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	IL6003826	A. BUILDING: _____ B. WING _____	C 05/03/2024

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S 000	Initial Comments Complaint Investigation: 2398723/IL165694 2492681/IL171589 2490586/IL169007	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610a) 300.1210a) 300.1210b) 300.1210d)3 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999		

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop, implement, evaluate, and reevaluate a plan to prevent a	S9999		

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continued insidious unplanned weight loss for one of three residents (R14) reviewed for unplanned weight loss. This failure resulted in R14 having a continued weight loss resulting in a significant weight loss of 18.55% in 90 days.

Findings include:

On 4/11/25 at 4:30pm V25 (R14's family) said R14 has lost a lot of weight. V25 said R14 lost about 30 pounds. V25 said she knows this because R14 would visit her home from time to time and she could recognize the difference in R14's weight. V25 said R14 has told her that the facility doesn't feed him.

On 4/9/24 at 12:08pm R14 observed awake, alert, unable to be interviewed. R14 observed with non-sensical speech, very low tone. R14 cannot be interviewed.

R14's physician order sheet dated 11/07/23 denotes orders for no added salt and concentrated sweets diet, regular texture, thin liquids consistency, add double portions at breakfast and sandwich at HS (nighttime).

R14 weight record dated 4/8/24 denotes R14 weighed 179.2 pounds. R14 weighed 220 pounds on 1/5/2024.

On 4/23/24 at 2:12pm with assist from V42 (Restorative Aide) and V50 (Restorative Nurse), R14 observed to weigh 175.3 pounds.

On 4/9/24 at 12:58pm V26 (Dietary Assistant) said the resident's meal is served based on the

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information on the meal ticket. V26 said the dietary staff do not inform nursing staff if a resident does not come down for meals. Request was made to review R14's meal ticket.

On 4/9/24 at 2:24pm V26 (Dietary Assistant) presents R14's diet slip. V26 reviewed the diet slip and stated she do not see any orders for double portion for breakfast and sandwich at night-time.

R14's diet slip presented by V26 does not denote double portions and sandwich at HS as noted in the physician order sheet.

On 4/11/24 at 8:46am V47 (Certified Nursing Assistant) said he was R14's CNA. V47 said he works with R14 often. V47 said he is familiar with R14. V47 said R14 was finished with breakfast, request was made to observed R14 breakfast tray. V47went to the food cart, retrieved R14's tray, R14's meal ticket observed on tray. R14's meal ticket did not denote double portions for breakfast and sandwich at HS. V14 said R14 ate 50% of meal. There was a half of a biscuit and sausage gravy observed on R14 tray. V47 said R14 did not have double portions for breakfast. V47 was asked if R14 should have double portions for breakfast. V47 said he does not know. V47 said he do not know if R14 had a significant weight loss. V47 said he is not aware of R14 having a weight loss. V47 said he does not know if R14 is currently on a calorie count.

On 4/9/2024 at 3:12pm V49 (Psych Physician) said he did not have much time to speak with surveyor as he had to pick his children up from day care. V49 said he does not deal with weight loss. V49 said psych medications do not cause

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weight loss but in-fact will result in weight gain. V49 was made aware that one of R14's recommendations for weight loss was to consult the psych provider. V49 said he will assess R14 in front of surveyor, surveyor made V49 aware that, that was not necessary. V49 said he will speak to the Director of Nursing regarding the recommendations for him to see R14 due to weight loss.

On 4/24/2024 V48 (Dietitian) said R14 is reviewed during the NARS (Nutrition at Risk) meeting in February 2024, V48 said R14 is reviewed for unplanned weight loss. V48 said R14 has had a significant weight loss in 6 months. V48 said initially in 2023, R14 had a desirable weight loss. V48 said the plan was to implement double portions at breakfast and a sandwich at HS, consult with the psych physician, and weekly weights. V48 did not respond when asked when did the planned weight loss become unplanned weight loss. V48 said usually the facility serve the resident meal based on the information on the diet slip. R14's diet slip from 4/11/24 (retrieved from meal tray) and 4/9/24 (presented by dietary assistant) reviewed with V48. V48 confirmed that there is not documentation denoting that R14 should have double portions for breakfast and a sandwich at HS. V48 said she believes she knows why but she does not want to discuss that with the surveyor. V48 made aware that surveyor retrieved the tickets on different days and surveyor cannot conclude that the physician orders and dietitian recommendations was followed for R14 for weight loss interventions. V48 was made aware that the psych physician said he does not see residents for weight loss, and that psych medications do not cause weight loss but in fact will result in weight gain. V48 said

