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
	IL6001028	A. BUILDING: ______ B. WING ______	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

(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
S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610 a) 300.1210 b) 300.1210 d)2) 300.1210 d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These regulations are not met as evidenced by:

Based on interview, observation, and record review, the facility failed to prevent the formation of pressure ulcers, failed to treat pressure ulcers as ordered by the physician and failed to provide pressure relief for residents with pressure ulcers for 2 of 2 residents (R39, R33) reviewed for pressure ulcers in the sample of 26. This failure has resulted in R39 developing an unstageable, pressure ulcer to the right knee.

Findings include:

1. R39's Admission Record, documents R39 was admitted on 6/21/22, with diagnoses of: pressure ulcer right hip, displace avulsion fracture of left ilium, nondisplaced zone I fracture of sacrum

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and, nondisplaced fracture of shaft of right clavicle.

R39's Care Plan, dated 6/28/22, documents "(R39) has both potential for and actual impairment to skin integrity r/t (related to) fragile skin, combative behaviors and was admitted with a non-blanchable discoloration to the right hip area which was noted to be a Stage one pressure injury. He was seen by the wound specialist and he noted it was an unstageable pressure injury on 7/5/22. He requires extensive assistance with bed mobility and is always incontinent of his bowels and has an indwelling urethral catheter. Returned from the hospital on 8/25/22 with new left lateral ankle Unstageable DTI (deep tissue injury)." It continues "9/27/2022 DTI to right inner knee. 9/27/2022 MASD (moisture associated dermatitis) to coccyx." R39's Care Plan Interventions document "6/21/22- Treat right hip wound as per POS/TAR (Physician's Order Sheet/Treatment Administration Record). 8/25/22-Treat the left lateral ankle wound as per POS/TAR." R39's undated Care Plan Intervention documents "(R39) needs staff to apply protective incontinent briefs and he wears (Pressure relieving) boots bilaterally to lower extremities when in bed."

R39's September 2022 POS, documents 9/2022 "Left lateral ankle: Apply betadine and calcium alginate. Cover with bordered dressing. every day shift for To Promote Wound Healing." It also documents "9/20/2022 Right hip: Apply betadine and leave OTA (open to air) every day and evening shift To Promote Wound Healing." It continues: "Right inner knee: Apply betadine and leave OTA every day and evening shift for To Promote Wound Healing."

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R39's Skin and Wound Evaluation, dated 9/27/2022, documents "New Facility Acquired Pressure Ulcer. Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration to right knee."

On 9/26/22 at 7:40 AM, R39 was lying in bed on his left side in fetal position with his knees pressed together, no pressure relieving between his legs or knees.

On 9/26/22 at 10:20 AM, V15, Registered Nurse (RN)/Wound Nurse, performed treatment to R39's pressure ulcers. R39 was lying in bed with pressure relieving boot on left foot and wedge between the outside of R39's left knee and the mattress. R39 had nothing between his legs and/or knees. R39's knees were pressing together, skin on skin. V15 removed the old dressing, dated 9/25/2022, from R39's right hip. The dressing contained a border dressing and calcium alginate. The dressing had a dark brown drainage to the dressing with a foul odor present. V15 then performed the treatment to the wound, leaving the wound open to air. V15 did not clean the wound bed prior to performing treatment. V15 then removed the old dressing to R39's left ankle, dated 9/24/2022. V15 then applied performed treatment and applied betadine, calcium alginate and border dressing. V15 did not clean the wound.

On 9/27/2022 at 1:50 PM, when asked what is the plan for R39's wounds, V22, Wound Doctor, stated, "The facility needs to stop using the wrong treatment." V22 stated he has put new orders in place today. V22 stated he would expect the nurses to follow the orders written, and would expect the nurses to clean the wound when performing the treatment.

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On 9/28/2022 at 10:50 AM V24, Certified Nursing Assistant (CNA), and V25, CNA, assisted R39 into the bed. V24 and V25 assisted R39 onto his back. There was no pressure relieving device between R39's knees. R39 had a 2 centimeter (cm) by (x) 2 cm purple and black discolored circular unstageable pressure ulcer to R39's right inner knee. The pressure ulcer was intact with black wound edges and approximately 1cm of dark purple, and black discoloration to the top and left side of the wound bed. V24 stated the pressure ulcer to R39's inner leg was new. V24 stated R39 obtained the wound due to his legs being pressed together.

