STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008528	A. BUILDING: _____ B. WING _____	C 01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE SENIOR LIVING	1901 13TH STREET HERRIN, IL 62948

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S 000	Initial Comments Complaint Investigation 22510301/IL154747	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. This requirement is not met as evidenced by. Based on interview and record review, the facility failed to ensure licensed/certified staff had background checks and were checked against the registry prior to employment. This has the potential to affect all 102 residents currently residing at the facility. Findings Include: The facility provided resident roster, dated 1/2/23, documents there are 102 residents residing at the facility. The facility untitled and undated employee roster ,with hire dates listed, documents V47 (current position - Helping Hand) had a start date of 8/12/22, and was listed as a CNA/Certified Nursing Assistant. V47's Health Care Worker Registry Check, dated	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 12/30/22, documents under Certifications, V47 was a no show for the CNA competency test on 8/19/21, failed the test on 8/23/21, failed the second attempt on 10/18/21, and failed the third attempt on 12/13/21. On 1/6/23 at 9:08 AM, V30 (Human Resources/HR) stated she was doing quarterly checks, and found one of the CNA's (V47) wasn't certified. V30 stated she called V2 (Director of Nurses) and V23 (CNA Supervisor), and they pulled V30 from providing direct care to the residents. V30 stated V47 was hired on 8/12/22, and that was before V30 started in the HR position. V30 stated the person who previously had the HR position is no longer employed at the facility. V30 stated V47 was pulled from working with residents on 12/30/22, the same day she discovered it. V30 stated there was also no background check documented in V47's personnel file until she did the quarterly review on 12/30/22. On 1/12/23 at 3:27 PM, V1 (Administrator) stated V47 was hired when the previous HR person, who no longer works at the facility, should have completed the Healthcare Worker Registry check and background check on V47. V1 stated it was caught and corrected when V30 did the quarterly reviews of staffing. (C) 2 of 3 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c)	S9999		

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S9999	Continued From page 2 300.1210 d)3) 300.3240 a) 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 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		

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S9999	Continued From page 3 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to protect the residents right to be free from neglect (R2) and failed to ensure care was provided per current standards of pracitce by failing to accurately assess, treat, document, and report a decline in condition to the physician and seek timely medical treatment for 3 of 5 (R2, R3, and R5) residents reviewed for neglect and quality of care in the sample of 25. These failures resulted in R2 becoming unresponsive on 12/28/22, and being admitted to the local hospital for end-of-life care, and R2's subsequent death from septic shock due to Covid-19, acute hypoxemic respiratory failure, acute on chronic renal failure, severe hyperkalemia, and severe	S9999		

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S9999	Continued From page 4 protein calorie malnutrition. Findings Include: The facility undated Covid-19 Line List documents R2 tested positive for Covid-19 on 12/22/22, R3 tested positive for Covid-19 on 12/19/22, and R5 tested positive for Covid-19 on 12/29/22. 1. R2's facility Admission Record, with a print date of 1/3/23, documents R2 was admitted to the facility on 10/20/2022 with diagnoses that include fracture of right femur, diabetes, anxiety disorder, depression, heart failure, atrial fibrillation, chronic obstructive pulmonary edema, history of pulmonary embolism, and cognitive communication deficit. R2's MDS (Minimum Data Set), dated 10/27/22, documents a BIMS (Brief Interview for Mental Status) score of 04, which indicates a severe cognitive impairment. This same MDS documents R2 requires assistance of one staff for bed mobility, transfer, dressing, toilet use, eating, and personal hygiene. R2's local emergency services transport record, dated 12/28/22, documents, "Upon arrival at scene EMS (Emergency Medical Services) met staff nurse who was unable to give much history of patient (R2). Nurse reported that (R2's) skin was cold, mottling at feet. Nurse reports (R2's) oxygen saturation was in mid-80's. (R2) was currently on oxygen at 4L (liters) nasal cannula ...At patient (R2) contact (R2) found unresponsive in bed breathing independently. Other nurse present states that (R2) is normally vocal when being touched, crying out in pain. This writer attempted to wake (R2) but no response from	S9999		

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S9999	Continued From page 5 (R2). Sternal rub performed without any response from (R2). Minimal pupil response when pupils were assessed ..." R2's local hospital record, dated 12/28/22, documents under Emergency Department Provider Notes, "C/O: (complaints of) unresponsive. DNR (Do Not Resuscitate). Onset: unk (unknown). EMS (Emergency Medical Services) reports NH (nursing home) RN (registered nurse) was unfamiliar w/ pt (with patient/R2) and called family reporting (R2) was unresponsive. Family wanted (R2) sent in .... Family notified us (R2) was dx (diagnosed) w/ Covid on Thursday last week. Family did not know (R2) signed DNR (Do Not Resuscitate) form and stated she never discussed it w/them. They note (R2) had been slowly declining and not eating well. V26 (Physician) examined (R2) and d/w (discussed with) the family the prognosis. Family was given some time to think about it. Ultimately, we agreed to ...provide comfort measures only ...." Under History Provided by: EMS personnel documents, " ...(R2) to ED (Emergency Department) via EMS (Emergency Medical Services) from (name of facility). EMS states that patient has been increasingly less conscious the past couple of days..." R2's local hospital records, dated 12/28/22, documents under Physical Exam, " ...Pt (patient/R2) was unresponsive to painful stimuli ...no gag reflex ...pupil is not reactive ...diaper was dry ...skin is mottled (at distal extremities) ...She did start to make sounds and have small movements after approximately 500 ml (milliliters) of IVF (intravenous fluid) ..." R2's local hospital records documents under End of Life Care that R2's diagnoses include Covid positive, acute hypoxemic respiratory failure, anion gap	S9999		

