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S 000	Initial Comments Complaint Survey: 2486983/IL177458, 2487002/IL177498 & 2486995/IL177492	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 1. 300.610a) 300.1210b) 300.1210c) 300.1210d)4)B 300.1210d)4)D 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	S9999		

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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:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.

D) Each resident shall have clean bed linens at least once weekly and more often if necessary.

These Requirements were NOT MET as evidenced:

Based on observations, interviews, and record reviews the facility failed to provide ADL (Activity of Daily Living) care to residents who are dependent on staff assistance with ADL's. This failure affected 3 [R2, R3, R4] of three residents reviewed for incontinence care and personal hygiene. This failure resulted in R2 feeling the urine and feces burning in R2's wound, R3 feeling itching and burning due to delayed care and R4 not receiving incontinence

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care for 12 hours and which resulted in R4 itching and scratching all night from urine.

Findings Include,

R2's clinical record indicates in part; R2's medical diagnosis was muscle wasting, paraplegia, and major depressive disorder. Minimum Data set [MDS] Section [C] dated 8/6/24, Brief interview mental status scored [15], indicates R2 is cognitively intact. MDS section GG dated 8/6/24 indicates R2 is dependent for activities of daily living [ADL] care, toileting, bathing, and transferring.

R2's care plan dated 6/13/22, document in part, R2 has a self-care deficit and require total assistance with for activities of daily living [ADL] care.

On 9/11/24 at 8:10 AM, R2 stated, "I have not been changed all night. I am soaked with urine and feces; and this happens all the time. I have a wound on my butt, and my wound needs to stay clean, the urine and feces burn like hell in my wound. I had this wound for years since I been here, this is why my wound will not heal because I sit in urine and feces."

On 9/11/24 at 8:15 AM, surveyor observed V26 [Certified Nurse Assistant] complete incontinence care for R2's. V26 and surveyor observed R2's under brief soaked with urine that leaked out on to the fitted sheet. There were crumbs all over his buttocks. V26 stated, "The white crumbs are the under brief disintegrating from being soaked with urine for so long the under brief is falling apart."

On 9/11/24 at 8:20 AM, surveyor observed R2's wound care with V28 [Wound Nurse Practitioner.

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V28 cleaned the area and also applied metro cream. V28 stated, "The metro cream to help prevent the wound from being contaminated with urine and feces to help prevent infection. R2 tells me his dressing comes off at times due to feces and urine, so the metro cream will help the wound from developing an infection. Incontinence care need to be provided timely to prevent contamination."

R4's clinical record indicates in part; R4 was admitted with hemiplegia and hemiparesis, flaccid hemiplegia affective left side, and essential hypertension. MDS section [C] dated 7/22/24, Brief interview mental status scored [13], indicates R4 is cognitively intact. MDS section GG dated 7/22/24, indicates R4 is dependent for activities of daily living [ADL] care, toileting, bathing, and transferring.

R4's care plan dated 7/22/24, document in part, R4 has a self-care deficit and require total assistance with for activities of daily living [ADL] care.

On 9/11/24 at 8:40 AM, R4 stated, "I am soaked with urine. I have not been changed since yesterday around 9PM. My fingernails are nasty, because I been itching and scratching all night from the urine eating at my skin. I am so nasty. I been asking to get a shower for the last couple of days. I'm treated like a dog."

R3's clinical record indicates in part; R3 was admitted with medical diagnosis of weakness, reduced mobility, abnormal gait and mobility, essential hypertension, and limitation of activities due to disability.

MDS section [C] dated 7/17/24, Brief interview

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mental status scored [8], indicates R3 is mildly cognitively impaired MDS section GG dated 7/17/24, indicates R3 is dependent for activities of daily living [ADL] care, toileting, bathing, and transferring.

On 9/11/24 at 7:22AM, surveyor heard R3 yelling out for help. Surveyor entered R3's room and observed R3 resting in bed, alert and orientated. R3 stated, "Help me, no one has cleaned me up all night long and this bowel movement is eating me up all over my a**, it is itching and burning so bad."

On 9/11/24 at 7:38 AM, V7 [Certified Nurse Assistant] and surveyor observed R3's incontinence care. Observed R3's under brief filled with feces and urine. The feces and urine were leaking out onto the incontinence pad with four brown colored circle rings. V7 stated, "I will go get the night nurse, R3 was not changed at all last night, the night nurse needs to see this."

On 9/11/24 at 7:45 AM, V8 [Registered Nurse] stated, "I saw the night certified assistant enter into this room to clean R3 up. The night certified assistant did not touch him at all. I am going to discipline her. I am so sorry."

On 9/12/24 at 3:33 PM, V14 [Assisted Director of Nursing] stated, "I started in serving nursing staff on ADL care, and once they come on the floor to complete rounds and if anyone is soiled the certified nurse assistant from the previous shift will be disciplined. Incontinence care rounds should at least be made every two hours."

On 9/12/24 at 4:05 PM, V2 [Director of Nursing] stated, "All nursing staff should make rounds every two hours to provide incontinence care. The

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nurse should make rounds to ensure incontinent care is being provided. If incontinent care is not being provided timely, it could potentially cause skin issues and infection."

Reviewed Facility's resident council:
4/9/24- Resident said she was sitting in feces for over two hours.
4/26/24- Family member concerned that resident was not receiving proper incontinent care throughout night shift.
4/13/24 Resident complaint, she did not have her call light for two hours, could not call for assistance.

Reviewed Facility's resident council minutes:
8/18/24 resident said they have to wait a long time for call light response to receive assistance.

Policy documents in part:
Guidelines for incontinence care date 9/21/23
-Ensure that residents received as much assistance as needed for cleansing the perineum and buttocks after an incontinent episode or with routine daily care. Frequent minimal every two hours checks as well as care planning.

(B)

Licensure Violations 2 of 3

300.1210b)
300.1210c)
300.1210d)2)
300.1210d)3

Section 300.1210 General Requirements for Nursing and Personal Care

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S9999	Continued From page 6 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Requirements were NOT MET as evidenced by: Based on interviews and record reviews the facility [A] failed to monitor and recognize change in condition for one resident [R3]out of 4 residents with known history of chronic kidney disease fluid volume status, [B] failed review and address diagnostic test results, and [C] failed to follow physician orders to schedule nephrology,	S9999		

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cardiology, and pulmonary consultant appointments. These failures resulted in R3 being sent to the emergency department very weak, massive volume overload, worsening kidney function, pulmonary edema, respiratory failure, hypotension, and diagnosed with cardiorenal syndrome, in acute renal failure, admitted to intensive care unit to place line for emergent dialysis.

Findings Include:

R3's clinical record indicated in part the following:

On 6/14/24, R3 was admitted with medical diagnosis include but not limited to chronic kidney disease, chronic obstructive pulmonary disease, type II diabetes, chronic congestive heart failure, cardiomegaly, essential hypertension, dependence on supplemental oxygen, abnormal gait, mobility, heart failure and atherosclerotic heart disease.

R3's care plan dated 6/18/24 indicate the following in part:
R3 has a medical diagnosis of congested heart failure. Interventions are to monitor and document any edema and notify the physician.
R3 has a medical diagnosis of heart failure. Interventions are to monitor, document, and report to physician changes in edema and changes in weight.
R3 has a medical diagnosis of chronic renal disease stage [3]. Interventions are to monitor lab reports of electrolytes and report to physician if potassium is over 5.5mg/dl.

R3's Physician orders:
Cardiology Consults Appointments were ordered on 6/15/27, 7/10/24.

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Pulmonary Consult Appointments were ordered on 6/15/24, 7/10/24.
Renal/Nephrology Consult Appointment were ordered on 6/27/24, 7/10/24.

R3's progress notes Dated from 6/27/24 to 8/27/24, there were eleven documented provider progress notes for multiple consults appointments [Cardiology, Pulmonary, Renal/Nephrology] and a need for a pulmonary function test.] [None of the Consult appointments or test were scheduled]

R3's Laboratory results:
6/16/24 R3 Labs:
B-Natriuretic Peptide [BNP] = 1159.2pg/ml [2.0-100]
Blood Urea Nitrogen [BUN] =61mg/dl [7-28]
Creatinine =1.76mg/dl [0.44-1.32]
Glomerular Filtration Rate [GFR] = 45ml/m [>60] [diagnosed with stage 3 chronic kidney disease.]

