STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	C 03/28/2023

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BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation: 2342402/IL157871	S 000		
S9999	Final Observations Statement of Licensure Violations I of IV: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 300.3210t) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on interview and record review the facility failed to implement safety measures to prevent resident to resident abuse for 2 of 5 residents (R12, R21, R39, R77, R110) reviewed for abuse in the sample of 47. This failure resulted in R21's repeated acts of abuse. This resulted in R110 sustaining a facial laceration, facial injury, and corneal abrasion. Findings include: 1. R21's Face Sheet, undated, documents R21 has a diagnosis of Paranoid Schizophrenia, Major Depressive Disorder (Recurrent) and Alcohol Abuse. R21's Minimum Data Set (MDS), dated 2/22/22, documents R21 has severe cognitive impairment. R21's Care Plan, dated 4/11/22, documents R21 is at risk for abuse/neglect, is verbally aggressive and difficult to redirect at times and has a history of peer-to-peer altercations. R21 has a history of aggressive behavior and has a past history of verbal and physical altercations and becomes easily irritated with peers. R21 has a history of criminal behavior and has been charged with aggravated battery, resisting police, criminal damage to property and assault with a deadly weapon. A state official with the Illinois Department of Public Health (IDPH) and the State Police performed a Criminal History Analysis and determined the resident to be moderate risk. R21 has the following interventions listed: 15-minute check program for increased monitoring for behavior reduction. R21's 15-minute resident monitoring sheets were reviewed with no documentation of 15-minute	S9999		

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S9999	Continued From page 3 checks being performed 4/21/22 through 3/8/23. R21's Criminal History Analysis Security Recommendation Report, dated 11/7/14, documents R21 is at moderate risk and requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient. The following specific considerations were important in arriving at the above recommendations: R21 is a 51-year-old male who was admitted to the nursing facility on 9/30/14. His criminal history consisted of convictions for aggravated battery, resisting a peace officer and criminal damage to property. The most recent occurred in June 2014, and he is currently on 2 years special probation. The resident interview noted he said he "gets in random fights here and there, numerous arrests for battery, aggravated assault with a deadly weapon, served one year in department of corrections for assault." His diagnosis is a major psychiatric disorder, and he has a history of alcohol/drug dependence. Nursing facility staff reported satisfactory behavior since his admission except for "once incident, swung his fist at another resident." Progress notes cited incidents of verbal aggression and one incident of physical aggression when he punched another resident in the arm. His compliance with psychiatric treatment and abstinence from alcohol/dry use should be closely monitored. In view of his criminal history, past and recent incidents of verbal/physical aggression and current legal circumstances, a moderate risk supervision status is recommended. In the event	S9999		

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his psychiatric condition escalates, and additional incidents occur, a high-risk supervision status is recommended. High risk - The resident requires a single room in close proximity to the nursing station to permit ongoing visual monitoring. The level of observation should be sufficient for early detection of behavioral changes. Regular assessment is necessary to determine whether closer monitoring or more frequent individual contact is indicated.

The Facility Incident Report, dated 12/11/22, documents R110 was observed striking a female staff member. R21 states that he doesn't like to see a man put their hands on a woman and he felt the need to defend the staff. R21 states he struck R110 in the face one time. R110 was noted with a laceration above his right eye and was sent to the emergency room for evaluation and treatment. Based on the facility's investigation, it is the determination that the incident did occur.

R110's Hospital After Visit Summary (AVS), dated 12/11/22, documents R110 was seen in the hospital for facial injury, assault, facial laceration, and abrasion of the left cornea.

The Facility Incident Report, dated 5/24/22, documents R39 became upset with a staff member for refusing to give him another resident's cigarettes. R21 states that R39 lunched at the staff member as if he was going to strike her. R21 stated that he believed R39 was going to hurt the staff member and he needed to defend her as he doesn't feel a man should hit a woman. R21 states that when he stepped between himself and the female staff member that R39 struck him in the arm. Staff state that the two residents (R21, R39) lost their balance

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and went to the ground. R21 states he struck R39 in the face while they were on the ground. R39 was noted to have some superficial scrapes and bruising to his face. Based on the facility's investigation, it is the determination of the facility that the incident did in fact occur.