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S9999	Continued From page 5 the double portion and sandwich is to increase calorie intake to stop weight loss. R14's dietary progress note dated 4/8/2024 denotes in-part weight warning, 7.5%, 10%, diet NCS/NAS (no concentrated sweets, no added salt) regular thin liquids, double at B (breakfast), sandwich at HS, plan recommendations continue current nutritional management. R14's care plan for weight loss denotes in part, resident has experienced weight loss, resident will not have any sig (significant) wt. (weight) until next review. Intervention refers to MD/RD if there is a 5% wt. loss x 1 mo. (month) or 10%, wt. loss over 6 months. Weight resident monthly per facility protocol, weekly weights/ NARs review. Provide diet as ordered. Notify MD of weight change greater than 5% x 1 month. Double portions at breakfast, sandwich at HS, refer to SS (social services)/psych, weight monitoring/NARS review refer to RD (Registered Dietitian). Facility policy titled care plan and procedures, no effective, review or revised date noted denotes in-part each resident will have a comprehensive assessment completed and will assist in the development of an individualized plan of care that will include goals and interventions aimed to improve or maintain the resident highest level of function prevent decline decrease risk of complications of medical conditions medications and diagnosis, decrease risk of injury or to promote comfort and end of life. Each resident will have a comprehensive assessment completed by the interdisciplinary team upon a mission quarterly and with significant changes and in individualized care plan will be developed and updated as needed with quarterly assessment, readmissions, and changes in	S9999		

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S9999	Continued From page 6 condition. Resident care plans will be reviewed and updated as needed with readmissions quarterly reassessment annually and with significant changes in condition. "B" Statement of Licensure Violations II of II: 300.610a) 300.1210a) 300.1210b)4) 300.1210d)3 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999		

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S9999	Continued From page 7 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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	S9999		

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S9999	Continued From page 8 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop an individualized plan of care for a resident identified to be at risk for aspirations and assessed to have impairments while eating. The facility also discharged resident from speech therapy before reaching the short-term goals identified in evaluation. This affected one of one resident (R13) reviewed for safe oral intake. This failure resulted in R13 becoming unconscious, CPR (cardiopulmonary resuscitation) being initiated, excessive amount of food found in R13's airway, and resident being admitted to hospital. Findings include: R13's face sheet shows diagnosis of alcohol dependence with alcohol induced persisting dementia, induced by alcohol dependence, heart failure, atherosclerotic heart disease of native coronary artery. R13's MDS (Minimum Data Set) dated 7/19/2023 section C for cognition denotes a score of 9 (cognitive impairments). Section G for functional status denote in part eating, self-performance is extensive assist (resident involved staff provide weight bearing support), support denotes 2 (one-person physical assist). Police report dated 8/12/2023 denotes in-part ambulance call, to nursing home name listed,	S9999		

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victim is R13, date of birth noted, other individual denotes V40 name and date of birth, call in at 12:34pm, In brief on 8/12/2023 at 12:34 pm, r/o (responding officer) was dispatched to (facility address noted) 4th floor (facility name noted) in regard to an ambulance call. Upon arrival r/o spoke with V40 Nurse (name is noted in police report) advise that patient identified as R13 was observed on the ground in the hallway in the middle of the hallway unresponsive and not breathing. Staff immediately began CPR (cardiopulmonary resuscitation) on R13 and called paramedics. R13 was seen eating lunch prior to this incident and believed that may have been choking. FD (fire department) arrived on scene and began working on patient. Patient was transported to (hospital name) for further treatment.

R13's emergency room records denote in-part, prior to seeing patient review of triage note, vitals. This is a 57-year-old male presenting as a cardiac arrest, patient was at the nursing home today was eating lunch walked out of the dining room, had jerky movements was lowered to the to the ground, turned blue, arrested. Patient often walked around all day long, staff did CPR for 10 minutes. EMS (emergency medical services) arrived and did additional 20 minutes of CPR. Patient initially pulseless, had 2 defibrillations for ventricle tachycardia. He receives epinephrine 4 times prior to arrival and his second shock was just prior to arrival. On arrival his first pulse check he had a pulse. Patient had a LMA (laryngeal mask airway) placed. They noted in route that there was some foreign material in his airway, but they were able to bag with that with slight difficulty. Resuscitation cardiac arrest. I spoke with patient's sister and nursing home. Per the family patient was at the nursing home, he has

