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| S 000 | Initial Comments<br><br>FRI of 5/26/2023\IL160569 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations 1of 2<br><br>1.<br><br>300.610a)<br>3001210b)<br>300.1210c)<br>300.1210d)6<br>300.3210t)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>Section 300.3210 General<br><br>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These Requirements were not met as evidenced by:<br><br>Failures at this level required more than one | S9999 | | |

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| S9999 | Continued From page 2<br>deficient practice statement.<br><br>A. Based on observation, interview, and record review the facility failed to protect a resident's (R9) right to be free from physical and mental abuse by V24 Certified Nurse's Assistant (CNA) and V25 CNA. This failure resulted in V24 and V25 taking away R9's walker, hiding it from R9, pushing R9, striking R9 on the arm, and then hitting R9 forcefully in the face with a clothing protector, resulting in R9 having a catastrophic reaction in which R9 became combative with V24 and V25 and R9 being removed from the facility by emergency services and taken to the emergency room.<br><br>B. Based on observation, interview, and record review the facility failed to protect resident's rights to be free of physical and verbal abuse by other residents by failing to supervise and implement behavioral interventions for wandering and physically aggressive behaviors for seven of seven residents (R2, R3, R6, R7, R8, R9 and R10) reviewed for abuse on the sample list of ten. These failures resulted in the repetitive physical abuse of R3 by R8, R9, and R10, and R3 being hit, punched, and pushed down. These failures also resulted in R6 physically attacking R7 by punching R7 in the head and pulling R7's hair, and then striking R2 on the arm. This failure has the potential to affect all 77 residents residing in the facility. These failures resulted in R3 being pushed to the ground by R8 and R3 sustaining a laceration to the back of the head which required emergency medical services and four staples to close the laceration. These failures also resulted in multiple occurrences of resident-to-resident physical abuse in which residents were hit, punched, and pushed down to the ground by other residents. These altercations could result in | S9999 | | |

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| S9999 | Continued From page 3<br>serious bodily injury and harm.<br><br>Findings include:<br><br>a.<br><br>The facility's video footage dated 6/3/23 at 5:07 PM, shows R9 sitting at a table eating dinner. R9's back is to the camera and there is no sound to this video footage. R9 is moving her hand across the table and is appearing to clean up something off of the table. V24 Certified Nurse's Assistant (CNA) walks over to R9's table and starts to wipe off the table with a clothing protector. R9 starts to grab at the clothing protector and knocks it off onto the floor. V24 then grabs R9's right hand squeezing it and walks away to the other side of the room. R9 continues to clean up the table when V24 walks over with towels. R9 tries to grab at the towels and V24 starts grabbing and squeezing R9's hands. V25 (CNA) then walks up to table and R9 begins hitting V24 on V24's backside. V24 then grabs R9's hand again and took something out of R9's hands. V25 removes dishes that are in front of R9 and when walking away pushes R9's walker away from the side of R9's table. R9 then stands up and grabs the walker. R9 walks with the walker over to V24 and V24 pushes R9 back with both hands and walks away from R9. R9 then grabs some paper towels and walks back to table to sit down. V24 then approaches R9 and attempts to grab something away from R9 and walks away. V25 then removes a roll of toilet paper off of R9's walker. V25 then folds R9's walker up and puts it in a room attached to the dining room and stands directly in front of the door obstructing R9's ability to get into the room to the walker. R9 then stands up to find the walker. V25 is noted to be saying something to R9 and begins moving both hands | S9999 | | |

