Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007322	A. BUILDING: ______ B. WING ______	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA EVERGREEN PARK	**10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805**

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S 000	Initial Comments	S 000		
	Complaint Investigations: 2497135/IL177666 2497587/IL178275			
S9999	Final Observations	S9999		
	Statement of Licensure Violations: ONE OF THREE 300.610a) 300.1010h) 300.1210b) 300.1210c) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,			

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but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' 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:

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,

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and prevent new pressure sores from developing.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failure to develop an effective pressure sore prevention plan to reduce the risk of developing wound infection, failed to ensure wound dressings were replaced after being soiled and failed to ensure the air loss mattress were set for according to resident weight. This affected three of three residents (R2 - R4) reviewed for pressure sore protocols. This failure resulted in R2 developing an infected pressure hand wound due to contracted fingernails pressing into the palm of her hand.

Findings Include:

1. R2's diagnosis include Vascular Dementia and adult failure to thrive.

On 9/25/24 at 1:30pm, V7 (wound director) said, R2 did not a treatment for her hand nor did R2 have a splints or carrot to prevent contraction.

On 9/25/24 at 1:51pm, V10 (restorative) said, R2 was on restorative services for range of motion and bed mobility starting on 2/2024 through 9/15/24. Restorative services would include flexion and extension of hands wrists, arms shoulders, knees if tolerable feet ankle and hip abduction if they can tolerate. R2 was receiving upper and lower extremities range of motion. Per restorative assessment R2 did not have any contractures at time of assessment 3/30/24. Restorative UDA completed on admission, annual. Quarterly and with significant change. V10 said she did not see any refusal by R2. If R2

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develops a contracture therapy will assess the resident and we will follow orders.

On 9/27/24 at 1:00pm, V15 (wound nurse practitioner) said, if she did not document R2's left hand wound in her notes dated 8/29/24, R2's left hand was not being treated.

On 9/27/24 at 4:33pm, V2 (don) said, she was not aware of R2's left hand wound until she reviewed the hospital records. R2 was not under hospice or palliative care.

Wound Specialist's Assessment of wound/pressure injury avoidability/unavoidabilty date 8/22/24 documents: right/left ear pressure, sacrum pressure, left hip pressure and left shoulder pressure. (A left hand was NOT documented).

Progress note dated 8/29/24 documents: Refer/transfer patient out for an immediate care and a higher level of care for worsening wound. She continues to lose significant weight and increased contracture. Wound assessment: Sacrum, left malleolus, left ear, right ear, left hip, left shoulder and left lateral heel. (A left hand was NOT documented).

Hospital paperwork dated 8/29/24 documents: patient had a left hand pressure wound in the palm with pus due to her contracted finger nail pressing on her skin. MRI left hand-small skin and superficial soft tissue ulcer and infection at the central palm, second metacarpal level , with second mild infectious tenosynovitis suspected in the deep adjacent index finger flexor tendons. Left palm superficial resolving infection with prior sutures removed, secondary to contracture of hand/nails. X-ray hand dated 8/29/24 documents:

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Clinical indication: open ulcer. Patient from nursing home with left hand infection.

2. R3 was admitted to the facility on 9/25/21 with a diagnosis of peripheral vascular disease, acquires absence of right leg below knee and left leg below the knee, hypertension, type II diabetes, pressure ulcer of right buttocks stage three and pressure ulcer of continuous site of back, buttocks and hip stage four.

R3's minimum data set dated 9/2/24 documents a brief interview for mental status score of 14/15 which indicates cognitively intact. Section GG for toileting hygiene documents: dependent which indicates helper does all the effort, or the assistance of two or more helpers is required for the resident to complete the activity. Roll left to right documents: substantial/ maximal assistance which indicates helper does more than half the effort to complete the activity.

R3's physician orders dated 9/18/24 documents: sacrum site cleanse with normal saline. Pat dry, apply medi-honey and calcium alginate 4 x 4 and cover with dry dressing every day shift every other day for wound care.

R3's physician orders dated 9/24/24 documents: right gluteal site cleanse with normal saline. Pat dry, apply medi-honey and calcium alginate cover with dry dressing every day shift every other day for wound care. R3's physician orders dated 9/22/24 documents: right ischium (gluteal site) cleanse with normal saline. Pat dry, apply medi-honey and calcium alginate cover with dry dressing every day shift every other day for wound care. Order discontinued 9/24/24.