The Facility Incident Report, dated 4/6/22, document R21, R33, R35 and a past resident were gathered in the day area waiting to exit the door to smoke. While waiting in the line to go outside to smoke, the past resident bumped into R33's leg. R33 asked the past resident to move his walker from next to her leg. R33 stated that the past resident didn't move the walker, so she assumed that he did not hear her speak so she shouted at him to move. R33 stated that R21 reacted because he believed that the past resident had hurt her. R21 admits to striking the past resident and being pushed back. R21 states when he was pushed back by the past resident, he fell into the back of the wheelchair of R35, which tipped R35 onto the ground on his bottom. Based upon the investigation, it is the determination of the facility that this incident did in fact occur.

R21's care plan fails to document that any new interventions were put into place after the altercations on 4/6/22, 5/24/22 or 12/11/22. The care plan also fails to document that R21 was placed in a private room, close to the nurse's station as recommended by the Criminal History Analysis Security Recommendation Report.

On 3/21/23 at 2:44 PM, R21 was observed in his room, quiet, calm and was on one-on-one supervision with V13 (Certified Nurse Assistant/CNA). V13 stated she is unsure why R21 is on one-on-one supervision. R21 denied

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S9999	Continued From page 6 concerns with the other residents and "it ain't nothin." On 3/23/23, R35 and R110 were unable to provide any details of the above incidents with R21. On 3/23/23 at 8:15 AM, V2 (Director of Nurses/DON), stated R21 is on one-on-one supervision due to an incident with another female resident. V2 stated it started in March 2023, she unsure of the exact date. V2 stated prior to this incident, R21 has not been on 15-minute checks or enhanced supervision that she is aware of. V2 stated enhanced supervision means 15-minute, 30-minute, hourly checks, more often than every 2 hours and it is determined by the interdisciplinary team if it is necessary. On 3/23/23 at 9:14 AM, V2 stated she has not been here throughout R21's admission but she is not aware of him being moved to a high-risk category related to his recent altercations. V2 stated she is not aware of him being in a private room or room close to the nurse's station since she has been at the facility. On 3/23/23 at 1:25 PM, V2 stated since she has been at the facility, they follow the recommendations of the Illinois State Police (ISP) for their identified offenders. V2 stated she was not here when R21 was admitted and was not aware of the recommendations from ISP. V2 stated they are aware now of the concerns with R21's altercations and R21 will stay on one-on-one supervision due to his resident-to-resident altercations. 2. R77's Face Sheet, undated, documents R77	S9999		

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S9999	Continued From page 7 has a diagnosis of Paranoid Schizophrenia, Anxiety Disorder, Bipolar Disorder, Intermittent Explosive Disorder and Major Depressive Disorder (Recurrent). R77's MDS, dated 5/9/22, documents R77 has severe cognitive impairment, has hallucinations and delusions. R77's Care Plan, dated 5/22/20, documents R77 is at risk for abuse and neglect. R77 has a history of peer-to-peer altercations. R77 has a history of aggressive, inappropriate, attention seeking and/or manipulative behavior. He has been physically aggressive. He is noted to get verbally aggressive toward staff and peers, is easily irritated and becomes angry very quickly. He has been noted to exhibit paranoid behaviors, thinking that others are talking about him or are out to get him. He tends to fixate his behaviors towards specific individuals. The Facility Incident Report, dated 8/16/22, documents R12 and R77 were involved in an altercation in the hallway. R12 and R77 were in the hallway by the kitchen door. Staff overheard R77 being loud and entered the hallway to see R77 attempt to hit R12. Staff state that R12 then stood and hit R77 on the top of the head before they could intervene. Staff immediately separated the residents and provided one on one with both residents but were unable to keep them calm and redirection was not successful. Both residents were sent to the emergency room for evaluation and returned later the same day. Based on the facility's investigation, it was determined that the incident did occur. The Facility Incident Report Form, dated 5/15/22, documents R12 and R77 were involved in an	S9999		

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altercation. R12 was visiting with his daughter in the lobby when R77 entered and began to yell at R12. R12 and his daughter stated that R77 came from behind and struck R12 in the back. R77 stated that he believed that the radio R12 had belonged to him and not R12. It was determined that the radio in question belonged to R12. It is the determination of the facility that the incident did in fact occur.