On 9/28/2022 at 12:00 PM V2, Director of Nursing (DON), stated she expects the staff to follow the physician orders. V2 stated she would expect the nurse to perform the correct treatment for the wound, and for it to be done as ordered.

On 9/28/2022 at 1:30 PM, V2 stated the facility had no other pressure ulcer/wounds and/treatment policy other than what was previously given.

On 9/29/2022 at 10:10 AM, V15 stated R39 does not move around in the bed. V15 stated the only movement she is aware of is when he is not on his left side, he will flip over to that side. V15 stated R39 has fragile skin and will get wounds and pressure ulcers quickly. V15 stated R39 is dependent on staff for care. V15 stated the pressure ulcer to R39's knee is new. V15 stated R39 is supposed to always have something in between his knees. V15 stated this has always been the case. V15 stated the pressure ulcer to R39's knee is because of his knees being pressed together.

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2. R33's Care Plan, dated 8/18/2022, documented, "Treat the Left buttock wound as per (Physician Order Sheet/Treatment Administration Record)."

R33's Physician Order sheet, dated 9/29/2022 documented, "Cleanse with wound cleanser. Left buttock: Apply Santyl, Gentamicin oint (ointment), crushed flagyl, and calcium alginate. Cover with dry dressing, everyday shift for To Promote Wound Healing related to PRESSURE ULCER OF LEFT BUTTOCK, STAGE 4 (L89.324) AND as needed."

On 9/28/2022 at 8:25 AM, V15, removed R33's old dressing. After she took a picture of the open pressure sore, V15 then applied the medication, calcium alginate and the bordered gauze dressing, without cleansing the wound.

On 9/28/2022 at 10:19 AM, V2 stated R33's pressure ulcers should have been cleansed before applying R33's treatment.

The Facility's Skin Management: Monitoring of wounds and documentation, dated 1/2022, documents, "It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility."

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300.610 a)
300.1210 b)
300.1210 d)6)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing 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

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see that each resident receives adequate supervision and assistance to prevent accidents.

These regulations are not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide assistance, supervision, and implement progressive interventions to prevent falls for 2 of 6 residents (R38, R196) reviewed for falls in the sample of 26. This failure resulted in R38 falling and sustaining a laceration to the back of the head, requiring 5 staples.

Findings include:

1. R38's Admission Profile, print date of 9/28/22, documents R38 was admitted on 8/24/22, and has diagnoses of: difficulty walking, unsteadiness on feet, repeated falls, Dementia, and Parkinson's Disease.

R38's Fall Risk Evaluations, dated 8/24/22, 8/27/22, 8/31/22 and 9/5/22, all document R38 is a high fall risk.

R38's Minimum Data Set (MDS), dated 8/31/22, documents R38 is severely cognitively impaired and requires limited assistance of 2 staff members for bed mobility, extensive assistance of 2 staff members for transfer and toilet use, limited assistance of 1 staff member for walking in room and on the unit and extensive assistance of 1 staff member for locomotion in a wheelchair. This MDS also documents R38 is not steady and only able to stabilize with staff assistance.

R38's MDS, dated 9/8/22, documents R38 is severely cognitively impaired, requires

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supervision and set up for bed mobility, limited assistance of one staff member for transfer, walking in room and on the unit, is totally dependent on one staff member for locomotion in a wheelchair.

R38's Care Plan, revision date 9/26/22, documents, "FALL: (R38) is at high risk for falls as evidenced by Cognitive deficits, Functional Deficits, History of Falls and Parkinson's disease. She takes Psychotropic medication which cause potential for adverse reactions. She also isn't able to communicate her basic needs at times." R38 had the following undated care plan interventions: "Assess pattern for sleeping and encourage resident per patter/preference; Document s/sx (signs/symptoms) of adverse effects of medication on resident; Encourage appropriate use of Assistive Device; Encourage resident to keep room free of obstacles/clutter; Fall risk assessment quarterly and as needed; Keep frequently used items within reach; Monitor for any changes in condition; Orient resident to surrounding frequently, including location of bathroom, dining room, bedroom and activity locations; Promote placement of call light within reach and assess residents ability to use; Rounding at a minimum of q (every) 2 hours and prompt or assist for changing in position, toilet, offer fluids, and ensure resident is warm and dry."