7/28/24 Labs:
BUN =71mg/dl [7-28]
Creatinine = 2.48mg/dl
GFR 26 ml/m [>60] - [There is a trend of deteriorating renal function.]
[Stat labs were collected on 7/28/24 at 21:08 (9:08 pm) and resulted in the facility's dashboard computer system on 7/28/24 at 21:54 [9:54PM]. Labs was not reviewed until 8/1/24 at 21:34 [9:34 PM] 4 days later by V9 [Nurse Practitioner]. Labs were not addressed or documented on by V9 or any other physician, nurse practitioner, nor nursing staff in the progress notes.]

8/27/24 Labs:
Potassium 6.0mmol/L
BUN=128mg/dl
Creatinine= 7.01mg/dl [0.44-1.32]

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GFR = 7ml/m [>60]
BNP= 26,862pg/ml [2.0-100]
[Stat Labs were collected 8/27/24 at 14:45 (2:45 pm) . Labs resulted on 8/27/24 at 19:39 [7:39 PM]. Labs was reviewed 8/28/24 at 11:16 AM by V9 [Nurse Practitioner] approximately 12 hours later, R3's labs were reviewed by V9 [Nurse Practitioner] R3 labs: Elevated potassium at 6.0, BUN at 128, creatinine at 7.0, and an eGFR of 7, indicating critical lab values. [R3 now exhibits lab findings consistent with stage 5 CKD or renal failure.]

R3's Progress notes indicates in part:
6/15/24 at 14:33 R3 noted with right leg edema, physician notified [V17 Medical Director/R3's Physician, no orders were given]

R3's 6/24/24 at 21:57 V18 [Physician] progress note:
R3 had no weight change, weight is 219.0 (pounds). Plan is for R3 to have a pulmonary function test, and pulmonary consult with V21 [Pulmonologist]. [V18 also provided V21's phone number in the note].

R3's 7/11/24 at 17:17 (5:17 pm) progress note documents - R3 noted with right leg edema, physician [V17] notified. (no orders were given)

R3's 7/11/24 at 20:03 (8:03 pm) V18 [Physician] progress note:
R3 had no weight change, weight is 219.0. Plan is for R3 to have a pulmonary function test, and pulmonary consult with V21 [Pulmonologist]. [V18] also provided V21's phone number in the note].

R3's 7/19/24 at 16:25 (4:25 pm) V18 [Physician] progress note documents: Plan is for R3 to have

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a pulmonary function test, and pulmonary consult with V21 [Pulmonologist]. [V18 also provided V21's phone number in the note]. Cardiologists consult with V23 [Cardiologist].

R3's 7/21/24 at 10:35 am V10 [Nurse Practitioner] progress note documents: No weight changes. Weight 219.0. R3's plan-Pulmonary function test, pulmonary consult, and cardiology consult.

R3's 7/28/24 at 18:50 (6:50 pm) V11 [Former Licensed Practical Nurse] progress note: Per V3 [R3's Family Member] R3 has swelling to his abdomen. Upon assessment R3 has distended abdomen that feels ridged and hard. Writer spoke with MD orders for stat x ray (as soon as possible) of R3's abdomen and D5 with ½ normal saline @80 ml/hr. for 48 hours continuous. Orders for stat CBC, BMP. Orders noted and carried out.

R3's 7/29/24 R3's stat abdominal Xray was completed on 7/29/24. Resulted on 7/29/24 at 21:06 (9:06 pm). Findings: Difficult evaluation. [Results was not relay to physician]

R3's 7/30/24 at 9:19 am V10 [Nurse Practitioner] progress note: No weight changes noted. Weight is 236.2 [On 7/21/24 V10 documented R3's weight 219.0. R3 gained 17.2 pounds in 9 days, however V10 did not notice the weight gain and documented no weight gain] Plan: Pulmonary function test, pulmonary consult, and cardiology consult.

R3's 7/30/24- V9 [Nurse Practitioner] progress note:
The resident is being evaluated today due to reports of abdominal firmness. The onset of the

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firmness is not clear. According to the nurse on duty, the resident's abdomen is less firm than it was the previous day. The resident reports no pain upon palpation, a complete stat abdominal ultrasound has been ordered. [Stat Ultrasound results was not relayed to V9]

R3's 7/31/2024 13:42 (1:42 pm) Dietary Progress Note documents: NUTRITION: RD Review (Skin, Weight), Weight(s): 236.2 lbs. (7/30), 219 lbs. (6/14)
Weight Change: Up 17.2 lbs. (7.9%) in 1 month. Weight is up in past 1 month. No edema, per provider note, 7/30. /Plan: Monitor weight, PO intake, skin updates. RD available, as needed WEIGHT WARNING. [Physician was not notified]

R3's 7/31/24 at 19:05 (7:05 pm) V18 [Physician] progress note documents: No weight changes. R3's weight is 236.2 pounds.
[V18 progress note on 7/11/24 at 20:03 R3 had no weight change, weight is 219.0. From last visit on 7/11/24 to 7/31/24 R3 gained 17.2 pounds]. Plan is for R3 to have a pulmonary function test, and pulmonary consult with V21 [Pulmonologist]. [V18] also provided V21's phone number in the note], nephrology consult, and cardiology consult. [V18 failed to address 17.2-pound weight gain.]

R3's abdominal ultrasound was completed on 8/1/24 , resulted on 8/1/24 at 21:14 (9:14 pm) . Results were reviewed by V9 [Nurse Practitioner] on 8/1/24 at 21:14. [V9 stated she went on vacation and did not report the findings to anyone]. Findings: Large amount of ascites. [V9 did not document on R3's ultrasound report findings. No progress note documented the abdominal ultrasound was relay to the physician by nursing staff nor no documentation the test was addressed by any physician, or nurse

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practitioner].

R3's 8/4/24 at 13:57 (1:57 pm) V22 [Nurse Practitioner] progress note: No weight changes. R3's weight 219.0 [R3's clinical record document 7/30/24 weight of 236.2]
Pulmonary function test, pulmonary consult, and cardiology consult. [V22 documented the weight gain, failed to address the weight gain]

R3's 8/7/24 at 10:45 am V10 [Nurse Practitioner] progress note: No weight changes noted. Weight is 236.2. Plan: Pulmonary function test, pulmonary consult, and cardiology consult.

R3's 8/13/24 [no time documented] V9 [Nurse Practitioner] progress note stated: On 8/13/24 The resident is being evaluated for their 30-day follow-up today. They are alert and oriented to both person and place. Vital signs have remained stable. The nurse reports that the patient is compliant with medication and exhibits no new behaviors. Assistance is needed with activities of daily living (ADLs) and mobility. The resident has been stable since the initial assessment, with no falls or new wounds in the past 30 days. They deny experiencing fevers, chills, headaches, dizziness, chest pain, shortness of breath, nausea, vomiting, diarrhea, or constipation. No signs of acute distress are observed.
[Upon V9 return back to work, V9 failed to address known, ultrasound results that showed large amount of ascites dated 8/1/24 that she reviewed while on vacation.]

R3's 8/16/24 06:21 pm V18 [Physician] progress note documents: No weight changes. R3's weight is 236.2 pounds.
Plan is for R3 to have a pulmonary function test, and pulmonary consult with V21 [Pulmonologist].

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[V18 also provided V21's phone number in the note], nephrology consult, and cardiology consult. [V18 documented the weight gain and failed to address]

R3's 8/19/24 at 10:25 am V10 [Nurse Practitioner] progress note: No weight changes noted. Weight is 238.2. [V10 note dated 8/7/24 note R3 weight at 236.2. R3 weight increased by 2 pounds. Plan: Pulmonary function test, pulmonary consult, and cardiology consult. [V10 documented the known weight increase and failed to address]

R3's 8/26/2024 19:42 (7:42 pm) V12 [Registered Dietitian] Dietary Progress Note documents: NUTRITION: RD Review (Skin, Weight) Weight(s): 238.2 lbs. (8/22), 236.2 lbs. (7/30), 219 lbs. (6/14). Weight Change: Up 19.2 lbs. (8.8%) in 2 months. Weight is up in past 2 months No edema, per provider note, 8/19. Weight fluctuations may be anticipated with diuretic therapy.