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| S9999 | Continued From page 4<br><br>in a swatting motion at R9 while blocking R9's ability to get to the walker. R9 then hits V25 on the shoulder. V25 then swings her arm and hit R9's left shoulder with her fist. A un-identified nurse attempts to intervene and V25 drops her cell phone on the floor and R9 hits V25's back with a clothing protector. V25 then takes the clothing protector off her back and with a very forceful motion swings the clothing protector into the air and strikes R9 in the face and chest with the clothing protector. R9 is then taken out of the room by the unknown nurse and V24.<br><br>On 6/8/23 at 12:15 PM, V24 stated there was an incident with R9 on 6/3/23 in the dining room. V24 stated R9 was upset that other residents in the dining room had been given soda pop but not her. V24 stated that caused R9 to squeeze a cup of soda for another resident and spill it onto the table. V24 confirmed that V24 grabbed R9's hands and put up her hands to push R9 away from her. V24 stated after R9 hit V25 with the clothing protector. V24 and the un-identified nurse then helped R9 to her room. V24 stated she is new to the facility and was not trained for the Dementia unit and did not know R9's behavior plan of care.<br><br>On 6/8/23 at 12:35 PM, V25 stated on 6/3/23 there was an incident with R9 in the dining room. V25 stated V24 was attempting to clean the dining room when R9 became combative. V25 stated she attempted to intervene and to get R9 to come out of the dining room. V25 stated after R9 hit her, V25 reached her arm out but didn't mean to hit R9 and then after R9 hit her with the clothing protector and she grabbed it and swung it and it hit R9 in the face. V25 stated V24 and an un-identified nurse had to make R9 go to her room and R9 continued to be physically | S9999 | | |

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| S9999 | Continued From page 5<br>aggressive and fighting the staff until the police showed up. V25 stated she is new to the facility and was not trained for the Dementia unit and did not know R9's behavior plan of care.<br><br>V24 and V25's employee files provided by V2 Administrator in Training did not contain documentation that V24 and V25 were trained on Dementia management and resident abuse.<br><br>R9's Discharge Instructions for Emergency room visit on 6/3/23 provided by V21 Corporate Nurse document R9 was seen in the Emergency room for agitation and aggressive behaviors related to Dementia.<br><br>V24 and V25's employee file provided by V2 Administrator did not include training for Abuse Prevention.<br><br>The facility's fax to the state agency written by V2 Administrator dated 6/3/23 at 8:01 PM documents, alleged physical altercation between staff and resident.<br><br>On 6/7/23 at 10:15 AM, V6 Dementia Unit Coordinator stated she took over five days ago. V6 stated she is not sure about the behavior tracking or behavior programs for the residents yet.<br><br>On 6/7/23 at 11:16 AM, V2 Administrator in Training stated the incident on 6/3/23 happened around dinner time. V2 stated someone at the facility called and reported that a CNA had swung at a resident. V2 stated she went into the building and had V24 and V25 go home. V2 stated the police were already at the building. V2 stated the next day V2 reviewed the video footage and V2 confirmed that V25 hit R9. | S9999 | | |

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R9's careplan with a revision date of 5/4/23 documents R9 has the potential to be verbally aggressive due to Dementia. This care plan includes an intervention to walk away from R9 if R9's response to staff is aggressive.

b.

1.) R3's care plan with a revision date of 10/7/22 documents R3 has a diagnosis of Dementia, wanders, and has a disregard for personal spaces. This care plan documents R3 as having severe cognitive impairment.

On 6/7/23 at 10:54 AM, R3 was walking up and down the hallways and going up to staff, other residents, and visitors touching their arms, jewelry, and shirts. R3 was noted to have staples to the back of her head.

R3's Incident note dated 4/4/2023 at 10:37 AM, written by V17 Licensed Practical Nurse documents, "Writer made aware by staff resident was struck with a walker by (R9). Upon assessment, (R9) stated "(R3) was in my room and (R9) wanted (R3) out." (R3) escorted from (R9's) room."

R3's Incident note dated 5/7/2023 at 7:30 PM documents, R3 was hit in the chest by R10 and R3 fell onto floor hitting her head.

R9's care plan dated 4/11/23 documents R9 has a diagnosis of Dementia and has the potential for verbal and physical behaviors. This care plan did not include a revision or update after the incident on 4/4/23.

R3's Incident note dated 5/7/2023 at 7:30 PM

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written by V16 Licensed Practical Nurse (LPN) documents, "(R3) was hit in the chest by (R10) and fell onto floor hitting her head."

R10's careplan dated 4/11/23 documents R10 has a diagnosis of Dementia and has the potential to become physically aggressive with staff due to Anger, Depression, Dementia, and poor impulse control. This careplan does not include a revision after the 5/7/23 incident with R3 until 6/3/23.

R8's Behavior Note dated 5/24/2023 at 6:06 PM, written by V19 LPN documents, "(V19) was informed by staff that (R8) throat-punched one of the (R3) on the unit; (V3, Director of Nursing) notified."

