STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003958	A. BUILDING: _____ B. WING _____	C 08/12/2024

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S 000	Initial Comments Complaint Survey 2485472/IL175801 2485462/IL175453	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.3240a) 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	S9999		

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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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to protect a resident (R3) from physical abuse from staff which affected one resident (R3) out of three residents reviewed for abuse. This failure caused R3 to suffer bilateral mandibular fractures to R3's face requiring oral and maxillofacial surgery.

Findings include:

R3's Brief Interview for Mental Status dated 07/18/24 shows that R3 has a BIMS score of 15 which indicates that R3 is cognitively intact.

R3's face sheet shows that R3 has a diagnosis which includes but not limited to chronic systolic congestive heart failure, chronic obstructive pulmonary disease, asthma, presence of automatic implantable cardiac defibrillator, essential primary hypertension, polyneuropathy in diseases classified elsewhere, acute kidney failure, seizures, hyperkalemia, polyneuropathy due to other toxic agents, diarrhea, hypotension, opioid dependence.

R3's Initial Facility Reported Incident dated 07/14/24 at 8:39 pm, documents in part "R3

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informed staff that R3's assigned Certified Nursing Assistant (CNA) V6 displayed behaviors inconsistent with facility standards. V6 was immediately suspended pending investigation. R3 was assessed for injuries. R3's family and physician were notified of the allegations and assessment findings. The local policy were notified of the allegations. A full investigation has been initiated and a final report will follow timely."

R3's Final Facility Reported Incident dated 07/19/24 at 11:21 pm, documents in part "Analysis and Conclusion: R3 informed the visitor that "a guy with tattoos on his neck punched R3 in the face and knocked R3's tooth out ... R3 was admitted to the local (sic) with bilateral mandibular fractures ... V6 attempted to redirect R3 in R3's room to calm down. R3's behaviors escalated and R3 grabbed V6 and began "tussling" with R3. V6 is no longer employed at the facility."

On 07/30/24 at 10:21 am, R8 (R3's Roommate) stated that R8 recalls R3 having an altercation with a male staff a few weeks ago. R8 stated that R8 was resting in R8's bed and heard a verbal altercation between R3 and a male Certified Nursing Assistant (CNA). R8 stated that when the male CNA left R3 and R8's room, R3 stated that R3 got hit in the mouth by the male staff and R8 observed blood on the floor near R8's bed. R8 was unable to give a description of the male CNA.

On 07/31/24 at 9:30 am, V3 (Human Resource Director) was questioned regarding V6 (CNA) employment status at the facility and V6 stated that R6's reason for termination was abuse allegation involving R3 that was substantiated.

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On 07/31/2024 at 10:02 am, V6 (Certified Nursing Assistant, CNA) stated that about two weeks ago V6 observed R3 sitting on the edge of R3's bed in R3's room when V6 brought R3's meal tray into R3's room. V6 stated as V6 was sitting R3's meal tray on R3's over bed table, R3 shoved R3's meal tray as V6 was attempting to set R3's meal tray down, spilling R3's meal tray onto V6's clothing. V6 then explained that R3 then stood up about one foot in front of V6 and spit onto V6 clothes, shirt, neck, and face. V6 stated that V6 then turned around and left R3's room to go clean up himself (V6). V6 stated that as V6 left R3's room V6 heard R3 cussing and very mad. V6 then stated that after V6 cleaned the spit and food off V6, V6 returned to R3's doorway and observed R3 still cussing and mad. V6 stated that V6 then informed V7 (Licensed Practical Nurse, LPN, R3's nurse) that R3 was agitated and to check on R3. V6 then explained that V6 was not certain when V7 went to check on R3. V6 stated that one hour and a half later after the V6 interaction with R3 spitting on V6, V2 (Director of Nursing, DON) called the facility and informed V6 that R3 stated that V6 "put his hands" on R3 and instructed V6 to make a statement regarding the interaction with R3 and to "clock out" and leave the facility. V6 stated that V6 followed V2 instructions and left the facility. V6 also explained that V6 was not R3's assigned CNA on 07/14/24 and that V6 was only bringing R3, R3's meal tray. V6 denied physically assaulting or having a verbal altercation with R3. V6 stated that on 07/15/24 V2 informed V6 that R3 suffered a broken jaw injury to R3's jaw. V6 denies having any knowledge as to how R3 sustained a broken jaw.

On 07/31/24 at 10:35 am, V7 (Licensed Practical Nurse, LPN) stated that a few weeks ago during V7's 3:00 pm - 11:00 pm shift at the facility, while

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V7 was passing medications, V30 (Certified Nursing Assistant, CNA) informed V7 that as V30 was walking pass R3's room, V30 saw R3's mouth bleeding. V7 stated that V7 asked V12 (LPN) to come with V7 to assess R3. V7 stated V7 assessed R3 with injuries to R3's face. V7 stated that V7 observed R3's mouth bleeding with lacerations to R3's lower lip, R3's mouth with a tooth missing that looked as if R3's missing tooth came from R3's lower mouth, and the right side of R3's face swollen. V7 stated that R3 informed V7 that a male staff member with tattoos (V6, CNA) beat up R3 and hit R3 in the mouth. V7 stated that V6 was the staff with tattoos identified by R3 and that V7 then followed the facilities protocol for abuse by calling V1 (Administrator), the on-call physician for R3, the local police and phoned V2 (Director of Nursing, DON) who then called the building and gave directives for V6 to leave the facility. V7 then stated that V6 was not an assigned CNA working on V7's unit. V7 said they never spoke with V6 and never reported any changes in R3 condition such as agitation, R3 shoving R3's lunch tray or spitting on V6 or V7, and ever seeing V6 working on V7's unit on 07/14/24.

