STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	01/27/2023

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NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1210b)3) 300.1210d)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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 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 were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident with a current UTI (Urinary Tract Infection) had orders for an indwelling catheter and failed to change the indwelling catheter. This resulted in R26 experiencing chronic UTIs with the need for IV (intravenous) antibiotic treatment. The facility failed to provide incontinence care in a manner to meet professional standards. These failures apply to 2 of 7 residents (R26, R95) reviewed for catheter and bladder care in the sample of 35. The findings include:	S9999		

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1. On 1/24/23 at 11:09 AM, R26 was lying in bed with an IV antibiotic connected to the IV site in his right hand. R26 had an indwelling catheter. The tubing of the catheter was hazy, and it was difficult to visualize the urine in the tubing. R26's catheter drainage bag was draining dark, amber urine with copious amounts of white sediment.

On 1/25/23 at 2:39 PM, V5 (Wound Care Coordinator) and V13 (Wound Care Nurse) were providing incontinence care and wound care to R26. During this process, R26's indwelling catheter appeared stiff and dirty from the meatus to halfway down the catheter. R26's catheter was draining dark, amber urine with sediment.

R26's Face Sheet dated 1/26/23 showed diagnoses to include, but not limited to stroke; disorders of kidneys and ureters; sepsis; CHF (Congestive Heart Failure); diabetes; dementia; bladder-neck obstructions; need for assistance with personal care; kidney stones; BPH (Benign Prostatic Hyperplasia); microcephaly; reduced mobility; ESBL (Extended Spectrum Beta Lactamase) Resistance of the urine; diabetes; and unspecified intellectual disabilities.

R26's Physician Order Sheet (POS) dated 1/26/23 did not contain an order for R26's indwelling catheter to include size, type, balloon size, and diagnosis for the indwelling catheter. R26's POS did not include an order to change R26's catheter or drainage system. The only order for R26's indwelling catheter on the POS was, "Foley catheter care q (every) shift and PRN (as needed) - notify the physician of changes and/or irritation at the site..."

R26's Medication Administration Record (MAR) for November 2022, December 2022, and

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S9999	Continued From page 3 January 2023 showed R26 did not have orders for his catheter or for changing the catheter or drainage system. R26's Progress Notes were reviewed from November 2022 to January 25, 2023. There were no notes that showed R26's catheter or drainage system had been changed. The surveyor requested the facility provide documentation of R26's most recent catheter change. The facility was unable to provide documentation. R26's Provider's Progress Note dated 1/23/23 at 9:17 AM, showed, "Patient is a poor historian due to cognitive/psychiatric impairment. Chief Complaint/Reason for Visit: UTI, recent adynamic ileus, leukocytosis, debility, anemia, hypertension, and CHF. HPI (History and Physical Information) relating to this visit: pt (resident) with recent + urine cx (culture), started on IV atb (antibiotics)... On 10/11/22 pt was sent to [local hospital] with vomiting and abd (abdominal distension)... Seen by ID (Infectious Disease) and was s/p (status post) IV atb treatment. Hospital course complicated by urine retention, failed Foley trial catheter was reinserted on 10/22/22 with plans to f.u. (follow-up) with urology in 2-4 weeks... On 10/27/22 pt was sent to ED (emergency department) with fever and anemia. Limited records available for review. pt admitted for Sepsis 2/2, GB (gallbladder) fossa abscess/phlegmon. Followed by ID and antibiotic course completed...Medications/Allergies: ... Meropenem (antibiotic) Intravenous Solution Reconstituted 1 GM (gram) intravenously every 8 hours for UTI for 7 days... Review of systems: ...Fever, + Gen (generalized) weakness... Awake, alert, no acute distress, calm, cooperative, appears comfortable... Decreased mobility, poor strength... Laboratory 1/2/23 .... urine cx =	S9999		