R8's Behavior Note dated 5/28/2023 at 1:17 PM written by V18 LPN documents, "(R8) observed by staff to have pushed another (R3), (R8) is agitated and redirected to his room for monitoring." Hospital Records dated 5/28/23 document R3 received four staples to a head wound after R3 fell (was pushed down by R8) on 5/28/23.

R8's care plan dated 5/3/23 documents R8 has a diagnosis of Dementia and poor impulse control and can become verbally aggressive to staff. This care plan does not include a revision after R8 "throat punched" R3 on 5/24/23 or after R8 pushed R3 to the ground on 5/28/23 until 6/8/23.

On 6/7/23 at 10:48 AM, V19 Licensed Practical Nurse stated R8 doesn't like R3 because she walks around and is in other peoples' personal space and is touching others. V19 stated "I don't remember who but on 5/24/23 a staff member told me that (R8) had throat punched (R3)." V19

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stated "I text (V3 Director of Nursing) but she never responded back. No one told us of any new behavioral interventions for (R8) or what to do to prevent (R3) from getting into people's space. (R8) is aggressive to staff and his family also. I know there were medication changes after he pushed her down on 5/28/23 but I don't know anything else besides that."

On 6/7/23 at 10:23 AM, V2 Administrator in Training stated the facility's interdisciplinary team meets in the morning to go over incidents. V2 stated V2 did not know about the incidents occurring on 4/4/23, 4/11/23, or 5/24/23 until the incident occurring on 5/28/23 between R8 and R3. V2 stated the facility did not put in new behavioral intervention or increase supervision of R3.

2.) On 6/5/23 at 1:45 pm, V8 Agency CNA (Certified Nursing Assistant) stated R6 has shown behaviors towards female residents and explained, R6 had physical contact and verbal outburst towards R7 and R2 both, just a few days apart from one another. V8 stated V8 was at the facility on both occasions. V8 stated, the first time was a week or two ago while V8 was sitting at the nurses station and R6 was sitting in R6's wheelchair in the hall across from the nurses station. V8 explained that R2 was trying to get by R6 but R6's foot was sticking out. R2 said "excuse me, can you please move your foot {talking to R6}" and the next thing V8 heard was R2 say "Ouch, you didn't have to do that," V8 stated then V8 heard R6 say, "you (expletive)!" V8 stated V8 stood up and asked what happened and R2 reported that R6 had hit R2 on the hand. V8 stated R2 had no bruising or even redness but V8 immediately separated R2 and R6 and reported it to V9 RN (Registered Nurse), and

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gave a written statement. V8 explained "a couple of days later, (V8) was across the hall from (R6's) room and (R7) was sitting outside of (R6's) room with (R7's) back to (R6's) door. Next thing (V8) knew, (V8) heard (R6) yelling "I (R6) told you to stay the (expletive) away from me" and then started hitting R7 in the back of the head and by R7's ear. V8 stated V8 immediately separated them both and reported the abuse. V8 explained in the past, R6 and R7 use to live next to each other and would constantly go after each other so the facility had to move them to separate halls.

The facility provided an initial abuse investigation dated 5/26/23 documenting a resident to resident altercation that included witness statements for the abuse between R6 and R7 but the facility did not provide an initial abuse investigation involving R6 and R2.

On 6/5/23 at 2:05 pm, R6 was outside smoking, then propelled R6's self back into the facility and sat across from nurses station.

On 6/5/23 at 2:05 pm, AIT (Administrator in Training) stated V2 was the Abuse Coordinator and explained R6 and R7 have a history between them and situations like this have happened previously, before V2 started working at the facility in March 2023. V2 stated there was no abuse allegation between R6 and R2 that V2 is aware of. At this time, V3 DON (Director of Nursing) was present and stated that V3 was aware of R6 hitting R2 on the arm and getting verbally aggressive with R2 because it was reported to V3 but that the unidentified staff that reported it said they had already made V2 aware of it.

On 6/6/23 at 9:05 am, V2 AIT stated V2 does

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indeed remember hearing about a physical abuse allegation between R6 and R2 but got the allegation confused and didn't realize that R6 had been involved in two separate abuse allegations, V2 thought the staff was talking about the abuse between R6 and R7. V2 stated the physical abuse between R6 and R2 happened on 5/27/23.