On 07/31/24 11:35 am, V28 (R3's physician) stated that V28 did not receive the call that R3 was in an altercation with a staff member at the facility. V28 stated that V28 was informed regarding R3's altercation with a staff member after V28 came to visit R3 at the facility and learned that R3 was in the local hospital with bilateral mandibular fractures due to an altercation with a staff member at the facility. V28 stated that V28 did not have any further details due to V28 learning about the altercation two days after R3 was sent to the local hospital. V28 denied that R3 was a combative resident, ever

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displayed self-inflicting injuries and that R3 was always pleasant. V28 was asked regarding how a resident could sustained a bilateral mandibular fracture and V28 stated, "If a resident suffers a hard blow/strike to one side of the jaw the impact could fracture the other side of the resident's mouth as well."

On 07/31/24 at 11:51 am, V2 (Director of Nursing, DON) stated that the altercation with R3 and V6 took place on Sunday 07/14/24 and that V2 was not in the facility and did not observe the altercation. V2 stated that V25 (Restorative Nurse) informed V2 that V25 observed blood on the floor in R3's room and that R3 stated to V25 that R3 was hit by a staff member V6 (CNA) who R3 named "Ken". V2 stated that V2 instructed V25 to inform V6 that V6 was involved in an investigation and to leave the facility. V2 stated that V2 then informed V1 of the abuse allegation. V2 also stated that V2 questioned V7 (Licensed Practical Nurse, LPN, R3's nurse) what transpired between R3 and V6 and that V7 stated that V7 did not witness anything between V6 and R3. V2 stated that V7 explained that V7 was down the hallway from R3's room passing medications prior to V7 learning about the altercation with R3 and V6. V2 explained that R3 was alert and oriented and not known to be a combative resident with staff or other residents and was easily able to be redirected.

On 07/31/24 at 2:27 pm, V1(Administrator) stated that V1 is the abuse coordinator and it is V1's first week working at facility. V1 received a call from V2 stating there was a possible abuse case at the facility. V1 stated that V1 instructed V2 to send the person in question home, interview the resident immediately, and if there was a physical harm to call the police as well as to send the

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resident out to the local hospital. V1 stated that V1 was informed that the staff member involved in the abuse allegation was V6 (CNA) and that V6 had already left the facility before V2 (DON) could instruct V6 to leave. V1 stated that V1 was informed that a family member reported to a nurse on the unit that R3 was bleeding and hurt. V1 stated that a police report was conducted, and the incident was labeled as a "Simple Battery" V1 explained that the local hospital determined that R3 suffered bilateral jaw fractures. V1 then explained that V1 concluded V1's investigation with R3 and V6 by substantiating abuse due to R3 being an alert, oriented resident, V6 being on the schedule during the time of the incident, R3 being able to describe V6 as the male staff with tattoos and as the person who assaulted him (R3). V1 stated that V6 fit the description of R3's perpetrator. V1 also stated that R8 (R3's Roommate) could not give an accurate definition but stated that R8 heard the argument between R3 and V6 on 07/14/24.

R3's progress notes dated 07/14/24 at 8:17 pm, authored by V7 (Licensed Practical Nurse, LPN) documents in part, "Reported physical altercation, observed facial injury. Head to toe observation shows right jaw swelling, laceration to inner lip with blood present ... Cold compress applied to jaw. Abuse protocol initiated; administration & management made aware via phone. CPD (Chicago Police Department) phoned, is in route to the facility."

The facility's document dated 07/15/24 and titled "Corrective Action Notice" documents in part: "V6 failed to follow abuse policy of the facility on 07/14/24, violation of union policy of Abuse page (pg.) 38#7 first offense discharge. Termination. Unable to serve to employee due to refusing to

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come to facility after completion of investigation."

R3's police report record dated 07/14/2024, documents in part "Incident: Simple Battery."

R3's hospital record dated 07/15/24 documents in part "chief complaint: Trauma. R3 brought in by Emergency Medical Service (EMS) from nursing home when R3 got into a fight with a staff member and got punched in the face. Per EMS R3 has bilateral mandibular jaw fx (fractures)."

R3's hospital record dated 07/15/24 documents in part: "Principle Problem: Bilateral mandibular fracture, closed, initial encounter ... Assault ... "Minimally displaced oblique fractures of the left mandibular symphysis and posterior right mandibular body are in unchanged alignment. Fracture line extends to the roots of the left mandibular central and lateral incisors ... Operating Room (OR) with OMFS (Oral and Maxillofacial Surgery) ... Subjective: ... Head to toe trauma examination redemonstrated pain and swelling and tenderness to the mandibles and difficulty moving jaw."

The facility's document dated January 4, 2018, and titled "Abuse Prevention Program Facility Policy and Procedure" documents in part: "Introduction: abuse is defined as the willful infliction 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 goods or services that are necessary to attain or maintain physical, mental, and 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

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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. V1. Protection of Residents: the facility will take steps to prevent potential abuse while the investigation is underway. Internal Investigation: 7. Final investigation report. The investigator will report the conclusions of the investigation in writing to the administrator or designee within 5 working days of the reported incident. The final investigation reports shall contain the following if the allegation is determined to be valid and the perpetrator is an employee, include on a separate sheet the employees name, address, phone number, title, date of hire, copies of previous disciplinary actions, and current status."

(A)

2 of 2

300.610a)
300.1010i)
300.1210b)
300.1210c)
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

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of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.

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' 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:

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

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and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interviews and record reviews, the facility failed to follow the recommendation of the dietitian and obtain a doctor's order for one-to-one feeding assistance for one resident (R4); failed to provide one-to-one feeding assistance; failed to elevate the head of the bed to an upright position for eating; and failed to care plan for one-to-one feeding assistance. These failures resulted in R4 being given food for lunch without one-to-one feeding assistance; R4 choked on the food and subsequently expired on 6/1/24.