On 9/24/24 at 1:10pm, R3's body assessment

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was completed by V4 (nurse). R3 was observed with gauze on her sacrum wound and right buttocks wound. No wound dressing was covering the gauze. V4 (nurse) said, R3 had a gauze covering her sacrum wound, he believed wound care had been in to provide R3's treatment.

On 9/24/24 at 1:19pm, V5 (CNA) assigned to R3. V5 said, he provided care around 8:00 am after R3 had a bowel movement. R3's dressing was soiled with feces and removed. V5 said, he placed a clean gauze on R3's wound and informed wound nurse but unable to recall nurses' name.

On 9/24/24 at 2:16pm, V7 (wound director) said, the nurse on the floor should have changed R3's dressing when it was soiled or replaced it within two hour after it was removed.

On 9/24/24 at 2:36pm, V7 (wound director) changed R3's dressing. During wound care observations V7 cleaned R3's wound and placed calcium alginate to sacral wound and covered with bordered gauze. There was no medihoney applied to site. R3's site to right gluteal/buttocks/ ischium was cleaned and bordered gauze placed. V7 said, she did not have the treatment for this site because the computer kicked her out. V7 then placed a clean dry dressing over area with no other treatment applied to site.

On 9/27/24 at 1:00pm, V15 (wound nurse practitioner) said, she would expect all treatment orders to be followed as ordered.

R3's braden scale dated 9/20/24 documents a score of six which indicates high risk for skin breakdown.

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R3's care plan dated 8/31/24 documents: Resident has an actual impairment to skin integrity. Interventions include apply wound treatment as ordered by the physician; monitor/document location, size and treatment of skin injury. Report abnormalities failure to heal, signs and symptoms of infection, maceration dated initiated 8/31/24.

R3's wound note on 9/18/24 documents under wound assessment: Wound# 1 Location: sacrum Primary Etiology: Pressure Stage/Severity: Stage 4; Size: 9 cm x 10 cm x 1.6 cm. Wound # 1 sacrum Pressure Treatment Recommendations: 1. Cleanse with normal saline. 2. apply Medical grade honey, Calcium alginate to base of the wound, 3. secure with ABD, Bordered gauze, 4. change Every other day, and PRN (as needed). Wound# 5 Location: right gluteal Primary Etiology: Pressure Stage/Severity: Stage 3 Size: 6.5 cm x 5 cm x 0.3 cm Wound # 5 right gluteal Pressure Treatment Recommendations: 1. Cleanse with normal saline .2. apply medical grade honey, Calcium alginate to base of the wound. 3. secure with ABD, Bordered gauze .4. change Every other day, and as needed. Wound# 6 Location: right hip Primary Etiology: Pressure Stage/Severity: Stage 4 Size: 8 cm x 11.5 cm x 0.1 cm. Wound # 6 right hip Pressure Treatment Recommendations: 1. Cleanse with normal saline. 2. apply Medical grade honey, Calcium alginate to base of the wound. 3. secure with Bordered gauze .4. change 3 times per week, and PRN .

Facility physician order policy revised 8/16/24 documents: it is the policy of this facility to ensure that all resident medications, treatments and plan of care must be followed in accordance to the

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licensed physician orders. The facility shall ensure to follow physician orders as it is written in the physician order sheet.

On 9/24/24 at 1:10pm, R3's body assessment completed by V4 (nurse). R3 was observed laying on an air mattress set at 320 pounds, static off with a flat sheet, cloth pad and wearing an incontinence brief.

R3's weight for September of 2024 documents 90.8 pounds.

On 9/24/24 at 2:35pm, V7 (wound director) was observed turning R3's air mattress knob as she walked passed R3's footboard. V7 said, she just turned R3's air mattress to 120lbs (pounds). It was on 240 pounds. It should have been set on 120lbs. V7 said, the air mattress should be set to a resident's body weight.

On 9/27/24 at 1:00pm, V15 (wound nurse practitioner) said, V15 said, mattress setting should be set accordingly to a resident's weight so the mattress is not to hard or to soft.

R3's wound note on 9/18/24 documents under preventative measures: The patient continues on an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus.

R3's braden scale dated 9/20/24 documents a score of 6 which indicates high risk for skin breakdown.

3. On 9/24/24 at 2:35pm, V7 (wound director) said, the air mattress should be set to a resident's body weight.

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On 9/24/24 at 3:00pm, R4's air loss mattress was set to 290 pounds with alternating pressure and confirmed by V7.

R4's weight for September of 2024 documents 219 pounds.

On 9/27/24 at 1:00pm, V15 (wound nurse practitioner) said, V15 said, mattress setting should be set accordingly to a resident's weight so the mattress is not to hard or to soft.

