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	IL6003594	A. BUILDING: ______ B. WING ______	C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	**2451 WEST TOUHY AVENUE CHICAGO, IL 60645**

(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
S 000	Initial Comments Complaint Investigations 2389661/IL166888, 23810696/IL168124, and 23810498/IL167887	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610 a) 300.1210 b) 300.1210 d)2) 300.1210 d)5) 300.1220 b)3) 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	S9999		

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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:
2) All treatments and procedures shall be administered as ordered by the physician.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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S9999	Continued From page 2 These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement interventions to prevent the development of a pressure ulcer or injury for a resident identified at risk; failed to document on the electronic treatment administration record (TAR) after each treatment for 1 (R2) resident with multiple acquired pressure ulcers; failed to revise the care plan to reflect alteration of skin integrity, approaches, and goals for care for 2 (R2 and R4) residents with multiple acquired pressure ulcers; and failed to provide specialty mattress for 1 (R4) resident with multiple acquired pressure ulcers. These failures affected 2 (R2 and R4) out of 3 residents reviewed for pressure ulcers. As a result of these failures, R2 developed a facility acquired stage III pressure ulcer to left ear, and a facility acquired stage IV pressure ulcer to coccyx / sacrum. Additionally, R4 developed a facility acquired unstageable pressure injury to sacrum, facility acquired deep tissues pressure to right heel, and facility acquired unstageable pressure injury to left heel. The findings include: 1. R2's electronic heath record (EHR) documented an admission date of 7/18/2023, with diagnoses not limited to Respiratory failure, Encounter for attention to tracheostomy, Dysphagia, Encounter for attention to gastrostomy, Cognitive social or emotional deficit following nontraumatic intracerebral hemorrhage, Other encephalopathy, Kidney disease stage 4 (severe), Chronic diastolic (congestive) heart	S9999		

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failure, Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, Epilepsy, unspecified, not intractable, without status epilepticus, Unspecified abnormalities of gait and mobility, Unsteadiness on feet, Contracture of muscle multiple sites, Abnormal posture, Need for assistance with personal care, Anemia in chronic kidney disease, Gastro-esophageal reflux disease without esophagitis, Covid-19, and Pressure ulcer of sacral region, stage 4.

Facility's concern form, dated 9/6/23, showed there was a concern regarding R2's wound being facility acquired.

MDS (Minimum Data Set), dated 10/24/2023, showed R2's cognition was severely impaired. R2 needed total assistance / dependent with oral, toileting and personal hygiene, shower / bathe self, upper and lower body dressing, roll left and right. MDS showed that R2 was always incontinent of bowel and bladder. MDS showed R2 had Stage IV pressure that was not present on admission or re-entry.

R2's care plan, dated 9/6/23, documented: Actual Alteration in skin integrity r/t (related to) new/worsening blister. No care plan found in R2's EHR for facility acquired Stage III pressure ulcer to Left ear and facility acquired Stage IV pressure ulcer to Sacrum/coccyx.

R2's wound assessment details report, dated 1/2/24, documented:
Wound: Coccyx
Date Identified: 08/07/2023
Source: Facility-acquired
Clinical Stage: Stage IV
Measurement Size (cm - centimeter): 4.00 x 3.00

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x 0.50 (L x W x D - Length / Width / Depth)

R2's wound assessment details report, dated 1/2/24, documented:
Wound: left ear
Date Identified: 11/27/2023
Source: Facility-acquired
Clinical Stage: Stage I
Measurement Size (cm): 1.2 x 0.20 x 0.00.

Assessment for level of risk for acquiring pressure wounds, dated 7/19/23, 8/18/23, 9/21, 10/21/23, 11/20/23 and 12/18/23, showed R2 was high risk.

R2's TAR (treatment administration record) was not signed/initialed that treatment was done or provided to sacrum on 10/3/23, 10/5/23, 12/14/23, 12/23/23, 12/24/23, 12/25/23 and 12/28/23. R2's TAR was not signed that treatment was provided to left ear on 12/14/23, 12/24/23, 12/25/23 and 12/28/23.

