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S 000	Initial Comments	S 000		

Complaint Investigation
2481136/IL169676

S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610a)
300.1010h)
300.1210b)
300.1210d)2)3)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, 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

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plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

Section 300.1210 General Requirements for Nursing and Personal Care

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

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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 are not made as evidenced by:

Based on interview and record review the facility failed to recognize, evaluate, and address weight loss; and the facility failed to consistently implement interventions, monitor the

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effectiveness of interventions and revise them as necessary. These failures resulted in 1 resident [R3] of 4 [R5, R6, R10] residents sent to the emergency department with a diagnosis severe sepsis related to health care aspiration pneumonia, dehydration, low blood oxygen, and significant weight loss [>10% change over 6 months].

Findings Include:

R3's clinical record indicates he is a 64 year old with the following medical diagnosis of dysphagia, oropharyngeal phase, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease, lack of coordination, weakness, unsteadiness, aphasia, cerebral infarction due to unspecified occlusion or stenosis, essential (primary) hypertension, need for assistance with personal care, limitation of activities due to disability, and personal history of covid-19. R3's minimum data set brief interview for mental status score [10] indicates R3 was mildly cognitively impaired dated 1/5/24.

R3's weights documented in part:
- R3 admission weight dated 1/8/2019 212 lbs. (pounds)
-1/30/20-204.2 lbs.
-2/10/21- 188.4 lbs.
-1/20/22-172.6 lbs.
-1/10/23-141.2 lbs.
-7/10/23 -130.8 lbs.
-8/11/23-128.0 lbs.
-9/5/23-124.8 lbs.
-10/1/23-119.6 lbs.
-11/22/23-111.8 lbs.
-12/12/23 112.2 lbs.
-1/9/24 106.8 lbs.

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-1/29/24 101.6 lbs.
Last six months from 7/10/23 to 1/29/24 R3 lost 29.2 lbs. [-22.32% significant weight loss]

R3's progress notes indicates in part:
V8 [Registered Nurse] Note: On 2/1/24 at 08:40 AM, R3 is alert, slow to respond. Blood pressure 100/62, respirations 16, temperature 96.7, SPO2 [blood oxygen] 89% room air, head of bed elevated, 2 Liter oxygen initiated via nasal cannula. Hydration initiated R3 pocketing fluid in his mouth, nebulizer treatment rendered. Physician notified, gave order to send R3 to hospital emergency room, family made aware.

V17 [Nurse Practitioner] Note: On 2/1/24 at 10 AM, Staff concern R3 is lethargy, malnutrition, chest congestion, less responsive, and progressive per nurse, no other or new medical complaints or staff concerns at this time.

R3's hospital record indicates in part: Dated 2/1/24. Admitting Diagnosis of sever sepsis related to health care aspiration pneumonia, and dehydration. Upon R3's arrival to emergency department, R3 was lethargic, hypoxic [low blood oxygen levels] a non-rebreather mask was placed, and tachycardic [elevated heart rate].

V10 [Registered Dietitian] 1/15/2024 21:08 Weight Note. Note Text: Follow-up on weights. R3 with noted significant weight loss x 6 mos. 18.6# (14.2%). Current weight 106.8 BMI 16.7 undernourished. On no added salt [NAS] pureed diet with honey thick liquid [HTL]. Oral intake variable. Diet supplemented 3 x day. Limited assistance at mealtime. On weekly weights x 4 weeks per recommendation. No pressure injury noted. Per MD notes R3 has declined. Needs to remain on pureed honey thick liquids due to

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coughing with his oral intake related to dysphagia. Meds reviewed and noted. No recent lab to assess. Will continue to monitor.
Recommendation: Fortified pudding. Continue weekly weights. [V10 noted R3 limited assistance at mealtime, coughing with meals, and weekly weights, recommended pudding that was already put in place on 10/11/23, no new intervention was put in place]

V4[Registered Dietitian 11/28/2023 16:53 Dietary Progress Note
Note Text: WEIGHT WARNING:
Value: 111.8
Vital Date: 2023-11-22 12:30:00.0
-7.5% change [10.4%, 13.0]
-10.0% change [13.2%, 17.0]
NUTRITION: RD Weight Review - follow up
Previously reviewed R3 for significant weight loss for three months and recommended adding supplement TID. Supplement currently in place, as well as double portions at all meals and additional pudding and sandwich/snack of choice at HS. Res now at 111.8#, BMI 17.5 - additional 4.6lbs. weight loss x 1 month, now triggers for significant weight loss x 3 and 6 months, underweight per BMI. oral intakes at meals tend to be either at 26-50% or 76-100%. Would now recommend adding additional super cereal at bedtime due to further weight loss.