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S9999	Continued From page 6 metabolic acidosis, acute on chronic renal failure, severe protein calorie malnutrition, and elevated troponin. R2's local hospital record, dated 12/28/22, documents a chest x-ray with findings documenting, " ...No acute cardiopulmonary process." R2's local Hospital Discharge Summary, dated 12/30/22, documents, " ...Primary Discharge Diagnosis Covid positive, acute hypoxemic respiratory failure, acute on chronic renal failure, severe hyperkalemia, anion gap metabolic acidosis, severe protein calorie malnutrition, and elevated troponin ..." R2's local hospital record, dated 12/28/22 to 12/30/22, documents under Hospital Course,"(R2) presented to (name of local hospital) ER (emergency room) from her nursing facility after becoming unresponsive ....Family was present throughout most of her time and she was kept comfortable before she passed away peacefully at 8:02 AM on 12/30/2022." R2's Certificate of Death Worksheet documents R2's Date of Death as 12/30/2022, with cause of death documented as septic shock due to novel corona Covid-19 virus infection, acute hypoxemic respiratory failure, and acute on chronic renal failure. This same form documents significant conditions contributing to death as severe hyperkalemia and severe protein calorie malnutrition. R2's facility Progress Notes document the following: 12/22/22 10:50 AM, "Family notified of resident (R2) being placed on isolation r/t (related to) (+)	S9999		

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S9999	Continued From page 7 (positive) Covid test. Family thankful for the call." 12/22/22 3:40 AM, "New orders per V27 (Nurse Practitioner) Vit C (Vitamin C) 500 mg (milligrams) PO (by mouth) BID (twice daily), Zinc 50 mg daily r/t Covid." 12/24/22 4:57 AM, "res (R2) non-compliant with care, refuses to stay in contact isolation. No s/o (signs of) discomfort. Cont. (continue) to receive routine pain meds (medications) as ordered. Congested non prod (productive cough). Cont on abt (antibiotic) therapy as ordered. Hollering freq (frequently) throughout shift." R2's facility Nursing Progress Notes do not document a nursing assessment or update related to R2's physical status until 12/28/22, when R2's progress notes document the following: 12/28/22 2:09 PM, " ...Resident listless/nonresponsive ...Gray color, mouth dry with tip of tongue black in coloration. Blue color noted to all extremities, cold to touch, v/s (vital signs) 96.4 (temperature), 90/50 (blood pressure), 24 (unknown), 26 (unknown), 88 (oxygen saturation) with O2 (oxygen) ...Notifications made: (V27, Nurse Practitioner) and POA (power of attorney). 3:52 PM "Hospital called report resident is admitted for end of life. Covid positive, hypoxia, family at side." R2's POC (Point of Care) Response, History Nutritional task, with a print date of 1/4/23, documents the following food intakes for R2, 12/25/22 8:46 AM 0-25%, 12:45 PM 26-50% and 12/26/22 12:00 PM 26-50, 12:29 PM 0-25%. There is no documentation of food intake for R2 on 12/27/22.	S9999		

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S9999	Continued From page 8 R2's POC Response History, Fluid Intake with meals and outside of meals task, with a print date of 1/4/23, documents R2 had the following fluid intakes, 12/24/22- 1020 cc's (cubic centimeters), 12/25/22- 1000 cc's, 12/26/22- 965 cc's, and 12/27/22- 250 cc's. R2's POC Response History, documents under safety checks tasks, with a print date of 1/4/23, R2 was checked 16 times on 12/24/22, 8 times on 12/25/22, 14 times on 12/26/22, and 12 times on 12/27/22, with the last check documented at 11:40 PM on 12/27/22. R2's Facility Care Plan, last review date of 12/01/22, documents under the Fall focus area an intervention that R2 is to be checked every hour. R2's Order Summary Report, with an order date range of 12/01/22 to 12/31/22, documents the following orders, 12/22/22- 10-day Covid-19 Quarantine Contact and Droplet Precautions, Covid-19 Positive/symptomatic monitoring Q 4 (every 4 hours) ...for Covid-19 daily monitoring for 10 days, and maintain droplet isolation precautions at all times r/t Covid + (positive). R2's TAR (Treatment Administration Record), dated 12/1/22 -12/31/22, documents the following physician order, with a start date of 12/22/22 6:00 AM, "Covid-19 Positive/symptomatic monitoring Q4 (every four hours): Fever (T>99.9F/temperature greater than 99.9 Fahrenheit), Temp (temperature), P (pulse), RR (respiratory rate), O2 Sat (oxygen saturation) & (and) symptoms (Fever, SOB (shortness of breath), Cough, Sore Throat)." R2's TAR documents R2 was monitored every four hours as ordered from 12/22/22 2:00 PM until 12/26/22 2:00 PM. There is no assessment and no vital signs documented on this form, from 12/26/22	S9999		

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S9999	Continued From page 9 2:00 PM until R2 was transferred to the local hospital on 12/28/22. The vital signs documented for 12/25/22 at 10:00 AM, 2:00 PM, and 6:00 PM are all as follows, B/P (blood pressure) 130/66, P (pulse) 72, RR (respiratory rate) 18, T (temperature) 98.5, and O2 sat (oxygen saturation) 92%. R2's MAR (Medication Administration Record), dated 12/01/22 to 12/31/22, documents an order to monitor R2's vital signs every shift, with a start date of 10/20/22. R2's vitals are documented and within normal limits each shift on 12/24/22 and 12/25/22. There are no vital signs documented on 12/26/22. The following vital signs are documented on 12/27/22 6 am-6pm shift, B/P 102/58, P 70, R 16, T 97.1, and O2 sat of 93%. There are no vital signs documented on 12/27/22 6 pm - 6 am shift. This indicates R2's vital signs were to be monitored every four hours and the same vital signs were documented multiple times on 12/25/22, no vital signs were documented after 2:00 PM on 12/26/22, and vital signs were documented once on 12/27/22 6am-6pm shift with none documented on the 6pm-6am shift. On 1/4/23 at 3:21 PM, V31 (Registered Nurse (RN)/Agency Nurse) stated she worked on 12/28/22 beginning at 6:00 AM. V31 stated during the morning medication pass (approximately 8:00 AM), unknown Certified Nursing Assistants told her she needed to assess R2. V31 stated R2 appeared listless, her tongue was black, her legs were mottling, her fingertips were blue, her vital signs were not within normal range, but R2 was comfortable. V31 stated she notified the physician and the family, and the family wanted R2 evaluated at the local emergency room. V31 stated she does not remember being told anything in report on the morning of 12/28/22	S9999		

