STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	C 06/24/2022

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
S 000	Initial Comments Complaint Investigations 2284382/IL147650 2284421/IL147698	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610a) 300.1210 b) 300.1210 c) 300.1210d)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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to do a thorough investigation on all falls reviewed, failed to determine the root cause of the falls, failed to do a fall assessment after a fall, failed to monitor and document vitals following a fall and/or failed to ensure fall interventions were in place for dementia residents (R2, R3) who are high risk for falls in order to minimize the risk of injury. In addition the facility failed to follow their fall prevention policies for 3 (R1, R2, R3) of 3 residents reviewed for falls and major injuries in the sample of 6 residents. These failures resulted in R1 and R2 sustaining a head lacerations requiring a hospital visit for sutures. The findings include:	S9999		

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On 6/21/22 at 11:30 AM, R3 is in a regular hospital bed that is 18 inches off the floor with one floor mat to the left of R3 and bed. There were bed bolsters on the mattress, but the bolsters were deflated and not correctly fitting the mattress. R3 has an overbed table over her as she sits up at a 45 degree angle in the bed. There is an empty supplement bottle with a straw and a 4 ounce water bottle with a straw. R3 is oriented to self only. At 2:10 PM, R3 is in bed with bed at the same height and bolsters still deflated and not correctly on the mattress. This was pointed out to V7, assigned certified nurse aide/C.N.A.

On 6/22/22 at 9:30 AM, 10:28 AM and 12:55 PM, R3 was in the bed, bed is 18 inches from the floor and one floor mat to the left of bed. The bed bolsters were deflated and not on the bed correctly. At 9:30 AM, the deflated bolsters were pointed out to V11 (C.N.A.). At 10:28 AM, the deflated bed bolsters were pointed out to V10 (Restorative Licensed Practical Nurse/L.P.N.) and at 12:55 PM accompanied by V22 (Diet technician), R3's bed bolster were still deflated and not fitting the mattress correctly.

R3 is a 93 year old dementia resident per the significant minimum data set (MDS) dated 4/27/22. R3's cognition/ brief interview mental score (BIMS) is a 5 indicating R3 is orient to self only. R3 requires extensive to total assistance with her activities of daily living, is non-ambulatory and is frequently incontinent of bowel and bladder. R3 was admitted to the facility on 2/5/22 per face sheet and MDS. R3's admission fall assessment 2/5/22 documents no vision problems yet R3's diagnoses include bilateral glaucoma per MDS. The fall assessment score would be 11 due to having impaired vision and

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S9999	Continued From page 3 not the score of 9. A score of 10 and above is high risk for falls. R3 had a fall on 5/2/22 at 2:27 A.M. which required a hospital visit and 3 sutures to the left scalp per incident report. Facility failed to do another fall assessment after this fall. The facility's incident report documents R3 was found on floor by staff when doing rounds. No one is sure how long R3 was on the floor. The incident report documents it was unwitnessed and the facility failed to do an investigation to determine how and why the fall occurred. There were no staff or resident interviews. The facility's final report documents under conclusion: R3 returned from the hospital with a diagnosis of urinary tract infection along with antibiotic therapy and 3 sutures to left scalp. On 6/23/22 at 8:28 AM, V21 (R3's power of attorney of healthcare) stated she spoke to R3 after the fall. R3 told V21 that the overbed table was removed and she was feeling for it and then fell out of the bed. V21 stated that R3 uses the overbed table to gage how far to go in the bed due to her bilateral glaucoma. On 6/21/22 at 4 PM, V1 (administrator) was given 3 names (R1, R2, R3) along with fall incident dates that needed to be reviewed. V1 was told to have all the information together including faxes, emails, interview statements, fall assessments, and recommended fall interventions together when presented tomorrow morning. On 6/22/22 at 9 AM, V1 was reminded about the incident reports. V1 stated that he is waiting on V3 (Assistant Director of Nursing/A.D.O.N.) to come in. V1 stated V3 called to say she would be late. At 11 AM, asked V1 to ask V3 where the reports are so you can get them. V1 responded	S9999		

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S9999	Continued From page 4	S9999		

he did get the reports but there are pages missing. V1 stated he was waiting to get all the papers. At 12:25 PM, V1 gave what papers he had, and other papers were given piece by piece. At 1 PM in V1's office, V1, V3 and V23 (Regional Nurse Consultant) were all present. Asked why the fall investigations have not been thoroughly investigated. V1 stated they were investigated but the documentation has been scattered and difficult to find. V1 stated the undated statement by V24 (L.P.N.) was lost so he called today to get another interview with V24. V23 stated that the facility had V26, a traveling D.O.N working at that time and had to reach out to him for some paperwork.