Findings include:

R4's Admission Record documents, in part, diagnoses of multiple sclerosis, protein-calorie malnutrition, dysphagia (oral phase), anorexia, schizoaffective disorder, cognitive communication deficit, and hypertension.

In R4's Death Certificate, V45 (Medical Examiner) documents, in part, that R4's cause of death is "choking" in the facility on 6/1/24 at 2:00 pm. R4's autopsy results were used to complete R4's manner of death which is an accident. R4's injury (accident) occurred on 6/1/24 at 1:55 pm in the facility, and the description of how R4's accident occurred is listed as "food lodged in airway."

On 7/30/24 at 11:40 am, V27 (R4's Family Member, HCPOA) stated "I (V27) got to the floor on 6/1/24 before 2 pm. I got off the elevator and saw 4 to 5 people at the front desk (nurse's station). I went into (R4's) room, and (R4's) roommate (R9) is in the first bed which is near

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the door. I went into my son's (R4's) room and he (R4's) usually facing me. (R4) wasn't. I hollered to (R4), and (R4) didn't say anything. (R4's) face was facing the window. I walk over next to (R4) and I can see food hanging from his mouth and saliva. I shook (R4) a little bit. (R4's) head was wobbly. Something was wrong. I called out, 'I need help.' (R4's) eye lids were closed. (R4's) not responding. The door was open, and no one was responding. I walked over to the door and yelled '(R4's) not breathing.' Then they (staff) responded. I said, 'Can you get the food out of (R4's) mouth?' The nurse (V9, Licensed Practical Nurse, LPN) said that R4 is a DNR (Do Not Resuscitate). I said that DNR is not related to food to be taken out of his mouth. V9 said, 'That's not possible.' There were 2 nurses there, and 2 Certified Nursing Assistants, CNAs. I said, 'Can't you do anything? Pull it out of (R4's) mouth?' V9 said that (R4) had passed. Food was hanging from (R4's) mouth. a grilled cheese sandwich was coming from the left side of his mouth. I took pictures." V27 stated that V27 said "Do something. (R4's) still warm" and that V9 said, "We can't do anything. (R4's) a DNR." V27 stated, "They finally pulled food out of (R4's) mouth, CNA was there too. Nurse (V9) brought a machine (vital signs) in and said '(R4's) gone.'" V27 stated, "It was after lunch around 2 pm. How long had (R4) been there like this? I don't know. (R4) can't feed (R4's) self. I had spoken with them (nursing staff) before about feeding (R4). They (staff) say 'Yes, (R4) does have a feeder. I would feed (R4). Sometimes (R4) could eat with right hand somewhat." When asked about R4's positioning when V27 entered R4's room on 6/1/24, V27 stated, "(R4) was in bed. (R4) was not moved up. (R4) was in a reclined position. (R4) wasn't sitting up in the bed. Not totally all the way flat but close." When asked approximately

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how high was R4's head of bed position, V27 stated that it was "4 to 6 inches from flat." When asked to describe the food coming from R4's mouth, "It seemed to be grilled cheese. It was chewed up with saliva. The half sandwich was on (R4's) left side.R4's left hand couldn't grasp much. The sandwich was on the left side between (R4's) body and left arm. There was no tray with food on it (table), (R4) had the sandwich."

Photographs provided by V27 (from 6/1/24) document R4 in a reclined head of bed position with R4's head turned to the left with R4's eyes closed and chewed up food (appears to be bread like) mixed with frothy saliva hanging out of R4's left side of mouth down to left side of chest. A half sandwich is noted on R4's left side in between R4's left arm and side with R4's left arm over R4's chest, and R4's right arm down on R4's right side. R4's bedside table is noted positioned over R4's lap in bed.

R4's Power of Attorney for Health Care form (dated 11/7/2014) documents, in part, that V27 is R4's healthcare power of attorney.

On 8/6/24 at 9:25 am, V37 (CNA) stated that V37 was working on 6/1/24, day shift from 7:00 pm to 3:00 pm, on R4's floor, and V37 was not R4's primary CNA. V37 stated that when V37 performs 1:1 feeding assistance for a resident, V37 will position the resident in a sitting position with head of the bed at a 90 degree angle and tell the resident that V37 will be back with the meal tray. V37 stated that V37 will then come back to the room with the tray; bring the table close to the resident; and V37 will face the resident while assisting to feed the resident. When asked why would V37 be facing the resident during 1:1 feeding assistance, V37 stated, "To make sure

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they don't choke or pocketing of food on side of the jaw. Like half breathing. When facing the resident, I can catch the resident with the food versus facing the same way towards the TV (television)." V37 stated that V37 would then stop the feeding and get the nurse immediately. V37 stated that V37 had provided positioning assistance in bed for R4 to eat in the past with R4's head of bed in a 90 degree position and tilting R4's foot of bed up so R4 "won't slide down with contracted legs." V37 stated that on 6/1/24 for the lunch meal, V37 passed V37's assigned residents' lunch meal trays to V37's residents. V37 stated that V37 later went back to the unit's dining room to get coffee for some residents, and when V37 was walking out of the dining room into the hallway, V37 was able to clearly view into R4's room where "I (V37) can see (R4) laying back and eating." V37 stated, "I didn't know what (R4) was eating, but (R4) was chewing on something. Did someone give (R4) the tray? Who's given it? (R4) is in there eating. (R4) wasn't sitting up. Everyone knows (R4) needs to be sitting up." When asked what did V37 do once V37 saw R4's head of bed down while eating on 6/1/24, V37 stated, "I am thinking who's in there feeding the resident. I asked nurse (V9, LPN), 'who is in there feeding with (R4's) head back?' (R4's) laying back and eating. I guess (V27, Family Member) is in there. I see (V27) in there, and (V27) just arrived. When asked how did you know that V27 just arrived in R4's room on 6/1/24, V37 stated, "(V27) was putting down (V37's) purse." V37 stated that V37 continued to deliver the coffee to V37's residents when V27 called out, "(R4) is choking."