R3's 8/27/24 at 13:59 (1:59 pm) V10 [Nurse Practitioner] progress note documents: No weight changes noted. Weight is 238.2. Plan-Echocardiogram, BNP monthly, cardiology consult, renal ultrasound, Pulmonary function test, and pulmonary consult. [V10 documented a weight increase and failed to address]

R3's 8/27/24 [no time documented] V9 [Nurse Practitioner] progress note stated: Resident is being evaluated today for reports of increased weakness. Resident noted A/Ox2 (Self and location). Resident assessed in privacy of bedroom with [V3/R3's Family Member] at bedside. R3 noted with generalized edema. CBC, CMP, BNP ordered stat. Denies any fevers, chills, headache, dizziness, chest pain, SOB, nausea,

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vomiting, diarrhea, constipation. No acute distress noted at this time.
[Stat Labs were collected 8/27/24 at 14:45 (2:45 pm) . Labs resulted on 8/27/24 at 19:39 [7:39 PM]. Labs was reviewed 8/28/24 at 11:16 AM by V9 [Nurse Practitioner] approximately 12 hours later, R3's labs were reviewed by V9 [Nurse Practitioner] R3 labs: Elevated potassium at 6.0, BUN at 128, creatinine at 7.0, and an eGFR of 7, indicating critical lab values. [R3 now exhibits lab findings consistent with stage 5 CKD or renal failure.]

R3 's 8/28/24 Hospital emergency department record shows: R3 entered the emergency department very weak, massively volume overload, worsening kidney function, pulmonary edema, respiratory failure, and hypotension. Per R3's daughter, R3 has been more confused over the past several days. Left leg edema progressive over the past week. Vital signs with hypotension, bradycardia, and left lower leg edema on arrival. Concern for cardiogenic shock. Nephrology to admit R3 to the intensive care unit and place a line for hemodialysis. Admitted to intensive care unit for further care. (R3 was admitted to the hospital on 8/28/24 at 1:02 pm) Nephrology was consulted and recommended dialysis and admission to the intensive care unit. Likely cardiorenal syndrome in acute renal failure, line to be placed by intensive care unit team for emergent dialysis.

Interviews:

On 9/10/24 at 10:13 AM, V3 [R3's Family Member] stated, "I noticed around the end of July, prior to R3 being sent out the end of August, that something was wrong, and he had swelling all over his body. I told the V11 [Licensed Practical

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Nurse] that R3's stomach was hard and swollen. V11 called R3's physician and he ordered labs, stomach x-ray, and intravenous fluids. The nurses told me the R3 was fine, he was dehydrated and needed the fluids. I trusted they were telling me the truth, because R3 had no other symptoms during that time, the end of July. The nursing staff and nurse practitioners kept telling me it was R3's congested heart failure and refused to send him to the hospital. On 8/27/28, I came to visit R3, and he could not speak, R3 always could talk. He was closing his eyes, and making sounds, but I could not understand one word coming out of his mouth, and he was really swollen in his arms, legs and abdomen area, the edema was worse. I asked V24 [Agency Licensed Practical Nurse] has R3 been like this all day, V24 said yes, and he just thought R3 was very tired. I told V24 this was not R3's normal state, something is wrong with R3, and go get some one that can help. V9 [Nurse Practitioner] came to see R3. V9 told me she would order stat labs and they should be back today to make sure R3 is okay. I asked V9 if R3 should be sent to the hospital, V9 told me she wanted to wait a few hours on the lab results. I explained I was concerned because R3 was very swollen, cannot speak, and keept closing and opening his eye. The nurse practitioner told me she would order labs stat. However, no one called me with the results on 8/27/24. The next afternoon on 8/28/24, V24 nurse called me and said they was sending R3 to the hospital due abnormal labs related to his kidney function. I believe no one followed up on his labs, V9 told me the results would come in a few hours. I feel the facility did not listen to me or cared about R3; they should have done something to help him about four weeks ago when he first started swelling up all over his body. I was the only one who noticed his

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edema and change in mental status, I am afraid if I did not demand for someone to see him on 8/27/24, he would have died in the facility. The facility never scheduled any of his important appointments with the Nephrologist, Cardiologist, or Pulmonogist to manage his health conditions, they were responsible to schedule all R3's appointments. R3 arrived in the emergency department and R3 was admitted to the intensive care unit to start a line for emergency hemodialysis. Now R3 needs hemodialysis three times per week, because of the facility's neglect." [R3's family member [V3] noticed change of condition, facility staff did not]

On 9/12/24 at 1:56 PM, V15 [Appointment Scheduler/Central Supply] stated, "I knew about R3's appointments and consults that needed to be scheduled. I received R3's first order dated for 6/15/24 from V33 [Licensed Practical Nurse]. According to my notes, R3 had additional orders for nephrology, pulmonary, cardiology and pulmonary test ordered, the appointments was not scheduled. I did not schedule R3's consult appointments, I believe it was due to his insurance, I am not sure. I did not notify V2 [Director of Nursing] or the any staff nurse that his appointments was not scheduled, I really cannot remember the reason I did not schedule R3 appointments."

On 9/17/24 at 1:04 PM, V11 [Former Licensed Practical Nurse] stated, "On 7/28/24, R3 appeared to look swollen, but he had edema in his legs and arms for a couple of weeks. Other than R3 being swollen he was stable, he was not experiencing any nausea, vomiting, diarrhea, he ate his meals. Around 6PM, R3's family member [V3] was concerned that R3's abdomen was swollen. During my assessment I noted his

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abdomen was swollen and hard. The swollen abdomen was new that V3 [R3's Family Member] had noticed. I called V2 [Director of Nursing] for V17 [Medical Director] direct phone number, because I was having difficulties getting in contact with V17. V2 gave me his number, and V2 was made aware of R3' swollen abdomen, she did not ask me any questions regarding R3's condition. I spoke with V17 and explained R3 has distended abdomen that feels ridged and hard and have no other symptoms. V17 gave orders for stat x ray of R3's abdomen and intravenous D5.45 normal saline [Dextrose 5% and 0.45% sodium Chloride] @80 ml/hour for 48 hours continuous. Orders also received for stat CBC, BMP. Orders noted and carried out. I did not see the results of the labs because I got off work at 7PM. Once the results are completed the nurse can see the results on the computer system's dashboard and or under the resident's name in the results tab. I gave report to V31 [[Licensed Practical Nurse] to check for R3's labs and test results and to call V17 with the results. V31 said she understood and will call V17. I documented V17 orders, I did obtain nor document any vital signs, V17 did not ask about R3's vital signs because I would have obtained them and documented. R3 seemed to be relaxed and not in distress."
[R3's family member [V3] identified R3's change of condition, facility staff did not recognize R3's swelling]

On 9/19/24 at 3:38 PM, V31 [Former Licensed Practical Nurse] stated, "I worked with R3 on 7/28/24, from 7PM to 7:30 AM. I received in report from V11[Licensed Practical Nurse] earlier that R3 family observed R3 with a hard distended abdomen and V17 [Medical Director/R3's Physician] ordered intravenous fluids, I assumed

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it was for dehydration, I really did not know the exact reason. Also, R3 was ordered stat labs and stat diagnostic x ray of his abdomen, and for me to call V17 with the results. After report, I logged onto the computer system, the dashboard shows all the labs that needs to be relayed. I checked for R3 labs and abdomen x ray, but they were not posted. I remember, at the start of my shift the IV company came and inserted a picc line in R3's arm, and I started his fluids right away. R3 was alert and oriented x3, speaking to me, he looked stable, I did not take his vital signs. I got busy during my shift and did not check the dashboard or R3's chart [results tab] for his stat lab results." [Family observed R3's change of condition, V31 did not address R3's labs]

On 9/19/24 at 3:14 PM V16 [Licensed Practical Nurse] stated, "I worked with R3 on 7/29/24 for day shift [7am-7pm]. I remember administrating intravenous [IV] fluids to R3 for dehydration. There is usually a nurse practitioner in the facility, and they review and address the labs. The labs are available on the computer system dashboard, and under each resident result tab, but I did not review labs for R3, I did not know he had stat labs ordered on 7/28/24."

On 9/19/24 at 3:20 PM, V8 [Registered Nurse] stated, "I worked with R3 on 7/29/24 and 7/31/24 from 7pm to 7am night shift and I did administer R3 IV fluids for dehydration. All resident labs appear on the computer system dashboard and under each resident chart. I did not check the system dashboard for any labs that was not relayed, because the day shift nurse usually takes care of the labs, not the night nurses. I did not check for R3's labs."