V24's undated statement documents that R3 was found on the floor, half on floor mat and other half of R3 on the bare floor. R3 was bleeding from the head. V24 was not sure what R3 hit her head on but guessed it was the rail of the overbed table. There were no other statements or staff interviews or any attempt to ask R3 what happened. On 6/22/22 at 1 PM, V1 stated the interview was over the phone today due to losing the original documentation.

There are no fall care plans on the floor for R1, R2 or R3.

On 6/22/22 at 3:40 PM, V10 (Restorative L.P.N.) stated that she does not keep the fall care plans on the floor but in a binder in her office. Asked V10 how is staff to know what fall interventions are to be in place if the care plans are in an office. V10 stated "I will bring you the care plan" for R2 and presented it. V10 was asked about R3's bed being 18 inches from the floor and if that is safe since R3 had a fall requiring sutures. V10 became defensive and stated she cannot be

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everywhere. V10 left the room and never returned. Only R2's care plan was presented.

On 6/21/22 at 2 PM, R1 stated he had a fall from his bed and sustained a laceration to the back of the head. R1 claims that he reported the fall to V16, (11 PM to 7 AM shift Licensed Practical Nurse/LPN) and she did nothing. R1 stated it was V25 (LPN) who assessed him and sent him out to the hospital to get several sutures. R1 stated he fell from the bed due to the bed wheels' lock not holding. R1 showed how the bed moves even with the lock on wheels. R1 stated the facility presented device to put under the wheels to prevent bed from moving but R1 says he can't lift the bed to put the device back into place when it dislodges.

V25's (L.P.N.) nurses note 5/15/22 documents R1 walking by V25 as she was passing medications. Asked R1 to take his meds and R1 responded he was not going to take them because he fell last night between 4 AM to 5 AM. V25 assesses R1 and finds a 2 inch laceration with dried blood on the back of his head. R1 was sent out 911. V25's written statement concurs with nurses' note.

Review of the facility's incident report 5/15/22 lacks interviews and how R1 sustained the laceration falling out of bed. The fall care plan was not available due to V10 keeping the care plans in her office. V10 never presented the care plan when requested. The incident report documents finding R1 on the floor near the bed with laceration to the back of the head. This contradicts V25's progress note and written statement.

On 6/22/22 at 2 PM in V1's office, V1, V3 and V23 (Regional Nurse Consultant) were all

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S9999	Continued From page 6 present. V23 stated at the time of R1's fall, the facility was using V25 (Regional Traveling Director of Nursing) who conducted the investigation. R1 is a 62 year old with diagnoses that include alcohol abuse, mental disorder and injury to lower back per the quarterly MDS 6/3/22. R1 requires limited assistance to supervision for his activities of daily living. R1 is assessed to have a BIMS of 15 indicating oriented times person, place and time. There was no documentation seen on monitoring R1 for 72 hours after a fall involving R1's head. There is only documentation seen for 5/16/22. Both R1 and R3 lacked documentation of their physical and mental status for each shift following the incident for a minimum of 72 hours. R2 is an 81 year old with a BIMS of 9 which indicates R2 is still able to be interviewed per the significant MDS 4/15/22. R2 suffers from delusions and requires total to extensive assistance with her activities of daily living. R2 is non-ambulatory and requires the use of a wheelchair and is frequently incontinent of bowel and bladder. R2 has had 3 falls in the facility with no injuries. The falls were on 3/30/22 at 5 am, 5/25/22 at 4:33 PM and on 6/8/22 at 7:58 PM. The fall assessments dated 4/29/21 documents high risk for falls, 3/30/22 documents high risk for falls but the assessment is inaccurate in regards to R2's vision. R2 is blind in one eye and has bilateral glaucoma. The assessment documents adequate vision. Another fall assessment done on 6/6/22 documents high risk.	S9999		