On 7/31/24 at 7:30 am, V9 (LPN) stated that V9 started working in the facility in October 2023 and floats to all of the units. V9 stated that V9 was

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R4's assigned nurse on 6/1/24 from 7:00 am to 3:00 pm. V9 stated that R4 was on a no added salt diet with regular texture and thin liquids. When asked about R4's feeding assistance level, V9 stated, "I want to be able to say he feeds (R4's) self. R4 always has tray in room feeding (R4's) self. If the food is not to (R4's) liking, (R4) would wait for (V27) to come into bring (R4) food." V9 stated that on 6/1/24, V9 had entered R4's room about 1:30 to 1:45 pm, and that R4 was alert and communicating, then V9 exited the room. V9 stated that V27 came around 2:00 pm. V9 stated, "(R4) had a peanut butter and jelly sandwich. (R4) was given it but (R4) could not consume peanut butter and jelly from my understanding. (R4) was already gone. It was an eminent thing." When asked do you mean R4's death, V9 stated, "Yes. It was that quick." V9 stated, "Staff brought (R4) the sandwich. I cannot recall who." V9 stated when V27 arrived to R4's room on 6/1/24 around 2:00 pm, "(V27) alerted me (V9) that (V27) felt (R4) needed help with breathing. (V27) said '(R4) did need help.' When asked where was V27 located when V27 is saying this to V9, V9 stated, "I am 5 inches away from room. Nurse's station is right outside (R4's) door. (V27) just walked out, and said, 'I believe (R4) is in need of help. Something's wrong with (R4)'." V9 stated that V9 responded immediately and assessed R4's body. V9 stated, "(R4's) body was warm, I felt for a pulse, and assumed there would be a pulse. Blood pressure we could not get already." When asked who was in R4's room with you, V9 stated that it was V36 (LPN), V33 (CNA), V34 (CNA) and V27. V9 stated that V20 (R4's assigned CNA) was initially with another resident. V9 stated that V9 was touching (R4's) body during assessment, and "(R4) was still warm as if (R4) was still alive." When asked did R4 have food particles coming from R4's mouth,

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V9 stated, "It was on the side of (R4's) chest, not out of (R4's) mouth or anything." When asked did V9 render any care to R4 then, V9 stated, "I did a (oral) sweep only, as if (R4) had choked. (R4) did not choke. (V27) felt that (R4) had choked. I just did that (sweep) for (V27), not because (R4) had choked." V9 stated that V9 and V36 checked for R4's pulse and blood pressure and were not able to feel a pulse or obtain a blood pressure reading at R4's time of death on 6/1/24 at 2:00 pm. V9 stated that R4 had a code status of DNR; therefore, V9 could not provide CPR (Cardiopulmonary Resuscitation) to R4. When asked did R4 require supervision while R4 was eating, V9 stated, "No, (R4) did not."

In R4's Health Status/Progress Note, dated 6/1/24 and timed 2:00 pm, V9 (LPN) documents, in part, "Note Text: Writer (V9) observed resident (R4) with head of the bed raised, no BP (blood pressure) and low pulse and unresponsive. Family (V27) at facility upon observation of resident (R4)."

In R4's Health Status/Progress Note, dated 6/1/24 and timed 2:00 pm, V9 (LPN) documents, "Note Text: Resident (R4) pronounced deceased per RN (Registered Nurse)."

R4's Physician Orders for Life-Sustaining Treatment (POLST), signed and dated 3/9/2020, documents, in part, that R4's advance directives for code status lists "Do Not Attempt Resuscitation/DNR" with "Comfort Measures Only (Allow Natural Death)."

On 7/31/24 at 11:10 am, V36 (LPN) stated that V36 worked on 6/1/24 for the day shift and that V36 was not R4's nurse on 6/1/24 or had interacted with R4 prior to this date. V36 stated

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that V36 responded to R4's room when V27 stepped out to say that R4 was choking. V36 stated that R4 was "foaming at the mouth," and "(R4) had a half-eaten sandwich in the left hand. Peanut butter and jelly sandwich on the side of (R4) leaned up against (R4's) mouth." V36 stated that V9 informed V36 at R4's bedside that R4 was a DNR, and V36 checked to palpate for R4's pulse; checked for a blood pressure reading and checked for spontaneous breathing with V36 finding no pulse, blood pressure or respirations for R4.

