STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006910	A. BUILDING: _____ B. WING _____	C 04/05/2018

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S 000	Initial Comments Complaint 1852029 /IL10142	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)3) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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 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:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

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S9999	Continued From page 2 following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 Regulations were not met as evidenced by: 1) Based on Interview and Record Review the facility failed to a) identify and implement preventative treatment and services for Pressure Ulcer risk, and b) timely identity an area of compromised skin and Pressure Ulcer for 1 resident (R2) reviewed for Pressure Ulcers. This failure resulted in R2 developing an unstageable pressure ulcer, resulting in hospitalization and comfort care measures. The Findings Include: 1) R2's Daily Skilled Nurse's Notes dated 2/15/18	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 3	S9999		

showed admission to the Long Term Care (LTC) facility on 2/15/18. R2's History and Physical from the local hospital showed an admission date of 2/12/18, and under "Impression" included the following diagnoses: Altered mental status, Mild worsening of chronic kidney disease most likely from dehydration, Chronic microscopic hematuria, Chronic Kidney Disease (CKD) Stage III to IV, Hypertension, Ataxia, History of Diastolic Heart Failure, and Chronic Obstructive Pulmonary Disease (COPD). The Discharge Summary from the local hospital lists a discharge date of 2/15/18 to the LTC facility, and under "Assessment," documents a diagnosis of "Advanced Dementia." The local hospital's "Patient Transfer Form" dated 2/15/18 documents that R2's weight upon hospital admission on 2/12/18 was 123 lbs (pounds), and height was 70 inches.

R2's Clinical Health Status form, Section N-Braden Scale for Prediction Pressure Sore Risk, dated 2/15/18, documented a Braden Scale score of 18, indicating R2 was at risk for pressure sores.

R2's Baseline Care Plan dated 2/15/18, documented that R2 was on a regular diet. The dietary risks section, specifically "risk for weight loss" was blank/not checked, and the dietary goal was marked as "prevent weight loss." The document further shows that R2 was continent of bowel and bladder. Under Skin Concerns, "skin intact" was checked. Skin break risk was blank/not checked, and Resident's skin integrity goal was blank/not checked. Under Skin break interventions, a specialty mattress was checked, but other skin break interventions such as turn and reposition, cushion for chair and wheelchair, and skin and wound treatments were left blank.

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S9999	Continued From page 4 This same document has four blank areas that could be used to document or write in any "Other Conditions" with possible documentation of Risk, Goal, and Interventions. These areas were also left blank. R2's available Daily Skilled Nurse's Notes dated 2/16/18 through 3/6/18 have boxes for nursing staff to check underneath the heading "Skin" for Day and Evening shifts. Under that section, each daily note available for review were all either marked "Skin WNL [within normal limits]" for both Day and Evening shifts, or were left blank/unchecked. In the same section, these notes also have boxes for nursing staff to check underneath "Skin Concerns" that include "Pressure Ulcer" and "Bruise." The boxes for "Pressure Ulcer" were never marked for any of the dates previously listed, and the box for "Bruise" was only marked on the Day Shift note for 3/2/18. In addition, these same notes have a section to document "GI [Gastrointestinal] Concerns," with options to check for "Poor Appetite" and "Poor or restricted fluid intake." R2's available Daily Skilled Nurses notes for 2/16/18 through 3/6/18 show "Poor Appetite" was marked on both Day and Evening shifts on 2/18/18, 2/19/18, 2/20/18, 2/24/18, 2/26/18, 2/27/18, 2/28/18, 3/1/18, 3/3/18, 3/4/18, and 3/5/18. Other nurses notes marked with Poor Appetite for R2 included: 2/22/18 (Day Shift), 2/23/18 (Evening Shift) 2/25/18 (Day Shift), 3/2/18 (Day Shift), and 3/6/18 (Day Shift). The dates and shifts in which R2 was marked for poor fluid intake include the following: 2/19/18, 2/20/18, 2/22/18, 2/24/18, 2/26/18, 2/27/18, 2/28/18, 3/1/18, 3/3/18, 3/4/18, 3/5/18 (both Day and Evening Shifts marked), and 2/18/18 (Evening Shift), 2/23/18 (Evening Shift), 2/25/18 (Day Shift), and 3/2/18 (Day Shift).	S9999		