V4[Registered Dietitian 11/14/2023 22:36 Dietary Progress Note
Note Text: WEIGHT WARNING:
Value: 116.4
Vital Date: 2023-11-10 09:05:00.0
-7.5% change [9.1%, 11.6]
-10.0% change [11.0%, 14.4]
NUTRITION: RD [Registered Dietitian] Weight Review

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Past medical history: hemiplegia/hemiparesis, COPD, aphasia, chronic pain, hyperlipidemia, and hypertension. Weights: current weight 116.4#, BMI 18.2 - R3 is underweight, triggered for significant weight loss for 3 months. Diet: NAS, pureed, HTL, double portions at all meals, ½ cup pudding at all meals, sandwich/snack of choice at bedtime. R3's oral Intake: varied intakes noted per amount eaten task. Skin: no known areas of pressure. Review: R3 with poor appetite per chart review, varied intakes noted at meals recently. R3's weight loss likely due to decreased oral intakes, not meeting estimated current needs. R3 is underweight per BMI, weight continues to trend down. Would recommend adding additional supplement TID for added nutrition to promote weight gain. Continue to offer food preferences at meal, add resident to weekly weights. Will continue to closely monitor oral intake and weight changes and further make additional recommendations as needed. Plan: Continue to follow with registered dietician available for consult as needed. Supplement 3x a day, and weekly weights.

V4[Registered Dietitian -On 10/11/2023 21:46
Dietary Progress Note
Note Text: WEIGHT WARNING:
Value: 119.6
Vital Date: 2023-10-10 13:59:00.0
-7.5% change [8.6%, 11.2]
NUTRITION: RD Weight Review
Past medial history of hemiplegia/hemiparesis, COPD [chronic obstructive pulmonary disease], aphasia, chronic pain, hyperlipidemia, and hypertension. R3 Weights: current weight of 119.6 pounds and BMI 18.7 - R3 with significant weight loss for 3 months. Diet: NAS [No added salt, pureed, honey thick liquid [HTL], double portions at all meals, ½ cup pudding at all meals,

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supplement drink three times per day. R3's oral Intake: mostly at 26-50% or 76-100% per amount eaten task. [R3 was not evaluated or assessed by a registered dietician from 3/23 to 9/23 a total of 7 months]

-On 2/9/2023 08:07 Dietary Progress Note
Note Text: NUTRITION: RD WEIGHT REVIEW
Value: 135.4
Vital Date: 2023-02-08 17:24:00.0
-10.0% change [23.2%, 40.8]
Weight loss reflecting significant changes x 180 days. Was seen by speech with diet downgrade. Meal portions modified. Records of amount eaten showing varied oral intake. Past medical history of hemiplegia and hemiparesis, chronic obstructive pulmonary disease, dysphagia, aphasia, and hypertension.

On 2/27/24 at 9:41 AM, V29 [R3's Family Member] stated, "I spoke with a nurse, four to five days prior to R3 being sent to the hospital, that R3 looks like he lost a lot of weight, and weak. I do not remember the day or time. I do not remember the nurse. After every feeding the staff were to clean out his mouth, to remove any left-over food. The hospital nurse told me that when R3 arrived at the hospital he had food in his mouth, staph infection in nose, bed sores, and pneumonia. The nursing staff should have been cleaning out his mouth. Nursing staff, dietician, speech therapist and the physician should have recognized R3 was losing weight and not swallowing his food before he got aspiration pneumonia and lost 100 pounds. The doctor at the hospital told me that R3's food was not going all the way into his stomach, some food was going into R3's lungs, which caused R3 to have aspiration pneumonia and sepsis. The doctor and speech therapist at the hospital told me that is

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why R3 lost weight, because he cannot swallow due to his dysphagia, and R3 needs a gastric feeding tube for his nutrition. The facility nurse, physician, or speech therapist never offered me or R3 a gastric feeding tube for his nutrition. No one at the facility notified me R3 was losing weight. At the hospital R3's weight was 100 pounds for a grown man. R3 used to weigh close to 200 pounds. The facility should have done something or offered us a gastric feeding tube for R3 before all the weight loss and decline in health, the facility let R3 slowly starve."