R38's Nurse's Note, dated 8/26/22 at 2:04 PM, documents, "Resident several times today has attempted to stand up and walk- Sat down on floor next to nurses' station today- Stated, 'I wanted to sit down.' Then several moments later, resident was crawling out of bed while it was in lowest position. Mat/mattress to be placed for safety measures. Appetite was fair today. Requires assist with all ADLs (activities of daily

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living)- Incont (incontinent) of bowel and bladder."

R38's Care Plan Intervention, dated 8/26/22, documents "8/26/22 Keep bed in lowest position."

R38's Nurse's Note, dated 8/27/22 at 1:59 PM, documents, "Called to dining room per family member- Resident had stood up out of wheelchair that was at table for resident lunch. She stood up, climbed over w/c (wheelchair), started ambulating towards kitchen. Resident then tried to sit on floor, bumping her head on a chair. Small knot felt with no injury."

R38's Fall Investigation, dated 8/27/22, documents, "Upon investigation, resident was witness by visitor, to stand from w/c in dining room, take a few steps away from table and fell to knees. RCA (Root Cause Analysis) - attempting to leave dining room. Staff to assist resident to dining room when meal service has begun and remove promptly to high traffic area at completion of resident meal."

R38's Care Plan Intervention, dated 8/27/22, documents "1:30pm Take to Main dining room when meal service has begun and remove from dining room and place in a visible/high traffic area when meal is finished."

R38's Fall Investigation, dated 8/27/22, documents, "Investigation revealed resident attempted to get up from bed unassisted, resulting in fall. RCA- resident attempted to ambulate from bed. Was not responding to a toileting need. resident with advanced dementia, delusions and hallucinations. Staff to place pillow for support/ positioning on open side of bed to serve as boundary."

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S9999	Continued From page 10 R38's Care Plan Intervention, dated 8/27/22 documents "10:30PM - use pillows to help for support/positioning on the open side of bed when in bed." R38's Nurse's Note, dated 8/28/22 at 2:03 AM, documents, "Resident found on floor by CNA (Certified Nurse Assistant) with resident self reporting she fell. VS (vital signs)- 97.0 (temperature)-60 (pulse)-18 (respirations)-135/68 (blood pressure) sats (oxygen saturation)- 97% on RA. 2 dime sized skin tears/abrasions sl (slight) bleeding noted to LFA (Left forearm) with a re-opened skin tear to L (left) elbow. Areas cleansed with wound cleaner and bandages applied. No complaints of pain. Neuro (neurological) check completed. Called son for resident and informed him of the incident and resident spoke to him for a while. Resident was assisted to bed. Call light in reach." R38's Social Service Note, dated 8/31/22 at 3:44 PM, documents, "(R38) and I were playing BINGO and she stated that she needed to use the restroom, another CNA (Certified Nursing Assistant) took her to her room, she then refused to be toileted, and they brought her back to the nurse's station at that she was agitated and got up from her chair several times and refused redirection. I offered for her to come with me as a means to calm her down she agreed but then she became physically and verbally aggressive to the point I had to call her son. (V23, R38's son) came to the facility, she was still worked up but eventually calmed down. Myself and the (V2, Director of Nurses) explained to (V23) that since being admitted (R38) has been needing 1:1 supervision to keep her safe and that a locked dementia unit would be better suitable for her. He agreed and said that he was going to look into	S9999		

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other facilities and let me know where to send a referral once a decision was made."

R38's Nurse's Note, dated 8/31/22 at 9:32 PM, documents, "CNA in room next to this resident. heard a loud 'thud'. noted that resident had fallen in bathroom. She immediately notified this nurse. This nurse went to resident's bathroom and noted that she was laying flat on her back with plate size diameter thick dk (dark) red clotty blood. resident alert and oriented to self. Resident stated 'I got dizzy and fell backward.' Placed towel under her head, then placed thick stack of 4X4s (with wound cleanser on them), to backside of head, then wrapped with kling. Careful to not move her head/neck, was log rolled slightly onto her right side. Other nurse called 911. Fire dept (department) arrived within a few minutes, sat resident up in sitting position, then resident immediately had yellow liquid emesis. Within a few more minutes the ambulance staff arrived and stood resident up, to ambulate her, to sit on stretcher. at 7:55 PM resident left per ambulance to go to (local) ER (emergency room)."