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S9999	Continued From page 7 The 3/30/22 fall investigation documents it was unwitnessed and R2 found on the floor with no injuries but no investigation as to how the fall occurred. The forms for documenting the fall were blank especially under the PREDISPOSING SITUATION FACTORS such as bed alarm, low bed, locked bed wheels, etc. The intervention for this fall is to ensure all personal items are within reach. The 5/25/22 fall investigation documents fall is unwitnessed. R2 is found on floor next to her bed. R2 stated that she had been on the floor for some time. There was no investigation as to when R2 was last observed and no staff statement from assigned CNA. The rest of the incident report is blank and incomplete. The recommendation is to exchange R2's bed for a low bed. The nurses note 5/26/22 documents the hospice being contacted and asking them to order a low bed and floor mat. There is no documentation when bed and floor mat were implemented. The 6/6/22 fall is finding R2 on the floor mat with her pillow and blanket. The incident report is incomplete and there is no root cause as to why R2 is getting out of bed. The facility's policy labeled ACCIDENT INCIDENT REPORTING POLICY documents the purpose is to ensure that accidents and incidents that occur with residents are identified, reported, investigated and resolved. To provide data base to study the cause of the accidents/incidents and to provide assistance in implementing corrective actions to prevent re-occurrence when possible. Under procedures: when possible, a descriptive statement may be obtained from resident or any witnesses. Utilize the witness statement form. (This form was not seen in any of the investigations reviewed.) The report is to be completed as fully as possible before the nurse ends the shift. A description of the circumstances	S9999		

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S9999	Continued From page 8 surrounding the incident/accident may be provided. Only facts may be documented not conjecture. Documentation of the resident's physical and mental status may be completed each shift following the incident for minimum of 72 hours or until the condition symptoms improve. Neurochecks may be completed as indicated. The occurrence is to be communicated shift to shift as part of the unit report until resident is stabilized. A more extensive investigation procedure is required for the following occurrences: Fall with significant injury. The resident care plan is revised as necessary to prevent or minimize further accidents/incidents when possible. This policy was not followed. The facility's policy labeled POST FALL MANAGEMENT PROTOCOL documents under section III of Accident/Incident Report and Investigation : to complete risk management after each fall which includes predisposing environmental factors, predisposing psychological factors, predisposing situational factors and witnesses. Under the section for Investigation of the Fall : interview resident, staff and others as appropriate. And analysis of the findings. Fall risk and care plan are reviewed and updated. Review interventions to prevent falls. This policy was not followed. (B) 2 of 3 300.610a) 300.1010h) 300.1210 b)4 300.1210 c) 300.1210d)3)	S9999		

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S9999	Continued From page 9 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 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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S9999	Continued From page 10 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as eviodenced by: Based on observation, interview and record review, the facility failed to provide incontinence care to dependent residents in a timely manner	S9999		

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resulting in residents being allowed to lay in their urine and feces for several hours and the staff being found in offices and common bathrooms instead of performing their duties and/or watching their cell phones at the nurses' station on the floor for 2 residents (R2, R3) of 2 residents reviewed for incontinence care in the sample of 6 residents. This failure resulted in R2's backside developing 3 small (quarter inch in size) open areas from laying in a disposable brief for an extensive period of time.

The findings include:

On 6/21/22 at 11:30 AM, in R2's room, V6 (hospice certified nurse aide/C.N.A.) was providing incontinence and personal care to R2. V6 stated she works and cares for R2 every Tuesday and Thursday. V6 stated that R2 recalls V6 from last Thursday. V6 stated when she comes in on her assigned Tuesday and Thursday mornings, R2 is always found saturated with urine and feces all over her body. V6 pointed to the soiled linen and soiled disposable brief on the floor. V6 stated the disposable brief was heavily saturated and soiled with feces and brown discolored urine stains. The ammonia smell from the urine was so bad that V6 and surveyor's eyes were burning from the ammonia smell. V6 stated the soiled disposable brief weighs about 7 pounds. The linen, hospital gown and bed pad were saturated and smelling of ammonia. R2 stated no one changes her during the night. V6 pointed to 3 red openings on R2's backside and stated it is from R2 laying in a saturated disposable brief for long periods of time. V6 stated the 3 red openings were not there on Thursday.

On 6/21/22 at 1:45 PM, V8 (restorative certified

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nurse aide/ C.N.A.) and V4 (Licensed Practical Nurse/L.P.N.) were asked about any open areas on R2. V8 stated R2 has one wound on the outer aspect of her leg. V4 confirmed that the wound is vascular. There was no wound seen on R2's legs. V4 stated that R2's skin is checked on her shower days, Wednesday and Friday evenings.

On 6/21/22 at 11:40 AM, in R3's room with V7 (C.N.A.) who stated it is her first day of work. V7 stated she is an orientee and has no idea who is to be training and assisting her. V7 stated R3 was changed this morning and it was not too bad. Asked if disposable brief was stained with dark yellow urine discoloration, V7 stated "yes".