R77's Care Plan, fails to document any new interventions were implemented after the altercations on 5/15/22 or 8/16/22.

The Resident's Rights and Residents' Safety Enhanced Supervision Guidelines, policy, dated 7/8/20, documents these guidelines emphasize a proactive intervention promoting enhanced physical, psychosocial well-being and person-centered care while promoting resident/resident representative care participation. The facility recognizes that there may be occasions in which standard approaches of every 2-hour rounds may need to be increased to more frequent, enhanced observation. With every 15, 30, hourly checks the staff will check/observe the resident's status/whereabouts every 15 minutes, 30 minutes or hourly.

The Abuse Policy and Prevention Program 2022, policy documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with

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S9999	Continued From page 9 resulting physical harm, pain, or mental anguish to a resident. The term "willful" in the definition of "abuse" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers ad behaviors that might lead to conflict. For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendations Report into the identified offender's plan of care including the security measures listed. "B" Statement of Licensure Violations II of IV: 300.610a) 300.1210b) 300.1210d)6) 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	S9999		

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S9999	Continued From page 10 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 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's beds was positioned at a safe height to prevent falls for 1 of 4 residents (R73) reviewed for falls in the sample of 47. This failure resulted in R73 falling from her bed while it was in the high position and sustaining bilateral mandibular dislocation and a 2-centimeter laceration above her left eye that required tissue adhesive to close while at the emergency room for evaluation and treatment. Findings include:	S9999		

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S9999	Continued From page 11 R73's Undated Face Sheet, documents she was admitted on 10/2/2019. R73's Fall Risk Evaluation dated 2/14/2023, documents a score of 25, a score of 10 or higher makes resident "high risk" for falls. R73's Quarterly Minimum Data Set (MDS), dated 2/28/2023 documents R73 has severely impaired cognitive skills for daily decision making; requires extensive assistance for bed mobility, transfers, dressing, toilet use, personal hygiene needed 2 persons physical assist. Walking did not occur during the evaluation period. R73 uses no mobility devices. R73 has had one fall since admission/entry or reentry with no injury. 10/16/20219 keep bed in lowest position and 12/19/2021 floor mats to be laid down after resident is in bed for the night with bed in lowest position. On 3/23/2023 at 8:50 AM, R73 was lying in bed with an injury to left upper eye. R73's bed was on the floor at that time. R97, R73's roommate, stated R73 fell out of bed about 10 minutes ago. R97 stated R73 fell out of bed, staff lowered her bed to the floor, it was in the high position when R73 fell out of bed. R97 stated staff in the room were upset that R73's bed wasn't in the low position. R97 stated R73 hit her head on the floor. There was a floor mat on the floor next to R73's bed. On 3/23/2023 at 9:25 AM, V24 (Certified Nursing Assistant/CNA), stated she came to work at 6:45 AM today and was assigned to R73. V24 stated she changed R73's clothes and provided incontinence care. V24 stated she was going to transfer R73 to her chair, but staff came in and	S9999		

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told her to shower another resident, so she left the room and forgot to lower R73's bed to the floor. V24 stated staff told her R73 stated a few minutes ago that R73 fell on the floor from the bed. V24 stated she knew R73 was a fall risk, and her bed was supposed to be lowered to the floor when she is in bed.

On 3/23/2023 at 9:32 AM, V27 (CNA) stated V25 (Medical Records) told her she needed help repositioning R73. V27 stated while V27 and V23 walked to R73's room, she noted the call light was on. V27 stated when V27 entered R73's room, she observed R73 was lying on the floor with her body on the floor mat and her head was off the mat, lying on the floor. V27 stated R97, R73's roommate, stated she pushed her call light because R73 just fell out of bed. V27 stated she knew R73 was a fall risk, and her bed was supposed to be lowered to the floor. V27 stated when she and V25 entered R73's room she observed R73's bed was in the high position. V27 stated after V4 (Licensed Practical Nurse/LPN), and V26 (LPN) entered R73's room and transferred R73 back to bed, she lowered the bed to the floor so R73 wouldn't get hurt anymore. V27 stated R73's bed should have never been left in the high position because she is a fall risk. V27 stated she observed blood on R73's forehead after the nurses transferred her to bed.

