoxemic [MEDICAL CONDITION] and diagnosed with [REDACTED]. The patient was treated with IV antibiotics, IV fluid, free water. The patient had mild improvement of his chemistries. However, his kidney status overall did not improve despite maximum medical treatment. The patient's condition deteriorated. On 1/25/13, the patient became unresponsive and the patient is pronounced dead at 3:15 p.m. Final Diagnosis: [REDACTED]. Secondary Diagnosis: [REDACTED]. m. On 2/6/13 at 1:51 p.m., the hospital Social Worker was asked about the [DIAGNOSES REDACTED]. She stated, I was told by QA (Quality Assurance) that it was because the patient was a tube feeder and that he never should have gotten to that point. that they should have been monitoring him. The lab work showed severe dehydration. n. On 2/6/13 at 2:41 p.m., Licensed Practical Nurse (LPN) #1, who provided care to Resident #1 on 1/17/13, 1/19/13 and 1/20/13, was asked why Resident #1 would be diagnosed with [REDACTED]. He stated, He was running a fever and that caused him to sweat. And he sweated a lot even before the fever. He was asked if, based on that, a resident's fluid needs would increase if they were sick and have a fever. He stated, Yes. He was asked who would be responsible for assessing the resident for the additional hydration needs. He stated, I guess, me. He was asked where that information would be documented if it was done. He stated, In the Nurse's Notes. o. On 2/6/13 at 3:14 p.m., a hospital QA representative was asked about the [DIAGNOSES REDACTED]. He stated, It's not that there was a gross neglect situation. The physician felt that there was no need in having a really high sodium and being dehydrated when the patient had a PEG tube. p. On 2/6/13 at 3:56 p.m., LPN # 2, who provided care to Resident #1 on 1/17/13 and 1/20/13, was asked during a telephone interview if she felt Resident #1's fluid needs would increase since he was sick and running a fever. She stated, Yes. She was asked who would be responsible for assessing the resident for the hydration needs. She stated, I would say the nurses, but honestly I didn't even think about that until you said it. I have taken care of tube feeders and I can't remember even one time checking with the doctor for extra fluid needs because they get their fluid from the tube feeding and flushes. But it's so obvious. I will think of it from now on. LPN #2 was asked where hydration assessments such as skin turgor and mucous membranes would be documented. She stated, The Nurse's Notes. But he didn't appear to be dehydrated. She was asked why a resident who receives all of their hydration through a PEG tube would be severely dehydrated. She stated, I don't know. That should never happen. q. On 2/6/13 at 4:25 p.m., the Director of Nursing (DON) was asked during an interview if she felt a resident's fluid needs would increase if they were sick and running a fever. She stated, Yes. She was asked who would be responsible for assessing the resident for the hydration needs. She stated, The nurses on the floor should be assessing that and contacting the doctor for an order. She was asked where hydration assessments, such as skin turgor and mucous membranes, would be documented. She stated, In the Nurse's Notes. The DON was asked if she knew the resident was diagnosed with [REDACTED]. She stated, No. r. As of 2/6/13 at 4:30 p.m., there was no documentation in the Nurse Notes to indicate hydration assessments had been conducted on the resident from 1/17/13-1/20/13 when he was sent to the hospital.
F 0327	**Give each resident enough fluids to keep them healthy and prevent dehydration.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to provide sufficient fluid intake to maintain proper hydration and health for Resident #1. The facility failed to conduct and document ongoing monitoring of the resident's hydration status and assess for increased fluid needs when the resident was diagnosed with [REDACTED].#1) of 2 (Residents #1 and #2) case mix residents who were at risk for dehydration. The failed practice resulted in actual harm for Resident #1, who was subsequently hospitalized with Severe Dehydration and Acute Kidney Injury, and had the potential to affect . 10 residents who were at risk for dehydration according to the Director of Nursing on 2/6/13 at 5:00 p.m. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 1/7/13 documented the resident had severely impaired cognitive skills for

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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