On 9/12/24 at 10:24 AM, V9 [Nurse Practitioner]

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stated, "I been working here through an outside agency, I'm contracted through the facility. R3 was alert and oriented x3, able to make his needs known. R3 was admitted with the diagnosis of chronic kidney disease, congested heart failure, and prostate cancer. On 7/30/24, V11 [Licensed Practical Nurse] alerted me that she received orders on 7/28/24 for abdominal Xray and Intravenous fluids Dextrose 0.45% saline at 80ml/hour for 48-hours and now R3's family is concerns that his abdomen is swollen. I do not understand why R3 was ordered intravenous fluids, and he has a diagnosis of chronic kidney disease and congested heart failure, let make it clear, I did not order those fluids. I reviewed the abdominal Xray results showed scattered air in the colon, but difficult to evaluate. Due to the results not giving much information, I ordered a stat abdominal ultrasound, because he had edema in abdominal area and lower extremities. I never received a phone call from the nurses regarding R3's results. On 8/1/24 I reviewed R3 results remotely, and the results showed large amount out of ascites, marginally enlarged liver without abnormality, and mild dilation of the extrahepatic bile duct. After I reviewed the ultrasound results, on that day I was off and on vacation. I knew R3 was a low sodium diet, diuretics, and awaiting nephrology consult. At the bottom of the ultrasound report, the diagnostic company printed that the results were faxed over to V17 [Medical Director/R3's Physician] office. I did not notify V17 [Medical Director/R3's Physician], V18 [Physician], V10 [Nurse Practitioner], V2 [Director of Nursing] nor any nursing staff, I was out of town and on vacation. However, they all knew I was on vacation." [R3's Family Member [V3] identified R3's change of condition]

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On 9/19/24 at 1:44 PM V12 [Registered Dietitian] stated, "I am contracted to work with the facility since October 2023. I usually review the resident's chart online and make adjustments and recommendations based on the resident's clinical chart, I basically work remote. However, there is another dietitian that attends the weekly weight meeting, but we all collaborate on the resident's comprehensive health via phone and or email. During the weight meetings, nursing administration V2 [Director of Nursing] and V14 [Assistant Director of Nursing], are present as well, for any nursing issues that the dietitian is not made aware of or any acute changes that need to be addressed regarding nutrition, wounds or weight. On 7/31/24, I reviewed R3's chart online remotely, and noted there was a 17-pound weight increase. The oral intake log documented R3 had a good appetite. I also reviewed, V10 [Nurse Practitioner] progress note dated 7/30/24 at 09:19, V10's assessment notes there was no documentation of concern regarding R3' weight. The note documented "no edema." V10 also documented, the weight of 236.0 pounds in her assessment note, with no concerns regarding R3's weight was noted. Once the medical provided did not express any concerns with R3 weight, and documented no edema, just the day before my review and R3 was on a no added salt diet, I did not change or add any new recommendations. The standard of care is that upon all new admissions and re-admissions the residents should be weighted weekly for four weeks then monthly if there's no concerns. R3 was admitted on 6/14/24 and weighed 219.0 pounds. The facility did not follow their weight protocol, R3's weight was not taken the weeks of 6/21/24 or 6/28/24, then R3 was admitted to the hospital on 6/29/24 and re-admitted back on 7/10/24. R3 weight was not taken on

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re-admission (7/10/24) and R3's weight was not taken during the weeks of 7/17/24, or 7/24/24. Then on 7/30/24 R3's weight was taken at 236.2 pound. The facility nursing administration is made aware of all the weights and any recommendation, it is the nursing responsibility to notify physicians, nurse practitioners and family of weight changes."

On 9/18/24 at 11:11AM, V14 [Assistant Director of Nursing] stated, "I been working her since 7/29/24. I do not see where the stat labs were addressed. I see that V9 [Nurse Practitioner] reviewed the stat labs on 8/1/24, because it is documented in the upper left corner of the lab. However, any provider and licensed staff is able to view any labs in the resident electronic chart under the result tab. The weight policy protocol is the restorative aides complete the weights for the facility. The restorative aides obtain the weights, they do not document the weights. Then they give the weights to me, and I review the resident previous weights. If there is a five-pound increase or decrease, in the resident's weight I have the resident re-weighed. Once the resident weight is confirmed, I would review the resident's medical diagnosis and call their physician and dietitian. R3's weight upon admission was 219.0 lbs. (6/14/24) [pounds], on 7/30/24 R3's weight was [236.2 pounds] verified on 8/1/24 [236.2 pounds]. R3's other weights were 8/7/24 [236.0 pounds], 8/12/24 [238.2 pounds], and on 8/22/24 [238.2 pounds]. I entered R3's weight for 8/12/24 and 8/22/24, but I did not look back at his previous weight, that was an oversight. V2 [Director of Nursing] was overseeing the resident's weight monitoring, I was only entering the weights into the resident's chart. When the physician or nurse practitioner give an order to monitor vital signs that mean blood pressure, heart rate, pulse,

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oxygen saturation percentage, respirations, and temperature. When there is a picc line inserted and intravenous fluids ordered, the nurses should closely monitor the resident condition, all vital signs, the picc line site, signs and symptoms of fluid overload and document in the resident progress notes. Any change in condition such as a change in vital signs, edema noted, or mental status change the physician or nurse practitioner should be notified immediately and documented in the resident's progress note."

On 9/19/24 at 11:34 AM V2 [Director of Nursing] stated, "R3's physician orders for needed appointments with nephrology, cardiology, and pulmonary, should've been scheduled, I am not sure. R3 went back to the hospital at the end of June to beginning of July. V15 [Appointment Scheduler/Central Supply] would know if the appointments were scheduled. My expectation is that soon as an order is placed for a consult or needed appointment, that V15 need to schedule the appointment soon as possible. The process to schedule an appointment is when the provider writes an order for a needed appointment, the nurse will place in the order and notify V15. I have not received any concerns from physicians or nurse practitioners that the orders for consult appointments was not being scheduled. If medical consult appointments are not scheduled, that does not mean a delay in treatment, because the resident is being managed here in the facility. I was not overseeing the resident weight. The former restorative nurse[V32] was responsible to oversee the weights. Weekly, the restorative nurse, [V32] dietician, assistant director of nursing, and I would meet and reviewed the weights, wounds, and gastric tube feeders which were the facility's nutritional at risk residents. I would write down any recommendations from the

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dietitian. If the dietician does not give any recommendation, then, there is nothing to report to the physician. The physicians and nurse practitioners are able to access the resident's complete chart while in the facility and remotely. All physicians and nurse practitioners are responsible to review the residents chart including the weights, I don't remember if R3 had a significant weight gain. All weights are documented in the resident's chart under the weight tab. If the dietitian did not have any recommendation for us to pass on to the physician, then it was nothing for us to report. If the dietician report recommendation for a significant weight increase or decrease, then the physician will be notified. I will check our significant weight change policy to see who is responsible for notifying the physician. I did not receive any information from nursing staff, providers or R3s' family that R3 was swollen all over his body. On 7/28/24, V11 [Former Licensed Practical Nurse] contacted me about R3's abdomen was only swollen and wanted V17 [Medical Director/R3's Physician] phone number. I did not discuss R3's weight gain with V11, I cannot remember every resident's weight. Again, the physician can access the resident's complete chart, and can review the dietician notes. My expectation of the staff nurses that receive an order for a stat labs or diagnostic test are to relay the results to the ordering provider soon as possible. The staff nurses should be on the lookout for the labs results to post on the facility's system dashboard. Again, the physicians or nurse practitioners should also follow up on their resident's stat orders they as well can check the dashboard remotely at any time." [Surveyor requested a copy of the facility's weight management policy]

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On 9/19/24 at 12:51 PM, V2 [Director of Nursing attended V30's interview] V30 [Restorative Aide] stated, "I been working here for six months. I go around the facility and obtain the resident's weights, then I gave the weights to V32 [Former Restorative Nurse], and she would place them in the resident's electronic chart. I just found this paper with some of R3's weights written down. R3 was admitted on 6/14/24 and I took his weights on 6/15/24 R3 weighed 223.6 pounds, 6/21/24, 223.4 pounds, 6/28/24 223.4 pounds, and on 7/9/24, R3 weighed 221.6 pounds. R3 came back from the hospital in July with the weight gain. I forgot to document all those weights in R3's electronic chart from June and July 2024." Surveyor asked about R3's weight in the computer system documented his weight on 6/14/24, R3 weight was 219.0 pounds. V30 stated, "I am not sure how R3 weighed 219.0 pounds on 6/14/24. Surveyor asked V30 how she obtained R3's weight on 7/9/24, because he was still in the hospital, and R3 did not re-admitted back into the facility until 7/10/24. V30 stated, "I don't know, I'm done, this is too much." V2 [Director of Nursing] stated, "Give me the paper back." [Surveyor declined V2's request] V2 [Director of Nursing] stated, "I spoke to fast, per my nurse consultant, the facility no longer have a policy on weight management, weight protocol, or significant weight loss."