R2's order summary report, dated 1/2/24, with order:
Site: Sacrum Cleanse with wound cleanser, pat dry with gauze, apply collagen and ALG to site and cover with dry dressing every day shift.
Site: Left Ear Cleanse site with NSS, Pat dry, apply xeroform and cover with dry dressing every day shift AND as needed for if dressing becomes compromised apply PRN (as needed).

Wound Nurse Practitioner notes, dated 1/4/23, documented:
1. Stage III pressure injury to left ear. Measures 0.4 x 0.2 x 0.1 cm. Wound is 100% granular tissue. Scant serous exudate.
2. Stage IV injury to sacrum. Measures 3.7 x 2.2 x 1 cm. Wound is 100% granular tissue.

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Moderate serous exudate.

On 1/4/24 at 10:34am, wound care observation conducted with V12 (Wound Care Coordinator), V15 (Wound Care Nurse) and V35 (Wound Nurse Practitioner). R2 was lying in bed, G-tube feeding on hold, with tracheostomy tube attached to cool aerosol. Air mattress in place; bilateral heel lift boots. R2's sacral wound was 100% granulating (beefy red), no maceration on surrounding area. V12 was doing wound treatment, assisted by V15. V35 measured sacral wound, and stated R2 has active Stage IV pressure ulcer with no bone exposure, measuring 3.7x2.2x1cm. R2 hadopen skin on left ear, and V35 stated that wound is still active and classified as Stage III pressure ulcer. V35 measured left ear wound, and stated it was 0.4x0.2x0.1cm, 100% granulation.

On 1/2/24 at 3:16pm, R2's EHR (Electronic Health Record) reviewed with V12, and V12 stated R2's has no wounds upon admission on 7/18/23. V12 stated R2 has facility acquired pressure ulcer to coccyx, and it was identified on 8/7/23. R2 has another facility acquired pressure ulcer on left ear.

On 1/4/24 at 10:06am, V35 (Wound Nurse Practitioner / NP) said she is following R2 due to multiple pressure ulcers. V35 stated R2 has facility acquired unstageable wound to sacrum, identified on 8/9/23. V35 stated, "(R2) went to the hospital, and debridement was done to the sacral wound. Upon (R2's) readmission, the wound to sacrum was classified as stage 4 pressure ulcer. Wound treatment should be done as ordered. If wound treatment is missed or not done, it could lead to worsening of wound, or the wound could deteriorate. The plan of care is important and

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S9999	Continued From page 6 should reflect the status of the wound for appropriate wound care or treatment. In theory, if care plan is not updated, the team is not aware of the status of the wound. (R2) has also acquired Stage III pressure ulcer to left ear." At 11:15am, V12 (Wound Care Coordinator/ Licensed Practical Nurse/LPN) stated wound care/treatment is done as ordered, and electronic treatment administration record (ETAR) is signed or initialed for accountability. V12 stated, "Signing ETAR is important; it is a documentation to prove that treatment was provided to the resident. If ETAR was not signed or initialed, it means that treatment was not provided to the resident. If wound treatment was missed or was not provided to the resident, wound could worsen, deteriorate, or could lead to infection. Care plan should reflect the status of the wound that would include goals and appropriate interventions." V12 stated the wound location sacrum/coccyx is the same. V12 stated wound documentation to left ear Stage I was a typo error, and it should be Stage III, not Stage I. Facility's Pressure injury and skin condition assessment policy, dated 1/17/18, documented: - The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care. - Physician ordered treatments shall be initialed by the staff on the electronic treatment administration record after each administration 2. R4 is a 68-year-old female, admitted to the facility 07/07/23, with diagnoses not limited to Alcoholic Cirrhosis of Liver ithout Ascites, Dysphagia, Unspecified Severe Protein-Calorie Malnutrition, Metabolic Encephalopathy,	S9999		