On 7/30/24 at 9:36 am, V8 (Former Consultant Dietitian) stated that V8 began employment in the facility in August 2023, and V8's last date of employment at the facility was 6/7/24. V8 stated that V8 remembers R4 and was following R4's dietary needs due to R4 having a pressure ulcer wound and weight loss. V8 stated that R4 had double protein at all meals and calorie and protein supplements. V8 stated, "I was very attentive to (R4's) weight loss because (R4) was not providing much assistance to feed (R4's) self." V8 stated that on floor rounds during meal service, V8 did observe R4 receiving one-to-one (1:1) feeding assistance by nurses and CNAs. When V8 observed, on occasion, R4 with a meal tray in front of R4 without staff in R4's room, V8 stated that V8 would ask the nurse on duty about R4 being assigned to 1:1 feeding assistance, and that the nurse would say, 'Yes, (R4) got a tray. We will stop to feed (R4)." V8 stated, "Some (staff) didn't know that (R4) was assigned 1:1." V8 stated that V8 did not have full access to the physician orders in the electronic health records (EHR) system where nurses and/or physicians will document the 1:1 feeding assistance order. V8 stated that V46 (Former Assistant Director of Nursing, ADON) and V47 (Former Director of

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Nursing, DON) confirmed that R4 was 1:1 feeding assist. When asked what were V8's expectations of nursing staff with R4's 1:1 feeding assistance, V8 stated that V8 "I expect the staff to be feeding (R4). (R4) does not communicate the best. Nurses or CNAs do 1:1 feeding. When I (V8) would see the tray in room, I would ask nurse about 1:1 feeding. Nurse would say (R4's) calming down. Take breaks." When asked to explain the 1:1 feeding assistance process, V8 stated, "Staff will set up the tray. Elevate the head of bed. Put resident in a sitting position to prevent choking when eating. Help feeding with spoon or whatever utensils. They will check for pocketing of food or swallowing problems or food spilling out of the mouth." When asked if this (pocketing of food, swallowing problems, or food spilling out of mouth) occurs, what should happen, and V8 stated, "I would expect them to stop and notify me and notify speech therapy. For (R4), I would have taken action to downgrade to mechanical soft diet. If there is an issue, we wouldn't want (R4) to choke. I would wait for speech therapy to do full evaluation. They may determine (R4) needs downgraded. For high risk for choking, I change diet to mechanical soft. I was never informed of this (with R4)." When asked about care planning dietary interventions for R4, V8 stated that the dietary care plans were updated by V21 (Dietary Manager).

R4's Dietary Progress Notes, 5/31/24 at 6:23 pm, V8 documents, in part, that R4's past medical history includes multiple sclerosis, pressure induced deep tissue damage, dysphagia, anorexia and protein calorie malnutrition. V8 documents that R4 has a weight change of -7.5% change with comparison weight from 2/5/24. V8 documents that R4's diet is no added salt, regular texture and thin liquids with supplements of

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double protein and high calorie and protein supplement drinks. V8 documents that R4 "requires 1:1 assistance to eat." V8 documents that R4 requires 1:1 feeding assistance in additional authored dietary progress notes on 8/16/23, 9/15/23, 11/28/23, 12/22/23, 2/16/24, 3/8/24 and 4/12/24.

R4's Weights Summary documents, in part, weights on 7/21/23 of 142 pounds, on 11/3/23 of 127 pounds, on 3/5/24 of 117 pounds and on 5/30/24 of 107 pounds.

On 7/30/24 at 1:34 pm, V21 (Dietary Manager) stated that V21 became the dietary manager in the facility in September 2023 and that V21's responsibilities include "doing care plans and assessments." When asked who is responsible for updating dietary care plans, V21 stated, "I am since November 2023." When asked did V21 update R4's care plan, V21 stated, "I don't know for (R4's) care plan. That was (V8's) thing to do." V21 stated that R4 did receive double protein at each meal and that R4 had a grilled cheese sandwich added to lunch and dinners.

R4's undated Meal Ticket documents, in part, that R4 receives double protein for breakfast, lunch and dinner; R4 receives added grilled cheese (sandwich) with meal for lunch; and R4 receives added grilled cheese (sandwich) and mash potatoes for dinner.

R4's Complete Care Plan (R4's care plan closed date 6/3/24 with reason for close as deceased) documents focuses which had been resolved and focuses that are canceled on 6/3/24 due to R4's care plan being closed. R4's care plan focus of nutritional problem with weight loss, initiated on 10/6/22, documents, in part, interventions of "(R4)

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would like a grilled cheese with each meal to assist in bettering (R4's) nutrition" and "RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (whenever needed)."

R4's care plan focus of self care deficit (ADLs Mobility) generalized weakness, initiated 10/9/23, documents, in part, interventions of "Head of Bed elevated" and "Set up tray at mealtimes" with no one-to-one feeding assistance documented.

On 8/6/24 at 10:45 am, V46 (Former ADON) stated that V46's employment with the facility ended in January 2024 after being the ADON in the facility for 5 years. V46 stated that V46 remembers R4 and that R4 had an "overall decline" with refusals of medications and weight loss. When asked if R4 was a 1:1 feeding assistance with eating, V46 stated, "Yes, I (V46) did know (R4) did. Times one staff to monitor at meals." When asked what is monitor, V46 stated, "To assist with feeding." V46 stated that there should be a physician's order that is placed in the EHR for 1:1 feeding assistance which is important so staff, including rotating nurses and CNAs, can see the plan of care. When asked if V46 spoke with V8 (Former Consultant Dietitian) about R4's 1:1 feeding assistance, V46 stated that V46 cannot recall an exact conversation with V8, but R4 was a 1:1 feed prior to V46 leaving the facility. V46 stated, "(R4) needed feeding assistant with diagnosis of multiple sclerosis. (R4) was weaker over time. One-to-one feeding for R4. Everyone was on board. I definitely know (R4) was a 1:1 feeding." V46 stated that in morning standup up meetings with nursing staff on R4's floor, the nurse or the CNA couldn't attend the brief meeting due to feeding R4 one-to-one in R4's room. When asked the

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process of 1:1 feeding, V46 stated that staff will reposition the resident to a high fowler's position (head of bed elevated); staff will read the meal ticket; set up the tray and describe to the resident what they are eating; and staff will assist with feeding the resident. V46 stated that staff will wait for resident and not rush resident while eating. V46 stated that 1:1 feeding assistance ends when the resident is done eating. V46 stated that 1:1 feeding assistance also includes staff sitting with the resident while the resident is using utensils to feed self, so the staff will guide the resident and supervises the entire meal. V46 stated that staff are looking for any observation of not properly chewing and swallowing food and choking. V46 stated that if that occurred, then the nurse will downgrade the diet immediately and notify the physician. When asked if R4 was eating in bed in a reclined position, what could occur, and V46 stated, "(R4) could definitely aspirate or choke. Food wouldn't go down properly."