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S9999	Continued From page 5 R2's Daily Skilled Nurse's Note dated 3/2/18, documented a small bruise to R2's coccyx. There was no documentation found in the Nurse's Note regarding a description of the bruise, such as color or size of the injury. R2's Daily Skilled Nurse's Note dated 3/3/18, documented that R2 was incontinent of bladder on evening shift, with no mention of a bruise as noted the day prior on 3/2/18. R2's Daily Skilled Nurse's Note, dated 3/4/18, documented the Physician was notified of nasal drainage, again with no mention of a bruise to R2's coccyx. R2's Occupational Daily Treatment Note dated 3/1/18, documented "CNAs report pt (R2) has area of skin compromise to buttock/sacral area....Collaboration with nurse on duty who reports was just informed of skin compromise." A Physical Therapy Daily Treatment Note dated 3/1/18, included a recommendation to place a pressure relieving cushion in both wheelchair and/or recliner when R2 is up. R2's Significant Change Care Area Assessment Summary dated 3/1/18, documented the following change in conditions: Decrease in his Cognitive Status, He is sleeping more, Resident is at risk for pressure ulcers. He relies on the staff for ADL help, He has decline in condition and continence too, He has a poor appetite, He was on a regular diet and now is on a pureed diet, He has poor appetite versus what he was when he first came in, he will occasionally pocket food and let food run out of the mouth. He is gradually losing weight. R2's Nurse's Notes dated 3/6/18, documented the following: Noted area to resident's coccyx.	S9999		

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S9999	Continued From page 6	S9999		

Noted unstageable 5 centimeters x 2 centimeters area. Area open and draining moderate amount of serosanguinous drainage. Area reddened open epithelial tissue with area of necrosis in center. MD notified with treatment request per facility treatment protocol. Order obtained and treatment applied. Physician Orders 3/1/18 through 3/31/18 listed the treatment as cleanse coccyx with wound cleanser and apply calcium alginate and foam dressing and change daily and as needed.

The Prescription for the Calcium Alginate Order contained the following: Dated 3/6/18, for the Calcium Alginate Dressing to area.

On 3/28/18 at 2:45 PM, V4 (Certified Nurse Aide/CNA) stated she worked 3/3/18 and 3/4/18 and toileted R2 one of those days and noted a sore area to R2's coccyx that was smaller than a quarter, very red, and V4 thought it was starting to open. V4 stated she wrote it on the CNA Report Sheet, but did not report it to the nurse.

On 3/29/18 at 9:15 AM, V5 (Registered Nurse/RN) stated that R2 was admitted for Dementia, Wandering, and declined by sleeping more and more. A medication adjustment was done and R2 did improve some, he ate better when the staff fed him. V5 stated the area to R2's coccyx was noted on 3/2/18 during a shower and was 1 centimeter (cm) in circumference. V5 went on to say that when she returned to work on 3/6/18, the area was 5 cm x 2 cm, and was black/brown in color. V5 stated that there was no assessment of the wound except for the 3/2/18 and 3/6/18 Daily Skilled Nurse's Note, and the 3/6/18 Wound Log. When questioned regarding the assessment of the area and palpation, V5 had no answer. Further, no documentation of a wound assessment could be found in the Nurses

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S9999	Continued From page 7 Notes or on the Wound Log for 3/2/18. R2's care plan documented a problem start date of 3/4/18 for the problem of "Resident is at risk for pressure ulcers. He relies on staff to adls. He has decline in condition and continence too. He has a poor appetite and sleeps more. Other factors that may affect the risk for breakdown: dementia, COPD, depression, CHF (Congestive Heart Failure), Remeron, Trazadone, HCTZ (hydrochlorathiazide), changes in alertness and age." The goal was listed as "Resident's skin will remain intact." Approaches also had a start date of 3/4/18 and included: conduct a systematic skin inspection nursing weekly, CNA daily with care pay particular attention to the bony prominence's, diet as ordered, encourage resident to have a good fluid and food intake, pressure reduction when resident is in chair and bed... Further, R2's care plan documented problem areas of decline in condition and at risk for weight changes that were also not initiated until 3/4/18, approximately 2-1/2 weeks after his admission. The Wound Management Program Policy, revised 2017, listed the following: #3 Residents identified at risk on the Braden scale will have this addressed on their care plan and will have interventions put in place for preventative measure. Interventions: pressure reducing mattress and/or cushion, be reviewed by a dietician and lab values as needed. Residents identified with wounds will have a care plan initiated regarding impaired skin integrity. #4 The facility will assess residents weekly for current skin conditions. #4 c. If any new areas are identified, write a nurse's note describing the area found and the protocol followed to treat it... d. The new area should also be noted on the 24 Hour Report. g. The nurse will measure the area; call	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF OLNEY	410 EAST MACK OLNEY, IL 62450