R4's wound note on 9/18/24 documents under preventative measures: The patient continues on an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus.

R4's braden scale dated 9/23/24 documents a score of 9 which indicates high risk for skin breakdown.

Air loss mattress operation manual documents: determine the resident weight and set the control knob to the weight setting on the control unit.

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Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the

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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.

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 and assistance to prevent accidents.

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S9999	Continued From page 10 These requirements were not met as evidenced by: Based on interview and record review the facility failed to follow their fall policy by not implementing new and effective fall interventions, completing an incident report/fall investigation following a fall for one resident who was identified as high risk for falls. This affected one of three (R1) reviewed for falls. This failure resulted in R1 sustaining three falls within 30 days and being transferred to the hospital with a diagnosis of a subacute subdural hematoma. Findings include: R1 was admitted to the facility on 7/30/24 with a diagnosis of unspecified dementia, hypertension, anemia, and atrial fibrillation. R1's minimum data set dated 8/2/24 documents under toilet transfer a score of three which indicates partial moderate assistance. R1's incident report dated 8/12/24 documents: R1 was found by staff on right side of bed near the window. R1 said he got up to go the bathroom and did not remember to use call light. Under predisposing situation factors: improper footwear and unsafe transfer without assist. R1's fall risk evaluation dated 8/12/24 under cognition documents: Resident displays memory problem. Under mobility Resident is not able to walk even with assistance device. Under history documents resident just had a fall. Score 16 which indicates high risk for falls. R1's care plan documents Safety/Fall Admitted in the unit on 7/30/24 R1 was observed that he is at	S9999		

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S9999	Continued From page 11 risk for fall /self injury related to multiple medical ,functional , mental; shortness of breath, renal disease, Diagnosis SIRS (Systemic inflammatory respiratory response syndrome; cardiovascular condition; congestive heart failure CHF, hypertension HTN, contributing factors; A. Physical /Functional Status Ambulation : Needs assist in walking poor sitting balance , poor standing balance unsteady gait , needs assistance in Transfer; Pain/discomfort B. Cognition /behavior: Forgetful needs reminders cues; Poor safety awareness regarding prevention to use call light; Call for assistance periods of restlessness and agitation Recent change in condition: newly admitted in the Facility , new environment admitted with a recent decline in function multiple aches and pain. Date initiated 8/13/24. Interventions initiated on 8/13/24 document the following: greetings to resident. Provide privacy, staff to make sure bed in lowest position; staff to give a friendly approach to resident , and to anticipate needs; Provide safe / therapeutic environment (Free from clutter) Manage pain for comfort and facilitate free movements; administer as needed medications for breakthrough pain see Medication administration record/ physician order sheet (POS) /MD (physician) as directed; If "resident is ambulating staff to make sure that:" Resident is wearing proper footwear; Bed locks /Wheelchair locks engage for transfer; Use assistive device during ambulation to prevent falls; Keep mostly needed items (i.e remote control, pitcher) within reach Ensure call light, phone, and supplies within reach; Skilled Rehab Therapy evaluation and Treatment as indicates >Signage >Non-skid socks >Transferred to hospital Date Initiated: 08/13/2024. There were no other fall interventions documented in R1's plan of care or any new updates after a fall on 8/17/24.	S9999		

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R1's fall risk evaluation dated 8/17/24 under cognition documents: Resident displays memory problem. Under mobility Resident is not able to walk even with assistance device. Under history documents resident just had a fall. Under narrative documents: While I was getting report the CNA (certified nursing assistant) came and told myself (V18) and the morning nurse (V14) that the patient was sitting on the floor. We went into the patients room and he was sitting between the bed and the wall with his back against the wall. He stated that he was trying to go to the bathroom and couldn't find his urinal. Myself (V18) and the other nurse helped him up to the bed and the CNA got his vitals. No bruises or skin tears were noted. Patient stated that he didn't hit his head and he fell due to feeling weakness in his legs. V14 contacted the family and the fall risk manager. I will continue to monitor his vitals and neuro checks.   Fall risk Score 15 which indicates high risk for falls.