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S9999	Continued From page 4 ...ESBL 50-100,000 colonies/ml... 1/18/23 ...ESBL GREATER THAN 100,000 COLONIES/ML... Assessment/Plan: UTI - Urinary Tract Infection: Recurrent on 12/9/22 urine cx Pseudomonas aeruginosa GREATER THAN 100,000 COLONIES/ML - completed Cipro at that time. 1/2/23 urine cx = ...ESBL 50-100,000 COLONIES/ML - now to completed macrobid per sensitivities. 1/15/23 urine cx collected and resulted. 1/18/23 = ...ESBL GREATER THAN 100,000 COLONIES/ML = discussed with [physician] per sensitivities will start Meropenem IV, pharmacy to dose... F/U (Follow-up) with urology as directed 2/17/23...Acute retention of urine: see by [doctor] at hospital. Foley. To follow up with urology as otpt (outpatient) for bilateral renal stones..." The surveyor requested R26's most recent Urology Visit Note. The facility was unable to provide documentation. On 1/26/23 at 9:35 AM, V3 (Director of Nursing/DON) said there is an order set for residents that require an indwelling catheter. V3 stated, "The order set includes the type and size of the catheter. I'm not sure that the order shows the diagnosis for the catheter. Does the diagnosis have to be part of the order? It's under the diagnosis section. The order set also includes the orders to change the catheter and the drainage system. If the doctor doesn't specify a time, then it is based on nursing assessment of the catheter. They should look to see if the catheter is intact and flowing. Hazy drainage tubing should be changed. That would just require a drainage system change. The catheter should not be stiff or dirty. I would have to look at it, but it sounds like the catheter should also be changed. If the staff are not changing the catheter or drainage	S9999		

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system, then the resident's risk for UTI increases." The surveyor asked V3 to find documentation that R26's catheter had been changed and the most recent urology visit. The facility was unable to provide that information.

On 1/26/23 at 11:44 AM, V19 (Licensed Practical Nurse/LPN) said she was the nurse for R26. V19 said R26 was dependent on staff of all care. V19 said R26 was on IV antibiotics for a UTI. V19 was not sure when R26's catheter had been changed last.

The facility's Use of an Indwelling Urinary Catheter Policy (dated 2013) showed, "...The facility is responsible for the assessment of the resident at risk for urinary catheterization and/or the ongoing assessment for the resident who currently has a catheter. This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions.

The facility's Catheter Care Policy (dated 2013) showed, "Daily catheter care will be done to prevent infection. A physician's order is required..."

2. R95's Face Sheet dated 1/25/23 showed diagnoses including but not limited to dementia, psychotic disturbance, mood disturbance, and anxiety. R95's facility assessment dated 12/12/22 showed severe cognitive impairment and staff assistance required for bed mobility, transfers, toilet use, and personal hygiene. The same assessment showed R95 is frequently incontinent of urine and bowel.

On 1/24/23 at 12:39 PM, R95 was in bed and lying on a cloth incontinence pad. The pad had a

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brownish/yellow dried ring of urine on it. V14 (Certified Nurse Aide/CNA) stated "R95 wets a lot and needs to be checked every few hours for incontinence." At 1:15 PM, V14 and V17 (CNAs) provided incontinence care for R95. Both CNAs donned gloves and rolled R95 to the side. R95's incontinence brief was heavily soaked through with urine. R95's bed pad and gown were saturated with urine. V14 stated incontinence checks should be done every few hours and the resident changed if they are wet. Bed pads and linens need to be changed if urine or stool are on them. V14 and V17 rolled R95 from side to side wearing gloves and removed the wet brief and wet linens. V14 wiped R95's buttocks and repeatedly used the contaminated gloves to reach into the peri wipe container. V14 wore the same gloves while touching the room curtain, new brief, new fitted sheet, new bed pad, new gown, and resident's body. V14 and V17 put a fresh incontinence brief on R95 and taped it closed. At no time was cleansing done to R95's front vaginal area. At 1:32 PM V17 (CNA) stated "We need to change our gloves when they are soiled and after wiping incontinent residents. I knew I should have changed my gloves after wiping the urine, but I was busy holding R95." At 1:37 PM, V14 (CNA) stated "Urine-soaked skin needs to be cleaned to prevent skin tears and urinary tract infections. It is an infection control thing. I just forgot to clean her front area and change my gloves."