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S9999	Continued From page 8	S9999		

physician to obtain appropriate treatment order, call the guardian/family member to inform him/her, document the area on the TAR (Treatment Administration Record) and initiate the treatment.

On 4/2/18 at 3:30 PM, V12 (Dietary Manager) stated that the Dietician is the person responsible for completing the Dietary History and Initial Screening assessment. V12 stated the Dietician comes monthly, and clarified that the Dietician was not called when R2 was admitted. On 3/29/18 at 9:31 AM, V2 (Director of Nursing/DON) stated R2 was not seen by the dietician because of his admit and discharge being between her visits.

R2's Resident Transfer Form with date of transfer noted as 3/6/18, documented that R2 was discharged from the LTC facility to a local Assisted Living Memory Care facility in the same town.

On 3/29/18 at 10:30 AM, V7 (Director of local Assisted Living Memory Care Facility) stated that she went to assess R2 at the LTC facility on 2/28/18 for admission to the memory care facility where she is employed. V7 stated that R2 was a planned admission to the memory care facility for 3/6/18. V7 said that during her assessment, R2 had been discontinued from physical therapy, but was still on speech therapy for swallowing. V7 stated that R2 was observed in a wheelchair, but he was able to get up and back in on his own. V7 said that on 3/6/18, a nurse from the LTC skilled care unit called to give report to the admitting nurse at the memory care facility, and said the LTC facility had just noticed R2 had an open area to his buttock, but had not dressed it yet. V7 stated that the LTC nurse told the admitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 9	S9999		

memory care nurse that R2's open area was about dime size. V7 stated that R2 arrived at the memory care facility by facility van around 4:00 PM on 3/6/18, and upon arrival, V7 definitely noticed a decline since seeing R2 on 2/28/18. V7 stated that R2 appeared to have lost weight, cheeks drawn, was extremely exhausted, and was in a wheelchair for mobility. V7 stated that the only document they received from the LTC facility were R2's physicians orders dated 3/1/18 through 3/31/18, adding that a discharge summary or plan of care was not received. V7 stated the memory care facility normally does skin checks at admission, but R2 acted so exhausted they let him go to his room and rest before supper. V7 then stated that on the morning of 3/7/18, memory care staff were assisting R2 to toilet to get him ready for the day, and noted a foul smell. V7 said the staff thought R2 had a bowel movement, and soon realized it was R2's skin breakdown. V7 stated she called R2's wife and physician to see if R2 could get an appointment since the open area was so bad. V7 stated R2's wife was unable to go on 3/7/18, so the appointment was made for 3/8/18. V7 stated while they were waiting for the ordered dressing to arrive, the memory care nurse received an order for a dry dressing to cover the open area.

On 3/28/18 at 3:30 PM, V8 (Licensed Practical Nurse-LPN/Assisted Living Memory Care Facility) said she sent R2 to the physician's office on 3/8/18, and it was reported to her that R2 was going to be a direct admit to the hospital from the physician's office.

R2's hospital History and Physical (H & P) dated 3/8/18, documented that R2 was admitted due to "weakness and large decub ulcer." Further, under History of Present Illness, the H & P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006910	A. BUILDING: _____ B. WING _____	C 04/05/2018

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S9999	Continued From page 10	S9999		

documented "Apparently he was just discharged from the nursing home skilled care unit and was brought to the assisted living facility for demented people but he was noted to be really weak with difficulty walking and had a large lesion in the buttocks that was foul smelling. In the clinic he was very weak and had a large decubitus ulcer in the coccygeal area." The document further noted by "Back Exam:" He has an approximately 2 x 4 cm at least stage III decubitus ulcer with slightly blackish eschar with surrounding mild erythema that extends to the buttocks, and by "Impression:" Acute Dehydration, Chronic Kidney Disease Stage IV, Advanced Dementia, Decubitus Ulcer in Buttocks with possible Infection.