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S9999	Continued From page 7 Unsteadiness on Feet, Unspecified Abnormalities of Gait and Mobility, Weakness, Need for Assistance with Personal Care, Opioid Dependence with Withdrawal, Alcohol Dependence with Withdrawal Delirium, Anxiety Disorder, and Hypokalemia. Upon admission, R4 was ambulating with use of a walker. R4 sustained a fall on 08/24/23 requiring hospitalization from 08/23 to 08/28/23, with left hip pinning for left displaced femoral neck fracture. R4 was non-ambulatory upon readmission post fall. R4's Braden Score for predicting pressure sore risk on 09/07/23 was assessed as being at moderate risk based on score of 13. R4 had surgical incision to left trochanter which healed 09/25/23 and surgical incision to left lateral upper thigh which healed 10/09/23. R4's skin care plan, initiated on 07/07/23, documented: R4's potential for pressure ulcer development (related to) history of ulcers and included three interventions including 1.) administer treatments as ordered and monitor effectiveness, 2.) educate resident family/caregivers as to causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent position, 3.) inform resident/family/caregivers of any new area of skin breakdown dated 07/07/23. There were no changes to R4's skin care plan focus or interventions since last revision date on 07/13/23. R4's MDS (Minimum Data Set), dated 07/13/23, documents R4's BIMS (Brief Interview of Mental Status) score of 10/15, indicating moderately impaired cognition, and R4's functional abilities documents R4 requires supervision or touching	S9999		

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assistance for eating, toileting, dressing, ambulating, transfers.

R4's MDS, dated 09/13/23, documented functional abilities that R4 requires dependent care (helper does all of the effort) for toileting, dressing and dependent care to substantial/maximal assistance with mobility and transfers.

R4's MDS (Minimum Data Set), dated 12/08/23, document R4's BIMS (Brief Interview of Mental Status) score of 06/15, indicating severely impaired cognition and R4's functional abilities documents that R4 requires substantial/maximal assistance with toileting, dressing, and rolling left to right. Other functional abilities (sit to lying, lying to sitting on side of the bed, sit to stand, chair to bed to chair transfer, toilet transfer) were not attempted due to medical condition or safety concerns.

R4 developed three facility acquired pressure injuries. Per V35's (Wound Nurse Practitioner) wound assessment signed 11/29/23, identified unstageable pressure injury to sacrum measuring (6.0x6.0x0.0) with 50% necrotic tissue with minimal serous exudate. V35's wound assessment, signed 12/16/23, documents facility acquired deep tissues pressure to right heel measuring (2.5x4.0x0.0) with 100% necrotic tissue, minimal serous exudate with deterioration in surface area and facility acquired unstageable pressure injury to left heel measuring (3.0x3.0x0.0). R4 was transferred to hospital on 12/16/23 for change in condition, including fever and shortness of breath. R4 expired on 12/31/23, per R4's electronic health record.

On 01/02/24 on 3:17 pm, V12 (Wound Care

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S9999	Continued From page 9 Coordinator/LPN) stated prevention measures are individualized per residents and general interventions include use of a low air loss mattress, frequent turning depending on resident comfort level, but typically every 2 hours, consult with the Registered Dietitian to see if appropriate to add in protein and vitamins. V12 stated R4's pressure wounds were facility acquired. V12 stated R4 used to be mobile with the use of a walker when R4 was initially admitted . V12 stated after R4's fall, R4 was in bed post-op, and totally dependent on staff for activities of daily living. V12 stated causes of R4 developing pressure wounds could be attributed to R4 not being ambulatory, spending longer periods of time in bed, no longer communicating needs and increased moisture related to incontinence. V12 stated R4 was being rounded on every 2 hours, turned every 2 hours, provided incontinent care as needed, and given nutritional supplements to aid wound healing. V12 stated R4 was at an increased fall risk, so therefore, a low air loss mattress was not indicated. V12 stated V12 had a meeting with V22 (Restorative Director) when R4 returned from the hospital in August 2023, and they decided it was not safe for R4 to use a low air loss mattress. V12 stated V12 did not think it would be appropriate to use a low air loss mattress, and therefore, did not recommend it to the Wound Care Nurse Practitioner. V12 stated V12 was not the Wound Care Nurse who was at the initial meeting when R4's pressure wound to sacrum was identified. V22 stated normally V22 would talk to the Wound Care Nurse Practitioner about changes in environment, such as ordering a low air loss mattress for a resident. V12 stated V12 does not know if use of a low air loss mattress was discussed with the Wound Care Nurse Practitioner. V12 stated the Wound Care Nurse Practitioner was aware R4 had fallen and	S9999		

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sustained injury, so V12 assumed the Wound Care Nurse Practitioner would also agree not to use a low air loss mattress due to R4's history of falling. V22 stated usually for someone who developed an acquired pressure wound, they would use a low air loss mattress. V22 stated, "It is rare to say no to a low air loss mattress, but (R4) was a special case."