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S9999	Continued From page 10 regarding R2's condition. On 1/5/23 at 10:45 AM, V15 (Licensed Practical Nurse/LPN) stated she worked on 12/24 and 12/25/22, and R2 was her normal self. When asked why R2's vital signs are all the same readings at each time on 12/25/22, V15 stated the Certified Nursing Assistant's (CNA's) get the vital signs, and V15 was just using the last recorded in R2's electronic health record. When asked about the oxygen saturation of 92%, V15 stated R2 would take her oxygen off. When asked if R2's oxygen saturation was rechecked to determine if they improved after reapplying her oxygen, V15 stated it was continually being rechecked. (There is no documentation in R2's medical record of oxygen saturation rechecks). On 1/5/23 at 10:10 AM, V13 (Certified Nursing Assistant/CNA) stated she provided care to R2 on 12/25, 12/26, and 12/28/22. V13 stated she attempted to feed R2, but R2 wasn't eating. V13 stated R2 was taking fluids. When asked if she checked R2's vital signs, V13 stated she was still in orientation and couldn't do vital signs yet. When asked how R2 appeared on those days, V13 stated R2 appeared, "Sick, really sick." V13 stated it was either 12/25 or 12/26/22 when she noticed R2 did not appear well. V13 stated R2 kept telling V13 she was dying. V13 stated she reported R2's appearance and condition to V15 (LPN/Licensed Practical Nurse). On 1/5/23 at 10:24 AM, V14 (Certified Nursing Assistant/CNA) stated she worked on 12/26-12/28/22. V14 stated she provided care to R2 and worked with V13 (CNA). V14 stated on 12/27/22, R2's tongue was going black, and R2's extremities were mottling. V14 stated R2 wouldn't eat anything, and R2 kept taking her oxygen off.	S9999		

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S9999	Continued From page 11	S9999		

V14 stated she made sure R2 stayed clean, dry, and comfortable throughout her shift. V14 stated R2 wouldn't swallow when she attempted to give her a drink, so the liquids would just run out of R2's mouth. V14 stated R2's oxygen saturation wasn't reading when R2 would take her oxygen off, but would go up to 92% when she had the oxygen on. V14 stated she didn't remember what nurse was working on 12/27/22, but she did report R2's condition to the nurse. V14 stated she checked R2's vital signs and kept her comfortable and in bed since she was so sick. When reviewed with V14, there were no vital signs documented, V14 stated when the vital signs are abnormal, she gives them to the nurse to review and document. V14 stated she didn't even think she could put abnormal results in the electronic record. V14 stated R2's blood pressure was low at one point and then high at another.

On 1/5/23 at 11:43 AM, V17 (RN/Registered Nurse) stated she was an agency nurse and worked at the facility and provided care to R2 on 12/27/22. V17 stated she held R2's blood pressure medication on 12/27/22 because R2's blood pressure was "soft." V17 stated V27 (Nurse Practitioner/NP) was at the facility, and she let her know R2's blood pressure was low and that she held the medication. There is no documentation in R2's medical record of V27 being notified. When asked if there was any follow up vital signs obtained after she held R2's blood pressure medication, V17 stated she was only able to get R2's vital signs one time during her 6 am-6 pm shift. V17 stated she had another resident who was critical that was being sent to the emergency room and four admissions that day. When asked if she notified administration that she couldn't provide the needed care, V17 stated, "They are well aware of staffing issues. I don't think I could

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S9999	Continued From page 12 notify them every day." V17 stated the CNAs did not report a decline in R2's condition to her, and did not get any vital signs on 12/27/22. V17 stated she gave report to V18 (Licensed Practical Nurse/LPN) who worked the shift after her (6 PM-6 AM), and told him to watch R2 since her blood pressure was "soft." R2's Facility Progress notes documents on 12/27/22, the following medications were "Held r/t (related to) hypotension" 8:39 AM-furosemide 40 mg (milligrams), 3:40 PM metoprolol tartrate 50 mg, lisinopril 5 mg, 3:41 PM- spironolactone 25 mg, and 5:33 PM- metoprolol tartrate 50 mg. On 1/6/23 at 1:29 PM, V11 (LPN) stated she worked on 12/27/22, but only saw R2 when she passed medications at 9:00 PM. V11 stated R2's lights were down, and she was going to bed. V11 stated she didn't get report of a decline in R2's condition. On 1/5/23 at 1:01 PM, V18 (Licensed Practical Nurse/LPN) stated worked from 12:00 AM to 6:00 AM on 12/28/22. V18 stated R2 was her normal self, and he had to reapply her oxygen when he would go into her room. V18 stated he administered medications to R2 at 5:00 AM on 12/28/22,, and she took them with no issues. V18 stated he forgot to chart R2's vital signs that were obtained during his shift. V18 stated he remembered R2's blood pressure was high, and R2's oxygen saturation was in the low 90's. V18 stated R2's respirations were in the 20's, not labored, but R2 had heavy breathing. V18 stated no one had reported to him R2's blood pressure was low or that she had a decline in her condition. On 1/5/23 at 2:31 PM, V28 (CNA) stated she took care of R2 beginning on the night of 12/27/22	S9999		

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S9999	Continued From page 13 until early morning on 12/28/22. V28 stated R2 was her normal self. V28 stated she did not check R2's vital signs because she did not have dedicated isolation vital sign equipment available. V28 stated she checked R2 every two hours. When asked if R2 ate or drank anything on her shift V28 stated, "I think I gave her some water." On 1/6/23, this surveyor reviewed R2's medical record with V2 (Director of Nurses/DON). V2 confirmed R2 did not have Covid monitoring documented, including assessment and/or vital signs on 12/26/22 at 6:00 PM and 10:00 PM, and no monitoring was documented on 12/27/22. V2 confirmed R2's hourly checks were not completed hourly, and the last hourly check documented was at 11:40 PM on 12/27/22. V2 stated there was one set of vital signs documented on 12/27/22, and R2's blood pressure was 102/58, and her oxygen saturation was 93%. V2 stated there was no documentation in R2's facility progress notes of nursing assessments or physician notification of R2's condition from 12/25/22 until 12/28/22. V2 stated she would expect the nursing staff to notify the physician if a resident has a decline in condition including not eating/drinking, and abnormal vital signs. V2 stated she would expect vital signs to be monitored per current standards or practice, physician orders, and policy and procedure. V2 stated if the nursing staff had notified her of R2's decline she would have called the physician and gotten orders for labs and IV fluids. On 1/5/23 at 1:55 PM, V27 (NP/Nurse Practitioner) stated she believed she saw R2 on the afternoon of 12/27/22 and assessed her. V27 stated R2 was "pretty much sleeping, very weak, ill appearing." V27 stated R2 was oxygen dependent, and she was able to get R2 to wake	S9999		