R6's MDS (Minimum Data Set) dated 4/10/23 documents R6 is non-ambulatory but requires supervision only with locomotion.

On 6/7/23 at 9:00 am, R6 was propelling R6's self throughout the facility in R6's wheelchair without supervision.

R6's Progress Notes dated 5/31/23 by V26 Behavioral NP (Nurse Practitioner) document R6 has a diagnosis of Vascular Dementia secondary to multiple CVA's (Cerebrovascular Accident's) with Right Sided Hemiparesis, Neurogenic Bladder, Aphasia. History of Schizoaffective Bipolar with ongoing issues with verbal outbursts and making false allegations and threats towards his peers and staff. He will curse people out or threaten to "kill them." or "call state." R6 had required medications adjustments due to R6's behaviors and upon follow up, it was reported that R6 had another violent incident with a female peer (R7). R6 was not happy that R7 was near R6's doorway and grabbed R7 by the hair. R6 admitted to the incident but stated "(R6) didn't care because (R6) didn't want (R7) near (R6)."

On 6/5/23 at 10:45 am, R7 was lying in bed. When asked questions regarding the abuse allegation between R6 and R7, R7 responded with "LaLaLa."

R7's Care Plan dated 2/20/23 documents R7 has

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impaired expressive communication related to CVA and can only speak a few words.

R7's Progress Notes dated 5/31/23 by V26 document R7 has a diagnosis of Vascular Dementia secondary to CVA with Right sided Hemiparesis and new onset behaviors of agitating R7's peers. The Notes state that R7 likes pushing R7's self into peers' rooms and got R7's hair pulled for refusing to leave, over the weekend. The Notes state that R7 has been impulsive and will touch peer's or go up to them and chat "la-la-la."

On 6/7/23 at 9:10 am, R2 was lying in bed and stated "a week or so ago," R2 was trying to propel R2's self down the hall to get R2's laundry from the laundry room and a "overbearing man" (R6) was sitting by the nurses station with (R6's) foot sticking out. R2 explained R2 asked R6 several times to please move R6's leg but R6 didn't so R2 tried to go by R6 and R6 hit R2 on the wrist. R2 stated "It hurt bad but didn't leave a bruise." R2 stated "staff was at the nurses desk and immediately came around to check what was going on and separated us." R2 stated R2 doesn't remember the exact date explaining, "I'm 96 and my memory isn't what it use to be."

On 6/7/23 at 10:23 AM, V2 Administrator in Training stated no one reported the physical abuse of R3 by R8, R9, and R10 that occurred on 4/4/23, 4/11/23, or 5/24/23 to her so the incidents were not investigated and the state agency, adult protective services, or local law enforcement were notified. V2 stated that after the incidents no new interventions were put into place to prevent further abuse.

On 6/7/23 at 10:54 AM, V20 Certified Nurse's

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| S9999 | Continued From page 12<br>Assistant stated R8 is physically aggressive and no one has told him about a behavioral plan for R8.<br><br>The facility Abuse Prevention Program dated 11/28/16 documents this facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined. Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, or saying things to frighten a resident, such as telling a resident that he/she will never be able to see family again. Mental Abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s), harassment, humiliation and threats of | S9999 | | |

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| S9999 | Continued From page 13<br>punishment or deprivation.<br><br>The Nurse's Midnight Census dated 6/4/23 documents there are 77 residents residing in the facility.<br><br>(B)<br><br>2 of 2 Violations<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)2<br>300.1210d)3<br>300.1210d)5<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care | S9999 | | |

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| S9999 | Continued From page 14<br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>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.<br><br>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. | S9999 | | |