R38's Fall Investigation, dated 8/31/22, documents, "Upon investigation, resident attempted independent ambulation to bathroom. Staff to assist to bathroom before and after meals and at bedtime as resident will allow. therapy screen, restorative program for toileting, falling star program, mattress lowered to the floor with mat next to the open side of the bed. (R38) has a preference to be on the floor."

R38's Nurse's Note, dated 8/31/22 at 10:35 PM, documents, "Report received from (local) ER nurse; resident to return to facility, received 5 staples to back of head (left open to air), to monitor concussion."

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S9999	Continued From page 12 R38's Care Plan Interventions, dated 8/31/22 document "Assist to toilet before and after meals and at bedtime as resident will allow. Therapy screen, restorative program for toileting, falling star program, mattress lowered to the floor with mat next to the open side of the bed. (R38) has a preference to be on the floor." R38's Nurse's Note, dated 9/3/22 at 1:37 PM, documents, "Resident is up per wheelchair- Staples are intact to back of head. She is alert to herself only- No impulse control- High fall risk- She is with staff most of day for safety. Mattress on floor, mat near by also for safety. Neuro check was wnl (within normal limits). She requires hands on assist with all ADLs (activities of daily living). In high traffic areas." R38's Nurse's Note, dated 9/5/22 at 3:55 PM, documents, "Resident sitting in w/c (wheel chair) near nurse desk. This nurse at nurse desk. Seen resident scoot to end of w/c seat and onto floor. No injury noted. Placed resident in a tilt back w/c." R38's Fall Investigation, dated 9/5/22, documents, "Upon investigation, resident attempting independent ambulation, impulsive, lack of safety awareness. Resident positioned in reclining high back w/c for comfort." R38's Care Plan Intervention, dated 9/5/22, documents "3:30PM Placed resident in a wheelchair with a reclining back for comfort and positioning." R38's Nurse's Note, dated 9/5/22 at 4:45 PM, documents, "Resident sitting in w/c (wheelchair) across from nurse desk. CNA sitting to the left of	S9999		

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S9999	Continued From page 13 her in regular chair. Resident got up out of w/c and walked a few steps to the right, then fell onto the w/c scale. This nurse jumped up from the nurse desk when CNA said she was getting up; I did not get to her quick enough to stop the fall. assisted back into w/c. not injury noted at this time. spoke with D.O.N. (Director of Nurses) about assigning a sitter for the evening, she approved." R38's Fall Investigation, dated 9/5/22, documents, "Upon investigation, resident with increased anxiety/ agitation. Repeated attempts to stand/ ambulate unassisted. Staff member placed 1:1 with resident until sx (symptoms) subsided." R38's Care Plan Intervention, dated 9/5/22, documents "4:30 PM charge nurse assigned a sitter to be with resident through this evening shift." R38's Nurse's Note, dated 9/5/22 at 7:25 PM, documents, "Now has two small light purple areas to left mid rib cage area that is 4cm (centimeters) X 2cm and to left lower shoulder blade area that is 10cm X 3cm. denies pain at this time. no swelling or redness noted." On 9/26/22 at 10:35 AM, R38 was laying on a mattress on the floor next to the bed. On 9/26/22 at 12:30 AM, R38 is laying with her head on mattress on the floor and her legs are on the bed. R38's Care Plan Intervention, dated 09/26/2022, documents "scoop mattress to minimize injury relating to resident rolling off the bed."	S9999		