On 9/25/24 at 11:03AM, V11 (Fall Nurse) said R1 had two falls on 8/12/24 and 9/11/24. V11 said there were no other incident reports for R1. R1 upon admission was not a fall risk and did not have any interventions in place prior to the fall. The fall on 8/12/24 documents R1 was trying to go to the bathroom independently without staff or using call light. Root cause that R1 needed to use the restroom. R1 had the following interventions implemented: signage (Call don't fall) , non skid socks, and hospital. V11 was asked if R1 went to the hospital following fall on 8/12/24 and confirmed R1 was not transferred to the hospital. V11 was unable to find any incident report of fall on 8/17/24. V11 was shown fall risk report dated 8/17/24 that documented fall. V11 said she was not informed of fall and there were no

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interventions put in place following the fall (of 8/17/24).

On 9/25/24 at 12:38PM, V18 (Nurse) said recalls assisting V14 (nurse) with fall for R1 on 8/17/24. V18 said it was change of shift and aide reported R1 was on the floor in his room. V18 said she was starting her shift and assisted V14 and other staff from getting R1 for the floor.

On 9/25/24 3:31PM, V14 (Nurse) who was identified in report on 8/17/24 said she getting report and standing at nursing station. An aide reported R1 was on the floor. V14 said she was in the doorway and observed R1 on the floor but did not assist with transfer or any documentation of incident. V14 said R1 was trying to get to the bathroom unassisted. R1 was one to two persons assist to the toilet. R1 used a wheelchair but it was not near R1. If there is a fall we do incident report, fall risk, neurochecks, notify family and doctor.

R1's incident report dated 9/11/24 documents: R1 was observed on the floor by his bathroom to have a bowel movement and fell when trying to get up from the toilet. A skin tear was noted on his coccyx. He also appeared to have hit his head on the sliding door of the bathroom. R1 was sent to local hospital for evaluation. Under mental status: alert with periods of forgetfulness, lack of safety awareness, oriented to person and situation. Predisposed situational factors documents: toileting needs, ambulating without assist, improper footwear.

R1' hospital record dated 9/11/24 documents a CT head scan under impression. Left convexity mixed density subdural collection noted with a width of 15mm (millimeters) compatible with a

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subacute subdural hematoma. There is mass effect on the left lateral ventricle and approximately 5mm midline shift to the right.

On 9/26/24 at 12:40PM, V16 (radiologist) said a subacute subdural hematoma can occur approximately between one to three months prior to the scan.

Facility policy titled Fall occurrence revised 7/26/24 documents: It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place and interventions are reevaluated and revised as necessary. An incident report will be completed by the nurse each time a resident falls. The nurse may immediately start interventions to address falls in the unit, even prior to the falls coordinator's investigation. The falls coordinator will add the intervention in the residents care plan.

(A)

THREE OF THREE
300.1210b)
300.1210c)
300.1210d)3)
300.2040b)2)

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

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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:

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.

Section 300.2040 Diet Orders

b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian.

2) The diet shall be served as ordered.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident prescribed a mechanical soft diet with thin liquids and gastrostomy tube received enough water to prevent dehydration. This affected one of three residents (R2) reviewed for dehydration. This failure resulted in R2 having a calculated free

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water deficit of 1.9L (liters), a high sodium level and according to the hospital record a large amount of colonic stool with large amount of stool in rectum compatible with fecal impaction.

Findings Include:

R2 had the diagnosis of Vascular Dementia, Metabolic Encephalopathy, Severe Protein-Calorie Malnutrition, Adult Failure to Thrive and Encounter for Attention to Gastrostomy (G-tube). Physician order sheet dated 8/1/24 documents diet: mechanical soft, thin liquids and enteral feed Jevity 1.2 via g-tube continuous at sixty-five milliliters per hour (65ml/hr) to total volume 1040ml in twenty-four hour period. Enteral feeding- Flush with one hundred milliliters (100 mL) water every four hours. Care plan initiated 3/20/24 documents: R2 has the following conditions and risk factors that put R2 at risk for dehydration: Increased weakness, medication regimen (i.e., use of diuretics, laxatives, enemas), poor skin elasticity, Presence of infection, fever, vomiting, diarrhea, nausea, excessive sweating. Diagnosis with severe Protein Calorie Malnutrition: Intervention: Review the comprehensive assessment (including the MDS and CAAs) to identify risk factors for dehydration.

On 9/27/24 at 9:40am, V17 (dietitian) said, enteral feeding (g-tube) feeding is calculated based on calorie and protein needs of the resident. If a resident has wounds with exudate or a fever more water needs to be added to the flushes unless the doctor has ordered fluid restrictions. All of R2's nutrition was being proved by g-tube feeding. R2 did not have anything documented issues that would suggest she had any water loss conditions (i.e fever). Dehydration can be determined by abnormal/elevated BUN

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and Sodium level. If R2 was receiving, the enteral feeding and water flushes as prescribed she would not be dehydrated.