On 1/26/23 at 9:25 AM, V3 (Director of Nurses) stated pericare always involves cleansing the front and back of a urine-soaked resident. Urine left on the skin can burn and cause breakdown. Gloves need to be changed when soiled or contaminated. Aides should stop and get fresh gloves before touching anything to control the

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S9999	Continued From page 7 spread of germs. The facility's Perineal Care policy, revision dated 10/2010, states under the steps in procedure section: "9. For a female resident ...b. Wash perineal area, wiping from front to back. (4). Gently dry perineum." The same policy states: "12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly." (B) (Violation 2 of 2) 300.610a) 300.1010g)4) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)3) 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 and dated minutes of the meeting.	S9999		

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S9999	Continued From page 8 Section 300.1010 Medical Care Policies g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following: 4) Orders from the physician regarding weighting of the resident, and the frequency of such weighing, if ordered. 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 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'	S9999		

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S9999	Continued From page 9 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. 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. 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. These requirements were not met as evidenced by: Findings resulted in two deficient practice statements. 1. Based on observation, interview, and record review the facility failed to prevent severe unplanned weight loss, failed to ensure weights were performed as ordered, and failed to implement interventions after a significant weight loss for 6 of 7 residents (R205, R56, R143, R99, R124, R35) reviewed for nutrition in the sample of 35.	S9999		

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S9999	Continued From page 10 These failures resulted in R205 sustaining a severe 20.33% weight loss over 6 months and R56 sustaining a severe 16.18% weight loss over 2 months. 2. Based on observation, interview, and record review the facility failed to administer tube feedings to a resident in a manner to prevent aspiration and failed to administer a tube feeding according to the physician orders for 3 of 6 residents (R224, R111, R45) reviewed for tube feedings in the sample of 35 and 1 resident (R137) outside the sample. These failures resulted in a significant weight loss for R224. The findings include: 1.A. R205's face sheet printed on 1/26/23 showed diagnoses including dementia with behavior disturbance, anxiety, depressive disorder, and psychosis. R205's facility assessment dated 11/19/22 showed moderate cognitive impairment and staff assistance needed for setup during eating. The same assessment showed a 5% or more weight loss in the last 6 months and R205 not on a physician-prescribed weight-loss regimen. R205's weights were reviewed for the last six months. The weight summary report showed on 8/18/2022 a weight of 164.8 pounds and on 1/26/2023 at weight of 131.3 pounds (loss of 20.33% in six months.) R205's physician orders showed an order start dated 11/22/22 for daily weights. R205's weights were reviewed from 11/3/22 to 1/26/23 and showed only 7 days those weights had been taken.	S9999		

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S9999	Continued From page 11 R205's nutrition/dietary note dated 11/16/22 showed an identified significant weight loss in October of 6.9% and a continued significant weight loss of 10.2% in November. The note stated downward weight trend noted. Goal is for weight maintenance. On 1/26/23 at 11:27 AM, V11 (Dietician) stated any resident with a 10% or more weight loss in 6 months is considered a significant weight loss and nutritional supplements should be added right away. Supplements and/or fortified foods should be ordered, and a physical assessment is needed. The resident should be assessed for the ability to eat alone, as well as laboratory and skin assessments done. The assessments and interventions should be implemented right away to prevent further weight loss. Weights should be done as ordered to catch further weight loss. If weights are not done as ordered there is no way the dietician can review the report and start additional weight loss interventions. R205's care plan was reviewed for nutrition and showed a focus area of risk for malnutrition as indicated by the nutritional assessment done on 9/14/22. The focus area addressed the October and November significant weight loss triggers, however the interventions did not. The last nutritional intervention was on 6/20/22 (same month as admission to the facility). The facility Nutrition (Impaired)/Unplanned Weight Loss policy revision dated 5/12/22 states under the assessment and recognition section: "1. The nursing staff will monitor and document the weight and dietary intake of resident in a format which permits readily available comparisons over time. 3. The threshold for significant unplanned and undesired weight loss	S9999		