On 01/03/24 at 9:08 AM, V24 (Certified Nursing Assistant) stated R4 was on a regular mattress the entire time R4 was at the facility. V24 stated a low air loss mattress and/or wedges were not used. V24 stated at some point, R4 did have orders for heel protectors, but R4 would kick them off. V24 stated R4 required extensive assistance with positioning, and stated R4 would only rotate positioning from side to side with staff assistance, R4 could not do it on her own.

Facility policy titled, Pressure Ulcer Prevention, dated 11/28/12, documents: purpose is to prevent and treat pressure sores/injuries and specialty mattresses such as low air loss, alternating pressure may be used as determined clinically appropriate and specialty mattresses are typically used for residents who have multiple stage 2 wounds or one or more stage 3 or stage 4 wounds.

(B)

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300.610 a)
300.1210 b)
300.1210 d)6)
300.1220 b)3)

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Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal 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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the

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nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide individualized fall risk measures in place prior to a resident sustaining a fall for a resident assessed as being at high fall risk upon admission; and failed to put new individualized fall risk interventions in place for each subsequent fall for one (R4) out of three residents reviewed for falls. This failure resulted in R4 sustaining a fall on 08/24/23, resulting in a left hip pinning for left displaced femoral neck fracture, and R4 also sustaining two additional falls on 09/21/23 and 11/13/23.

Findings include:

R4 is a 68-year-old female, admitted to the facility 07/07/23, with diagnoses not limited to Alcoholic Cirrhosis of Liver Without Ascites, Dysphagia, Unspecified Severe Protein-Calorie Malnutrition, Metabolic Encephalopathy, Unsteadiness on

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Feet, Unspecified Abnormalities of Gait And Mobility, Weakness, Need For Assistance With Personal Care, Opioid Dependence With Withdrawal, Alcohol Dependence With Withdrawal Delirium, Anxiety Disorder, and Hypokalemia.

R4's MDS (Minimum Data Set), dated 07/13/23, documents R4's BIMS (Brief Interview of Mental Status) score of 10/15, indicating moderately impaired cognition. R4's Activities of Daily Living (ADLs) Assistance documents R4 requires supervision or touching assistance for eating, toileting, dressing, ambulating, transfers.

R4's MORSE Fall Scale Evaluation, dated 07/07/23, documents score of 55, indicating high risk for fall, based on criteria including, but not limited to R4's history of falling, use of walker, and secondary diagnosis.

R4's care plan, dated 07/07/23, documents R4 is at risk for fall (related to) deconditioning, gait/balance problems and encephalopathy. Interventions included educate R4/family/caregivers about safety reminders and what to do if a fall occurs (07/07/23), review information on past falls and attempt to determine cause of falls. Record possible root cause. Alter remove any potential causes as possible (07/07/23), needs activities that minimize the potential for falls while providing diversion and distraction (07/07/23), and physical therapy to evaluate and treat as ordered (07/07/23).

On 08/23/23 at 5:00 am, V55's (Licensed Practical Nurse, Agency) progress note documented V55 "heard a thud and (R4) cried out for the nurse, when (V55) entered (R4's) room (R4) was sitting upright on the floor. (R4)

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states that (R4) walked toward (R4's) nightstand to get her pants and stumbled backwards hitting her head on the wall. (R4) was transported to hospital for evaluation." Per hospital records, R4 was hospitalized 08/24-08/28/23 with a hip fracture requiring left hip pinning for left displaced femoral neck fracture. R4 was non-ambulatory upon readmission.