On 2/27/24 at 11:25 AM, V3 [Speech Therapist] stated, "I been working here for five months. There is only one speech therapist here at this facility. I first saw R3 on 8/30/23. R3 was evaluated because he had difficulty swallowing, dysphagia. Some of R3's symptoms were pocketing food in his mouth, some of his food was spilling out of his mouth instead of him swallowing the food, which makes R3 high risk of aspiration. R3 had a stroke and was diagnosed prior to his admission to the facility with dysphagia and oropharyngeal, which means R3 has difficulty initiating a swallow, unable to chew, and will hold food making R3 high risk of aspiration, weight loss, due to R3 not able to eat enough calories. The goal during speech therapy was for V3 to train the staff on feeding and 1 to 1 feeding assistance and aspiration precautions. Such as, R3 sitting up, feeding R3 slow, small bites, no straws, and to make sure R3's mouth was clear before giving him another bite of food. I trained staff verbally, whoever was working with him at the mealtime. I did not train all the certified nurse assistants or nurses; I did not have them sign a training in-service form. I worked with R3 three times per week and sat and fed R3 maybe one meal. R3 speech therapy ended on 10/27/23,

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due to insurance cut. At the time of discharge from speech therapy, R3 still actively had moderate dysphagia, needed one to one feeding assistance with every meal, cues, and close monitoring for aspiration. I was aware of R3's weight loss, I did not recommend a gastric feeding tube, or video swallow. I did not speak with the family to see if they wanted R3 to be treated more aggressive by getting a gastric feeding tube. I did not recommend a video swallow; the physician or dietitian could have made those recommendations as well. I thought the dietician and physician monitored R3's weight closely. Again, I have not seen R3 since 10/7/24. If R3 had further decline, he should have been referred for speech therapy again."

On 2/27/24 at 11:45 AM, V4 [Former Registered Dietitian] stated, "I covered the facility from October 2023 to November 2023, the facility did not have a registered dietician on site. Reviewing my documentation from October 2023, R3 had past history medical diagnosis of hemiplegia/hemiparesis, chronic obstructive pulmonary disease, and dysphagia. In October 2023 R3's weight was 119 pounds which was a significant weight loss in three months. R3's diet was no added salt, pureed, thick liquids, double portions at all meals, pudding, supplements three times per day. R3's food intakes varied, and was not adequate, which lead to R3's weight loss. R3 already had multiple supplements in place, but his weight continued to trend down with additional supplements. I did not recommend a video swallow or gastric tube, because I was only filling in two months. There was no dietician on site in this facility. I cannot recommend or down grade any one's diet, I am not a speech therapist. The speech therapist and physician should have been monitoring R3's weight and swallowing

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capabilities closely. A dietitian should have been monitoring R3 weekly with weekly weights, or at least monthly to assess R3's weight and intake. My last assessment I completed for R3 was in November 2023. I noted R3 lost three more pounds, R3 was underweight [BMI-18.2], poor appetite, and various amounts of meal intake. R3's weight loss was likely due to decrease oral intake, not meeting estimate current needs. R3's weight continued to trend down. I sent my recommendations to the director of nursing, but I did not recommend gastric feeding tube, or video swallow. The director of nursing was made aware of R3's weight loss, and she should have notified the physician. Any resident that is trending down with their weight should be monitored at minimum monthly."