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S9999	Continued From page 12 will be based on the following criteria ...6 months-10% weight loss is significant; greater than 10% is severe." 1.B. R56's admission sheet documents she was admitted to the facility on 2/25/11 with a primary diagnosis of multiple sclerosis (MS). The facility assessment of 11/8/22 shows R156 to have severe cognitive impairment. The order summary sheet for active orders of January 2023 shows R56 to have a monthly weight. The weights and vitals summary shows a documented weight of 158.9 pounds in January 2022, March and April 2022 she was 148. 6 pounds. No further weights were documented until August 2022, and R56 was 144.8, and the next weight was November 2002 and R56 was down to 136 pounds. No further weight was documented. On 1/26/23, V22 and V23 (Restorative Nurses) said the restorative department was responsible for monthly weights and monitoring. V22 said the restorative aides do the monthly weights and if there is a daily weight, nursing will complete those weights. V22 said "For new admits we do the initial weight and the first 4 weekly weights." V23 said "Every resident should be weighed every month with or without a physician order. The dietician will review the weights every month, then she will let us know if a re-weight needs to be done. The restorative aides will get those weights. The weights are documented in the computer under the weights and vitals." V22 said weekly weights would be done by nursing, and the order would be on the MAR/TAR (Medication Administration Record/Treatment Administration Record). V22 said R56 was weighed yesterday and she weighed 114 pounds. V22 said R56 has	S9999		

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S9999	Continued From page 13 MS and now needs to be fed by staff. V22 said the last weights were done in November because the restorative aides were pulled to work on the floor, so the weights do not get done. V22 and V23 said they both get pulled off restorative duties to work on the floor as well. V22 said no weights were done for September or October. The nutrition/dietary note of 1/26/23 shows V11 documented a note for weight loss. The progress note shows R56 to be 62 inches in height and weighed 114.4 lbs, low for her age. The note shows a 15.9% weight loss over 2 months. On 1/25/23 at 9:00 AM, V24 was observed sitting at R56's bedside feeding her breakfast. V24 said R56 used to be able to feed herself but now she needed to be fed by staff. R56 was lying in bed with the head of the bed elevated. R56 appeared to have a flat affect and did not respond to verbal conversation. R56's care plan shows R56 to be at risk for malnutrition related to disease process of MS, dementia and comorbidities. The interventions include notify the physician/RD of weight change greater than 5% in one month time and weigh the resident daily or monthly as needed. 1.C. R143's admission record shows she was admitted to the facility on 7/7/21 with a primary diagnosis of dementia. The 1/11/23 facility quarterly assessment shows R143 to have severe cognitive impairment. The same assessment shows her to be 60 inches in height and weighing 98 pounds. The assessment shows a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, and she is not on a physician-prescribed weight-loss regimen.	S9999		

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S9999	Continued From page 14 R143's weights and vitals summary documents weights January thru May 2022, the next weight was September 2022 at 107.2 pounds, and R143 was not weighed again until November, and she was down to 97.6 pounds, a 9% weight loss. R143 was seen by her primary physician on 1/14/23 and ordered nursing to obtain a weekly weight. The order was acknowledged by the RN on duty. The weight and vitals summary and progress notes were reviewed and show no weights were obtained after the physician order for weekly weights. On 1/26/23 at 10:34 AM, V3 (Director of Nursing/DON) said the restorative department is responsible for obtaining weights, including all weekly and monthly weights. She said they will they take the weights and give a copy to her and dietary. The RD will review as well. On 1/26/23 at 9:30 AM, V22 said weekly weights would be done by nursing. 1.D. The admission record for R99 shows she was admitted to the facility on 12/8/22. The order summary sheet shows 2 active orders for weights. Both orders were placed on 12/9/22. One order is to obtain daily weights. Notify MD if weight gain of more than 2 lbs (pounds) per day or more than 5 lbs in one week. The second order is to weigh the guest weekly for 4 weeks. R99's weights and vitals summary shows she was weighed on 12/12/22, and 1/19/23. No weights were documented for a daily weight or weekly weight as ordered. 1.E. R124's face sheet showed a 59-year-old	S9999		