Upon readmission, R4's fall risk care plan interventions were adjusted on 08/29/23 as follows: keep furniture in locked position, keep needed items, water and personal items in reach, maintain a clear pathway free of obstacles, staff will assist R4 with hygiene care and dressing as needed, receive physical therapy((PT)/occupational therapy (OT) as ordered, be sure call light is within reach and encouraging R4 to use it for assistance as needed, ensure R4 is wearing appropriate footwear when transferring or mobilizing in wheelchair.

On 01/03/24 at 9:08 am, V24 (Certified Nursing Assistant) stated after R4's fall in August 2023, R4 was bed bound, and was no longer using a walker, and did not get out of bed anymore, and R4's cognition was declining. V24 stated R4 was in a room which was at the end of the hallway near the dining room, not near the nursing unit.

On 01/04/24 at 12:45 pm, V54 (Certified Nursing Assistant) stated V54 is a CNA, who used to take care of R4. V54 stated before R4's fall, R4 was "out and about" participating in activity functions, walking around the unit using a walker, and could do things for herself. V54 stated R4 declined "big time" after the fall, and spent all of her time in bed, requiring total care. V54 stated R4 was continually trying to get up out of bed, and R4's

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room was at the end of the hall, not near the nursing unit.

On 01/03/24 at 11:59 pm, V22 (LPN Restorative/Fall Coordinator) stated upon initial admission, R4 had unsteady gait, but was able to ambulate with a walker. V22 stated R4 was determined to be at a high risk for falls based on unsteady gait, use of a walker, history of falling, and medical diagnoses. V22 stated R4 fell early in the morning on 08/24/23, while trying to get herself dressed. V22 stated staff was aware of R4's preference to get up very early in the morning and get herself dressed. V22 stated having R4's bed in the lowest position and use of two floor mats were interventions V22 thinks the facility was using for R4. Upon reviewing R4's care plan, V22 stated V22 does not see low bed position or use of floor mats as part of R4's care plan, but stated it should have been part of R4's care plan, so that the staff would know what to do. V22 stated the facility uses agency nursing and CNAs, so it is important for resident care plans to be up to date. V22 reviewed the new intentions added (08/27/23) to R4's fall care plan, and stated it is possible having some of these interventions previously implemented before R4's fall in August could have potentially prevented R4 from falling.

On 09/21/23 R4 sustained a second fall. Per nursing progress note, dated 09/21/23, R4 was found sitting on floor with no injuries. R4's care plan, dated 09/22/23, had an intervention added of R4 will receive assistance with getting up out of bed to transfer into wheelchair from nursing staff as tolerated.

On 11/13/23, R4 sustained a third fall. Per nursing progress note, dated 11/13/23, R4 was

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S9999	Continued From page 16 found lying on floor to the right of her bed. R4 reports R4 was trying to get out of bed, and states R4 hit her head and had pain,; full body assessment completed, and R4 was sent to the hospital for evaluation. Per hospital records, R4 was admitted due to fall with no findings/injuries. R4's fall risk care plan was updated 11/13/23, documenting R4 was sent out for medical evaluation due to fall. There were no new interventions added to R4's fall care plan after the 11/13/23 fall. On 01/03/23 at 2:00 pm, V21 (Director of Rehab) stated, "(R4) was discharged from physical therapy on 08/04/23, and doing well at discharge, requiring supervision with transfers, ambulating 100 feet with roller walker with supervision, eating independently. (R4) was re-evaluated by physical therapy 08/29/23, following a fall with left femur fracture and was being seen by physical therapy from 08/29/23-09/25/23 and 09/27/23-10/27/23. At this time, physically (R4's) level changed from supervision to maximum dependence on bed mobility and transfers, upper extremity dressing moderate assistance, lower body dressing was dependent, grooming was moderate assistance, eating was supervision with minimal assistance. At the end of the two months, (R4) improved to a lying to sitting on the side of bed from max to moderate assist, but was still a maximum assist with transfers from bed to chair, requiring a (mechanical lift) lift for safety purposes. Due to (R4's) minimal progress, (R4) was discontinued from therapy." V21 stated R4's barriers included R4's cognitive deficits, and poor safety awareness, which increased her risk for falls and progress in therapy. V21 stated safety measures should have included R4's bed in the lowest position and floor mats on floor next to R4's bed, and these should have been care planned. V21	S9999		