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| S9999 | Continued From page 15<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These Requirements were not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to: develop and implement a care plan for a resident at high risk for skin breakdown, ensure proper nutrition and hydration via a jejunostomy feeding tube, ensure patency of the jejunostomy tube to prevent dehydration and promote wound healing, implement pressure relieving interventions, and completed pressure ulcer treatments as ordered for a resident. These failures affect one (R1) of three residents reviewed for pressure ulcers on the sample list of ten. These failures resulted in R1 becoming dehydrated and developing an infected stage III pressure ulcer requiring hospitalization for treatment. R1 also required surgery to replace a nonpatent enteral feeding tube.<br><br>Findings Include:<br><br>The facility Decubitus Care/Pressure Areas Policy dated January 2018 documents it is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer. A stage III pressure ulcer is described as broken skin, affecting full thickness and presents as a deep crater. Upon notification of skin breakdown, 4) notify the physician for treatment orders. 7) Nursing personnel are to notify dietary personnel | S9999 | | |

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| S9999 | Continued From page 16<br><br>of any pressure areas to seek nutritional support. 8) When a pressure ulcer is identified, additional interventions must be established and noted on the care plan in an effort to prevent worsening or re-occurring pressure ulcers.<br><br>The facility Enteral Feedings Policy dated April 2016 documents 3. each tube feeding order may contain the following information: formula name, method of administration, route (site of entry), rate of feeding, time of feeding, flush volume and times, and additives. 5. The dietitian shall be notified of each new admission or re-admission of tube-fed residents. The dietitian will provide a tube feeding assessment and any applicable recommendations to nursing staff at the facility within 72 hours of admission. Nursing staff will relay the dietitian's recommendations to the physician. 10. Physician order for pre-med and formula administration flushes will be sought. 11. A record of daily intake of the tube feeding and the flushes for the resident will be kept by the nursing department. 12. Placement of the tube will be confirmed via aspiration of residual. If unable to confirm placement via aspiration, air instillation method may be used. 23. Residents receiving a tube feeding shall have an appropriate care plan developed.<br><br>R1's MDS (Minimum Data Set) dated 5/6/23 documents R1 was admitted to the facility on 4/29/23 with severe cognitive impairments, has slurred speech and is rarely able to make R1's self understood, has no skin impairments but is at risk for skin breakdown, requires extensive assist of two staff for bed mobility, has not transferred in the past seven days {out of bed}, and receives enteral tube feedings.<br><br>R1 does not have a care plan for R1's risk of skin | S9999 | | |

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| S9999 | Continued From page 17<br>breakdown or for any pressure relieving interventions.<br><br>On 6/6/23 at 10:32, V29 MDS/Care Plan Coordinator stated "residents with feeding tubes and pressure ulcers should have that care planned." V29 confirmed R1 does not have a care plan for his enteral feedings, risk of skin breakdown or actual pressure ulcer explaining, with switching to computerized charts, "I'm a little behind."<br><br>R1's ongoing medical record Diagnosis List documents the following diagnoses: Traumatic Hemorrhage of the Right Cerebrum, Encephalopathy, Dysphagia, and Autism.<br><br>R1's Hospital Discharge Orders/Facility Admission Orders dated 4/29/23 documents an order for an enteral tube feeding of Jevity 1.5 70 ml (milliliters) per hour for 14 hours. There were no free water flushes included on the hospital discharge orders, however there was a handwritten note that documents 350 ml QID (four times a day) next to the enteral feeding order.<br><br>On 6/6/23 at 10:15 am, V10 Corporate Nurse stated V10 assumes that 350 ml QID is the flush order, but "the nurses should have called to clarify" that with V12 (R1's Physician). At this time, V10 also stated that R1 should have been assessed by V14 RD (Registered Dietitian) within 72 hours of admission.<br><br>R1's medical record does not document V12 Physician was contacted to clarity R1's enteral feeding order or to obtain an order for free water flushes. The only nutritional assessment in R1's medical record is dated 6/4/23 {36 days after | S9999 | | |

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admission). R1's Nutritional Assessment by V14 RD documents R1 has MASD (Moisture Associated Skin Damage) to the right and left inner buttocks and left lower buttock. Estimated nutritional needs are 1980 calories, 86 gm protein, and 1980 ml fluids. R1's increased needs estimated to maintain weights and promote wound healing. At this time, V14 suggests to increase tube feeding to Jevity 1.5 at 70 ml per hour for 16 hours. If tolerating after 48 hours, increase it to 18 hours. Again if tolerating after 48 hours, increase it to 20 hours feeding time and to decrease water flush to 350 ml water QID.