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dementia in the setting of alcohol abuse. He was eating in the dining hall, got up and walked out to the hallway. Began to have choking, staff came to assist, they lowered him to the ground where he continued to choke and went unresponsive and turned blue. He started CPR. Suspected hypoxic arrest. Here with occlusion of airway, able to bag with removal of significant foreign body. Impression and plan; cardiac arrest. Chief complaint; cardiac arrest. R13 is a 57-year-old at (nursing home name) presenting for cardiac arrest. History per EMS (emergency medical services), NH (nursing home) staff, chart review based on clinical condition. Per EMS, they were called for cardiac arrest to NH. Witnessed, bystanders EMS chest compressions. There were concerns about a choking episode. EMS removed a significant amount of food from his airway upon arrival. They placed a supraglottic device. They were able to use BVM (bag valve mask) without resistance. Downtime prior to EMS arrival at the nursing home was 12 minutes. EMS remained on scene for 19 minutes. They administered a total of 3 rounds of epinephrine. Initially patient was PEA, asystole. V-fib, PEA, V-fib, PEA. A total of 3 rounds of epinephrine. Two defibrillations. Antiarrhythmics not given. Normal accu-check. Patient arrives to us with I-gel in place. Repeated accu-check in the 200s. Definitive airway established, see MDM. Additional history obtained from nursing home staff. Patient has resided at nursing home x 4 years. He is admitted for severe alcohol induced dementia. The patient was in the dining room, ate lunch. Walked out of the dining room into the hallway and started making chocking noises. They immediately went to attend to him and then the patient collapsed, was cyanotic. CPR was initiated. Full code. ED course, based on history and airway findings, concerns for aspiration

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S9999	Continued From page 11 event, hypoxia, cardiac arrest. ED diagnosis; cardiac arrest. R13 fire department report dated 8/12/2023 denotes in part in summary: was dispatched to the nursing home to assist fire department for 57-year-old male for the reported cardiac arrest, U/A (upon arrival) to the scene pt (patient) was found lying supine on the ground unresponsive, pulseless, and apneic with (fire department) crew actively performing CPR with BVM (bag valve mask) ventilation. Healthcare staff on scene stated the patient was eating when he walked into the hallway gasping for air and was witnessed collapsing to the ground inro cardiac arrest. Nursing home staff originally began CPR and applied AED, patient had been down approximately ten minutes when crew arrived. When visualized the vocal cords via laryngoscope crew noted an excessive amount of food in the patient's airway. Crew began to remove the debris, via forceps from patient airway intermittently between ventilations. Number 4 I-gel inserted after vocal cords were still unable to be visualized due to aspiration, confirmed by other crew members. Continues CPR began. On 4/23/24 at 10:56am V40 (Licensed Practical Nurse/LPN) said she was in the dining room when she observed R13 with jerky movements. V40 said she went over to R13 and R13 became unconscious. V40 said a code blue was called and R13 was lowered to the floor. V40 said R13 did not have a pulse nor did R13 have any respirations. V40 said she don't know why she was in the dining room; she just knows she was there. V40 said she don't know how long she was in the dining room. V40 said she did not see R13 eat his lunch. V40 said R13 was finished with lunch when she observed him. V40 said she don't	S9999		

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remember if R13 needed assist with meals. V40 said she don't know who she told to call a code blue; she doesn't know who she told to call 911. V40 said she don't know if R13 had issues with chewing or swallowing, she doesn't know if R13 had all his teeth. V40 said she started chest compression on R13 when R13 was observed unconscious. V40 said she may have talked to the paramedics when they arrived on the scene. V40 said she did not tell the medics that R13 was found in the hallway unconscious. R13 Fire department report reviewed with V40. V40 said she don't know why the paramedics stated that in their report. V40 denied telling the paramedics that R13 was in the hallway collapsed. V40 said sometimes the hospital do call the facility when they want more information on the resident. V40 said she don't remember if she talked to the emergency room regarding R13. V40 denied knowing if R13 was at risk for choking, V40 denied that R13 was at risk for aspiration.