R2's hospital Consultation dated 3/8/18 listed the reason for consultation as "Sacral decubitus" and documents that the area is a full fledged necrotic area. "Patient has a large sacral coccyx decubitus it is unstageable is a large area of eschar measures 7-1/2 cm by 5-1/2 cm in size. Culture and sensitivity was obtained deep to the eschar. Patient also has a lot of inflammation on the surrounding buttocks particularly the right side. This is exceptionally tender tone." The "Impression" noted: Large unstageable sacral coccyx decubitus in need of surgical debridement in the operating room under mask anesthesia. This may likely involve the bone.

The hospital H & P dated 3/8/18 also listed an Addendum that included: "Discussed with his daughter, wife and brother about his medical condition and his overall poor prognosis. They have decided to do comfort measures only. Will cancel surgical consult. Will stop everything and will start IV (intravenous) Morphine and Ativan and oxygen. Will do in house comfort care."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HELIA HEALTHCARE OF OLNEY	410 EAST MACK OLNEY, IL 62450

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S9999	Continued From page 11	S9999		

On 4/2/18 at 2:10 PM, V11 (Physician) stated that R2 had an unexpected decline due to the formation of his Pressure Ulcer, and that the Pressure Ulcer contributed to R2's death. V11 stated the facility should have done better pressure ulcer prevention measures on admission, as well as assessing for nutrition and hydration needs. On 4/5/18 at 2:25 PM, V11 (Physician) stated that R2 was highly prone to a pressure ulcer and yes this was preventable. V11 stated that R2 was at risk to develop a Pressure Ulcer because of his mental state, physical state, and being malnourished. However, V11 also clarified that if the facility would have put hydration, nutritional and preventative measures in place for pressure ulcers, R2 would have been alive for a few weeks to a few months more, but not long term.

The Certificate of Death Worksheet dated 3/13/18, documents R2's cause of death as Acute Renal Failure and the significant condition contributing to the death as Advanced Dementia and Decub Ulcer on Buttocks.

2) Based on record review and interview, the facility failed to assess and address a resident's nutritional status and hydration needs on admission, and to implement preventative services and interventions based on such assessment for 1 resident (R2) reviewed for nutrition/hydration needs. These failures resulted in a significant weight loss and a rehospitalization for dehydration.

The Findings Include:

R2's Daily Skilled Nurses Note, dated 2/15/18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF OLNEY	410 EAST MACK OLNEY, IL 62450

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S9999	Continued From page 12	S9999		

documented an admission date of 2/15/18 to the Long Term Care (LTC) facility. The Patient Transfer Form from the local hospital dated 2/15/18, documented that prior to admission to the LTC facility, R2 was a patient at the hospital from 2/12/18 through 2/15/18. This same form listed R2's date of birth as 3/23/48, R2's height as 70 inches, showed R2 was on a regular diet, and documented a weight of 123 lbs (pounds) that was obtained at the hospital on 2/12/18. The Graphic I & O (intake and output) form showed this weight was obtained via bed scale. R2's admission history and physical from the hospital dated 2/12/18, documented that R2 was having increased confusion and his appetite was poor lately. Under "Impression," the following were listed: Altered mental status, could be multifactorial in etiology, Mild worsening of chronic kidney disease most likely from dehydration, Chronic kidney disease Stage III to IV, History of diastolic heart failure, and COPD (Chronic Obstructive Pulmonary Disease). This same document included the plan for R2 to admit to the Medical Floor and cautiously hydrate with IV fluids. R2's "Assessment" section of the hospital progress note dated 2/13/18 documented worsening mental status, dehydration, acute on chronic kidney disease from dehydration, dementia, and ataxia. R2's "Assessment" section of the hospital progress note dated 2/14/18 documented worsening mental status, acute kidney disease from dehydration improving, dementia, ataxia, and microscopic hematuria which is chronic. R2's "Hospital Course" section of the hospital Discharge Summary dated 2/15/18, documented "His renal function improved. His BUN was 43 with creatinine of 2.3 and it went down to 22 and 1.6 respectively." The "Assessment" section of this same document included the following: "1) acute on chronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006910	A. BUILDING: _____ B. WING _____	C 04/05/2018

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S9999	Continued From page 13	S9999		

kidney disease secondary to dehydration, 2) Advanced Dementia, 3) Hypertension, 4) Chronic microscopic hematuria, and 5) chronic kidney disease stage 3." The "Disposition" section of the Discharge Summary further documented R2 would be transferred to the LTC facility, activity as tolerated, Physical Therapy to follow, and diet of low salt.