On 7/31/24 and 8/5/24, multiple attempts were made to contact V47 (Former DON) by phone with no success.

R4's Order Summary Report for discontinued orders documents, in part, diet orders with order date of 3/4/2020 for no added salt diet with regular texture and thin liquids, and order date of 12/3/2020 with no added salt diet with regular texture and thin liquids with double protein with meals. No physician order for R4's one-to-one feeding assistance is listed for R4.

On 7/31/24 at 12:23 pm, V2 (DON) stated that V2 started the position of Director of Nursing on 2/14/24 and was familiar with R4. When asked if R4 required supervision while eating, V2 stated, "Not to my knowledge, (R4) did not." When asked

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when would V2 expect your staff to provide supervision for a resident eating, V2 stated, "Any meal, supervision, if you notice a patient can't do something; they need to be monitored." When asked if there is an order for 1:1 feeding assistance, how does the nursing staff know of it, and V2 stated, "1:1. There's an order, and it's on the dietary ticket. 1:1 feeding in (EHR). Each staff sees in (EHR)." V2 stated, "If it's something like supervision, staff are made aware. Dietary ticket. It's available in (EHR)." When asked what was R4's assistive level of eating, V2 stated, "Everyone did (R4's) tray set up. (R4) was encouraged to eat."

On 7/31/24 at 2:43 pm, when asked how should R4 be positioned for eating, V2 stated that staff "make sure the head of bed is elevated. The tray is in front of (R4) and opened up all of (R4's) drinks and milk. Make sure to set food where (R4) is able to reach it." When asked the elevation height of R4's head of the bed, V2 stated, "I would like it to be high fowlers (60-90 degrees) to prevent and make sure that resident is not exposed to choking." When asked about R4's continuing weight loss, V2 stated, "I (V2) may have been notified of weight loss, but I can't recall. If necessary to, I look at a weight. I think with (R4), (R4) was kind of up and down."

On 7/31/24 at 3:14 pm, V20 (CNA) stated that V20 started working in the facility in April 2024 and that V20 was R4's assigned CNA on 6/1/24 for the day shift 7:00 am to 3:00 pm. V20 stated that on 6/1/24 for lunch service, "(R4) was my resident. I (V20) was on break. I didn't give (R4) (R4's) tray." When asked to describe what normally happens when V20 would serve R4's meal tray to R4, V20 stated, "Set (R4's) tray up for (R4). If it's not in reach, set tray up and

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utensils where (R4) can pick it up. Sit (R4) up. Head of bed up." When asked did V20 ever witness R4 spilling food on himself while feeding, V20 stated, "I have seen (R4) spill stuff on (R4). The day that (R4) choked, I witnessed a sandwich in (R4's) mouth." When asked on 6/1/24, when V20 returned from V20's break, what happened, and V20 stated, "Like I always do. I look at my residents when I came back to make sure they are okay. Everything was okay. If they might need help. I go and check. Everyone was okay. I was in the process of making sure (R4) was okay. I went to the breakroom to braid (R11's) hair. I didn't go in (R4's) room. I asked (V33) to go to check on my residents. I want to see how everyone was doing. (V33) checked on my residents. (V33) said they were okay. 20 minutes later, (V27) came hollering and screaming. I went and (R4) had a grilled cheese in (R4's) mouth." V20 stated that when V20 got to R4's room, V9 was saying that R4 was a DNR. V20 stated, "(V27) was saying can we do something. Nothing but to wipe (R4's) mouth. (V27) was taking pictures. Other aide (V34) and nurses (V9, V36) already in there. They were taking food out of (R4's) mouth. (R4) was pocketing food from the mouth." When asked to describe what V20 observed with R4 on 6/1/24 responding to V27's call for help, V20 stated, "I see food particles. (R4) had sandwich coming from (R4's) mouth. I knew it was grilled cheese." When asked was R4 a 1:1 feed assistance, V20 stated, "Not that I know of." When asked how would V20 know if R4 was 1:1 feed assistance, V20 stated, "Nurses tell you. Tell on your set. Nurses tell you everything who going to be fed."

On 8/5/24 at 4:24 pm, V33 (CNA) stated that V33 was working on 6/1/24 during the day shift on R4's floor and was not assigned as R4's primary

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CNA. V33 stated on 6/1/24, "Passing lunch trays was busy that day." V33 stated that V20 (CNA) passed R4's lunch meal try to R4 (despite V20 denying this). When asked on 6/1/24, what brought V33 to R4's room, V33 stated, "I (V33) was taking my break in the dining room and that's when another CNA (V34) come in and said that (R4) was not breathing. We all went in there." V33 stated that V33 could see that R4 "was not breathing" and that V33 could "see food on (R4's) chest. Breadcrumbs like sandwich." V33 stated that V27 stayed in the room with R4 and staff, and did record R4.

On 8/5/24 at 8:32 am, V34 (CNA) stated that on 6/1/24, V34 was working the day shift (7:00 am to 3:00 pm) and working on the assigned set of residents next to R4's room. V34 stated that V34 had not seen R4 earlier in the lunch meal with R4's food tray. V34 stated that around 2 pm, V34 was getting ready with linens in the hallway to perform resident care for R16, and V27 called out for the nurse for R4. V34 stated that V34 responded to R4's room and that V9 was trying to remove food from R4's mouth.