On 4/23/24 at 1:38pm V43 (Certified Nursing Assistant/CNA) said she was R13's aide on 8/12/2023. V43 said R13 spoke Spanish but was able to understand English when she communicated with him. V43 said she passed R13 his tray lunch tray on 8/12/23, but she did not assist R13 with his meal. V43 said she only cut R13's food up. V43 said she was in the dining room doing a one-to-one observation with a resident that was experiencing a behavior episode. V43 said lunch was over, trays had been picked up. V43 said she looked over and saw R13 shrugging his shoulders. V43 said she did not hear R13 making any coughing sounds. V43 said she thought R13 was exercising. V43 said V40 was in the dining room, and she got V40 attention and told her to check on R13. V43 said V40 was in the dining room covering for another

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aide that was completing patient care at that time. V43 said V40 went to R13 and placed him on the floor from the chair. V43 said V40 told her to call code blue. V43 said she don't know who called 911. V43 said all the staff came to assist V40. V43 said she don't know who came, she doesn't recall. V43 said she don't know what happened after that because she was removing the resident from the dining room. V43 said she often worked with R13 and R13 did not need any assistance with meals. V43 said she has never assisted R13 with any meals. V43 said she only cut up R13's food (set up tray). V43 said she cut the food up because that's what they do for all the residents on the 4th floor because they have dementia. V43 said R13 does have dementia. V43 said some residents on the 4th floor be gobbling their food down, V43 said the residents eat fast. V43 omitted reporting her observations of residents gobbling there food down to the nurse or the Director of Nursing. V43 denied knowing if the resident that was gobbling their food down were at risk for aspiration. V43 said she only observed R43 being assisted with meals once. V43 said the residents were served pork on 8/12/23. V43 denied that R13 was at risk for choking/ aspiration. During a follow up interview on 4/24/24 at 3:56pm V43 said she documented 3, 2 for eating for R13 on 8/12/24 for breakfast and lunch. Review of the documentation denotes 3 is for extensive assist, and 2 is for one-person physical assist. V43 said she thought she was documenting for set up only. V43 said she received training on documentation in the system. V43 said she knows the difference in extensive assist and set up because she helps R3 get dressed and R13 needs extensive assist with dressing. Review of V43 documentation for R13, denotes V43 documented 3, 2 for eating for R13 on multiple days that week for multiple meals.

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V43 then said R13 does need a lot of cueing when eating, V43 said R13 was constantly reminded to eat his food. V43 said she puts R13's hand on the spoon and guide R13 to put the food in his mouth also when she had to cue him. V43 described R13 would stop eating and began to stare, that's why he needs constant reminders to eat. V43 said she cuts R13's food up because he has dementia. V43 said V40 was responsible for monitoring the dining room on 8/12/23 and V40 was responsible to monitor the residents for safety. V43 said V40 was to monitor to make sure the residents were eating, monitor the residents for choking, and assist and cue the residents as needed. V43 said usually there are 3 to 4 staff (activity aides and social worker) monitoring the big dining room, and all CNAs would monitor the small dining room during meals times. V43 restated that she did not assist R13 with lunch on 8/12/2023. V43 denied that she spoke to the paramedics when the arrived at the facility on 8/12/2023.

Review of the facility 4th floor dining room time for 8/12/23 denotes V40 name listed for the 12:30pm time. There is no name or time listed for the 12:00pm time. V43 name is listed for the 11:30am time.

On 4/23/24 at 2:28pm V51 (Rehab Director) said R13 was referred to speech therapy on 3/9/2023 for a swallow assessment due to weight loss and increased need for assistance/ cues required to complete meals for adequate and safe oral intake. V51 said she did not conduct the evaluation, V51 said she was not sure of some of the language in the evaluation and discharge summary. V51 agreeable to have a speech pathologist assist with review of R13's speech evaluation and discharge summary. On 4/26/24