R2's Baseline Care Plan from the LTC facility dated 2/15/18, documented that R2 was on a regular diet. The dietary risks section, specifically "risk for weight loss" was blank/not checked, and the dietary goal was marked as "prevent weight loss." This same document has four blank areas that could be used to document or write in any "Other Conditions" with possible documentation of Risk, Goal, and Interventions. These areas were also left blank.

R2's admission Dietary History and Initial Screening assessment dated 2/16/18 is lacking R2's height, weight, usual or goal weight, prior weight loss, weight history in the last 12 months, BMI (Body Mass Index), and meal consumption reported or observed. This assessment was also blank in the section to document potential risk factors/referral criteria for new admission, such as observed intake of less than 50% 2 of 3 meals, BMI less than 19, or diagnosis of dehydration, and has an option to refer to RD (Registered Dietician) via fax, or to mark a box indicating "No potential risk factors or referral criteria at time of screening." Other sections not completed include the estimate of calorie, nutrient and fluid needs, and whether intake is adequate to meet those needs. On 4/2/18 at 3:30 PM, V12 (Dietary Manager) stated the Dietary History and Initial Screening assessment is completed by the dietician, however clarified that V12 completes

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S9999	Continued From page 14	S9999		

the chewing/swallowing, dining needs, and likes and dislikes section of the document within 72 hours of admission. V12 added that the Certified Nurse Aides (CNA's) provide her with the admission height and weights and sometimes the height comes from the admission record. V12 stated the dietician comes monthly and the dietician was not called when R2 was admitted.

R2's available Daily Skilled Nurse's Notes dated 2/16/18 through 3/6/18 have boxes for nursing staff to check underneath the heading "GI [Gastrointestinal] Concerns," with options to check for "Poor Appetite" and "Poor or restricted fluid intake." R2's available Daily Skilled Nurses notes for 2/16/18 through 3/6/18 show "Poor Appetite" was marked on both Day and Evening shifts on 2/18/18, 2/19/18, 2/20/18, 2/24/18, 2/26/18, 2/27/18, 2/28/18, 3/1/18, 3/3/18, 3/4/18, and 3/5/18. Other nurse's notes marked with Poor Appetite for R2 included: 2/22/18 (Day Shift), 2/23/18 (Evening Shift) 2/25/18 (Day Shift), 3/2/18 (Day Shift), and 3/6/18 (Day Shift). The dates and shifts in which R2 was marked for poor fluid intake include the following: 2/19/18, 2/20/18, 2/22/18, 2/24/18, 2/26/18, 2/27/18, 2/28/18, 3/1/18, 3/3/18, 3/4/18, 3/5/18 (both Day and Evening Shifts marked), and 2/18/18 (Evening Shift), 2/23/18 (Evening Shift), 2/25/18 (Day Shift), and 3/2/18 (Day Shift). None of these notes mentioned notification of R2's Physician or the Dietician for poor appetite or poor fluid intake.

R2's Daily Skilled Nurse's Notes for day shift dated 2/26/18, documented nursing staff notified MD (Medical Doctor) of increased sleep, however there was no mention of notifying the MD or Dietician of poor appetite or poor fluid intake. R2's Nurse's Notes dated 3/1/18, documented that resident is very sleepy and following one step

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 15	S9999		

request. Transfers with one assist. R2's Daily Skilled Nurse's Note, dated 3/4/18, documented the Physician was notified of nasal drainage, again with no mention of poor appetite or poor fluid intake being reported to the Physician or to the Dietician.

The Speech Therapy Daily Treatment Note dated 2/28/18 documented "The pt (R2) demonstrated severe impairments with regular solids as ordered. Downgraded diet consistency to puree with thin liquids with recommendation for 1:1 feed and to check for pocketing. Notified nursing and dietary of recommendation to change."