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stated, "(R4) was picked up again by therapy 11/15/23 for physical therapy following another fall. (R4) had changed to moderate to maximum assist for lying to sitting, and transfer was not attempted due to safety on the day of eval (evaluation). (R4) was discharged from therapy on 12/12/23, and was still max (maxium) for bed mobility, unable to transfer requiring 2+ assist with (mechanical lift), and at this point (R4) was a feeder. (R4's) fall was a big set back that had a significant change in (R4's) functional status." V21 stated if R4's fall/injury was not to that level of severity, then the setback would not have been that significant. V21 stated the fall contributed to R4's lack of mobility because R4 was not able to ambulate as she could upon initial admission to the facility. V21 stated R4 had poor self-awareness of R4's deficits, which placed R4 at higher risk for continued falls.

On 01/04/23 at 10:22 am, V20 (R4's Medical Doctor) stated R4 was identified as being at high risk for falls upon admission. V20 stated fall risk precautions were in place for R4, and R4 was receiving physical therapy. V20 stated V20 did not know what they do specifically for their fall precautions, because they are specific to each resident, but there are standard things they do for fall precautions. "For example, put a resident closer to the nursing station, watch them more carefully, low bed potentially, no clutter in the room, well lit room, no rugs." V20 stated R4 was also under weight and malnourished, which leads to deconditioning, and places a resident at increased risk for falls and fractures.

Facility policy titled Fall Prevention Program, dated 11/21/17, documents:
1.) the purpose it to assure the safety of all

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residents at the facility, the program will include measures which determine the individual needs of each resident and implementation of appropriate interventions.
2.) Care plan incorporates preventative measures and interventions are changed with each fall.

Facility policy titled Comprehensive Care Plan, dated 11/17/17, documents: "the purpose to develop a comprehensive care plan that directs the care team and incorporates the residents' goals, preferences and services that are able to maintain the resident's highest practicable physical, mental and psychosocial well-being and the care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving."

(A)

3 of 3

300.610 a)
300.1210 b)
300.1220 b)3)

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

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the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requiremenst are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow their weight policy, and failed to care plan a resident that

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sustained significant weight loss for 1 out of 3 residents (R5) reviewed for nutrition. These failures resulted to R5 experiencing significant weight loss that was not reported, addressed, or care planned.

Findings include:

R5 is 53 years old, initially admitted on 5/2/2023, with principal diagnosis of end stage renal disease, dependence on renal dialysis, and hypertensive heart.

R5's BIMS (Brief Interview of Mental Status), dated 11/2/2023, scored 15; meaning R5 has an intact cognition.

Documentation of R5's weight history reads that resident was declining as to his weights:
Initial weight of R5 dated 5/4/2023 was 201.9 LBS (pounds)
6/2/2023 weight was 187 LBS post dialysis.
7/3/2023 weight was 187 LBS post dialysis.
8/1/2023 weight was 180 LBS post dialysis.
9/13/2023 weight was 178 LBS post dialysis.
9/19/2023 weight was 167.2 LBS post dialysis.
10/03/2023 weight was 176 LBS post dialysis.
11/1/2023 weight was 160.6 LBS post dialysis.
12/1/2023 weight was 160.6 LBS post dialysis.
12/13/2023 weight was 155.1 LBS post dialysis.
12/22/2023 weight was 144.1 LBS post dialysis.
1/2/2023 weight 59.4 KG (kilograms) or 130.95 LBS post dialysis.

V48 (Registered Dietitian) progress notes:

Date 6/18/2023, documents R5 had significant weight loss at 1 month, which is unplanned or unavoidable related to osteomyelitis, fluid loss, and hemodialysis visits.

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Date 8/15/2023, documents R5 had significant weight loss at 3 months, which was planned and likely related to fluid loss.

Dated 10/5/2023 and 10/9/2023, documents R5 had significant weight loss at 1 month, which was planned and likely related to fluid loss.