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S9999	Continued From page 14 On 9/27/2022 at 3:50 PM, R38 was sitting in her wheelchair at the nurse's station, unattended. R38 then stood up and with a wobbly gait, walked over to a resident, who was in a reclining geriatric chair, and grabbed onto his chair. She then turned and stumbled pass her empty wheelchair and tripping over the front wheels causing a wavering gait towards the nurse's station. She then grabbed onto the nurses' stations counter. R38 let go of the nurses' stations counter and walked towards the surveyor, with a very unsteady, wobbly gait. R38 then grabbed the surveyor's hands tightly and held on to the surveyor until staff came to assist her. There were no staff at the nurse's station or in the high traffic area. On 9/26/22 at 11:20 AM, V23 stated, "She falls, and I guess this extra mat on the floor is so she doesn't get hurt. She crawls out of bed. I don't like the fact that she is on the floor. My dog sleeps on the floor. I don't want to see my mom on the floor, but she crawls out of bed, I guess. She fell in the bathroom not too long ago and split her head open she needed staples. I think they keep her at the nurse's station often." On 9/26/22 at 12:18 PM, V26, Registered Nurse (RN), stated, "She wanders, and she falls. The mattress on the floor is in her care plan because she falls and crawls out of bed." On 9/28/22 at 2:48 PM, V19, RN, stated, "(R38) is very impulsive and quick. She gets agitated and gets very combative. She will fall asleep in her wheelchair and then wake up after a few minutes and try to get up. You can put her to bed, and she will be asleep and the next thing you know she is in the hall walking using the handrails. She is very wobbly. You will see her, and you try to get to her	S9999		

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S9999	Continued From page 15 quickly, but you can't run to her because you're afraid you will startle her. When she fell into the wheelchair scale the CNA was sitting right next to her. (R38) just got up that fast. The CNA tried to grab her, but she wasn't fast enough. The night that she fell in the bathroom, I am not sure what she was doing in there and I can't tell you when she was seen last, but she is so fast. She will be asleep and then she is awake trying to walk. We take turns looking after her. She doesn't have an assigned sitter most of the time. A CNA will watch her and then a nurse so we do the best we can but we have other things we need to do. I think the only thing that will keep her from falling is to have an assigned sitter just for her." On 9/28/22 at 9:45 AM, V2, Director of Nurses (DON), stated, "We have been trying our best to keep her safe. The aides and the nurses will take turns watching her. We have tried to get family involvement so our staff can get a break. She really needs to be in a dementia unit, but the son was not real receptive to that. Realistically with the staffing crisis that we have today, I just don't have staff to dedicate just to her." V2 agrees R38 needs a 1 to 1 sitter to remain safe. 2. R196's Care Plan, dated 9/27/2022, documents "FALL: (R196) is at risk for falls related to cognitive deficits, Poor Balance and Visual Impairment." It also documents "ADL: (R196) has ADL functional deficits due to corneal ulcer affecting her visual status, weakness from CHF and she requires extensive assistance with bed mobility, transfers, locomotion, toileting, personal hygiene and supervision with eating and limited assistance with the dressing ADL. She is currently on AROM (active range of motion), Bed mobility, dressing and grooming programs. She is	S9999		

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currently receiving PT, OT (occupational therapy) and ST therapy services. She will improve bed mobility status by the next review date. It continues "Monitor for changes with daily care abilities and provide more or less assist if needed."

R196's Event Report, dated 9/26/2022 at 12:45 PM, documents R196 was found on the floor on her left side. C/o (complaining of) right side of cheek and right arm pain.

R196's Nurse's Note, dated 9/26/2022 at 1:05 PM, documents "Resident found lying on the right side of her body, along the side of the bed. Stated 'Yes'" to hitting head, C/O right side of her cheek. C/O right arm hurting from fall but denies feeling like it is broken. ROM WNL (within normal limits) for resident's baseline. C/O left arm with ROM but states "It's been that way, nothing new". Stated "I fell out of bed, I was yelling for help, nobody came". Staff assisted her into sitting position, put gait belt on and 2 assisted her into wheelchair. Partial body assessment completed, more to be assessed after into bed. Will follow up with a note later. Only a couple of slightly red areas to right arm noted at this time. No noted call light on outside of resident's room. Vital signs being taken for follow up nero checks. Socks on feet, no shoes, staff applied shoes before transfer. Bed in normal position. "

On 9/27/2022 from 11:30AM to 11:55 AM R196 was yelling out for help. R196's door to room was closed. No staff responded to R39 yelling.

On 9/27/2022 from 12:00 PM to 12:20 PM R196 was yelling out for help. R196's door to room closed. No staff responded to R196 yelling.

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On 9/27/2022 from 12:30 PM to 12:40 PM R196 was yelling out for help. R196's door to room closed. No staff response.

On 9/27/2022 at 12:50 PM, R196 observed on the floor.

On 9/27/2022 at 12:55 PM R196 stated she tried to get up out of the bed. R196 stated she called for help, and no one came.