On 2/27/24 at 2:12 PM V10 [Registered Dietitian] stated, "I started working here 1/1/24. R3 was noted with significant weight loss for six months of 18.6 pounds which is 14.2%. R3's last weight obtained was evaluated by me as 106.8 pounds which made R3 undernourished. R3's diet was no added salt, pureed foods with honey thick liquid. R3's intake was poor and varied. R3's diet was also supplemented with a shake three times per day. I recommended R3 on weekly weights for 4 weeks, R3 did not have any pressure ulcers. However, when I reviewed R3's clinical record the physician noted R3 has declined. I also noted R3 used to weigh 212 pounds upon his admission in 2019 and had a steady decline with his weight. Upon my assessment R3 could not swallow foods. In the physician documentation I did not see any aggressive recommendation, such as a gastric feeding tube. I did not make the recommendation of video swallow or feeding tube, the physician and speech therapist makes those type of recommendations, I just worked

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with R3 in January 2024. Due to R3's weight loss he should have been followed closely and he is high risk for aspiration. Weekly weights are done so the dietitian can intervene with new interventions to stop, the weight loss. The facility did not complete weekly weights as recommended starting on 11/14/23. I recommended weekly weight again on 1/15/24, R3 missed a total of 7 weights. From 11/14/23 to 1/29/24. Weekly weights help the dietitian accurately assess the resident weight and implement interventions right away to prevent further weight loss. My plan was to monitor R3's weekly weights for one month, then to recommend a gastric feeding tube. R3 needed to be monitored weekly. However, I could not consistently implement interventions, and monitor the effectiveness of current interventions for weight loss due to the fact there were no weekly weights completed for R3."

On 2/27/24 at 1:02 PM, V8 [Registered Nurse] stated, "I have been working here for sixteen years. R3 has been on my unit for a year or more. I worked on 1/31/24 double shift [7AM-3PM and 3PM-11PM] and 2/1/24 day shift [7am to 3PM]. R3 was alert and oriented x 1-2. During meals, R3 would have difficulty swallowing his food. R3 had weakness, and dysphagia from a past stroke. I would assist R3 with some of his meals every so often, to help out the certified nurse assistants [CNA] sometimes. R3 was a one to one feed assist, he needed to be in a sitting upright position, fed him slowly, and I had to check his mouth to make sure he swallowed the food. R3 often pocketed his food, I would remove the food, stop feeding and give him a supplement shake. On 1/31/24, I did not feed R3 any meals, and I did not receive any concerns from R3's CNA. R3 normally has a cough, that was not abnormal for

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him. R3 never ate all three meals, and when he ate it was usually less than 50% of the meal, that was his normal. On 2/1/24 upon the start of my shift, prior to the resident's breakfast, R3 appeared to be lethargic, unable to swallow his thicken liquid, just running out of his mouth, and I could hear chest congestion. R3's oxygen was low [89% room air] and I started oxygen 2 Liters per nasal cannula. I notified V17 [Nurse Practitioner], V17 gave an order to send R3 out to hospital for evaluation. V2 [Director of Nursing], and R3's family member was notified of the change in condition and transfer to hospital."

On 2/27/24 at 1:56 PM, V9 [Certified Nurse Assistant-CNA] stated, "I was R3's CNA on 2/1/24 day shift [7AM to 3PM]. Upon making rounds R3 was not looking good. R3 was weak, and tired. I called for the nurse to check on R3. The nurse told me to get R3 ready because he was going to the hospital. R3 did not have any breakfast. When I got R3 ready for the hospital, I did not check his mouth because I did not feed him anything. I worked with R3 for about a year. During that time R3 had a poor appetite, and lost weight. R3 would sometimes hold food in his mouth. I would tell R3 to spit out the food. R3 needed to be encouraged to swallow."

On 2/28/24 at 10:16 AM, V22[Licensed Practical Nurse] stated, "I was very familiar with R3. I was R3's nurse on 1/31/24 second shift [3PM to 11 PM]. R3 is on aspiration precautions and ate dinner as normal, the CNA did not report any issues regarding R3. His [R3] vital signs were normal, R3 was able to swallow his medications without a problem."

On 2/28/24 at 2:28 PM, V30 [Registered Nurse] stated, "I am familiar with R3. I was R3's nurse on

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	IL6000822	A. BUILDING: ____ B. WING ____	C 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE 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 12	S9999		

1/30/24 night shift [11PM to 7AM]. R3 was not scheduled for medication at 6AM medication pass, he usually sleeps at night. R3 did not have any change of condition during my shift, nor did he eat or drink throughout the night."