On 6/22/22 at 9:30 AM, V11 (C.N.A.) stated R3 has no skin breakdown. At 1 PM, V11 stated he changed R3's brief around 9:45 to 10 AM. V11 stated when he removed R3's brief it was heavily soiled and weighed about 6.5 pounds. V11 stated that he understood there was no night shift C.N.A. on the floor. Informed V1 (Administrator) of what V11 stated and V1 stated he would look into it. An answer was never provided. At 4:30 PM, V1 stated that V17 (scheduler) is being demoted from the position. V1 stated he is given the planned staff schedule but never given the actual worked schedule.

On 6/22/22 at 2:48 PM, V17 stated he has been doing the staff schedule for 5 months. V17 provided a staff schedule with check marks by staff's names. V17 stated the receptionist will check staff members' names as they come in the front door. Asked V17 how does he know which staff members are going to which floor if staff do not initial by their name that they are on this floor. Asked V17 for a scheduling policy. V17 stated there is no policy for scheduling. The staffing

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S9999	Continued From page 13 V17 provided for 6/21/22 was inaccurate. It documents 4 CNAs names but lacks V7's name. Informed V17 that there were 3 C.N.A. on the floor per V4 (L.P.N.) and V5 (Registered Nurse/R.N.). They were V7, V9 (Agency C.N.A.) and another C.N.A. who was never identified or seen. The staffing reflected nurses V5 and V27 on the 3rd floor for 7 AM to 3 PM shift. Informed V17 that it was V5 and V4 that were the nurses on the floor. The 6/22/22 schedule for 7 to 3 shift nurses was inaccurate for the 3rd floor. Scheduled is V5 and V28 (nurse) but V5 and V29 (agency L.P.N.) were the nurse seen on the 3rd floor. During rounds on 6/21/22 between 11:30 AM to 12:05 PM on the 3rd floor, V8 (Restorative CNA) was found in the common bathroom. Asked what he was doing, V8 responded "getting a tissue". There was no tissue in his hands. Later during the noon meal, V8 was to feed R2 for restorative eating. At 1:45 PM, V8 stated he forgot to feed R2. On 6/22/22 at 12:55 PM, accompanied by V22 (Dietary Technician), upon exiting the elevator, both V29 (Agency L.P.N.) and V5 (Registered Nurse) were sitting at the 3rd floor nurses' station watching a cell phone. Asked what they were doing, V29 stated they are watching a gospel show. Asked them if they are on break and both had no response. Looking for V8 (restorative C.N.A.) during the noon meal, V8 was not out on the floor assisting with meals. V8 was found in the restorative office with V10 (restorative L.P.N.). Asked what he was doing, V8 responds "what do you mean?" Informed V8 that it is lunch time and is he not supposed to assist with meals? V8 had no response and left the room.	S9999		

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S9999	Continued From page 14 Review of the facility's grievances show many complaints about the lack of care provided to the residents. V21 (R2's niece) complained on 3/25/22, 5/25/22 and 6/16/22 about the lack of linens and supplies (gowns, towels, flat sheets), poor grooming, bathing and hygiene and the room smelling. V21 documented that staff informed her that were no linens available. There were other complaints from R8 (dated 1/18/22 1/19/22), R9 (same dates as R8), R10 (date 4/1/22), R11 (1/17/22), R12 (1/17/22), R13 (1/18/22) and R14 (1/11/22) about the lack of care, leaving resident in wheelchair overnight, no staff to provide care and medications not being provided. R10 through R14 are no longer residents. There are too numerous of complaints to document from other residents and family members complaining about the lack of care. The policy labeled INCONTINENCE/CONTINENCE ASSESSMENT documents if resident is and determined to have total true incontinence related to dementia with the loss of susception for need to void, resident is not a candidate for incontinence management program. Implementation of an appropriate incontinence product will be indicated on resident's care plan. R2's care plan (4/15/22) and R3's care plan (4/27/22) for incontinence care documents to toilet resident at regular intervals throughout the day at a minimum of 2 to 3 hours and to record on unit tracking log. The care plans do not address the type of incontinent product to be used. R3 does have a history of urinary tract infection per the 5/2/22 fall incident. Both have care plans on skin integrity due to incontinence.	S9999		

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S9999	Continued From page 15 (B) 3 of 3 300.610a) 300.1010h) 300.1210 b) 300.1210 c) 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 300.1010 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 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		

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S9999	Continued From page 16 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 meet as evidenced by: Based on observation, interview and record review, the facility failed to ensure all residents are receiving all their planned meals and the required assistance for feeding, failed to determine the root cause of significant weight	S9999		

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loss and failed to follow their nutritional and weight policies for 2 (R2, R3) of 3 residents reviewed for weight loss and feeding assistance in the sample of 6 residents. These failures resulted in R2 and R3 having significant weight loss due to inadequate oral intake and then placed on hospice due the significant weight loss.