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S9999	Continued From page 14 up and answer a couple of question. V27 stated she did not prescribe any new orders for R2. This surveyor reviewed with V27, R2's oxygen saturation of 92%-93% on 12/25 and 12/27/22, vital signs not being monitored, fluid and food intake, and that V17 had held R2's blood pressure medication on 12/27/22. V27 stated she was not aware of that information, and if she had been she would have ordered labs, a chest x-ray, and possibly intravenous fluids. V27 stated if a resident's oxygen is trending low, she typically sends them to the emergency room for evaluation. V27 stated she did a head-to-toe physical assessment of R2 and did not see any mottling. R2's Physician Progress note, dated 12/27/22 (not timed), documents, "(R2) is seen today for Covid. She (R2) is resting in bed during exam. Confused per baseline and unable to aid in assessment. Oxygen intact via NC (nasal cannula). No distress noted. She is weak and ill appearing. No concerns reported by nursing." Under Objective the physician progress note, documents, "Recent Vitals: Reviewed, Date/Time Vitals taken: today, Reviewed at the nursing home with staff. Physical Exam: Constitutional: General: She is not in acute distress. Appearance: She is well-developed. She is ill-appearing. She is not diaphoretic ... Skin: General: Skin is warm and dry ...Psychiatric: Speech: Speech normal. Behavior: Behavior is cooperative. Cognition and Memory: Cognition is impaired. Memory is impaired. Judgement: Judgement is inappropriate." There is nothing documented under Assessment/Plan. Under Diagnosis and all orders for this visit the physician progress note documents, "Covid." This physician progress note, documents under "Plan: Covid: Acute. Covid precautions/isolation per facility	S9999		

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S9999	Continued From page 15 protocol: vitamin regimen, ...if not already taking or other anticoag. Nursing staff will monitor temp and O2 sat each shift and prn (as needed). Supportive therapy. Will monitor for worsening systemic infections. Orders reviewed/signed. Pt (R2) instructed in importance of adequate fluid to stay hydrated. Pt (R2) instructed to inform nursing staff of questions, concerns, changes or concerns." On 1/10/23 at 1:54 PM, after reviewing V27 (NP) interview on 1/5/23 at 1:55 PM with V27 and V39 (Physician), V27 stated she couldn't say the outcome would have been different for R2 if she had known, R2's vitals were not being monitored as ordered, R2's oxygen saturation was trending down, R2 had a decline in food/fluid intake, R2's blood pressure was low, R2's medication had been held, and R2's extremities were reported as mottling, and been able to order labs, intravenous fluids, and chest x-ray. V39 stated, "I don't think it would have, having read (R2's) record from the hospital, it may not have made a difference." On 1/5/23 at 8:50 AM, V25 (Emergency Room Physician) stated R2 was "near dead" when she was arrived at the emergency room on 12/28/22. V25 stated R2's family was not aware R2 had signed a Do Not Resuscitate form, so V25 discussed with R2's family the potential outcomes, and they decided to admit her with comfort care measures only. V25 stated R2 appeared like someone who had been pretty sick for a few days. V25 stated if R2 had been assessed at the emergency room a few days before, it would have "presumably" been a better outcome. V25 stated R2 was mottling and the length of time for that depends on the disease process. V25 stated in his experience, it is a multi-day process. V25 stated fluid intake is	S9999		

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S9999	Continued From page 16 incredibly important for someone who is acutely ill. V25 stated R2 was in multiorgan failure and hypoxic when she arrived at the emergency room. V25 stated in the 24 hours prior to her coming to the emergency department, someone should have noticed a decline in R2's condition. V25 stated the odds are good R2 would have made it through the hospitalization if she had been treated earlier. V25 stated at the very least, R2's primary physician should have been notified so they could have ordered labs, fluids, and/or determine if R2 needed evaluated at the emergency room. R2's Facility Care Plan, last review date of 12/01/22, documents a Focus area of "(R2) is a risk for s/sx (signs/symptoms) of Covid-19. 12/22/2022 Covid + (positive)." Interventions are documented as 10/21/22- "Educate Staff, Resident, family and visitors of Covid-19 signs and symptoms and precautions. Follow facility protocol for Covid-19 screening/precautions, observe for s/sx of Covid-19-document and promptly report s/sx: coughing, sneezing, sore throat, respiratory issues, provide alternative methods of communications with family/visitors." 12/22/22- "Maintain droplet isolation, maintain droplet precautions." And 12/27/22 - "Administer medication as ordered." 2. R3's facility Admission Record, with a print date of 1/11/23, documents R3 was admitted to the facility on 12/09/22, with diagnoses that include fracture, pleural effusion, heart failure, anemia, chronic kidney disease. R3's MDS, dated 12/26/22, documents a BIMS score of 10, which indicates R3 has a moderate cognitive impairment.	S9999		