On 9/19/24 at 4:22 PM V32 [Former Restorative Nurse] stated, "I worked at the facility for about six weeks. My last day was 8/9/24. I was a part of the weight team. The facility weight policy was to weight the admissions weekly for four weeks then monthly. Most of the time that did not occur. Residents were not weighed weekly for four weeks. If a resident's weight showed a five-pound increase or decrease the restorative aide would

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re-weight the resident to make sure the weight was accurate. The restorative aids were not allowed to place in a resident's weight into the computer system. V2 [Director of Nursing], V14 [Assistant Director of Nursing], and I documented the weights in the resident's electronic chart. Weight was not kept or stored on sheets of paper. I attended the weekly weight meetings. The director of nursing [V2], assistant director of nursing, dietitian and I would attend the meeting. I remember R3, had a significant weight increase, review his weights, and notice R3's weight was taken a few times in just a few days to verify R3's weight. During the meetings V2 [Director of Nursing] would take notes on all the weight gains and weight loss. V2 was responsible to notify the physician of the resident's weight gain or loss, I was not responsible."

On 9/13/24 t 12:15 PM, V10 [Nurse Practitioner] stated, "When I exam any resident I first review the resident's chart, such as labs and test results as a standard practice. I had a visit with R3 on 7/12/24, R3 seemed to be doing well. I ordered for R3 to be scheduled to see Pulmonogist and to complete a pulmonary function test due to him having chronic obstructive pulmonary disease. On 7/21/24 I reordered the R3 to be scheduled to see Pulmonogist and to complete a pulmonary function test, because I did not see that the test or appointment was completed. I do not recall ordering the intravenous fluids for R3, I do not remember. If I order IV fluids, I would have documented as such. On 7/12/24 visit I documented no weight change and current weight was 219.0, on 7/21 I documented no weight change, and current weight was 219.0, on 7/30/24 I documented no weight change, and I documented in the same note R3's current weight was 236.2. At the time of documenting on R3 I

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did not realize R3 had gained 17.2 pounds in 9 days, it was an oversight. I missed R3's weight gain. I did not review R3's diagnostic test results for the abdominal Xray nor the abdominal ultrasound. I now see the results of the ultrasound showed large amount of ascites, which means R3 was in fluid overload. I am not sure what caused R3 to go into fluid overload, the intravenous fluids that he received for 48 hours, roughly mean R3 received about 3 ½ liters of fluid, that could have potentially sent R3 into fluid overload. I did not order the ultrasound, so I was not looking for any results. Whoever ordered the ultrasound should have reviewed the results and sent R3 to the hospital for further treatment. On 8/19/24, I visited R3 and documented no weight change and then I documented R3's current weight was 238.2 which was a two-pound increase, again I have the same answer, it was an oversight. I missed R3's weight gain, I did not notice the weight increase, it was an oversight. On 8/27/24, I assessed R3 and ordered for R3 to have an echo cardiogram, renal ultrasound, pulmonary function test, and pulmonary consult because R3 had signs of fluid overload, and needed those tests completed. I did not order any test or diagnostic test, after I felt he was having signs of fluid overload, because his appointment should have been scheduled and a nephrologist should have been driving R3's care. I'm sorry, but I must end this conversation; I need to go take care of my residents that are waiting for me."

On 9/20/24 at 5:38 PM V24 [Agency Licensed Practical Nurse] stated, "I worked with R3 on 8/27/24 and 8/28/24 both days were during day shift [7AM-7PM]. I am an agency nurse, but I have worked with R3 several times. R3 is normally alert oriented x3, very loud and likes to

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call out profanity while speaking. On 8/27/24, upon making rounds R3 was sleeping. Later I was passing medication to the residents, and noted R3 was speaking in a low tone, I could not understand what R3 was saying, but he took his medication. R3 looked swollen as usual, so because he was swollen in his extremities and abdomen, it was nothing new for R3; I just thought R3 was tired. Later, in my shift R3's family member [V3] came and got me, saying R3 was swollen, and not responding like he normally does. I observed R3 resting in bed and appeared swollen as he normally looked for the past month, but he was still confused from the morning, I could not make out what he was saying, like he was mumbling, weak and very tired there was no change from the morning. V3 [R3's Family Member] requested for R3 to be cleaned up. R3 required two staff members to provide ADL care and reposition R3. V3 [R3's Family Member] became upset concerned about R3 and requested for someone to assess R3, and I explained to V3, that V10 [Nurse Practitioner] saw R3 earlier with no new orders. V3 continued to request R3 be assessed by a provider. I went and asked V9 [Nurse Practitioner] she was in the facility, to come see R3. V9 assessed R3 and gave orders for stat labs. I placed the in the stat orders. At the end of my shift, I gave report to V8 [Registered Nurse] the night nurse [7PM-7:30AM] that R3 had stat labs ordered and to call V9 with the results. The next day on 8/28/24, upon making rounds in the morning, R3 was not talking at all, appeared very weak, very tired, and sleeping. I had a hard time arousing R3, he looked much worse. I did not check for R3's lab results, because I thought R3's labs were already addressed by V8 [Registered Nurse]. V8 should have checked for the stat results and relayed them to V9. I had to start my medication pass.

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On 8/28/24, around 9AM, V9 [Nurse Practitioner] told me to send R3 to the hospital due to his stat lab results from the day prior 8/27/24, were critical. V9 asked why she was not made aware of R3's critical lab results that posted on the facility's dashboard on 8/27/24 around 7:30 PM. I explained to V9 [Nurse Practitioner], that V8 [Registered Nurse] received in nurse report to check for the stat labs and to notify V9. I notified the director of nursing, and R3's family member [V3] and called for the ambulance and R3 was transported to the emergency department. I did not document on 8/27/24, because I got busy and just forgot to document. I cannot remember if I took R3's vital signs."

On 9/12/24 at 10:24 AM, V9 [Nurse Practitioner] stated, "The next visit with R3 was on 8/13/24, and R3 looked much better, no new orders were given on 8/13/24. On 8/27/24, staff nurse came and asked to assess R3, because his family member was concerned. I assessed R3 and noted he had an increase in weakness, noted generalize edema in his abdomen, and extremities. I ordered stat labs and a cardiologist consult; I ordered the stat labs early afternoon on 8/27/24. I did not receive a phone call from the staff nurse regarding the stat lab results. The next day on 8/28/24, I reviewed the stat labs (8/27/24) and noted R3 with elevated potassium at 6.0, BUN at 128, creatinine at 7.0, and an eGFR of 7, indicating critical lab values. Lab values from 07/28/24 showed K+ (potassium) 4.6, BUN 71, Creatinine 2.48, GFR 26. There is a trend of deteriorating renal function. The resident, previously diagnosed with stage 3 chronic kidney disease (CKD), now exhibits lab findings consistent with stage 5 CKD or renal failure. Also due to the fact I was not sure what his labs indicated at that present time because the lab

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results were sitting for almost twelve hours before I reviewed the labs and addressed them. Again, the facility staff nurses do not relay any kind of labs or test orders regardless of, if they were ordered stat or not. The labs results indicated R3 went from chronic kidney disease stage III to chronic kidney disease stage 5, which means renal failure. I gave an order to send R3 out to the emergency room for further evaluation. Typically, before any licensed staff can send a resident out to the hospital, they first call the director of nursing, then call V17 [Medical Director], to see if there is any way possible to keep the resident in the facility and not send them to the hospital. The goal of the facility administration is to keep their re-hospitalization rate down by keeping the residents in the facility. I did not follow the chain of command; I told the nurse to send R3 out immediately. There were two physician orders on 6/27/24 and 7/10/24 for R3 to see a nephrologist. I do not know why R3 did not go to see any consults that was ordered. R3 needed to be managed by a nephrologist and cardiologist."
[On 7/30/24, and 8/27/24 R3's family member [V3] identified R3's change of condition, facility staff did not]