On 6/6/23 at 10:46 am, V14 RD confirmed the 6/4/23 nutritional assessment for R1 was the first time V14 had assessed R1's nutritional needs. V14 explained, V14 comes to the facility once a month and when V14 was in the facility on 5/30/23, R1 was in the hospital, so R1 was not able to be assessed at that time. V14 stated, when a resident with a feeding tube is admitted to the facility, the facility should obtain a correct height and weight on the resident and notify V14 so an assessment can be completed to ensure the resident is receiving the required nutrition and hydration. V14 stated nobody at the facility reached out to V14 with that information or to alert V14 of having a resident (R1) with a feeding tube until V14 was in the facility on 5/30/23. V14 stated when R1 developed the pressure ulcers on 5/19/23, the facility should have alerted V14 of the change in condition so that additional recommendations could be made, but that didn't happen either.

R1's Order Summary Report dated 6/5/23 documents an order dated 4/30/23 for an enteral feeding of 70 ml (milliliters) per hour one time a day for a diagnosis of Dysphagia, to start on

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| S9999 | Continued From page 19<br><br>5/1/23 {2 days after admission}. There is no free water flush orders until 5/31/23 {32 days after admission}. The free water flushes are for 380 ml water QID (four times a day). This Order Summary documents a treatment order dated 5/19/23 to cleanse all wounds, apply Medihoney to the wound bed and apply hydrocolloid dressing and change three times a week on Monday, Wednesday and Friday and PRN (as needed) if the dressing is soiled or loose.<br><br>R1's medical record does not document any intake monitoring for R1's enteral tube feeding or free water flushes to show how much nutrition and hydration R1 was receiving.<br><br>R1's Progress Notes dated 5/19/23 documents R1 has a current skin issue including MASD (Moisture Associated Skin Damage) to three areas. R1's ongoing medical record Wound Measurements document R1 developed MASD to the Right inner buttock measuring 6.8 cm (centimeters) by 1.6 cm by 0.1 cm, left inner buttocks (lower) 2.3 cm by 1.0 cm by 0.1 cm, and left inner buttocks 5.3 cm by 0.9 cm by 0.1 cm.<br><br>There is no documentation in R1's medical record including R1's May 2023 TAR (Treatment Administration Record) and Progress Notes that R1's wound treatment was completed as ordered.<br><br>R1's Progress Notes dated 5/25/23 by V28 Agency LPN (Licensed Practical Nurse) documents {on 5/24/23} R1 appeared confused and drowsy and upon further assessment was found to be "in delirious state with both hands raise to grab imaginary object, (R1) appear(s) drowsy but still respond to verbal command. (R1's) eyes are red with discharge." R1 was sent to the hospital for evaluation. | S9999 | | |

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| S9999 | Continued From page 20<br><br>R1's Hospital History and Physical dated 5/25/23 by V11 Hospital NP (Nurse Practitioner) documents R1 has resided at the nursing facility for one month and during this time has become dehydrated and developed a stage III pressure injury that was not present upon admission. Upon physical exam, R1 appears chronically ill and poorly nourished with a stage III pressure ulcer to the buttocks and coccyx with green drainage. R1 was noted to be septic and was admitted to the hospital with the following Diagnoses: Acute Sepsis related to Pressure Injury, Dehydration, Critical Hypernatremia, Electrolyte Imbalance, Lethargy, and Raised Serum Creatinine.<br><br>R1's abnormal laboratory tests on 5/24/23, upon arrival to the hospital, were as follows: Sodium = 175 (normal is 135-145), BUN (Blood Urea Nitrogen) = 98 (normal is 8-25), Creatinine = 2.09 (normal is 0.7 - 1.5), BN/CR ( BUN/Creatinine ) = 46.89 (normal is 10-27), and WBC (White Blood Cell) Count = 13.5 (normal is 4.3 - 11).<br><br>R1's Hospital Physician Notes dated 5/31/23 by V11 documents R1 was brought into the hospital from a local nursing home due to being severely dehydrated with a critical sodium level of 175. R1 has a J-tube (jejunostomy tube) for enteral tube feeding of Jevity 1.5 to run at a rate of 70 ml per hour from 2:00 pm - 4:00 am with a 380 ml water bolus along with water flushes between medications. J-tube was replaced while at the hospital. R1 was septic upon arrival mostly likely due to the sacral pressure ulcer. Acute Kidney Injury was due to pre-renal and dehydration. After fluids were given, R1's Creatinine levels returned to normal. | S9999 | | |