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S9999	Continued From page 17 R3's Care Plan, dated 12/28/22, documents a Focus Area of Covid + (positive) on 12/19/22 Resolved. This same care plan documents the following interventions 12/12/22- Educate staff, resident, family, and visitors of Covid-19 signs and symptoms and precautions. Follow facility protocol for Covid-19 screening/precautions. Observe for s/sx (signs/symptoms) of Covid-19-document and promptly report s/sx: coughing, sneezing, sore throat, respiratory issues. Provide alternative methods of communications with family/visitors. 12/20/22- Maintain droplet isolation as ordered. R3's Order Summary Report, dated 1/11/23, documents the following physician orders, "Covid-19 Positive/Symptomatic monitoring Q4; Fever (T>99.9F) Temp, P, RR, B/P, O2 Sat & Symptoms (Fever, SOB, Cough, Sore Throat) ..., Maintain Droplet Isolation precaution at all times r/t Covid +." R3's TAR (Treatment Administration Record), dated 12/1/22 to 12/31/22, documents a physician order to monitor for Covid-19 symptoms and monitor vital signs every four hours, with a start date of 12/22/22. R3's same MAR does not document Covid monitoring and/or vital signs were done on 12/26/22 at 10:00 PM, 12/27/22 at 2:00 PM, 6:00 PM, and 10:00 PM, and 12/28/22 at 6:00 PM. 3. R5's facility Admission Record, with a print date of 1/10/23, documents R5 was admitted to the facility on 12/30/22. R5's MDS, dated 12/9/2,2 documents a BIMS score of 06, which indicates R5 has a severe cognitive impairment.	S9999		

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S9999	Continued From page 18 R5's Care Plan, with a review date of 12/19/22, documents a Focus Area of, "(R5) is at risk for s/sx of Covid-19, Covid + 12/29/22." This same care plan documents the following interventions. 12/05/2022- Educate staff, resident, family and visitors of Covid-19 signs and symptoms and precautions. Follow facility protocol for Covid-19 screenings/precautions. Observe for s/sx of Covid-19-document and promptly report s/sx: coughing, sneezing, sore throat, respiratory issues. Provide alternative methods of communication with family/visitors. 1/03/23-maintain droplet precautions. R5's Care Profile, with a print date of 1/12/23, documents a physician order, dated 12/31/22, for, "Covid-19 positive/symptomatic monitoring Q4: Fever (T>99.9 F), Temp, P, RR, B/P, O2 Sat & symptoms (Fever, SOB, Cough, Sore Throat) ..." R5's TAR, dated 12/1/22 to 12/31/22, documents an order to monitor vital signs and for Covid-19 symptoms every four hours for eight days, with a start date of 12/31/22 at 2:00 PM. The same TAR does not document vital signs and/or Covid monitoring was done at 10:00 PM at 12/31/22. R5's TAR, dated 1/1/23 to 1/31/23, documents an order to monitor vital signs and for Covid-19 symptoms every four hours for eight days, with a start date of 12/31/22 at 2:00 PM. The same TAR does not document vital signs and/or Covid monitoring were done as ordered on the following dates/times; 1/1/23 8:00 AM, 1/2/23 2:00 AM and 6:00 PM, 1/4/23 6:00 AM, and from 1/5/23 6:00 AM through 1/8/23. On 1/6/23 at 8:52 AM, V2 (DON) stated she would have expected vital signs/assessments to	S9999		

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S9999	Continued From page 19 have been done as ordered and per current standards of practice. The facility Abuse Prevention Training Program, dated 11/22/2017, documents, "The objective of the Abuse Prevention Program is to comply with the seven-step approach to abuse and neglect detection and prevention ...Federal and state laws and regulations mandate that "a nursing home resident has the right to be free from verbal, sexual, physical, and mental abuse, exploitation, corporal punishment, and involuntary seclusion." The following definitions for these actions are based on federal and state laws, regulations, and interpretive guidelines: ... Neglect is a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident (201 ILCS 45/1-117). Neglect is also the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress (42 C.F.R. § 483.5)." The facility undated Notification of Resident Change in Condition Policy documents, " ...It is the policy of this facility to promptly notify the resident, their legal representative(s) and attending physician of changes in the resident's health condition .... Standards: 1. A licensed nurse shall promptly inform the resident, consults with the resident's physician and if known, notify the resident's legal representative or an interested member of: ...b. A significant change in the resident's physical, mental, or psychosocial status, i.e., deterioration in health, mental or psychosocial status in either life threatening	S9999		

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S9999	Continued From page 20 conditions or clinical complications ....2. The licensed nurse is to use professional judgment in determining changes in condition based on assessment and findings or signs and symptoms of change which could lead to deterioration if not treated. 3. Clinical change in condition is determined by resident visualization, medical record review, clinical assessment findings and care plan review. Review of high-risk clinical issues such as skin breakdown, falls, weight loss, dehydration and others are conducted on a daily basis. 4. Following the assessment, observing signs and symptoms, and obtaining vital signs, the attending physician, family/guardian will be promptly notified of significant findings ....7. Changes in the resident's condition will be communicated to the direct care staff by verbal shift-to-shift report, revision in resident assignments and by use of the 24-hour written shift report ...11. The licensed nurse will document in the nurse's notes all assessment findings and all attempts to notify physician(s)." The facility Guidelines for Notifying Physicians of Clinical Problems, dated 4/2007, documents, "Overview: These guidelines are to help ensure that 1) medical care problems are communicated to the medical staff in a timely , efficient and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record ...The Charge Nurse or supervisor should contact the Attending Physician at any time if they fell a clinical situation requires immediate discussion and management ..." The facility Policy and Procedure for SARS-CoV-2 (Covid-19), dated 3/22/22, documents under "Residents with Confirmed Covid-19 ...Monitor the resident every four hours for clinical worsening. Include an assessment of	S9999		

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S9999	Continued From page 21 symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and to quickly manage serious infections." (A) 3 of 3 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)2) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 22 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure dietary recommendations were implemented for 2 of 3 (R1 and R2) residents reviewed for nutrition in the sample of 25. This failure resulted in R2 having a severe weight loss of 8.5% in less than one month, and R1 having a severe weight loss of 9.5% in one month and 9.3% in two months. Findings Include: 1. R2's facility Admission Record, with a print date of 1/4/23, documents R2 was admitted to the facility on 10/20/2022, with diagnoses that include fracture of right femur, urinary tract infection, diabetes, anxiety, depression, bipolar disorder, atrial fibrillation, chronic obstructive pulmonary disease, hypertension, cognitive communication deficit, and need for assistance with personal care. R2's MDS (Minimum Data Set), dated 10/27/22, documents a BIMS (Brief Interview for Mental Status) score of 04, which indicates a severe cognitive impairment. This same MDS documents R2 requires assistance of one staff for bed mobility, transfer, dressing, toilet use,	S9999		