Dated 11/6/2023 and 11/24/2023, documents R5 had significant weight loss at 1, 3, and 6 month,s which was planned and likely related to fluid loss.

Dated 12/15/2023, documents R5 had significant weight loss at 3 and 6 months, which was planned and likely related to fluid loss.

On 1/2/2024 at 1:57 pm, R5 was not in his room. Nursing staff stated every Tuesday, Thursday, and Saturday R5 goes down to the basement to do dialysis. In the basement, R5 was seen in dialysis clinic. V50 (Dialysis Registered Nurse) said that it will take few minutes for R5 to finish dialysis.

On 1/3/2024 at 12:10 pm, R5 was on his bed, and appeared to be weak and unable to respond to questions when asked. R5 was visually thin, with his body showing his bones prominence to his face, body, upper and lower extremities. R5's lunch tray was on a moving table at the foot area of the bed. V24 (Certified Nursing Assistant) came inside the room and stated, "He (R5) has been like this for a week. He does not eat at all." V24 gave R5 half spoon full of puree food and green beans. R5 did not eat any of the food. V24 gave R5 juice and said, "This is the only thing he takes." R5 took a few sips and stopped responding to V24. At 2:10 pm, V25 (Registered Nurse), stated, "(R5) was declining, he was not

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like this before." V25 stated staff used to just set up the table, and R5 would eat. R5 did not need to be fed before. V25 said R5 has protein supplement that was given to him today; it is inside her cart, and was given today. Upon checking her cart, protein supplement cannot be found. V25 said if not in her cart, she borrows from the other cart, and showed the protein bottle in another cart. V25 was asked, how much food R5 ate during lunch? V25 pointed to V26 (Certified Nursing Assistant) and said, "Did you feed (R5)?" V26 said, "Yes, (R5) did not each much." V25 was informed it was V24 who fed R5, and not V26. V25 said, "I did not know that it was (V24) who fed (R5)." V25 was asked if any of the staff encouraged or offered alternative food or supplement to R5? V25 said, "I was not aware (R5) did not eat."

On 1/4/2023 at 11:30 pm, R5 was brought by V24 (Certified Nursing Assistant) down to dialysis center. V50 (Dialysis Registered Nurse) observed taking the weight of R5, and said R5's current weight pre dialysis is 63 KG (kilograms) or 139 LBS (pounds).

On 1/4/2024 at 10:58 am, V48 (Registered Dietitian) stated, "(R5) had significant weight loss, and it was due to many factors, not only fluid loss. Interventions need to be in the care plan. Staff should encourage (R5) when not eating. (R5's) weight on 12/13/2023 was 155.1 LBS, that decreased to 144.1 LBS, or 11 LBS decrease on 12/22/2023 was a significant weight loss." V48 stated it was not communicated to him to address the problem. V48 said, "Yes, there was lapse of communication."

A review of R5's full care plan does not address significant weight loss.

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On 1/3/2024 at 3:54 pm, V16 (Dietary Technician) stated she does the assessment and care plan of R5. V16 took the copy of R5's full care plan, after review. V16 stated, "There is no plan of care for significant weight loss that addresses the problem. The care plan needs to be updated based on recommendation of the Dietitian. Whatever the dietitian recommends needs to be put on the care plan."

On 1/4/2024 at 12:32 pm, V2 (Director of Nursing) reviewed R5's care plan and stated, "This is not correct, I mean the care plan of (R5) does not address significant weight loss, and its goal cannot be achieved. Yes, (R5) is losing weight, and there are many factors, including antibiotic use."

Weight Policy, dated 11/14/12 with a revision date of 11/17/19, was reviewed and reflects:

Residents identified at nutritional risk may be weighed weekly or by weekly as per the physician order or Interdisciplinary Team.
Re-weight should be obtained if there is a difference of 5# or greater (loss or gain) since previous recorded weight.
Re-weight should be taken as soon as possible after an unanticipated weight change is noted and prior to calling a physician (Usually within 72 hours).

Undesired or unanticipated weight gains/loss of 5 % in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physicians, Dietician, and/or Dietary Manager as appropriate.

(B)

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