On 7/31/24 at 3:45 pm, V35 (CNA) stated that V35 worked on 6/1/24 on the day shift on R4's floor and did pass R4's lunch tray to R4 on 6/1/24. When asked about R4's passing on 6/1/24, V35 stated that V35 was rendering patient care and did not respond to R4's room on 6/1/24.

Facility document titled "CNA Daily Assignment Sheet" and dated 6/1/24 for day shift (7:00 am to 3:00 pm) documents, in part, V9 (LPN) assigned as R4's nurse (per room number), and V20 (CNA) assigned as R4's CNA (per room number). V33 (CNA), V34 (CNA), V35 (CNA), V36 (LPN) and V37 (CNA) are also listed as working on R4's

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unit on 6/1/24 for day shift. In the section listed as "Feeders," R4's room number is not documented.

On 8/1/24 at 12:33 pm, V2 (DON) stated that the process for a receiving an order from a doctor is that the nurse will place the doctor's orders into the residents' EHR. When asked how the nurses can receive doctor's orders, V2 stated that doctor's orders can be verbal, telephone or written. When asked if a dietitian gives a recommendation for a resident to the nurse, like double portions, supplements or 1:1 feeding assistance, what is the process, and V2 stated, "Nurse will let the doctor know to get the order" for the diet recommendation. V2 stated, "Usually, the dietitian communicates with either the doctor or a nurse. It depends on the dietitian. I know they (dietitians) definitely communicate with the physician." V2 stated, "If the dietitian tells a nurse, then the nurse will call the doctor." V2 stated, "The dietitian communicates with the physician. Then the physician would call the nurse to enter it into the system (EHR)."

R4's Order Summary Report, dated 7/29/24, document no physician order for one-to-one feeding assistance. R4's diet order, with order date of 12/3/2020, documents "No Added Salt (NAS) diet. Regular texture, Regular Thin Liquids consistency, Double protein with meals."

R4's Minimum Data Set (MDS), dated 3/22/24, documents, in part, a Brief Interview of Mental Status (BIMS) score of 9 which indicates that R4 has moderate cognitive impairment. R4's Functional Abilities and Goals for eating is coded as "Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided

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throughout the activity or intermittently."

R4's MDS, dated 6/1/24, documents, in part, that R4's discharge reporting is death in facility.

On 8/6/24 at 10:08 am, V25 (Restorative Nurse) stated that V25 has been the restorative nurse in the facility since February 2024, and that V25 was "not sure" of R4's diet for the restorative assessment of 3/14/24. V25 stated that the 3/13/24 transferred over to the MDS quarterly assessment for R4 (3/22/24). When asked what does touch assistance mean, V25 stated that the staff hand R4 the spoon, saying "Here's your spoon, I need you to eat today. Optimum goal is the intake. We want the resident to take in more." V25 stated that the staff will pass the juice or cup to the resident, set up the tray close to the resident and encourage the resident to eat. V25 stated to make sure resident is in sitting position "where resident is able to eat and not have airway restricted." When asked about supervision by staff, V25 stated that staff have to make sure resident is putting food in mouth correctly and not pocketing and that staff would be there "intermittently, often" to supervise. When asked what is considered 1:1 feeding assistance, V25 stated that it's "spoon feeding the resident" with staff doing the work. V25 described R4's eating assessment as R4 mostly using right hand with a modified spoon (weighted) and that R4 "took (R4's) time a lot" to eat. When asked if V25 stayed the entirety of R4's meal during the assessment, V25 stated no and that it was a "random visit."

R4's Wound and Skin Alteration Review, dated 5/20/24, documents, in part, that R4 has a stage 3 pressure ulcer to the left heel with skin treatment including "diet/hydration program."

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On 8/1/24 at 12:08 pm, V31 (Attending Physician) stated that V31 made rounds on R4 in the facility, and the last time that V31 visited and saw R4 in the facility was "end of May" 2024. When asked about R4 being a resident in the facility with what kind of needs did R4 have, V31 stated that R4 had "advanced multiple sclerosis and (R4) needed nursing home care which (R4's) family could not provide." When asked about R4's weight loss interventions, V31 stated, "(R4) was being seen by the dietitian, and recommendations were being taken from dietitian." When asked if a dietitian makes a recommendation for a resident, how is V31 made aware, and V31 stated, "The nurse will call me to go over the dietitian's order. I will give my order, and they (nurses) will carry it out." When asked was V31 made aware of dietitian's recommendation for 1:1 feeding assistance for R4, V31 stated, "Yes." When asked did V31 provide an order for R4's 1:1 feeding assistance, V31 stated "Yes." When asked if V31 expects the facility to have executed V31's order for 1:1 feeding assistance for R4, V31 stated, "Yes. Correct." When asked the expectation of facility staff in performing R4's 1:1 feeding assistance, V31 stated, "When (R4) is eating, one to one assistance is required. The CNA must be at the bedside and feeding (R4) with the appropriate utensils and monitoring (R4) at the bedside until the meal is over." V31 stated that R4 had multiple sclerosis which could affect R4's swallowing. If R4 is "chronically aspirating, aspiration leads to pneumonia, then infection, which can lead to death." When asked would V31 expect R4 to have choking as a natural disease process, V31 stated that if R4 was having difficulty swallowing food, the consistency of R4's food would need to be evaluated. V31 stated that R4 "required 1:1 feeding." V31 reiterated that R4

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could aspirate food, lead to pneumonia, then infection and death, and needed 1:1 feeding. When asked if choking is a natural cause of death for R4, V31 stated, "No."