The findings include:

On 6/21/22 at 1:40 PM, R2 stated she did not have lunch as R2 laid in the bed. R2's noon meal was found on the dietary cart, untouched. At 1:45 PM, V8 (Restorative Aide) stated he usually feeds R2 because R2 is on the restorative list for eating. V8 stated he fed R2 her breakfast but forgot to feed her the noon meal. V8 stated that R2 ate 40% of her breakfast which consisted of coffee, juice and one egg. Asked V8 if 40% is accurate statement since R2 ate one egg? V8 had no response. V8 stated he does not document the amount of food that is consumed by R2. V8 stated he verbally tells the nurses the amount. V8 stated he understands R2 is to be fed all her meals. A grilled cheese sandwich was sent up on disposable plate along with a juice cup. There were no utensils, napkins, condiments or cup provided to R2. V8 was present in R2's room and agreed utensils and cup should have been provided.

On 6/22/22 at 1:06 PM, in R2's room, there were 2 trays of food and V11 (Certified Nurse Aide/C.N.A.) was asking R2 to eat. R2 refused and when she heard the name of the oral supplement, R2 stated she would take that. Asked V11 about V8, the restorative aide who is the one responsible to feed R2. V11 stated not to know where V8 is now.

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At 1:12 PM, V8 was found in the restorative office with V10 (Restorative Licensed Practical Nurse/L.P.N.). Asked V8 what he was doing? V10 had a bewildered look and stated, "what do you mean?" Informed it is lunch time and trays are on the floor and is it not his responsibility to feed R2. V8 had no response.

Review of R2's weights document her weight to be 86.8 pounds (#) on 6/9/22. R2's weight was 92.8 # on 5/9/22, 96.8 # on 4/14/22, 93.6 # on 3/31/22, 91.6 # on 3/25/22 and 88.4 # on 3/17/22. R2's weight stays in the 80's fluctuating between 80.6 # to 88 # from March to January of 2022. On 12/8/21, R2's weight was 91.8 #. R2 is 62 inches tall, and her ideal body weight is between 131 # to 159 #. R2 has been a resident in this facility since 10/27/20 per the minimum data sets (MDS).

Review of V19's (Registered Dietician) progress notes 5/30/22 and 4/29/22 addresses the significant weight fluctuations. The 6/17/22 dietary assessment documents the weight loss reverses the previous weight gain resulting in significant weight changes of 5% in 30 days, 7.5% in 90 days and 10% in 180 days. The 5/30/22 assessments documents R2 being placed on hospice on 4/14/22.

On 6/21/22 at 11:30 AM, V7 (CNA) stated she is assigned to R3. V7 stated this is her first day on the floor and is an orientee. Asked where her trainer was, V7 stated she does not know. Later at 2:10 PM at the 3rd floor nurses' station, asking nurses (V4, V5) who is assigned to R3 and who is training V7? No one knew at first then stated it is V9 (Agency CNA). Asked where V9 is? No one knew and then V9 popped up. Asked V9 how often she works this floor, V9 stated a couple of

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times only. Asked V9 how she knows which residents need assistance, V9 responded, "Only knows what the nurses tell her. If she is not told, it does not get done." Turned to nurses V4 and V5 and asked both of them if it makes any sense to have an agency aide training an orientee. Neither responded. Asked about R3's meal intake, V9 stated she fed R3, and she ate 50% after struggling to remember who is R3.

On 6/22/22 at 9:30 AM, V11 (C.N.A.) stated he is the usual CNA assigned to R2 and R3 and works a couple of days a week. V11 stated R3 can feed herself but requires set-up. V11 stated R3 ate 100% her breakfast. At 12:45 PM, V11 gave R3 her pureed food which was not a pudding consistency but thinning and spreading on the disposable plate along with plasticware and disposable 6 ounce cup of lemonade. V11 handed R3 the plastic fork and R3 took one bite and said "yuck". R3 asked for her ice cream. V11 removed a cup of prepared ice cream (which was from an outside vendor) from R3's refrigerator and gave it to R3 along with plastic spoon. R3 enjoyed eating the ice cream. V11 stated that V21 (R3's family member) provides the ice cream, pudding and apple sauce due to R3 not liking the facility's food.