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S9999	Continued From page 23 eating, and personal hygiene. R2's Care Plan, with a review date of 12/01/22, documents the following Focus Area, with an initiation date of 10/21/22, "(R2) is at risk for potential nutritional problem (wt/weight loss) related to anxiety, sob (shortness of breath)." The interventions for this Focus Area are documented as 10/21/22- "Monitor wts as ordered. Provide and serve diet as ordered. Monitor intake and record every meal. RD (Registered Dietician) to evaluate and make diet changes recommendations PRN (as needed)." There are no new interventions documented after 10/21/22. R2's Care Plan further documents the following Focus Area, with an initiation date of 10/21/22, "(R2) is at risk for dehydration related to: Diuretic use." The interventions for this focus area are documented as, 10/21/22- "Administer medications as ordered. Monitor/document for side effects and effectiveness. Encourage and offer fluids to drink. Monitor vital signs as ordered/per protocol and record. Notify MD (Physician) of significant abnormalities. Monitor/document bowel sounds and frequency of BM (bowel movements): provide medication per orders. Monitor/document/report to MD PRN (as needed) s/sx (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, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, or dry/sunken eyes. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." This same Care Plan documents a Focus Area with an initiation date of 10/21/22, "R2 requires assist with adl's (activities of daily living) r/t Fatigue, impaired	S9999		

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S9999	Continued From page 24 balance, pain." The interventions for this Focus Area with a date of 10/21/22- "Eating requires set up supervision." R2's Dietary Nutritional Assessment, dated 10/24/22, documents R2 is 64 inches tall with a weight of 150 pounds. This assessment documents R2 is on a regular, mechanical soft diet, and regular/thin liquids. Eating patterns are documented as 51-100%. Under Additional Comments this assessment documents, "Wt. of 150# (pounds) was obtained from admitting paperwork. Resident was admitted to facility on 10/20 from the hospital ...She is alert and feeds herself." This nutritional assessment documents a BMI (body mass index) of 18-26. R2's nutritional goal is documented as, "Maintain weight and skin integrity. Tolerate current diet with meal intakes >50%." The assessment documents R2's nutritional needs as 68 grams of protein and 1909 ml (milliliters) of fluid. On 1/13/23 at 10:19 AM, V26 (Dietitian) stated when she did the assessment on 10/24/22, the facility had not weighed R2 yet. V26 stated she used the discharge weight documented on R2's hospital discharge records. V26 stated these weights tend to be inaccurate. R2's Progress Notes, dated 11/14/22, documents, "RD (Registered Dietitian) Weight Review: Ht (height)-64" (inches), Wt -114.2# (pounds), BMI 19.6. Resident (R2) is showing a significant weight loss of 7.6% x 1 month (123.6# in Oct). PMH (Past Medical History) of CHF (Congestive Heart Failure) on diuretic therapy which can cause some weight fluctuations. Other PMH (Past Medical History) includes depression, anxiety, and bipolar disorder which makes resident increased risk of poor nutritional status and meal intakes. (R2) is receiving a Regular,	S9999		

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S9999	Continued From page 25 mech (mechanical) soft diet with thin liquids. She feeds herself with set-up and is consuming 26-100% of her meals. Due to weight loss, recommends starting fortified foods at all meals and add ice cream cup daily with supper for extra calories. Monitor weights and intakes; Refer to RD as needed." R2's Progress Notes, dated 12/19/22, documents, "RD Weight Review: Ht -64", Wt -106 # (pounds), BMI -17.9. Underweight. Resident showing significant weight loss of 7.2% x (times) 1 month (114.2# in Nov/November) and 14.2% since her admission ~(approximately) 2 months ago (123.6# in Oct/October). PMH includes UTI (urinary tract infection), anxiety, depression, COPD (Chronic Obstructive Pulmonary Disease), CHF, falls, muscle weakness, and others. Weighed daily and on chronic diuretic therapy which can cause weight fluctuations. R2 is receiving Regular, mech soft diet with thin liquids. RD's recs (recommendation) from last month were ordered 12/05 and continue-fortified foods at meals and ice cream daily with supper. Her meal intakes are varied 0-100%. Per discussed with staff and RD's observation, R2 is very emotional at times and does better when staff are present to encourage her and cue her to eat. Recommend starting mighty shake each morning with breakfast to prevent further weight loss. Monitor weights and intakes; Refer to RD as needed." R2's Weight Summary log documents the following weights: 10/27/22- 123.6 pounds, 11/2- 114.2, 11/27- 109.8, 11/30-108.0, 12/4- 106.0, 12/5- 106.3, 12/6- 106.0, 12/7- 106.0, 12/11- 105.9, 12/12- 104.5, 12/15- 104.2, 12/16- 103.4, 12/17- 104.2, 12/21- 103.2, 12/22 103.0, 12/23- 100.0, 12/24/22- 97.0 pounds. This indicates a	S9999		

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S9999	Continued From page 26 severe weight loss of 8.5% from 11/27/22 to 12/24/22 and a severe weight loss of 21.5% in 3 months. R2's POC (Point of Care) Response History form, with a print date of 1/4/23, documents the types of assistance a resident may receive with eating as: Independent - "No help or staff oversight at any time," Supervision - "Oversight, encouragement or cueing," Limited Assistance- "Resident highly involved in activity: staff provide guided maneuvering of limbs or other non-weight bearing assistance," Extensive Assistance- "Resident involved in activity, staff provide weight-bearing support." This same form documents R2 received the following assistance with meals, 12/19-independent, 12/20-independent one meal limited assistance two meals, 12/20-independent 2 meals, supervision 1 meal, 12/21-independent 2 meals, supervision 1 meal, 12/22-independent 2 meals, supervision 1 meal, 12/23-independent 3 meals, 12/24-independent 2 meals, limited assistance 1 meal, 12/25 independent 2 meals, 12/26-independent 1 meal, extensive assistance 1 meal, 12/27/22-independent 1 meal. This same form does not document the type of assistance R2 received for a 3rd meal on 12/25 and 12/26 or for two meals on 12/27/22. R2's POC Response History form, with a print date of 1/4/23, documents under Question 2- "How resident eats and drinks, regardless of skill ..." This same form documents R2 received set up help only, for three meals on 12/19, 12/21, 12/22, 12/23, for one meal on 12/20, two meals on 12/24, and one meal on 12/26/22. This form documents R2 received One Person Physical Assist on 12/20 for 2 meals, 12/24 for 1 meal, and 12/26 for 1 meal. This form documents R2	S9999		