On 9/13/24 at 1:22 PM, V18 [Physician] stated, "I been working at this faciality for ten years. I work under V17[Medical Director/R3's Physician], as a house physician, however, V17 is R3's primary care physician. Upon assessing any resident, I review the resident's chart, notes, lab and diagnostic results in general. I documented on 7/19/24, 7/31/24, and 8/16/24 that R3 did not have any weight changes, but reviewing the current weight that I documented, R3 did in fact show a weight increase from 7/19/24 to 7/31 a weight gain of 17.2 pounds in 12 days, I did not

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focus in on the weight gain. If there was a concern about R3's weight gain, the nursing staff, or the dietitian should have notified me of the weight gain. I don't monitor every resident's weight. On 7/31/24, I did review R3's labs and saw his labs were abnormal, but he looks good and said he was feeling better, so I did not recommend any new orders. I did not notice the trending down in R3's kidney function from lab results dated 6/27/24 to 7/28/24. I did not order intravenous fluids on 7/28/24, R3's labs indicated his renal function was worsening. I do not know who ordered the intravenous fluids, there were to many providers managing R3's care with different approaches, there was V17, V9, V10 and myself. On 7/31/24, I continued to order for R3 to get an appointment with pulmonary consult, nephology consult, and cardiology consult. On 8/16/24, I assessed R3. I did not review the abdominal ultrasound results. I reviewed R3's results now, and it shows large amount of ascites. I did not order this test, so I did not review the results. Large amount of ascites in the abdomen means R3 was in renal failure and fluid overload and should have been sent out to the hospital on 8/1/24, when the results were reviewed by V9 [Nurse Practitioner]. I would have never order intravenous fluids here at the facility for R3, due to his medical diagnosis of chronic kidney disease and congested heart failure. R3 would have needed frequent labs to monitor his fluid volume and electrolytes. On 6/16/24 R3's GFR was 45 means R3 had chronic kidney disease stage III. On 7/18/24 R3's GRF lab value was 26 which means R3 was in acute renal failure his kidney function worsens and on 8/28/24, R3's GFR was 7 which meant R3 was in renal failure stage 5. On 7/31/24, after reviewing R3 labs I should have sent R3 out to the hospital on 7/31/24. No nurse called me regarding R3's

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ultrasound results that showed large amount of ascites, I would have given the order to send R3 out to the hospital. Cardiogenic shock means the heart is unable to pump due to too much fluid. The provider has to balance between the diuretics, fluid volume and electrolytes, R3's needed labs weekly to monitor the balance closely."

On 9/19/24 at 11:01 AM, V17 [Medical Director/R3's Physician] stated, "I am the medical director of the facility, and R3's primary physician. On 7/28/24, staff nurse informed me that R3's family member was concerned that R3's abdomen was swollen. Upon the nurse assessment, she said R3 abdomen was swollen and hard. I ordered stat [immediately] labs [blood levels], and stat x-ray of R3's abdomen. I also ordered on 7/28/24, intravenous fluids, D5 0.45 % saline at 80ml/hour continuous for 48-hours because he had nausea, vomiting and was NPO [nothing by mouth]." [R3' family identified R3's change of condition] [Surveyor read R3's progress to V17 -noted dated 7/28/24 at 18:50 V11 [Licensed Practical Nurse] progress note: Per V3 [R3's Family Member] R3 has swelling to his abdomen. Upon assessment R3 has distended abdomen that feels ridged and hard. Writer spoke with MD orders for stat x ray of R3's abdomen and D5 with ½ normal saline @80 ml/hr. for 48 hours continuous. Orders for state CBC, BMP. Orders noted and carried out]. V17 stated, "I do not know why the nurse did not document R3 had a swollen stomach from nausea and vomiting, that would be the only reason why, I would order intravenous fluids for R3 to prevent dehydration. I did not document my orders in R3's electronic chart remotely. Residents with chronic kidney disease and congestive heart failure, can receive intravenous

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fluids, but the labs need to be monitored. I ordered stat labs, and stat abdomen x-ray but I never received the results of any labs or diagnostic test results. It is the responsibility of the resident's nurse to call me with the results. I am able to access the resident chart remotely, however I am not going to keep checking the system to see when R3's results post. As the medical director I expect all medical staff to do their jobs, we all have our own license and practice independently and the facility staff does not practice under my license. When other providers, physicians and nurse practitioners visit a resident, I would expect them to talk and exam the resident face to face and receive important updates regarding the resident status from the nurse. The physicians and nurse practitioners do not have time to review every resident's chart in detail. I do not expect the physicians or nurse practitioners to review the residents' labs results, diagnostic test results, or weights during the visit. It is the responsibility of the nursing staff to report any abnormalities occurring with the residents. The nursing staff did not notify me that R3's kidney function has worsened. There were interventions in place for R3's weight gain since June. The interventions were for R3, to be scheduled for appointments to see a Nephrologist, Cardiologist, and Pulmonogist with a pulmonary function test. The facility physicians, nurse practitioners, and I are not specialist in those areas, and that is why R3 was referred out to see those specialists to assist with managing R3's medical conditions. When any physician or nurse practitioner write an order for a consult appointment or medical test to be scheduled, I expect the facility destinated person or nursing staff to schedule the needed appointments, call the insurance companies and complete the necessary steps to schedule an appointment. If

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for some reason an appointment cannot be scheduled, then the nursing staff should notify the physician or nurse practitioner immediately for additional instructions. Everyone needs to complete their job and follow the standards of care. I expect as the medical director that all providers document their visit with accurate information, and to address any changes of condition, and document the interventions. I am not sure why the physicians or nurse practitioners would document no weight change, but they documented a weight change in the same progress note. The wound care nurse notified me a couple of times that R3's leg was swollen, again edema is normal for anyone with renal disease. The wound care nurse notified me a couple of times that R3's leg was swollen, again edema is normal for anyone with renal disease. R3's increase in weight change was not abnormal for R3. It is normal for R3's weight to increase 17 pounds within one month, because he has chronic kidney disease and congested heart failure. On 8/28/24, R3 was sent to the hospital and needed dialysis, that was going to happen eventually anyway, it is part of his chronic kidney disease process. R3 was seen by multiple medical providers at the facility and R3 was stable. R3's weight gain was normal, and the physicians, or nurse practitioners didn't need to be alerted of R3's weight gain. I did not review the dietitian progress note, if V12 [Registered Dietitian] noted a significant weight increase for R3, then V12 should have notified the physician or nurse practitioner. As the medical director I expect, when any of the physicians or nurse practitioners go on leave or vacation it is their own responsibility to notify the facility and the other providers to cover all the resident's care. I have nothing do with the providers going on vacation, that is not my responsibility. At this

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moment reviewing R3' labs today on 7/28/24, the labs showed R3's kidney function worsen from his June labs, and 8/28/24 R3's labs results showed R3 was in kidney failure. R3's abdominal ultrasound on 8/1/24 showed large amount of ascites, which could have possibley meant that R3 was in fluid overload, but again I never got those results. On 8/1/24, the ultrasound results showed V9 [Nurse Practitioner] reviewed the results, and she [V9] did not notify me or any other facility providers of R3s' results, nor did she do anything for R3. If I was made aware of R3's lab results and ultrasound results, R3 should have been sent to the hospital prior to 8/28/24, it's hard to say if R3s' outcome would have been different. Again, because R3 was going to end up on dialysis eventually anyway."

On 9/18/24 at 12:10 PM V34 [Nephrologist] stated, "I assisted with managing R3's care when he came into the hospital emergency department on 8/28/24. R3 presented to be very weak, with test results and assessments indicated R3 was experiencing massively volume overload, kidney failure, pulmonary edema, respiratory failure, and hypotension. R3 was experiencing visible generalized edema [all over body]. I ordered for R3 to be admitted into the intensive care unit, and a line placement for R3 to start emergent hemodialysis. I was not aware that R3 received intravenous fluids several weeks earlier and abdominal ultrasound. Whenever a person with chronic kidney disease stage 3, along with congestive heart failure receives intravenous fluids, the resident's fluid volume status and kidney function must be monitored closely. Labs should be taken at least daily, depending on the rate and amount of the intravenous fluids, also the resident's intake and output, and their weight, all need be to be monitored closely, to prevent

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potentially leading to fluid volume overload. If after receiving the intravenous fluids, R3 had an abdominal ultrasound a few days later and if the results found large amount of ascites, and if labs showed the Glomerular Filtration Rate [GFR] was 45ml/m on 6/16/24, then on 7/28/24 GFR was 26, R3 was potentially experiencing signs of fluid volume overload and should have been sent to the emergency room at that time for further evaluation and treatment, potentially R3 could have been managed, without the emergent assistance of hemodialysis and avoided kidney failure. R3 went from stage 3 kidney disease to end stage kidney disease [Stage 5] all within approximately six weeks or so, typically if a person is being managed by a nephrologist, potentially it could take years for the disease process to accelerate from stage 3 to end stage kidney disease, but each case is unique."