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S9999	Continued From page 15 male with diagnoses including severe protein calorie malnutrition, sepsis, malignant neoplasm of the anus and rectum, gastrostomy, colostomy, and metabolic encephalopathy. R124's weight record showed a 11/3/22 weight of 112 pounds. This record showed he was 70 inches (5 foot 10 inches) tall. R124's 12/2/22 weight was 103 pounds, and 8% weight loss in one month. There was no January weight on record. R124's nutritional care plan showed no new interventions since it was initiated on 10/23/22. Interventions included weigh at the same time of day monthly and as needed and record. 1.F. On 1/24/23 at 10:49 AM, R35 was lying in bed on his back with his feet crossed. R35 had contractures to his bilateral upper extremities at his elbows, wrists, and hands. R35 appeared frail and the outlines of his bones were prominent. R35 had thickened water and orange juice on his bedside table. R35 said he had to drink thick liquids because he choked and ended up with pneumonia. R35's catheter drainage bag contained dark amber urine. R35's face sheet dated 1/25/23 showed diagnoses to include, but not limited to Parkinson's Disease; influenza; RSV (respiratory syncytial virus); sepsis; COPD (chronic obstructive pulmonary disease); CHF (congestive heart failure); osteoarthritis; depression; anxiety; need for assistance with personal care; dementia; and insomnia. R35's facility assessment dated 1/2/23 showed he was cognitively intact; was setup and supervision for eating; and had a Stage III	S9999		

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S9999	Continued From page 16 pressure ulcer. R35's Weights and Vitals Summary printed 1/25/23 showed on 10/17/22 he weighed 141.3 pounds and on 11/14/22 he weighed 135 pounds (demonstrates a 4.46% weight loss in 1 month). R35's weight summary showed that his weight was trending down over the last year. R35 did not have any weights entered after 11/14/22. R35's Physician Order Sheet dated 1/25/23 showed he had orders for nectar thick liquids; a frozen nutritional treat BID (2 times a day) at lunch and dinner; and nutritional shake supplement TID to support weight gain. R35's Care Plan (initiated 7/7/21) showed, "The resident is at risk for malnutrition per Mini Nutrition Assessment score of 9. Potential for weight changes d/t (due to) disease processes of Parkinson's Disease, dementia, and major depressive disorder. On nectar thick liquids secondary to dysphagia... Reviewed 11/23/22... Interventions: Assist with feeding resident as needed... Monitor weight monthly or per facility protocol..." R35s 11/23/22 Dietary Assessment showed he was at risk for malnutrition and underweight. A gradual weight loss and fluctuation is noted..." On 1/26/23 at 11:24 AM, V11 (Dietician) said she just started covering the facility on 1/17/23. V11 stated, "I saw a lot of problems at the facility and missing weights. The weight trends are based on the information entered in to the EMR (Electronic Medical Record). If a weight was not done, then the weight trends will not be accurate. I usually print a report when I go the facility. If I notice that weights haven't been done, then I follow-up with	S9999		

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emails and phone calls to management. Sometimes the weights get done and sometimes they don't. It's been difficult to get weights at the facility. It's very frustrating. I can't calculate appropriate dietary recommendations for the resident without appropriate weights and resident information. The EMR calculates the weight loss and will show a trigger when significant weight loss occurs. It doesn't notify me or the staff of weight loss, but it will show up when you print the report. The facility staff does not regularly contact me about weight loss. The front-line staff are the most valuable source of information related to a residents' intake and weights. I try to see residents with significant weight changes as soon as possible. If the resident hasn't had a weight done in 2 months, then I would have no way of knowing if they have experienced a significant weight loss. I enter my recommendations directly into the EMR and I expect those interventions to be completed."

2.A.R224's face sheet showed a 45-year-old male with diagnoses of pneumonitis due to inhalation of food and vomit, dysphagia, cerebral infarction, sepsis, diabetes, hypertension, spinal stenosis, gastrostomy and myocardial infarction.

On 01/24/23 at 11:34 AM, R224 was lying flat in bed. R224 was receiving a tube feeding at 90 milliliters (ml)/hour (hr) through a pump. The tube feeding container's label showed the solution was started at 3:00 AM.

At 01:16 PM, R224 was supine in bed. The tube feeding pump was off and the tubing was still attached to R224. There was tube feeding solution in the tubing.

On 01/25/23 at 09:58 AM, R224 was lying flat in

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bed. R224 was receiving a tube feeding 1.5 at 51 ml/ hr. The feeding solution label showed the tube feeding was started at 3:40 AM.