On 3/23/2023 at 9:35 AM, V25 stated she walked by R73's room and noted her geriatric reclining chair was in the doorway. V25 stated she peeked into R73's room and noted R73's feet were hanging off the bed. V25 stated she went and got V27 (CNA) to assist her in repositioning R73. When V25 and V27 got to R73's hall, V25 noted R73's call light was on. V25 stated when she and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 V27 entered R73's room, R97 stated R73 just fell out of bed and R73 hit her head on the floor. V25 stated R73 was lying on the floor on her fall mat at that time. V25 stated she left R73's room and got V4 (LPN) to assess R73. V25 stated R73 is a fall risk, and her bed should have been in the low position, but it wasn't when she entered the room. V25 stated R73's bed was in the high position. V25 stated she didn't know who lowered R73's bed to the floor after she fell but that it was definitely in the high position when R73 fell out of bed. V25 stated she was upset because she is a CNA and knew R73's bed should have been in the low to the floor position and due to lack of common sense, staff left her bed in the high position and R73 is now at the hospital because of staff not doing their jobs. V25 stated she observed blood on R73's eye after the fall. On 3/23/2023 at 9:43 AM, V4 (LPN) stated V25 reported to her that R73 fell from her bed. V4 stated she entered (R73's) room and V26 (LPN) also assisted her. V4 stated she and V26 assessed R73 for injuries at that time and noted blood from her eyebrow (V4 couldn't recall which eyebrow) and V26 called the ambulance to transfer R73 to the hospital. V4 stated she couldn't recall what position R73's bed was in when she entered the room because she was focused on assessing R73 at that time. V4 stated she wasn't assigned to R73 today but that she was assisting with the fall. V4 stated she didn't know if R73 was a fall risk. On 3/23/2023 at 9:50 AM, V26 (LPN) stated staff reported R73 fell from bed. V26 stated when he entered R73's room he observed R73 lying on a fall mat next to her bed, her head was off the fall mat, and there was blood on R73's head. V26 stated he didn't know where the blood was	S9999		

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	IL6007983	A. BUILDING: _____ B. WING _____	C 03/28/2023

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S9999	Continued From page 14	S9999		

coming from. V26 stated staff called the ambulance because R73 hit her head. V26 stated R73's roommate told V26 that R73's bed shouldn't have been in the high position. V26 stated he didn't observe the height of R73's bed at that time because he was focused on R73. V26 stated all residents are considered a fall risk at the facility.

R73's Nurse's Note, dated 3/23/2023 at 8:42 AM, documents, "Wound nurse reported to this nurse that resident fell from bed and has a laceration to left brow. Care provided to area by wound nurse. Neuro assessment normal for resident. Ambulance transport called. EMTS (Emergency Medical Technicians) arrived, and report given. Report given to local hospital. Resident transferred to local hospital."

On 3/23/2023 at 2:40 PM, V2 (Director of Nurses/DON), stated she spoke to the emergency room staff at the local hospital, and it was reported R73 sustained a displaced bilateral temporal mandibular joint (TMJ.) V2 also stated ER staff stated they glued the laceration on R72's head.

R73's Physician Order Sheet (POS), dated 3/24/2023.documents apply ice pack x 15 minutes to TMJ joint (top of lower jaw just in front of ear) 3 times daily x 3 days for reduced jaw dislocation.

R73's Hospital Records, dated 3/23/2023 documents, laceration repair with tissue adhesive to left eyebrow 2 centimeters (cm) and mandibular dislocation.