On 9/28/2022 at 12:00 PM V2, DON, stated she would expect the staff to respond as soon as possible to a resident's yell for help.

The policy Fall Prevention and Management, dated 7/22, documents, "General: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed."

(B)

3 of 3

300.610a)
300.1210 b)
300.1210 d)3)
300.1220 b)3)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and

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procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

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

d) Pursuant to subsection (a), general nursing 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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assist with feeding, monitor weights, and implement progressive interventions to prevent weight loss for 1 of 3 residents (R40) reviewed for weight loss in a sample of 26. This failure resulted in R40 having a significant weight loss of 10% in 1 month and 17 % in 3 months.

Findings include:

R40's Admission record, dated 09/29/2022, documented an admission date of 6/07/2022, with diagnoses of stroke, dysphagia, other lack of coordination, and major depressive disorder.

R40's Care plan, dated 06/23/2022, documented, "Provide one-to-one staff intervention to promote proper nutritional intake." It continues, "Offer between meal snacks & meal substitutions, as appropriate. Offer the resident a bedtime snack."

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S9999	Continued From page 20 R40's Minimum Data Set (MDS), dated 09/01/2022, documented her cognition was moderately impaired, and she required limited assistance of 1 staff member for eating. R40's Dietary Evaluation, dated 08/30/2022, V18, Dietician, documented, "85 (year old) resident with significant weight loss June-August." The facility was unable to provide any further Dietary Evaluations prior to 08/30/2022. R40's Physician's order sheet, dated 9/29/2022, documented a diet order on 7/06/2022, "(Carbohydrate Consistency Diet. Diet (Mechanical)/SOFT texture, THIN LIQUIDS consistency, Health shake with all meals; May take meds whole one at a time in applesauce." It continued to document, ", "Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime for (weight) loss." On 9/27/2022 at 12:30 PM, R40 was served her lunch tray. A Certified Nursing Assistant (CNA) prepared it by opening containers and then walked away. R40 had a partitioned plate containing cooked cabbage, beef, bread and butter, and a health shake. On 9/27/22 at 12:45 PM, R40 fed herself approximately 2 bites of a sweet potato, and drank some of her health shake. V6, CNA, was sitting at the table, but was assisting 2 other residents. V8, Licensed Practical Nurse, (LPN) walked up, spoke to R40, but didn't provide and verbal cues or assistance. V8 then walked away and returned at 12:50 PM. At that time, V8 was standing up as she assisted R40 with a few bites and drinks, and then she walked away and assisted another resident. At 1:00 PM, R40 stated	S9999		

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the sweet potato was really good. R40 consumed approximately 40% of it. Her bread was covering her cabbage, and no beef was consumed.

R40's Weights and Vitals summary, dated 09/29/2022, documented on 6/10/2022, her weight was 140.0 pounds (LB) and on 07/01/2022, R40's weight was 125.7 LB. This was a 14.3 lb. weight loss, or a 10.1% weight loss. The summary documents on 8/11/2022, R40's weight was 117.5 LB. , a 17% weight loss in 3 months.

R40's Care Plan was not revised with progressive interventions after her August 2022 weight loss.

R40's Physicians Order Sheet, dated 9/27/2022, documented an order dated 9/26/2022, "Admit to (local) Hospice."

On 9/28/2022 at 12:15 PM, V2, Director of Nurses (DON) stated weekly weights should have been done starting on admission, and they should have weighed her (R40) on admission instead of 3 weeks later. V2 continued to state they used R40's hospitals discharge weight.

On 9/28/2022 at 12:25 PM, V18, Dietician, stated R40 has had a significant weight loss, and she required assistance from staff to eat.

On 9/28/2022 at 2:49 PM, V19, Registered Nurse, stated R40 requires staff to hand her food and "encourage her to eat."

The facility's policy, "Activities of Daily Living," dated 01/2021, documented, "C. Adaptive equipment, assistance and instruction are given as required."

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S9999	Continued From page 22 The facility's policy, "Weight Change Policy," dated 09/2022, documented, "2. Upon identification of a newly significant weight change, complete NAR's weekly review tool. 3. Notify Dietician, physician and resident representative. 4. Dietician will review and provide recommendations." (B)	S9999		