Review of R3's weights document 114 # when admitted to the facility on 2/5/22. On 3/8/22, R3's weight was 115.8 #, on 3/17/22 it was 122.2 #, on 3/25/22 the weight is 119.2 # . There was no April '22 weight. On 5/12/22, R3's weight is down to 98.2 #. Then on 6/9/22, R3's weight is up to 101.6 #. R3 is 62 inches tall.

Review of V22's (Dietary Technician) dietary admission assessment dated 2/7/22 documents malnourished. The next dietary assessment is

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dated 4/25/22 and V22 documents the March weight of 119 # because there is no April weight.

V19's (Registered Dietician/R.D.) dietary assessment dated 3/25/22 documents significant weight gain with 5 % in 30 days and 7.5 % in 90 days. V19's recommendations is to provide double portions protein/meat all meals, a supplement shake daily, weekly weights and NAR (Nutrition At Risk) review. Staff to feed and assist with all meals, monitor oral intake, weights, labs and skin. V19's assessment dated 5/27/22 documents the significant weight loss of 7.5 % in 90 days and 10 % in 180 days. V19 documents R3 being put on hospice care. The June '22 Physician Order Sheet (P.O.S.) documents R3 was put on hospice on 5/24/22. .

Review of R2's and R3's meal intake in the electronic medical record shows no documentation as V8 had stated earlier. In addition, both R2 and R3 have vision problems and require assistance per significant MDS dated 4/15/22 and 4/27/22, respectively. R2 is blind in one eye per MDS.

Review of R2's and R3's medication administration record (MAR) for June '22 documents the supplemental shakes were not given. R2 is to receive Ensure 4 times a day, 0900, 1300, 1700, 2100 per physician order. R2 did not receive her 1700 and 2100 shake on 1st, 2nd, 3rd, 4th, 7th, 11th, 12th, 17th, 18th and 21st. The 2100 shake not provided on the 6th and 20th and the 0900 and 1300 shakes not provided on the 19th. R3's order is 1 can of Glucerna three times a day. R3 did not receive her 1700 and 2100 supplement for June 1st, 2nd, 3rd, 4th, 7th, 11th, 12th, 17th, 18th and 21st of 2022. No documented explanation. Nor are the missed

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supplemental shakes documented in any dietary progress note which would contribute to the weight loss.

On 6/22/22 at 12:35 PM, V22 (Diet Technician) stated she questions the accuracy of the weights. V22 stated the weights going up and then to suddenly go down makes no sense. V22 stated the facility has had problems with having consistency with staff taking and recording the weights, inaccurate scales that were not calibrated and no consistency with staff taking weights. V22 stated the facility is aware and is trying to resolve the issues but it has been a struggle.

On 6/23/22 at 8:28 AM, V21 (R2's and R3's power of attorney for healthcare) stated that the reason both R2 and R3 were placed on hospice is due to the significant weight loss which was discussed in the care plan meetings.

On 6/23/22 at 9:04 AM, V19 (R.D.) stated that inadequate oral intake would definitely impact the weight loss. V19 stated she was in the facility and asking the nurses about resident's weight loss in which no one could give her any information as to why the weight loss is happening. V19 stated that this really frustrated her so much she was shouting at the nurses. V19 stated she was unaware of the missed supplements for June '22. V19 stated that both R2 and R3 were placed on hospice due to significant weight loss.

The facility's policy labeled NUTRITION AT RISK (NAR) documents the facility will have a systematic interdisciplinary effort to identify, track, intervene and monitor residents that are at high risk for weight loss and dehydration.

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S9999	Continued From page 22 The facility's policy labeled CLINICAL NUTRITION DOCUMENTATION documents the facility will have a systemic and interdisciplinary approach for obtaining and monitoring weights. The facility will designate a trained staff member to obtain all weights. Weights will be obtained upon admission, readmission to facility, then weekly for 4 weeks and then monthly unless otherwise ordered. Monthly weights are to be obtained no later than the 5th of each month with re-weights obtained by the 7th. Nursing will notify the dietician or designee of any significant weight changes. Significant weight change is defined as: 5 % in 1 month, 7.5 % in 3 months and 10 % in 6 months. Significant weight change refers to percentage of body weight not related to an explainable event such as, resolution of edema, etc. A reweigh will be obtained and recorded for all significant weight changes. The facility designee will record the method used to obtain the weight and any adaptive devices weighed, record the weights and any re-weights in the electronic medical record. (B)	S9999		