The Facility's policy "Fall Prevention and Management" dated 05/2015 documents "This

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S9999	Continued From page 15 facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed." It continues under guidelines, "1. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall." "A" Statement of Licensure Violations III of IV: 300.610a) 300.2040b)1)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 300.2040 Diet Orders b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The	S9999		

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S9999	Continued From page 16 attending physician may delegate writing a diet order to the dietitian. 1) The resident's diet order shall be included in the medical record. 2) The diet shall be served as ordered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record, the facility failed to implement Registered Dietitian recommendations to improve nutritional status for 1 of 3 residents (R73) reviewed for weight loss in the sample of 47. This failure resulted in the resident having severe weight loss of 16.46% in 3 months. Findings include: R73's Undated Face Sheet, documents she was admitted to the facility 10/2/2019. R73's Weight Summary, dated 12/9/2022 documents R73 weighed 114.6 pounds. R73's Minimum Data Set (MDS), dated 2/28/2023, documents R73 as 66 inches tall, 104 pounds. It also documents R73 has had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and is on a mechanically altered diet and therapeutic diet. R73's Care Plan documents resident at risk for complications with weight and nutrition r/t (related to) history of not eating moderate protein-calorie malnutrition third. Goal: resident will consume adequate nutrition and weight to remain stable throughout next review. Interventions: 10/7/2019 allow resident extra time to eat, allow resident to choose supplemental diet, if possible, assist resident with meals as needed, dietary consultant	S9999		

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S9999	Continued From page 17 to determine preferred foods, give consistency of food that is easy to eat and swallow, if dessert is uneaten, offer a snack later, monitor nutritional/hydration status, monitor residents' food intake and document, monitor weight and labs. 5/10/2021 house supplement 120 milliliters (ml) TID (three times a day) 6/25/2021 appetite stimulant, 8/2/2021 fortified foods, 10/28/2021 offer snacks in between meals, 6/30/2022 assistance with all meals. There were no new progressive interventions added. R73's Physician's Order Sheet (POS) dated 2/2023, documents 1/22/2020 provide HS (night) snack q (every) evening, 6/25/2021 Megace (appetite stimulant) 20 mg (milligrams) 2 tablets BID (twice a day), 8/30/2022 hi cal (supplement) TID (three times a day) 120 ML (milligrams), 11/16/2022 regular diet pureed texture nectar thick liquids consistency, related to dysphagia, oropharyngeal phase. Fortified food TID, high calorie dessert BID, health shake TID. R73's Undated Dietary Card, documents breakfast: super cereal and nectar thick liquids. Lunch and supper: fortified mashed potatoes, nectar thick liquids, high calorie dessert. No dislikes/allergies or other documented on dietary card. Dining room south hall - feeder assistance. No health shake was documented on the dietary card. R73's Dietary Nutrition at Risk Follow Up, dated 2/2/2023, documents weight as of 2/1/2023: 106.8 pounds. ST (speech therapy) has reported that resident has decline in function and with eating and taking meds. Had a fall and brief hospitalization in January. Regular diet with fortified foods TID and high calorie dessert BID. Hi Cal, 120 mL TID, megace. Will add health	S9999		

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S9999	Continued From page 18 shakes TID. Cont. (continue) to monitor. R73's Weight Summary, dated 2/8/2023 documents R73 weighed 105.6 pounds. R73's Dietary Nutrition at Risk Follow Up, dated 2/9/2022, documents ST has reported that resident has decline in function and with eating and taking meds. Had a fall and brief hospitalization in Jan. (January) Reg (regular) diet with fortified foods tid and high cal dessert BID. Hi Cal, 120 mL TID, Megace. Health shakes TID. Cont. to monitor R73's Weight Summary, dated 2/15/2023 documents R73 weighed 104.2 pounds. R73's POS, dated 2/15/2023 documents weekly weights. R73's Dietary Nutrition at Risk Follow Up, dated 2/16/2023, documents ST reported resident has decline in function with eating, taking meds. Reg diet with fortified foods TID and high cal dessert BID. Hi Cal, 120 mL TID, Megace. Health shakes TID. Eating 25 -100% of meals. Encourage intake and provide assistance with eating as needed. Will follow. R73's Weight Summary, dated 2/22/2023 documents R73 weighed 102.2 pounds. R73's Dietary Nutrition at Risk Follow Up, dated 2/23/2023, documents ST reported resident has decline in function with eating, taking meds. Pureed diet, nectar thickened liquids with fortified foods tid and high cal dessert BID. Hi Cal, 120 mL TID, Megace. Health shakes TID. Eating 25-100% of meals. Encourage intake and provide assistance with eating as needed. Will	S9999		