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S9999	Continued From page 27 received no set up or physical help for one meal on 12/27, and does not document any type of support R2 received for the other two meals on 12/27/22. On 1/4/23 at 2:30 PM, V26 (Dietitian) stated staff had to be patient with R2, because R2 was tearful all the time. V26 stated she needed staff to make sure they spent time with R2 to encourage her to eat. V26 stated she wonders if that was happening, and if that was why R2's weight declined. V26 stated she expected staff to be with R2 when she ate, and that was why she made it a specific recommendation for staff to sit with R2 while she ate. On 1/4/23 at 11:15 AM, V20 (Dietary Manager) stated if a resident has a weight loss, they refer that resident to the Dietitian, who makes recommendations, and then the facility implements the interventions. V20 stated they do not have to wait for a physician order to implement the interventions and the floor nursing staff are the nurses who notify the physician of a weight loss. V20 stated the nurses administer the 2.0 cal (calorie) supplement and Boost supplements, and Dietary staff serve the mighty shakes. V20 stated she remembered R2, and that R2 was depressed and struggled to eat at times because of depression. V20 stated R2 was served mighty shakes, ice cream, and fortified foods. On 1/5/23 at 8:14 AM, V20 stated she believed R2 ate more meals in her room than in the dining room. V20 stated she couldn't remember the level of assistance R2 required. On 1/4/23 at 3:34 PM, V18 (LPN/Licensed Practical Nurse) stated the Dietitian sends him the dietary recommendations and he takes them to V27 (NP/Nurse Practitioner) to sign the orders	S9999		

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S9999	Continued From page 28	S9999		

for the recommendations. V18 stated he was responsible for monitoring the resident weights between the dietitians visits to the facility. V18 stated there had been a lot of inconsistencies in the facility weights, so they had recently started a new system. After reviewing R2's medical record (POC History) with V18, V18 stated R2 should have been receiving assistance at mealtimes. V18 stated he had seen CNA (Certified Nursing Assistant) staff redirecting R2 back to her table during mealtimes, but since R2 had been diagnosed with Covid-19, she had been isolated to her room and not eating in the dining room.

On 1/5/23 at 9:35 AM, V23 (CNA Supervisor) stated R2 required assistance to eat at times. When asked if she was aware of a dietary recommendation for staff to sit with R2 and encourage her during meals, V23 stated she was not aware of that. V23 stated there are staff in the dining room to encourage residents to eat. When asked if R2 ate in the dining room after being diagnosed with Covid 19 on 12/22/22, V23 stated R2 would have been served her meals in her room while on isolation.

On 1/5/23 at 9:50 AM, V12 (CNA) stated she was familiar with R2, and when asked what assistance R2 required to eat, V12 stated R2 fed herself. V12 stated they would put R2's food down and walk away, and R2 would eat.

On 1/5/23 at 11:32 AM, V16 (CNA) stated R2 would sometimes eat independently, and other times would require different levels of assistance.

On 1/6/23 at 8:52 AM, V2 (Director of Nurses/DON) stated she was not aware R2 had a significant weight loss. V2 stated she was not sure what type of assistance R2 required to eat.

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S9999	Continued From page 29 V2 stated she was not made aware of R2's decline in condition, including not eating or drinking until 12/28/22, when R2 was transferred to the local hospital for evaluation. This surveyor reviewed R2's POC History Response forms with V2, and V2 stated it appeared as if R2 was independent with eating a lot of December 2022, with some supervision and limited assistance documented. V2 stated she would have expected the nursing staff to notify R2's physician of her decline, including R2's decline in food and fluid intakes. On 1/5/23 at 1:55 PM, V27 (Nurse Practitioner) stated she was not notified R2 was not eating or drinking, and if she had been, she would have ordered lab work and intravenous fluids. V27 stated she would expect the nursing staff to notify her if a resident has a significant weight loss and that they would follow the dietitian's recommendations. On 1/10/23 at 1:54 PM, when asked if he thought implementing R2's dietary recommendations of having a staff member sit with her while she ate would have prevented R2's weight loss, V39 (Physician) stated, "I can't imagine that would have made a tremendous difference." V39 then asked V27 (NP) what she thought, and V27 stated, "I don't know that I saw anyone sit down with her (R2). I can't say that it would have made a difference though." 2. R1's facility Admission Record, with a print date of 1/4/23, documents R1 was admitted to the facility on 10/21/22 with diagnoses that include vascular dementia, heart failure, major depressive disorder, chronic kidney disease, muscle weakness, and dysphagia.	S9999		

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S9999	Continued From page 30 R1's MDS, dated 10/28/22, documents a BIMS score of 10, which indicates R1 has a moderate cognitive impairment. This same MDS documents R1 requires assist of staff to set up for meals. R1's Care Plan, review date 12/01/22, documents a Focus Area initiation date 10/24/22 of "(R1) is at risk for nutritional problem (wt loss) related to: depression, pain, GERD (gastroesophageal reflux disease), dementia." The Interventions documented for this focus area are as follows: 10/24/22 "Monitor wts as ordered ...Monitor/document/report to MD (physician) PRN (as needed) for s/sx (signs/symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appears concerned during meals ...Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss > 5% in one month, >7.5% in 3 months, >10% in 6 months ...Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated ...Provide served diet as ordered. Monitor intake and record q (every) meal ...RD to evaluate and make diet change recommendations PRN." R1's weight summary documents the following weights, 10/21/22- 158.0, 10/23- 157.4, 11/2- 155.6, 12/13- 156.1, 12/22- 156.1, 12/23- 151.2, 12/24- 141.2, 12/30- 140.8, 12/31- 141.7, 1/3/23- 141.2, 1/4/23 144.4 pounds. This indicates a 9.5% weight loss in one month and a 9.3% weight loss in 2 months. R1's Request for Diet Change, dated 10/24/22, documents under Summary, "RD Initial Assessment: Ht-75" (inches), Wt-157.4#,	S9999		