The "Weekly Weights" form documented two weights recorded for R2. The first showed 126.7 lbs on 2/19/18 and the second showed 129.1 lbs on 2/26/18.

On 4/3/18 at 9:10 AM, V1 (Administrator) stated fluid intake is not recorded unless the physician orders intake and output monitoring. V1 stated R2 did not have an order for intake and output monitoring. On 4/3/18 at 1:50 PM, V1 stated that R2's height and weight were obtained from the hospital transfer sheet dated 2/15/18, which were documented as being completed at the hospital on 2/12/18. V1 stated ideally a height and weight is obtained on admission. V1 stated R2's admission height and weight was not completed because he resisted care at times per his admission sheet dated 2/15/18. V1 stated ideally staff would try again or try a different staff member. V1 stated that R2 weighed 126 pounds on 2/19/18. V1 also stated that R2 was reviewed in the facility's internal review program on 2/21/18, and since R2 showed a weight increase from the 2/12/18 hospital weight, it was agreed that R2 was stable, and to wait until the dietician

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S9999	Continued From page 16	S9999		

came. V1 added that R2's weight was 129 on 2/26/18, and R2 was again reviewed in the facility's internal review program on 2/28/18. V1 stated at that time, speech therapy was seeing R2 for pocketing food and he was downgraded from a regular diet to a pureed diet, but the internal review program continued to agree the dietician did not need to see R2 until 3/13/18. When asked about tracking of snacks, V1 stated the CNA's chart bedtime snacks on the CNA sheets and on (R2's unit) HS (bedtime) snack record sheets. V1 added that dietary staff also goes around with a cart to every resident at 10:00 AM and 2:00 PM, and accepted snacks are not recorded. V1 provided an undated Per Menu/recipes standard for fluid/snacks that showed a total of 20 ounces is offered at breakfast, a total of 14 ounces is offered at lunch, a total of 20 ounces is offered at dinner, and unidentified amounts of ounces at snack time.

Side two of R2's CNA-ADL tracking forms, (which were undated, but verified by V1 they were for the months of February and March 2018) under "Eating" showed spaces for staff to document codes for how the resident eats and drinks regardless of skill (such as independent, supervision, total dependence, no help from staff, setup help only, one person physical assist, etc.), and another space to document the percentage of each meal consumed for breakfast, lunch, and dinner. These forms for 2/16/18 - 3/6/18 were filled out for each meal with regard to R2's self-performance and support provided, however there were no percentages of consumption documented for dinner the entire time period except for 50% documented on 3/5/18. In the section for snacks, there are spaces for staff to document Day, Evening, and Night shift snack tracking with codes of 0 - Not offered, 1 - Offered,

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S9999	Continued From page 17 or R - Refused. These are also all blank, with the exception of 2/22/18 and 2/27/18, in which 1's were entered in the Day Shift slot to indicate snacks were offered, and 3/3/18 and 3/4 18, in which "R" was entered in the Day Shift slot to indicate snacks were refused. The sections for "Dietary Substitute Offered (Indicate Number Offered and % taken)" and "Fluids Offered (Indicate Number offered and mL's (milliliters) Consumed" are also all blank for the entire time period. On these same forms, only 7 out of 41 documented meals were recorded with greater than 50% consumption of the meal. On 3/3/18 breakfast consumption was recorded as 10% of the meal, lunch and supper were recorded as refused; 3/4/18 breakfast and lunch were recorded as refused (4 meals refused and 1 meal 10%), with no documentation that an alternative was offered. On 4/5/18 at 11:30 AM, V4 (CNA) stated she fed R2 during his stay at facility. V4 stated R2 was a picky eater and he was hard to get to eat. V4 stated R2 had to be assisted to sit up sometimes. V4 also stated she used ice one night on his lips to encourage him to eat and drink. On 3/29/18 at 9:31 AM, V2 (Director of Nurses/DON) verified that R2 was not seen by the dietician during his stay and stated this was because of R2's admit and discharge dates being between her visits. On 4/3/18 at 2:10 PM, V2 stated that (R2's unit) HS snack record sheets were initiated on 4/3/18, and that prior to that, the CNA's documented snacks on the CNA Activities of Daily Living (ADL) tracking form. (A)	S9999		