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S9999	Continued From page 19 follow. R73's Medication Administration Record (MAR), dated 2/2023 documents staff administered hi cal 120 ml TID per physician's orders. No documentation health shakes were administered. R73's POS dated 3/2023, documents 6/25/2021 Megace 20 mg (milligrams) 2 tablets BID (twice a day), 8/30/2022 hi cal TID (three times a day) 120 ML (milligrams), 11/16/2022 regular diet pureed texture nectar thick liquids consistency, related to dysphagia, oropharyngeal phase. Fortified food TID, high calorie dessert BID and health shake TID. R73's Weight Summary, dated 3/2/2023 documents R73 weighed 98.6 pounds. R73's Dietary Nutrition at Risk Follow Up, dated 3/9/2023 documents pureed diet, nectar thickened liquids with fortified foods TID and high cal dessert BID. Hi Cal, 120 mL TID, Megace. Health shakes TID. Eating 25-100% of meals. Enc. intake and provide assistance with eating as needed. Will follow. R73's Weight Summary, dated 3/10/2023 documents R73 weighed 99.0 pounds. R73's Dietary Nutrition at Risk Follow Up, dated 3/16/2023, documents pureed diet, nectar thickened liquids with fortified foods TID, high cal dessert BID. Hi Cal, 120 mL TID, Megace. Health shakes TID. Eating 50-100% of meals. Resident being fed BF (breakfast) by CNA (Certified Nursing Assistant) this AM, tol (tolerated) well. Will follow. R73's Weight Summary, dated 3/16/2023	S9999		

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S9999	Continued From page 20 documents R73 weighed 98.4 pounds. R73's MAR, dated 3/2023 documents staff administered hi cal 120 ml TID per physician's orders. No documentation health shakes were administered. On 3/23/2023 at 8:50 AM, R73 was lying in bed and had a very thin appearance. The Facility's Hi Cal and Shake list, dated 3/24/2023 documents R73 received hi cal for lunch and supper. Shakes were not listed for R73. On 3/24/2023 at 11:37 AM, V34 (Licensed Practical Nurse/LPN), stated in January 2023, R73 was self-propelling in her wheelchair, smoking cigarettes and talking more. She's had a rapid decline since then. On 3/24/2023 at 12:00 PM, V35 (Cook) showed 2 cases of vanilla shakes, one case of chocolate shakes and one case of strawberry shakes. There were 50 shakes in each case. V35 stated she looked at R73's dietary card and it doesn't have health shake documented on it so she's probably not receiving them. V35 stated the dietary staff are trained to follow the residents' dietary card and so if health shakes aren't on the card, dietary staff don't know to put it on there. On 3/24/2023 at 12:52 PM, V28 (Registered Dietitian/RD), stated she expects staff to follow physician's orders and facility policies. V28 stated when she has RD recommendations it goes through nursing, they send the recommendations to the resident's physician and if he/she agrees, then it is added to the resident's current POS. V28 stated she updates the	S9999		

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resident's dietary care plan herself and she does that weekly when there is a new intervention to add. V28 stated the resident's care plan should be updated for current dietary interventions. V28 stated when she added health shakes to a resident's diet, she would have updated the resident's care plan at that time. V28 stated she orders health shakes to resident's diet when they are losing weight. Health shakes and hi cal is not the same thing, if both supplements are ordered she expects staff to document both supplements are being administered. If there is a physician's order for the resident to receive a HS snack, she would expect staff to administer the HS snack and to document what percentage of the snack the resident ate.

On 3/24/2023 at 1:16 PM V5 (Dietary Manager) stated the RD inputs dietary recommendations in the computer system and that is how they are communicated to him. The RD recommendations are then added to the residents' dietary cards and dietary staff place the items listed on the resident's dietary card on the resident's tray. If an RD recommendation is not documented on the resident's dietary card, it is not placed on the resident's tray. V5 read R73's dietary card and stated R73 doesn't have a shake listed so she wasn't receiving them, and he didn't know why R73 wasn't receiving the shake if it was ordered by the Registered Dietitian, there must be a blip in the computer system or something. V5 didn't know if R73 was losing weight, the Registered Dietitian does all the clinical stuff.