Policies documented in part:
Infusion Therapy dated 7/2016.
Complications associated with intravenous therapy: Pitting edema. Prevention: Assess resident prior to infusion therapy for history of complication related to intravenous [IV] therapy such as cardiac or respiratory problems, present fluid status, ability to tolerate fluid volume. Monitor closely for signs and symptoms of fluid intolerance, fluid flow rate should be ordered and maintained appropriately according to resident's medical condition and monitor intake and output. Nursing interventions are slow or stop infusion, notify provider immediately, document observations, interventions, resident's response and outcome in resident's medical chart.

Change in Condition policy dated 1/2024.
-The nurse will notify resident change of condition when there is change in resident physical, mental

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or psychosocial status.
-Abnormal lab or diagnostic test results. A significant change in condition is a decline or improvement in the resident status that will not normally resolve itself without intervention by staff or clinical interventions. The nurse will record any changes in the resident's medical condition or status.

Physician, Nurse Practitioner Visits [No date]
To ensure that all residents receive the care and services that meet their medical needs.
Physician, Nurse Practitioner for review of the resident's medical condition, and overall medical management of the resident.
The physician, Nurse Practitioner will be notified of any changes or resident condition to ensure proper medical management of the resident.

Licensed Nurse Job Description
-chart nurses notes in an informative manner that reflects the care provided to the resident. Notify the residents physician and next to kin when there is a change in the resident's condition.
Monitors seriously ill residents as necessary.
The facility clinical staff lack the education and knowledge when to implement the facility change in condition policy.

Resident's Rights [No date]
You should receive the services and or items included in the plan of care.

Lab/Scheduling/Tracking [No date]
It is the policy of the facility to ensure that laboratory tests ordered by the physician are systematically scheduled and tracked so that ordered lab work is obtained and results are received and reported timely.
Lab results will be available to the facility and

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physicians in the system.

(A)

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300.610a)
300.1210b)
300.1210d)5

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

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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.

These Requirements were NOT MET as evidenced by:

Based on observations, interviews, and record reviews the facility failed to follow their skin condition assessment policy to ensure three [R1, R2, R3] of three residents wound dressings were checked for placement, and cleanliness, and failed to complete wound care as prescribed for one [R1] resident. These failures resulted in R1 developing a stage II pressure wound on his left rear thigh, R2's wound increased in size, and R3 developed moisture associated dermatitis.

Findings Include,

R1's clinical record indicates in part; R1 was admitted with the medical diagnosis of heart failure, chronic obstructive pulmonary disease, schizoaffective disorder, reduced mobility, abnormal gait and mobility, lack of coordination, acquired absence of left leg below knee, and muscle weakness. R1's minimum data set dated 8/15/24, R1 is cognitively intact [scored 15], alert

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and oriented x3.

R1's Weekly Skin Assessments document in part:
Left back thigh facility acquired stage II pressure ulcer noted on 6/6/24.
6/6/24 measured 2.0 x 0.5 x 0.2 cm.
6/12/24 measured 1.7 x 0.5 x 0.1 cm.
6/19/24 left back thigh was healed.

R1's Left back thigh re-opened back up on 8/7/24 measured 4.0 x 3.0 x 0.1 cm [centimeter].
On 8/14/24 measured 3.0 x 5.0 x 0.5 cm [wound size increased].

R1's Physician order:
8/28/24- Lt thigh rear: cleanse with normal saline. Apply collagen to site. cover with 4x4 foam dry. Three times per week and as needed. Everyday shift on Monday, Wednesday, and Friday.

R1's ETAR [electronic treatment administration record] documented on 9/6/24, V5 [Wound care Nurse] documented [9- see nurse note]. No PRN [change as needed] order signed out from 9/4/24 to 9/9/24.

R1's Progress note:
Type: Skin/Wound Note
9/6/2024 11:06:44
Writer [V5] attempted to treat [R1]'s wound, (R1) begins to talk aggressive to writer, resident was not easily redirected and did not allow writer to do tx [wound care treatment] all parties made aware of refusal current plan of care on going.

R1's ETAR (treatment record) indicated his wound care was completed on 9/4/24 [Wednesday]. R1's next treatment was due on 9/6/24 [Friday], wound care was not complete, nor on 9/7/24 [Saturday], and 9/8/4 [Sunday]. On

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9/9/24 R1's ETAR indicates his wound care was completed. [R1 did not receive wound care for four [4] days]

On 9/10/24 at 11:22 AM, V6 [Facility's Ombudsman] stated, "I am the Ombudsman for this facility. On 9/9/24, R1 called my work cell phone early morning and asked me to please help him, that no one has changed his wound dressing since 9/4/24. R1 said he is supposed to receive wound care on every Monday, Wednesday, and Friday's, and he thinks his wound is infected. R1 said he had someone take a picture of his wound, and it looks horribly infected. R1 said that V5 [Wound Care Nurse] came to change his wound on 9/6/24 but had a very disrespectful mouth and they both had words. R1 said that V5 told him that he would not get his wound care. On 9/6/24, 9/7/24, and 9/8/24, R1 said he been asking the nursing to change his wound dressing, they all said no, the wound care nurse will change your dressing it's not my job and told him he is not due for a dressing change until Monday. I called the facility several times on 9/9/24, I was told V2 was unavailable due to her being in meetings. On 9/10/24, I continued to call V2 and did not receive any phone call back. Then I started emailing V2, with no respond back until this morning, after you [IDPH Surveyor] walked into the facility. I had to email the facility's corporate nurse for assistance. Today when I saw V2, I asked her, if she spoken to R1 regarding his wound care and V2, told me no. V2 said I did not have time because we have a surveyor in the facility."

On 9/11/24 at 9:18 AM, R1 stated, "I was supposed to receive wound care on every Monday, Wednesday, and Friday's, and my wound is infected. I had someone takes a picture

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of my wound, and it looks terrible. V5 [Wound Care Nurse] came to change my wound on 9/6/24 but she was disrespectful, with a big mouth running off with her words. Then I told V5 back off, so V5 told me that I would not get wound care. On 9/6/24, 9/7/24, and 9/8/24, I been asking the nursing to change my wound dressing, they all said no, the wound care nurse would change your dressing, it's not my job and told me it was not due for a dressing change until Monday. Whenever my dressing come off, I cannot get no one to put another dressing back on. The staff nurse will not touch my wound, they all say it is the wound care nurse's job, and I have to wait until the wound care nurse come in. Even when the wound care nurse come in the next day, the wound care nurse still doesn't come to place a dressing or help me, I been told I have to wait until the next time the dressing is due to be changed. I have to move around with an open wound on the back of my leg, leaking fluid and causing me pain, all the time. My wound only gets changed or a dressing placed three times per week."

On 9/11/24 at 9:42 AM, surveyor observed R1's wound care with V28 [Wound Nurse Practitioner]. R1 did not have a dressing on his wound. R1 stated, "The dressing has been off since yesterday evening. R1's wound was beefy red, no drainage, no four odors noted. V5 [Wound Care Nurse] was present during wound care.
On 9/11/24 at 9:55 AM, V5 [Wound Care Nurse] stated, "I will change the order from three times per week to daily wound change. When I tried to change R1's wound dressing on 9/6/24, he started speaking disrespectful to me, I told the staff nurse I did not complete his dressing change. I did not make any other attempts to complete R1 wound care. I did not notify the

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director of nursing or R1's physician."

R2's Weekly Skin Assessment document in part:
R2's clinical record indicates he is cognitively intact.
Sacrum stage four wound, R2 was admitted with sacrum wound on 5/2023.
5/2023 measured 1.8 x 1.5x x 3.2 cm.
6/26/24 measured 1.5 x 1.0 x 2.4 cm
7/3/24 measured 1.5 x 1.0 x 2.4 cm
7/31/24 measured 2.0 x 1.0 x 2.0 cm
8/7/24 measured 2.0 x 1.0 x 2.2 cm
[R2's wound size increased]

R2's Physician order:
1/3/24-Sacral wound cleanse with normal saline medihoney then cover with calcium alginate then cover with dry dressing only use metro cream for contamination daily and as needed for wound care.