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| S9999 | Continued From page 21<br><br>R1's Hospital Discharge Instructions dated 5/31/23 document to ensure adequate water is given during flushing of tube and in between medications, R1 to have an air mattress, and Barrier Cream to bottom with foam dressing to open stage 3 pressure ulcer.<br><br>On 6/6/23 at 11:05 am, V11 Hospital NP stated V11 is assuming R1 was not getting R1's feeding and/or water flushes explaining, "there is no way that (R1) could have gotten so dehydrated if they (facility) were giving (R1) the ordered fluids." V1 stated R1's J-Tube was totally blocked off so and wondered how long it was blocked off, explaining "that could have been why they were not giving fluids and/or feedings." V11 stated V11 had to have a surgeon come in and replace R1's J-tube. V11 also stated R1 had a "nasty sacral pressure ulcer, that (R1) hadn't had the month prior." R1's "eyes were sunken in and (R1) was very lethargic. I felt they had neglected (R1) by not giving (R1) these ordered fluids/feedings." V11 also stated, R1 "not getting the proper nutrition, hydration, turned, cleaned up and bathed" is what caused R1's pressure ulcer to develop and then become infected. R1 "should not have developed that pressure ulcer." R1 probably had MRSA (Methicillin Resistant Staphylococcus Aureus) in the wound, based on the appearance of the wound with green drainage, that's why R1 was given IV (intravenous) Zosyn {Antibiotic}. V11 explained upon discharge, V11 ordered R1 to continue using the foam dressing to the pressure ulcers, as it will adhere to the wound and has a soft cushion to it.<br><br>As of 6/5/23, R1's Physician Orders still document a treatment order of Medihoney and hydrocolloid to R1's pressure ulcers, not the foam dressing that was ordered at the time of hospital | S9999 | | |

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discharge on 5/31/23, or the order for an air mattress. These order now clarify the type of enteral tube feedings to be Jevity 1.5 but continues to order it at 70 ml per hour but does not document for how long, and also does not document flush orders or the recommendations of V14 from 6/4/23.

On 6/5/23 at 11:30 am, R1 was lying on R1's back in bed, on a regular mattress. At 11:45 am, V3 DON (Director of Nursing), V9 RN (Registered Nurse) and V8 Agency CNA (Certified Nursing Assistant) entered R1's room to complete the ordered dressing changes. R1 was rolled to right side to reveal a foam dressing taped to left buttocks, which was not dated. V9 removed the dressing to reveal a 7.3 cm by 2.0 cm beefy red open area to the left buttocks with a full thickness,deeper area, in the middle of it measuring 1.5 cm by 1.7 by 0.2 cm. V9 cleansed the wound, applied Medihoney to the wound bed and then covered the wound with a hydrocolloid dressing. V3 confirmed the wound treatment that was originally on the wound was not what was showing as the active order on the physician order sheets but wasn't aware of the order for a foam dressing from the hospital. R1 was positioned on R1's back with a wedge slightly under R1's left hip. At 1:40 pm and 2:20 pm, R1 remained in the same position. At both times, R1 had dried BM (Bowel Movement) smeared down R1's legs and across the top of R1's right leg.

On 6/5/23 at 2:25 pm, V10 stated there was no monitoring of R1's enteral nutritional and fluid intake because "nobody put the order in to do so. V10 also stated R1 should have been getting feeding/flushes per the admission orders.

On 6/6/23 at 8:58 am, 10:27 am, and 12:20 pm,

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| WATSEKA REHAB & HLTH CARE CTR | 715 EAST RAYMOND ROAD WATSEKA, IL 60970 |

| (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 23<br>R1 was sitting in a wheeled chair, reclined approximately 45 degrees, in the lounge across from the nurses station watching television. At 12:26 pm, V13 CNA stated V13 is assigned to R1 and that R1 was gotten up around 6:30 am {almost six hours prior} and placed in the chair. V13 stated V13 has not repositioned or toileted R1 since getting R1 up due to R1 being asleep every time V13 has checked on R1.<br><br>(B) | S9999 | | |