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S9999	Continued From page 15 V51 said R13 did not have dysphagia, and the diagnosis dysphagia is a treatment diagnosis to allow for the speech evaluation. V51 said R13's last speech treatment date was 3/22/23, and that 6/2/23 was not correct. On 4/26/24 at 12:25pm am V56 (Speech Pathologist) said she did not complete the assessment for R13 in March 2023 however was agreeable to review the evaluation and discharge summary. V51 was present. V56 said R13 was referred per MD orders and facility dietary tech for evaluation for swallow assessment due to recent decline in weight and increase need for assistance/ cues required to complete meals for adequate and safe oral intake. V56 said R13's evaluation denotes labial closure for solids, mild (difficulties). V56 described R13 had difficulties with bring the lips to a closure, R13 ate with his mouth open. V56 said R13 noted with rapid mastication (R13 ate fast). Bolus formation - moderate (difficulty). V56 said R13's evaluation denotes R13 was found to have swallow disorder involving the oral phase. Patient presents with mild oral dysfunction, evidenced by difficulty initiating oral stage, anterior spillage of solids, incomplete bolus formation, inadequate mastication/ rotary chew pattern, effortful mastication, oral residue, and poor attention to task. V56 said R13 had behaviors, the therapist documented R13 would get up walk away, R13 would eat fast. V56 explained that difficulty initiating oral phase could be getting R13 started with the meal, anterior spillage is food falling out the mouth, R13 had difficulty chewing the food and forming a bolus of the food (that's when chew the food and mixing it with saliva making it a bolus, inadequate mastication is inadequate chewing of the food, oral residue is when some food remains in the mouth after swallowing, and	S9999		

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S9999	Continued From page 16 poor attention to task.) V56 said the recommendations was for dysphagia treatment. Supervision was distant supervision. Strategies to facilitate safety and efficiency, it is recommended the patient use the following strategies and or maneuvers during oral intake, general swallow techniques/precautions, alterations of liquids/solids and bolus size modifications, upright posture during meals and upright posture for greater than 30 minutes after meals, environmental modifications via reduction of distraction, setup and food cutting up assistance, supervision. V56 said general swallow techniques and precautions as listed. V56 described alternating between solids and liquids would be taking a sip of water/liquids after swallow food. V56 described cutting the food into small sizes would be bolus size modifications, sitting upright during meals and sitting up after meals for greater than 30 minutes would aide in digestion of food. During the evaluation short term goals are developed based on the identified issues. Review of R13's goals, patient will improve oral clearance during meals in response to cues/strategies provided by ST (speech therapist) and trained caregivers at 80% of opportunities. Patient will improve bolus control and labial seal to reduce bolus loss in response to cues/strategies provided by ST and trained caregivers at 80% of opportunities. Patient will improve attention to meals in response to cues/strategies and environmental modification provided by ST and trained caregivers. V56 said R13's discharge recommendations were that prognosis was good with consistent staff follow through. R13's recommended diet was regular texture, thin liquids, swallow strategies/position: to facilitate a safety and efficiency, it is recommended patient use the following strategies and maneuvers during oral intake; general swallow techniques/	S9999		

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precautions, alterations of liquids/solids, rate modification and bolus size modifications, upright posture during meals and upright posture for greater than 30 minutes after meals, meal intake in dining room. Supervision for oral intake; distance supervision. V56 said she don't know how the facility planned to ensure swallow techniques/precautions, alternating between liquids and solids, rate modifications and bolus size if the recommendation is distance supervision. V56 said the discharge report denotes R13 was discharged prior to meeting his goal for oral clearance at 80% of opportunities. V56 said R13 was discharged meeting goal at 50-60% of opportunities. R13 did not meet his goal for improving bolus control and labial seal to reduce oral bolus loss in response to cues/strategies, and R13 continued to need for redirection and attention to meal. V56 said R13 was at risk for aspiration due to the swallowing difficulties identified, eating with mouth open, incomplete bolus formation, inadequate bolus control, inattention, fast eating, and difficulty with oral clearing. V56 said upon review of the evaluation and discharge, she would have questions as to why was R13 discharged before meeting his short-term goal.

On 4/23/24, V13 (Director of Nursing) said he was not at the facility during the code blue for R13. V13 said the nurse documented what happened. V13 was asked if R13 choked on food. V13 said the nurse documented what happened. V13 said the facility did not complete an incident report for R13. V13 said he is aware that R13 was admitted to the hospital for aspiration. V13 said he is aware that R13 expired.

On 4/26/24 at 2:00pm V50 (Restorative Nurse) said she was the restorative nurse, she was not

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employed in 2023, review of R13's care with V50, V50 said R13 required extensive assist of one-person physical assist with meals. Review of R13's annual restorative review with V50, V50 said R13 required extensive assist with eating, support of one-person physical assist with eating.

4/30/24 at 1:57pm V10 (Prior Restorative Nurse) said she is familiar with R13. V10 said she was the restorative Nurse in 2023. V10 said R13 required extensive assist of one-person physical assist with meals. V10 said the staff should be assisting with feeding by sitting with R13, cutting up R13's food, cueing R13 as needed, assisting R13 with eating. V10 said the aides are aware of the level of care the resident need because it's listed on the (electronic) charting. V10 said the aides also document the level of assist that's provided during ADLs and eating in the (electronic) charting.