On 9/27/24 at 1:00pm, V15 (wound nurse practitioner) said, R2 wasn't eating well. R2 had enteral feedings. Enteral feeding will supply all nutritional and hydration needs that are not processed by eating. R2 was malnourished. R2 did not have any edema. Refer to the dietitian for amount of R2's caloric intake and hydration needs which should be provide by the g-tube feeding. V15 said, she sent R2 to the hospital for decondition and worsening wounds.

On 9/27/24 at 1:41pm, V19 (dietician) said, R2 was a dual feeder. R2 had g-tube feeding and a diet. R2 would eat a spoon full or bite of food. R2 was receiving Jevity 1.2 at 65ml/hr and 100 ml of water flushed every four hours. R2 was receiving all of her nutrition/hydration from the enteral feed/flushes. R2 received a total of 1439 milliliters (ML) of water daily between the two sources of nutrition prior to being discharge to the hospital. It would be impossible for R2 to be dehydrated with the water from the formula and water flushes. Elevated sodium levels are indicators of dehydration. R2 did not have any fever.

R2's diet order dated 5/7/24 documents: Regular diet, Mechanical Soft texture, thin liquids consistency. Stop date 8/29/24.

R2's enteral feed dated 2/27/24 documents: Enteral feeding- Flush with 100 mL water every 4 hours. Stop date 8/29/24.

R2 enteral feed order dated 7/4/2024 documents: every shift for feeding Jevity 1.2 via g-tube continuous at 65ml/hr total volume 1040ml in a 24

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hour period. Start at 2pm. Turn off during activities for daily living (ADL's) and as needed (PRN). Stop date 8/29/2024.

R2's Medication Administration Records do not document the administration of 100ml of water at 2200 on 8/27/24 and do not document the administration of Jevity 1.2ml at 65ml/hr on 8/27/24 in the "PM".

R2's nutritional note dated 8/26/24 documents: RD completed Nestle Mini Nutritional Assessment (MNA). Resident scored a two (2) which is consistent with at high risk of malnutrition category. Resident meets criteria for severe protein calories malnutrition related to diagnosis of metabolic encephalopathy as evident by moderate loss of muscle mass of the temporalis, trapezius and interosseous muscle and moderate loss of subcutaneous fat from Orbital and buccal fat pads and triceps. Resident condition and current decline. No dietary interventions at this time.

R2's nutritional note dated 8/6/24 documents: RD monthly enteral note. Resident is a dual feeder and receives a Mechanical Soft, thin liquid diet. During writer's meal rounds, resident had finished ~35% of her breakfast tray, which is consistent with staff report of poor to fair by mouth (PO) intake at mealtimes, thus resident receives the remainder of her nutrition via tube feed (TF). Currently ordered to receive Jevity 1.2 at 65ml/hr over 16 hours, or until a total volume of 1040ml infused. TF provides the resident with 1248kcals/day (39.6kcals/kg), 57g of protein (1.81g/kg) and 839ml of H_2O. Additional flush of 100ml every 4 hours, for a total of 1439ml/day (45.7ml/kg). No reported issues tolerating tube feeding. Current TF regimen and protein

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supplement exceeds resident's estimated nutritional/fluid needs. No significant weight changes noted; weight has fluctuated x past 6 months; however, weight has trended up since last month due to TF adjustment. Current TF regimen and protein supplement exceeds resident's estimated nutritional/fluid needs. No edema noted. Medications noted. No recommended changes present at this time. Resident remains at increased nutritional risk secondary to mechanically altered diet, enteral feeding, BMI (body mass index), diagnosis and medications.

Progress note dated 8/29/24 documents: Refer/transfer patient out for an immediate care and a higher level of care for worsening wound. She continues to lose significant weight and increased contracture.

Hospital paperwork dated 8/29/24 documents: Emergency department (ED) to hospital admission, Results dated 8/29/24 at 1524 (3:24PM) documents Sodium 154 High reference range (136-145mmol/L, Bun 25 High reference range (10-20mg/dL). ED (Emergency Department) course: CT incidentally notable for large stool burden suggestive for fecal impaction. Large amount of colonic stool with a large amount of stool in the rectum compatible with fecal impaction. Nephrology- follow up note dated 9/4/24 documents: Hypovolemic hypernatremia sodium 158 secondary to volume depletion inadequate G-tube replenishment, calculated free water deficit 1.9 Liters.

(A)