On 9/11/24 at 8:10 AM, R2 stated, "I have not been changed all night. I am soaked with urine and feces; and this happens all the time. I have a wound on my butt, and my wound needs to stay covered and cleaned. My dressing came off and none of the nurses would clean my wound a put another dressing on me, they all told me to wait until the treatment nurse come in today. The urine and feces burn like hell in my wound. I had this wound for years since I been here, this is why my wound will not heal."

On 9/11/24 at 8:15 AM, surveyor observed V26 [Certified Nurse Assistant] complete incontinence care for R2's. V26 and surveyor observed R2's under brief soak with urine that leaked out on to the fitted sheet. Once V26 turned R2 over his buttocks area wound was uncovered. There was not wound dressing on the wound, in the under

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brief, or bed. There was an open wound hole with white crumbs all over his buttocks and inside his wound. V26 stated, "The white crumbs are the under brief disintegrating from being soaked with urine for so long the under brief is falling apart. I have to go to the laundry department for more towels and linen, I'll be back in a few minutes."

On 9/11/24 at 8:20 AM, surveyor observed R2's wound care with V28 [Wound Nurse Practitioner. V28 cleaned the area and also applied metro cream. V28 stated, "The metro cream to help prevent the wound from being contaminated with urine and feces to help prevent infection. R2 tells me his dressing comes off at times due to feces and urine, so the metro cream will help the wound from developing an infection."

R3's Weekly Skin Assessment document in part:
R3's clinical record indicates he is cognitively intact.
9/11/24-perineal, scrotum, bilateral inner thighs have moisture associated dermatitis, redness and excoriation with red patches [no measurements]
Sacrum unstageable wound measures 1.0 x 1.0 x 0.4
[This assessment was completed 9/11/24 at 16:19, surveyor observed resident in bowel movement at 7:45 AM]
R3's clinical record Minimum data set, brief interview mental status indicates R3 is alert and oriented X3, he is cognitively intact.

On 9/11/24 at 7:22AM, surveyor heard R3 yelling out for help. Surveyor entered R3's room and observed R3 resting in bed, alert and orientated. R3 stated, "Help me, no one have cleaned me up all night long and this bowel movement is eating me up all over my a**, it is itching and burning so bad."

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S9999	Continued From page 44 On 9/11/24 at 7:38 AM, V7 [Certified Nurse Assistant] and surveyor observed R3's incontinence care. Observed R3's under brief filled with feces and urine. The feces and urine were leaking out onto the incontinence pad with four brown colored circle rings. Observed R3 with redden small open superficial arear to peri area, groin, and buttocks. V7 stated, "I will go get the night nurse, R3 was not changed at all last night, the night nurse needs to see this." On 9/11/24 at 7:45 AM, V8 [Registered Nurse] stated, "I saw the night certified assistant enter into this room to clean R3 up. The night certified assistant did not touch him at all. I am going to discipline her. I am so sorry. I am not sure why R3 do not have a dressing on his wound. I will replace the dressing". V7 stated, "I will clean R3 up right now, I need to go get more bath towel to soak off the dried feces." R3's progress note dated 9/11/24 at 16:19 V20 [Wound Nurse] document in part: R3 is alert and orientedx3. With open areas to the sacrum, moisture associated dermatitis to perineal area, scrotum, and bilateral thighs. [Noted after 7:45 AM observation] On 9/17/24 at 1:03 PM, V4 [Wound Care Coordinator] stated, "Moister associated dermatitis is causes by excessive moisture, from being wet too long. If a resident is not provided timely incontinent care, it could potentially cause moister associated dermatitis. R3 was admitted on 9/10/24 and his skin admission assessment did not note any moister associated dermatitis on R3's peri area. On 9/11/24, R3's skin assessment was completed by the wound team and moister associated dermatitis was noted."	S9999		

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On 9/10/24 at 3:00 PM V4 [Wound Care Coordinator] stated, "I have been the wound care coordinator her for three years. The Wound Detail report information is inputted by the wound care nurse practitioner. Under the subtitle 'Acquired at Facility' means the wound developed while the resident was in the facility. I see on the report the answer is 'no' for all resident on the report. I am not sure why the report reflexes 'no' for all residents. There are some residents that did in fact acquire or develop a wound while in the facility. I did not notice that when I gave you the report, the report is not accurate. On the report I provided, I wrote (FA) which means facility acquired, (A) which means the resident was admitted to the facility with the wound. There are two other treatment nurses, we are here daily to complete wound care. After we leave for the day, the staff nurse is capable of changing a wound dressing as needed. The wound team stagger the schedule, so we have a wound nurse in the facility on the weekends as well. Whenever a wound dressing comes off the staff floor nurse should replace the dressing to promote healing and prevent infection. On 9/6/24 when R1 and V4 was not getting along, and V4 told the staff nurses that R1's dressing was not completed. Then the floor staff nurses should have made attempts to change his dressing and document the attempts. If a dressing is not clean, changed or the dressing is not replaced, it could potentially cause a wound infection or worsening of the wound."

On 9/11/24 at 11:10 AM, V28 [Wound Care Nurse Practitioner] stated, "If the resident does not receive wound care treatments as ordered, it could potentially cause an infection, worsen the wound, or could stop the healing process. If the

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resident is not receiving timely proper incontinence care, it could potentially cause skin excoriation from the moisture, cause a wound, make a wound worse or cause an infection. All wound treatment orders also have a change wound dressing as needed order, so any licensed nurse should be able to apply the wound dressing to protect the wound."

On 9/12/24 at 4:20 PM, V14 [Assistant Director of Nursing] stated, "I have not received any concerns that R1 concerns that his wound was infected. I recently seen R1's wound, because he needed a dressing change. I saw the wound, and the wound was not infected no odor, and discharge, he had no signs or symptoms of infection was noted. If a wound dressing comes off or need changing the staff floor nurse should complete wound care and sign it out on the electronic treatment administration record [ETAR] immediately after completing the treatment. If there is no signature in the ETAR, then the treatment was not completed. If a resident refuses a wound care treatment, the staff nurse should make multiple attempts, if not successful then call the physician to receive new orders. Also, the nurse can educate the resident the importance of wound care. If a bandage is not change or covered as prescribed, it could potentially cause an infection, or the wound could worsen."

On 9/12/24 at 4:38 PM, V2 [Director of Nursing] stated, "If a resident refused his wound care, it is his right to refuse, we cannot make him. It is not the other staff nurse's responsibility to complete wound care, after it was already offered, V5 offered R1 wound care on Friday, and he refused. I do not expect the other weekend nurses assigned to R1 to complete his wound

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care from Friday. R1 can not expect his wound treatment to be completed whenever he decides he wants it. R1 received wound care on Monday, 9/10/24 which was his scheduled next day for wound care. I did not receive any emails from V6 [Ombudsman] regarding R1 until this morning, and I responded. The other staff nurses did not have to make attempts to change R1's wound. The staff nurses said that R1 did not ask for a wound change over the weekend. If there is no signature on the electronic treatment record, it does not mean the treatment was not completed, it just means the nurse forgot to sign out the treatment, as nurses we have the right to forget to document. The standard of care is once you administer medication or a treatment the nurse should sign out on the resident's electronic mediation or treatment administration record at that time, but the nurse has the right to forget to sign. I have not found any nurse that worked the weekend say they completed R1's wound care. If a wound is not changed as ordered or a dressing is not on the wound, it could or could not make the wound worsen. R1's wound is not infected according to the wound care nurse practitioner notes, and there is not documentation from the wound care team that states R1 wound is or was infected."

Policy documented in part:
Skin Condition Assessment and Monitoring
-Pressure and Non-Pressure dated 2/14/23.
-Assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions, and assuring interventions are implemented.
-Each resident will be observed for skin breakdown daily during care from the certified nurse assistant and unit nurse.
-Dressings which are applied to pressure ulcers,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014781	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 48 skin tears, wound lesions or incisions shall include the date of the licensed nurse who performed the procedure. Dressing will be checked daily for placement, cleanliness, and signs of infection. -Physician ordered treatments shall be initialed by the staff on the electronic treatment administration record after each administration. -A licensed nurse shall observe the condition of wound daily or with dressing changes as ordered. (B)	S9999		