On 01/26/23 at 09:26 AM, V3 (Director of Nursing/DON) said "A resident receiving a tube feeding should be in an upright position to prevent aspiration. No one with aspiration precautions should receive a tube feeding while lying flat in bed because I don't want them to choke."

On 01/26/23 at 11:24, V11 (Dietician) said "The staff doesn't contact me regularly about consults or weight loss trends. I see residents as soon as significant weight change noted. When I see them (the residents), I put recommendations directly in the orders so everyone can see. If I order it, then I'm expecting every one to be done. I do the calorie recommendations. They don't have the types of feedings that I want to use, so they are having to do substitutions. As long as the resident is receiving a higher calorie content feeding (1.5 is > 1.2) then it is fine to stay at the same rate. There wouldn't be a problem. But if they substitute for a lower calorie feeding, then the rate would need to be adjusted to meet the calorie needs. I expect the substitutions to be temporary. I order a certain formula because that is what is best for the resident. If the facility cannot obtain that specific formula, then they should tell me. I will need to do additional calculations for the feeding available. I expect the tube feedings to run at the rate I have ordered. The rate is determined by the calorie needs of the residents. If it is running slower, then the resident is not getting all the necessary calories required. This could lead to weight loss and be detrimental to wound healing. The rate and timing of the tube feeding is all determined by the calorie calculations. I would expect that the residents

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received their tube feedings at the appropriate times to ensure they are getting adequate nutrition. A resident on tube feeding should not be malnourished. If the tube feeding is not hung at the appropriate times, then that would be a problem. They should be following the schedule. And if they are not, then I should be notified.

R224's physician order sheet (POS) showed a 1/17/23 order for {Name brand} 1.2 at 90 ml/hr, on at 10:00 AM and off at 7:00 AM.

R224's weight record showed a December 12/7/22 weight of 162.8 pounds. R224's 1/6/23 weight was 150 pounds, a significant weight loss of 12.8 pounds.

R224's care plan showed a significant weight loss of 7.9% in one month. There were no new care plan interventions after the significant weight loss was recorded.

R224's 1/9/23 facility assessment showed moderate cognitive impairment. This assessment showed he was totally dependent for bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and bathing.

R224's care plan initiated 12/13/22 showed the resident needs the head of the bed elevated 45 degrees during and 30 minutes after tube feed.

The facility's 12/2011 Enteral Nutrition Policy documents "Adequate nutritional support through enteral feeding will be provided to residents as ordered. Risk of aspiration will be assessed and addressed in the individual care plan. Risk of aspiration may be affected by diminished level of consciousness, moderate to severe swallowing difficulties, and improper positioning of the

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S9999	Continued From page 20 resident during feeding." 2.B. R137's Admission Record printed by the facility on 1/26/23 showed she had diagnoses including hemiplegia and hemiparesis following a cerebral infarction (paralysis and weakness affecting one side following a stroke), dysphagia (difficulty swallowing foods or liquids), following cerebral infarction aphasia (a disorder that affect how you communicate. It can impact your speech, as well as the way you write and understand both spoken and written language), and gastrostomy status (g-tube). R137's facility assessment dated 11/4/22 section C does not show a BIMS (Brief Interview for Mental Status) score. The assessment showed R137 had modified independence with her cognitive skills for daily decision making. The assessment also showed R137 was dependent on staff for eating (includes intake of nourishment by tube feeding). R137's Order Summary Report, provided by the facility on 1/26/23, showed Enteral Feed Order every shift {Name brand} 1.2 at 77 cc/hr (cubic centimeter an hour-cc measurement is the same as ml measurement) x 21 hours. R137's care plan initiated on 11/4/22 showed she requires tube feedings of {Name brand} 1.2 related to dysphagia. The care plan showed "Provide GTF (g-tube feedings) as ordered." The care plan also showed "RD (Registered Dietitian) to evaluate quarterly and PRN (as needed). Monitor caloric intake, estimate needs..." R137's cognition care plan initiated on 11/5/21 showed she had impaired cognitive function/dementia or impaired thought processes related to difficulty making decisions, disease process cerebral infarction, impaired decision making. R137's Weights and Vitals Summary, provided by the facility on 1/26/23, showed a 3.4 pound weight loss from 1/20/22-12/15/22. R137's most recent Registered	S9999		