On 8/5/24 at 10:40 am, when asked about which nurse V31 (Attending Physician) gave R4's 1:1 feeding assistance orders to, V31 stated that V31 does not recall the specific nurse when V31 gave the verbal order. When asked why was R4 in need of a 1:1 feeding assistance order, "(R4) was not able to feed (R4's) self." V31 stated that it was combination of R4 not being able to mechanically feed himself and "issues with (R4's) swallowing." When asked if R4 had a previous downgrade of R4's diet from the regular texture, thin liquids (that R4 was receiving when R4 passed in the facility), V31 stated, "It's the dietitian who decides if (R4) is tolerating the consistency and is to recommend order" and that the DON can put in the downgraded diet order. When asked if R4 was receiving 1:1 feeding assistance on 6/1/24, could R4's death of choking been prevented, "Yes, with one-to-one feeding and it depends on the meal, the type of food."

On 8/7/24 at 11:03 am, V1 (Administrator) clarified with this surveyor by stating that the provided job description for "Charge Nurse" covers all staff nurses who work in the facility on all of the floors/units.

Facility job description updated October 2013 for "Charge Nurse" who reports to the DON documents, in part, "Job Summary: Organize and assign all jobs to be done on his/her shift so that the workload is evenly divided among his/her employees on the basis of staff size and qualifications ... care for the clinical nursing needs of residents on his/her wing ... Requirements: ...

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2. Excellence in all aspects of quality nursing including exceptional care ... Main Duties: A. Support the facility's philosophy of care and strive to achieve its goals and objectives ... D. Supervise all aides in performing their duties by checking their work closely to ascertain that assignments have been completed ... G. Assist in updating the Care Plan every 30-90 days depending on the resident's condition ... K. Personally receive or place calls to physicians and transcribe all physicians' orders ... P. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty ... Q. Make rounds and observe individual residents who are experiencing episodes of ... deterioration in health status ... so as to be acquainted with the resident's status, both physically and emotionally and to ascertain that the staff is rendering proper care. R. At all times abide by polices of the facility and ascertain that employees under his/her supervision do the same. S. Supervise serving of prescribed diets and fluid intake ... W. Detect and correct situations that have a high probability of causing accidents or injuries to residents."

Facility job description updated October 2013 for "Certified Nursing Assistant" who reports to the DON documents, in part, "Job Summary: The purpose of this position is to assist the nurse in the providing of resident care primarily in the area of the daily living routine ... Job Requirements: ... 2. Show willingness to provide good nursing care ... A. Support the facility's philosophy of care and strive to achieve its goals and objectives ... C. Carry out assignments for resident care including (but not limited to) ... f. restorative nursing procedures ... M. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty ... P. Detect and correct

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situations that have a high probability of causing accidents or injuries to residents."

Facility policy titled "Activities of Daily Living (ADLS)" and dated September 2023 documents, in part, " ... Altered diets: When a person does not have good strength and coordination of the tongue, teeth, and lips, chewing and swallowing can be difficult. Diet changes may be recommended by a physician, nurse practitioner, speech therapist or nursing when a resident is having difficulty chewing or swallowing food. Examples of altered diets are pureed, mechanical soft, and ground meat. An altered diet allows residents to enjoy food without fear of coughing and choking and makes swallowing safer ... Dining Interventions ... Special Equipment. General: Identify appropriate equipment for each resident. Allow time for positioning and assistance with utensils. Use verbal instructions as appropriate. Allow for rest breaks and changes in food choices on the plate."

Facility policy titled "Policy & Procedure Weight Assessment and Interventions" with last review date of January 2024 documents, in part, "Policy: Ensure that residents are monitored for undesirable weight loss or gain so appropriate interventions can be put in place in a timely manner. Procedure: 5. The dietician will document desirable and undesirable weight changes and will discuss with the interdisciplinary team to identify possible interdisciplinary approach/interventions."

Facility policy titled "Care Plan" and dated April 2024 documents, in part, "A. Policy: All residents with have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal

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status. B. Procedure: ... 4. ... b. The Interdisciplinary Team develops a comprehensive, individualized care plan based on interdisciplinary team assessments and comprehensive assessment of the resident prior to the care conference ... 5. Care plans are reviewed and discussed individually. a. Concerns, problems, needs, and/or strengths are listed based on resident's individual needs. Physicians' orders and personal care and nursing needs are also listed based upon comprehensive assessments ... c. Approaches are written clearly to be understood by all. Approaches include specific departments and staff member(s) responsible. Approaches must reflect Interdisciplinary Team involvement ... f. Notation is made on the care plan when a goal is resolved and changed."

Facility policy titled "Nutrition Intervention Program" and dated March 2014 documents, in part, "Policy: Residents identified as needing additional nutrition interventions will be started on the NIP Program. Identified Residents include, but no limited to: 1. Significant weight loss at 1 month, 3 months, 6 months. 2. Significant change in food intake. 3. Significant weight change upon re-admission. The nutrition interventions can be initiated by the food service manager, dietician, or nursing staff. Nutrition Interventions include: 1. Update resident's food preferences. 2. House Supplement 2.0 60 ml (milliliters) TID (three times a day). 3. Supplemental foods, such as, pudding, ice cream at lunch and dinner, (fortified cereal) at breakfast. 4. ST (Speech Therapy) evaluation if noted with dysphagia. Nutrition Interventions for Identified Residents with Pressure Wounds include, but not limit to: ... Stage III: ... Double protein/meat every meal."

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S9999	Continued From page 31 Facility policy dated January 2024 and titled "Resident Rights" documents, in part, "Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to "promote and protect the rights of each resident" ... Right to a Dignified Existence ... Quality of life is maintained or improved ... Equal access to quality care." No violation issued	S9999		