On 4/30/24 at 2:20pm V52 (Assistant Administrator) said she completed R13's restorative assessment on 7/19/2023 for R13. V52 said R13 needed extensive assist of one-person physical assist with eating. V13 explained that she was helping the Director of Nursing when she completed R13's assessment. V52 said she completed a physical assessment and she also review the 7-day look back for R13 and it was documented that R13 needed extensive assist of one-person physical assist greater than 3 times. V52 said the staff did not inform her of any issues, concerns with R13's eating abilities.

R13's progress note dated 8/12/23 completed by V40 at 1:05pm denotes in-part resident was noted at approximately 12:30pm in the dining room and had finished eating (per staff), he

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S9999	Continued From page 19 started to have some jerky movements and was lowered by staff to the floor. Resident loss consciousness and code blue was called. CPR was initiated and 911 was called. Resident was taken to hospital via stretcher, resident sister was notified, MD (Medical doctor) was also called, and supervisor made aware. At 1:55pm hospital called back, and stated resident was admitted to hospital with diagnosis of aspiration. All parties made aware and resident belongings remain in his room, at this time meds placed in proper storage. R13's physician order sheet dated 3/9/2023 denotes in-part ST (speech therapy) to evaluate and treat 5 times a week for 4 weeks for dysphagia management s/p (status post) weight loss and increased need for assistance at meals. R13's care plan dated 7/19/23 denotes in-part R13 requires assist with ADL's (activities of daily living) to maintain highest possible level of functioning as evidence by the following limitations and potential contributing diagnosis, schizophrenia, heart failure, dementia, weakness, abnormalities of gait and mobility, hyperlipidemia, chronic kidney disease, anemia, anxiety disorder, unsteadiness on feet abnormal posture. Bed mobility up to EXT-X1 (extensive assist x1), transfer up to EXT-X1 (extensive assist x1), toileting up to EXT-X1 (extensive assist x1), eating up to EXT-X1 (extensive assist x1), transfer. R13 will maintain present level offunction without decline by next review. Assist with meals as needed, bathing dressing transfers as needed, explain all tasks prior to starting, ensure proper positioning while in bed/chair, encourage resident to participate in all areas of care we are involved in exercise program as tolerated, rest periods as needed, involve social services as needed, turn	S9999		

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S9999	Continued From page 20 and reposition every 2 hours, all meal trays to be set up with milk and other container open. R13's care plan for alteration in nutrition denotes in part receives therapeutic diets or mechanically altered diet, receives double portion with all meals, staff supervision with all meals. R13's care plan dated 7/19/23 denotes in part R13 has some or all-natural tooth loss, R13 will tolerate diet as ordered through next review. Monitor for chewing difficulty, monitor for mouth, or tooth pain, refer to dentist as needed encourage good oral care and/or assist with oral care as needed, encourage resident to wear dentures and/or bridges if applicable and that food serves as appropriate. R13's death certificate denotes date of death 8/16/2023, cause of death complications of choking, how injury occurred choked on food bolus. Facility policy titled Care Plan Policy and Procedures, no effective or review date noted, denotes in-part each resident will have a comprehensive assessment completed that will assist in the development of an individualized plan of care that will include goals and interventions and to improve or maintain the residents highest level of function prevent decrease the complications of medical conditions medications and diagnosis decrease risk of injury or to promote comfort at end of life. Each resident will have a comprehensive assessment completed by the interdisciplinary team upon admission quarterly and with significant changes and an individualized care plan will be developed and updated as needed with readmissions and changes in condition. Weather care plans will be reviewed and updated as needed with readmissions quickly and with any significant	S9999		

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S9999	Continued From page 21 changes in condition. The MDS nurse will be the primary lead of the care conference but in the absence of MDS the nurse, Social Services or other designee may conduct the meeting. The care plan will also be updated with any additional identified problems or approaches. Review of R13 care plan there is not documentation denoting the identified issues observed during the speech evaluation had resolved, there is no documentation of reevaluation of identified issues for safe oral intake for R13. Upon exit of this survey the facility failed to present the plan to ensure safe oral intake for R13, and or plan to reduce risk for aspiration for R13. Facility failed to present documentation denoting R13 was discharged from speech therapy before he met his short-term goals. Facility failed to present documentation for plan for aspiration for R13. "A"	S9999		