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S9999	Continued From page 21 Dietitian (RD) assessment was requested three times. R137's last name was spelled when requested two of the times. The RD assessment for two different residents were provided. R137's RD assessment was not provided. On 1/24/23 at 1:52 PM, R137's tube feeding showed it was started at 4:00 AM. The container was a 1,500 ml (milliliter) container. The pump that delivers the tube feeding showed it was running at 70 ml/hr (milliliters an hour). The container still had 1,320 ml in the bottle. V33 (Licensed Practical Nurse/LPN) verified the bottle showed it was started at 4:00 AM. V33 said it is a 1500 ml container running at 70 ml/hr. V33 said the order is 70 ml/hr continuous for 21 hours. V33 said the bottle showed 1,320 ml were still in the bottle. V33 said the feeding is stopped during R137's bed bath, when flushing the g-tube and when giving medications. V33 was not able to explain why there was such a discrepancy in the amount that should have already been delivered (if three hours was subtracted, due to being ordered for 21 hours, that would still leave six hours and 52 minutes that should have been delivered. 7 times 70 equals 490 ml. 1500-490 equals around 1,010 ml that should be left in the bottle). On 1/26/23 at 11:04 AM, R137's tube feeding bottle showed {Name brand} 1.5 running at 70 cc/hr. The bottle showed it was started on 1/25/23 at 11:00 PM. 560 ml of feeding was still left in 1,000 ml bottle. (If started at 11:00 PM on 1/25/23 and three hours is subtracted for down time, that leaves 9 hours the feeding should have been delivered. 9 x 70 ml/hr = 630 ml that should have been delivered. The bottle showed only 440 ml had been delivered since 11:00 PM on 1/25/23).	S9999		

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2.C. R111's Admission Record, provided by the facility on 1/26/23, showed she had diagnoses including dementia, Alzheimer's disease, dysphagia (difficulty swallowing foods or liquids), protein-calorie malnutrition, and gastrostomy status (g-tube). R111's facility assessment dated 11/28/22 showed she had severe cognitive impairment and was dependent on staff for eating (includes intake of nourishment by tube feeding). R111's care plan initiated on 12/20/21 and last updated on 10/8/22 showed R111 requires tube feedings of {Name brand} 1.2 at 65 ml x 21 hours. The care plan documented R111 is dependent with tube feeding and water flushes. The care plan also showed RD (Registered Dietitian) to evaluate quarterly and PRN (as needed); monitor caloric intake, estimate needs, make recommendations for changes to tube feeding as needed. R111's RD assessment dated 12/27/22 showed Tube feeding {Name brand} 1.2 at 65 ml/hr x 21 hours a day. On at 10:00 AM, off at 7:00 AM. The assessment showed R111's current enteral (tube) feeding provides 1,430-1,716 kcal/ml fluid per day (kcal is short for kilocalories, which is another word for calories). R111's Order Summary Report, printed by the facility on 1/26/23, showed an order for Enteral Feed Order every shift administer feeding. Formula {Name brand} 1.2. Rate 65 ml per hour x 21 hours a day. Off at 7:00 AM. On at 10:00 AM.

On 1/24/23 at 11:05 AM, R111 was lying in bed with head of bed up. The tube feeding bottle showed she was receiving {Name brand} 1.5 at 65 ml/hr. The container showed it was started at 4:00 AM. 890 ml were left in the 1,000 ml container. V16 (Nurse) verified {Name brand} 1.5 container showed it was started at 400 AM on 1/24/23. V16 verified that there was 890 ml in the container at that time and the pump was running