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S9999	Continued From page 31 BMI-19.7. Resident (R1) was admitted to facility on 10/21 from (name of regional facility). Recent fall with 12 sutures to R (right) brow line on arrival. Another fall noted since admission. Resident (R2) is alert with confusion that is new per report. PMH of stroke, vascular dementia, CHF (Congestive Heart Failure), heart disease, HTN (hypertension), HLD (hypersensitivity lung disease), depression, anxiety, CKD3 (Chronic Kidney Disease Stage 3), spinal stenosis, dysphagia, and constipation. Meds reviewed. No recent labs available to review. He is receiving a regular diet with thin liquids. Feeds self with intakes 51-100%. Start fortified foods at all meals and 2.0 cal supplement 60 cc BID (twice daily) to support weight maintenance. Monitor weights and intakes. Refer to RD as needed." On 1/5/23 at 8:07 AM, V12 (CNA) was observed serving R1 breakfast. R1's room tray had scrambled eggs, ground sausage, toast, and orange juice. V12 stated R1 did not have any cereal on his tray, and would get it if he asked for it. On 1/5/23 at 9:50 AM, V12 stated she was not aware of any supplements R1 received with his meals. R1's undated dietary card documents R1 is served a regular mechanical soft diet. The card does not document R1 is served fortified foods. R1's Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 11/1/22 to 11/30/22, 12/1/22 to 12/31/22, and 1/1/22 to 1/31/22, do not document an order of administration of 2.0 cal 60 cc BID. R1's Care Profile, with a print date of 1/12/23 ,documents a physician order for Resource 2.0 Nutritional Supplement 60 ml (milliliters) two	S9999		

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S9999	Continued From page 32 times daily with a start date of 1/9/23. R1's TAR/Treatment Order Administration Record, dated 1/1/23 to 1/31/23, documents a physician order to weigh R1 daily and call physician if weight is greater 3 pounds in one day, or 5 pounds in one week, with a start date of 12/21/22. On 1/5/23 at 10:45 AM, V15 (LPN/Licensed Practical Nurse) stated the floor nurse was responsible for notifying the physician of any significant weight loss, and it should be documented in the progress notes if they are notified. V15 reviewed R1's progress notes and was not able to locate a note documenting R1's physician was notified of R1's weight loss. V15 stated R1 had an order for 2.0 cal, and he didn't like it. This surveyor reviewed R1's physician orders with V15, and the order for 2.0 cal was not documented at this time. On 1/4/23 at 2:30 PM, V26 (Dietitian) stated she had a general concern about the facility getting residents weighed timely and accurately. V26 stated she pulls a monthly weight report to review when she makes her visits to the facility to assess residents. V26 stated she sends her report to V1 (Administrator), V18 (LPN) and pretty much everyone. V26 stated it is V18's responsibility to take her recommendations and get them signed off on by the physician. V26 stated she thinks there was a time V18 was behind in getting the orders put into the electronic health system. V26 stated when she ran the weight change report for R1, it did not show a weight loss since it is a monthly weight report and doesn't show the weights that are obtained daily/weekly. V26 stated the ten-pound drop should have been a trigger to notify the physician, especially with the physician	S9999		

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S9999	Continued From page 33 order to do so. V26 was asked if there was anyone monitoring the weights and notifying her if anyone triggers a significant weight change, and V26 replied "not that I am aware of." V26 stated she would have expected the recommendations of 2.0 cal and fortified foods to have been implemented, and it not being implemented could have had an impact on R1's weight loss. On 1/5/23 at 8:14 AM, V20 (Dietary Manager) stated she was not aware R1 should have been receiving fortified foods, and if R1 had been served that diet this morning, he would have been served oatmeal. On 1/6/23 at 8:52 AM, V2 (DON/Director of Nurses) stated she had heard R1 had a 10-pound weight loss. V2 stated she felt like it could be an error, and R1 should be reweighed. V2 stated V18 (LPN) is responsible for monitoring weights. V2 stated she would have expected V27 (NP/Nurse Practitioner) and V26 (Dietitian) to be notified of a significant weight loss, and for R1 to have been reweighed immediately. When asked why the Dietitian's recommendations of 2.0 cal and fortified foods weren't implemented, V2 stated V18 is supposed to be updating that. V2 stated the nurses could also get the orders from V27 and put the orders in. On 1/5/23 at 1:55 PM, when asked if she had been notified of R1's weight loss, V27 (NP) stated it would be hard to say. V27 stated weight losses usually go to the Dietitian. V27 stated she had not been notified of R1's weight loss because she would have done a visit if she had. V27 stated she would expect R1's weights would be done daily as ordered, she would be notified of any significant weight change, and the dietitian's recommendations would be sent to V27 for	S9999		

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S9999	Continued From page 34 review. On 1/10/23 at 1:54 PM, when asked if implementing R1's dietary recommendations would have prevented his weight loss, V39 (Physician) deferred to V27 (NP) who was present for the interview, and V27 stated, "It wouldn't have hurt but there is no way to predict the outcome." Both V27 and V39 stated they did not remember the facility staff notifying them of R1's weight loss. The facility Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, dated 8/2008, documents under Assessment and Recognition, "1. Monitor and document the weight and nutritional status of residents in a format which permits readily available month-to-month comparisons." Under Cause Identification the protocol documents, "1. The physician and/or designee will review possible causes of anorexia or weight loss with the nursing staff and/or dietitian before ordering interventions. a. For individuals with recent or rapid weight loss (for example more than a pound a day), the staff and physician should consider possible fluid and electrolyte imbalance as a cause .... Monitoring ...1. The physician and staff will monitor the nutritional status, response to interventions, and possible complications of such interventions ...of individuals with impaired nutritional status. 2. The physician will help staff adjust nutritional interventions and will modify the treatment of underlying causes of impaired nutritional status depending on the resident's responses, wishes, prognosis, complications, etc." (B)	S9999		