On 3/24/2023 at 3:14 PM, V2 (Director of Nursing/DON), stated the facility's RD, V3 (Assistant Director of Nursing/ADON), and the restorative nurse have a NARS (Nutrition at Risk Screen) meeting weekly, and they review all the

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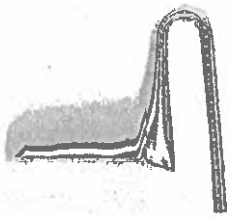
S9999	Continued From page 22 weights and assess residents that are losing weight. If there is a concerning amount of weight loss from one week to another V2 stated V3 will have staff reweigh the resident to ensure the weight is accurate. In the NARs weekly meeting, V3 and the RD add interventions to residents' care plans to ensure they don't lose weight. V2 stated she would expect a new progressive intervention to the resident's care plan when a resident is losing weight. New interventions should be added to the resident's care plan the same day of the NARS meeting takes place. V2 stated she expects residents' care plans to be updated and staff to be following the interventions on each resident's care plan. V2 wasn't aware no new progressive interventions have been added to R73 care plan since 11/2022. V2 stated she just found out today that the CNAs aren't documenting that the resident is drinking the health shake, they are documenting what percentage residents are eating per meal in 25% increments. V2 stated food related RD recommendations should be documented on the resident's dietary card, including health shakes so dietary staff know to put the health shake on the resident's meal tray. V2 didn't know why R73's health shake wasn't documented on her dietary card. The Facility's policy "Weight change Policy" dated 06/2015 documents "It is the policy of this facility to monitor the nutritional status of all residents. Including all significant or trending patterns of weight change." "B" Statement of Licensure Violations IV of IV: 300.610a)	S9999		



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S9999	Continued From page 23 300.1210d)1) 300.1630d) 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 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to administer insulin per the physician's orders for 1 of 2 (R91) residents reviewed for	S9999		

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S9999	Continued From page 24 insulin administration in the sample of 47. This failure resulted in (R91) being admitted to the local hospital with a diagnosis of hyperglycemia. Findings include: R91's Undated Face Sheet, documents she was admitted to the facility on 12/28/21. R91's Physician's Order Sheet, (POS), dated 03/23, documents diagnosis of type 2 diabetes with hyperglycemia. 01/20/23: Glargine 10 units subq (subcutaneous), every day at 9:00 AM. R91's Medication Administration Record (MAR), dated 03/23 documents a blank box dated 03/20/23 for the Glargine 10 units at 9:00 AM. R91's Nurse's Note, dated 03/21/23 at 1:22 am, documents, "CNA (Certified Nurse Assistant), this CNA reported to this nurse (V14) that resident doesn't look like her normal self. Resident presents very lethargic. Blood sugar 436, 98.2 88 40 122/82 85% RA. O2 (oxygen), applied via nasal cannula O2 now at 92% 2 L (liters). Sternum rub done to resident with no arousal. This nurse (V14) called the residents POA (Power of Attorney), to update her on resident's condition. POA wants her sent to the hospital. Resident sent to local hospital. On 3/22/23 at 2:00 PM V2 (Director of Nurses/DON) stated, she expects staff to follow Physician's Orders and to document when medications including insulin was administered to the resident on the MAR. She wouldn't say what it means if the resident's MAR box is empty because she would have to investigate the specific situation first.	S9999		

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S9999	Continued From page 25 On 03/22/23 at 12:58 PM V19 (Pharmacist) stated, she expects all medications including insulin to be administered per physician's orders. A blank box on the resident's MAR possibly means the nurse didn't document the insulin wasn't administered. V19 expects the nurse to sign off when insulin was administered. If the resident didn't receive the scheduled 9:00 AM dose of insulin on 03/20/23 that is considered a significant medication error and could have cause the hyperglycemia she experienced on the morning of 03/21/23. The Facility's Timely Administration of Insulin Policy, revised 11/17, documents administer insulin at appropriate times and document on the medication administration record the time insulin was administered. All insulins will be administered in accordance with Physician's Orders. "A"	S9999		