On 2/28/24 at 10:26 AM, V27 [Certified Nurse Assistant] stated, "I was R3's Certified Nurse Assistant that worked with R3 on 1/31/24 on second shift [3PM to 11PM]. R3 is a one-to-one feed assist, the bed was in low position, and R3 was sitting up in bed while I feed him dinner. R3 was not coughing during his meal. He ate less than 50% of his dinner, which is usual. No, I did not check his mouth after eating, because he did not eat enough dinner, there was no food in his mouth."

On 2/27/24 at 2:37 PM, V7 [Assistant Director of Nursing] stated, "I been working here for two years. R3 is on my nursing unit that I manage. R3 is alert and oriented. R3 noted a decline in his health for about a year, he is much slower to respond and weight loss. V2 and I record the weights from the restorative aide into each resident's chart. I did notice R3 was having some weight loss, but V2 [Director of Nursing] and the dietitian were overseeing the weight loss. If there was any weight loss, V2 or I would notify the physician, and family. I do not recall notifying the physician or family regarding R3's weight loss, because the physician was here reviewing R3's chart. R3 was noted to be pocketing his food on and off since last year, and his diet was downgraded. R3 at times was not able to swallow his food, coughing and pocketing his food. Some signs of aspiration are fever, coughing, pocketing food and lung congestion. On 2/1/24, R3 had signs of aspiration and was sent to the hospital."

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S9999	Continued From page 13 On 2/27/24, at 1:31 PM, V2 [Director of Nursing] stated, "I been working here since 7/22. There were times last year the facility did not have an on-site registered dietician. The registered dietician would review the resident's charts and email me recommendations. The floor nurse or I would notify the physician of the recommendations. The restorative aide would obtain the facility resident's weights, V7 [Assistant Director of Nursing] and I would enter the weights in each resident chart. I entered R3's weights on 9/5/2023 [124.8 Lbs.], 10/10/2023 [119.6 Lbs.], 11/10/2023 [116.4 Lbs.], 12/12/23 [112.2lbs.], 1/9/24 [106.8lbs.], and 1/29/24 [101.6lbs.]. During the times I entered R3's weights there was a total of 23.2 pounds weight loss in four months. Every time there was a weight loss, I did not notify the physician. The dietician and physician should have been looking at the resident's chart and weights. As nurses we report what we see. I could not make recommendations; it is out of my nursing scope. It is the physician's responsibility to address the weight loss. I have not received any concerns from R3's family regarding weight loss concerns. Weights were given to the dietician, to also address weight loss. R3 did not have a video swallow, nor was R3 or R3's family member offered a gastric feeding tube. I did not make R3's family aware of R3's weight loss, nor did I see documentation that R3's family member was made aware." On 2/28/24 at 4:10 PM, V17 [R3's Nurse Practitioner] stated, "R3 was admitted to the hospital with a diagnosis of aspiration pneumonia. That is when food goes down into the lungs instead of the stomach. I was not made aware of R3's weight loss, poor intake, coughing while eating, and holding food in his mouth. Once those	S9999		

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issues presented, R3 should have been sent to the hospital for a complete a video swallow and evaluation. Then R3 and R3's family should have been offered a gastric feeding tube. R3 should have been offered a gastric feeding months ago. R3's aspiration pneumonia, and significant weight loss was avoidable. If I was made aware I would have sent R3 to the hospital immediately for a video swallow and offered a gastric tube."

Policy documents in part-
Change of Condition Policy dated 7/23/13.
-Ensure the resident's attending physician and representative is notified of changes in the resident's condition and or status.
-Notify the physician when there is a significant change in the resident physical, mental or psychosocial status
-Notify the physician deemed necessary or appropriate in the best interest of the resident
-Notify the physician when there is a significant change of condition is a decline and impacts more than one area of the resident's health status
- Any change in the resident condition will be reported to the MD and the Director of Nursing for further interventions.

Weight Protocol Policy dated 3/19/14.
-Ensure that all residents are weighed and any resident who is nutritionally at risk as a result of weight loss, decrease or poor appetite.
-All weekly weights will be brought to the meeting and discussed with a new intervention recommended.
-Weekly weights will be completed 2 days prior to the meeting.

(A)