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S9999	Continued From page 23 at 65 ml/hr. V16 said it should have less in the container if it was started at 4:00 AM and it is now 11:05 AM. V16 said it should have delivered 260 ml. V16 said it should have about 760 ml in the container. On 1/25/23 at 9:41 AM, R111's tube feeding was {Name brand} 1.5. The machine was off. The bottle showed it was started at 1:47 AM. There were 840 ml left in the 1,000 ml bottle. (If started at 1:47 AM and stopped around 7:00 AM, that would be around 5 hours. 5 x 65 = 325 ml that should have been provided. The bottle showed only 160 ml were delivered). On 1/26/23 at 11:24 AM, V11 (Registered Dietitian) said she does the calorie recommendations. V11 stated "They don't have the types of feedings that I want to use, so they are having to do substitutions. As long as the resident is receiving a higher calorie content feeding (1.5 is > 1.2) then it is fine to stay at the same rate." V11 said she expects the tube feedings to run at the rate she has ordered. The rate is determined by the calorie needs of the residents. If it is running slower, then the resident is not getting all the necessary calories required. This could lead to weight loss and be detrimental to wound healing. The rate and timing of the tube feeding is all determined by the calorie calculations. V11 said she would expect that the residents received their tube feedings at the appropriate times to ensure they are getting adequate nutrition. If the tube feeding is not hung at the appropriate times, then that would be a problem. They should be following the schedule. V11 said if they are not, then she should be notified. Facility Enteral Nutrition policy, with a revision	S9999		

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S9999	Continued From page 24 date of December 2011, showed "Adequate nutritional support through enteral feeding will be provided to residents as ordered." 2.D. On 1/24/23 at 11:19 AM, R45 was lying in bed with his tube feeding running at 65 ml/hr by pump. The tube feeding bottle was dated 1/24/23 at 3 AM. R45's lips and oral mucous membranes appeared dry and crusty. On 1/26/23 at 10:18 AM, V20 (Licensed Practical Nurse) stated "R45's tube feeding is on hold right now, but I believe it was running at 65 ml/hr. I can go check." V20 entered R45's room and turned the feeding pump on. The tube feeding was set at 65 ml/hr. The surveyor asked V20 why R45's Medication Administration Record (MAR) showed two different rates (65 ml/hr and 80 ml/hr). V20 replied, "I'm not sure, I would have to look." V20 opened the MAR, saw both orders, but did not clarify the answer any further. R45's face sheet printed 1/25/23 showed diagnoses to include, but not limited to acute respiratory failure, aspiration pneumonia, sepsis, diabetes, unspecified convulsions, iron deficiency anemia, schizoaffective disorder, dementia, reduce mobility, need for assistance with personal care, severe protein-calorie malnutrition, osteoarthritis, dysphagia, stroke, and muscle wasting and atrophy. R45's facility assessment dated 1/9/23 showed he had moderate cognitive impairment; was totally dependent on staff for bed mobility, transfers, toilet use, and personal hygiene; was always incontinent of bowel and bladder; and pressure ulcers. R45's Weight and Vitals Summary printed	S9999		

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NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

(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 25 1/25/23 showed on 1/17/23 R1 weighed 140 pounds. R45's Braden Scale for Predicting Pressure Sore Risk dated 1/13/23 showed R45 was at "High Risk," with a score of 11. R45's Physician Order Sheet showed an order on 1/17/23 of {Name brand formula} 1.2 at 80 ml/hr x 21 hours. R45's January 2023 MAR showed, "Enteral Feed Order every shift {Name brand} 1.2 at 65 ml/hr x 21 hours/day (start date - 1/13/23). This entry was signed out as administered as ordered. However below this entry, the MAR showed, "Enteral Feed Order every shift {Other Name brand} 1.2 @ 80 ml/hr (Start date 1/17/23). This order was only signed out on 1/25/23 and once for the day shift of 1/26/22, by V20 (LPN). V20 could not explain why. On 1/26/23 at 11:24 AM, V11 (Dietician) said she uses the weights and the residents current tube feeding order to determine if the resident is receiving adequate calories and nutrition. V11 stated "I expect the tube feeding formula and rate to be correct. If it's not, then the resident is not receiving the nutritional needs that I assessed. If the rate is running too slow, then the resident is not getting all the calories needed. This could lead to weight loss and be detrimental to wound healing. The rate and timing of the tube feeding are determined by the residents' caloric needs. If the facility is not following the orders, then they should be notifying me. This is very frustrating." (B)	S9999		