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
	IL6012355	A. BUILDING: ______ B. WING ______	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRALIA MANOR	1910 EAST MCCORD RTE 161 EAST CENTRALIA, IL 62801

(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 Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210d)2) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 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	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 requirements are not met as evidenced by:

Based on interview and record review the facility failed to provide necessary services that are consistent with professional standards to prevent the development and worsening of pressure ulcers for 1 of 3 residents (R17) reviewed for pressure ulcers in a sample of 37. This failure resulted in R17 developing an infected and painful stage 3 pressure ulcer to his coccyx requiring debridement on three occasions.

Findings include:

According to R17's admission face sheet printed 5/4/22, R17 was admitted to this facility for short term rehab services after a hospital stay at the

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local hospital. R17's Face Sheet documents R17 diagnoses include Parkinson's Disease, weakness, unspecified dementia with behavioral disturbance, disorder of the skin and subcutaneous tissue-unspecified. Per R17's admission nurses note dated 2/5/2022, R17's wished to return home where he lived with his wife and has daily family support to help with daily needs.

The Admission Observation Report, dated 2/05/2022, shows R17's skin was assessed, and the coccyx was pink in color and blanches.

An assessment for predicting pressure sore risk was completed for R17 on 02/05/2022 in which R17 scored a 14 indicating R17 was at moderate level of risk for developing pressure related complication to his skin. Factors listed on this assessment which contributed to R17's risk of pressure sore development included: Slightly Limited Sensory Perception-responds to verbal commands but cannot always communicate discomfort or need to be turned, and has some sensory impairment which limits the ability to feel pain in 1 or 2 extremities, Moisture-Occasionally skin is moist and requires extra linen changes, Mobility, Very Limited, makes occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently, Adequate Nutrition eats about 1/2 food offered, eats a total of 4 servings of protein each day, occasionally will refuse a meal, but will usually take a supplement when offered, and Friction/Shearing due to requires moderate to maximum assistance with moving, complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assist. Spasticity, contractures, or agitation leads to

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almost constant friction. R17's MDS (Minimum Data Set), dated 2/12/2022, under section C, BIMS (Brief Interview Mental Status) score is 13, cognitively intact, under section G, Functional Status, R17 requires extensive assistance x 2 person physical assist with bed mobility, transfers, and toileting.

R17's Current Care Plan documents,"R17 is at increased risk for pressure injury R/T (related to) decreased mobility, dementia and Parkinson's ...Unstageable area noted to coccyx. Infection to coccyx wound. With a problem start date of 2/5/22. Approaches include: Assist resident with turning and repositioning, Start Date: 02/05/2022, Pressure reducing device in wheelchair and bed, Start Date: 02/05/2022, Provide incontinent care after each incontinence episode, Start Date: 02/05/2022, Side rails/enablers to assist with turning and repositioning, Start Date: 02/05/2022, therapy as ordered, Start Date: 02/05/2022, High Calorie, High Protein Supplements (HCHPS), Start Date: 2/10/2022, Administer treatment to coccyx until resolved, Start Date: 03/11/2022, Air mattress, Start Date: 03/18/2022.

The Physician Order Report dated 02/05/2022-05/04/2022, shows R17's treatment orders under treatments flow sheet, "02/05/2022-02/24/2022, Apply antifungal cream to coccyx MASD (Moisture-Associated Skin Damage) areas twice a day. Discontinue when healed"., "02/23/2022-3/11/2022, Cleanse wound on coccyx with medline wound cleanser, pat dry, apply antifungal/barrier cream to coccyx and apply optifoam at bedtime; 7:00 p.m. - 11:00 p.m.", "03/11/2022-03/25/2022, Cleanse wound on coccyx with medline wound cleanser, pat dry, apply medihoney to wound bed/gauze, cover with bordered foam dressing at bedtime; 7:00 p.m. -

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S9999	Continued From page 4 11:00 p.m.", "03/11/2022 - 03/28/2022, Cleanse wound on coccyx with medline wound cleanser, pat dry, apply medihoney to wound bed/gauze, cover with bordered foam dressing once a day as needed"., 03/11/2022 - open ended, measure wound to coccyx and update wound management"., "03/25/2022 - 03/28/2022, Cleanse wound on coccyx with wound cleanser or normal saline (NS), pat dry, apply medihoney to wound bed/gauze, cover with bordered foam dressing at bedtime; 3:00 p.m. - 11:00 p.m."., "03/28/2022- 03/29/2022, Cleanse wound on coccyx with wound cleanser or NS, pat dry, apply medihoney to wound bed/gauze, cover with bordered foam dressing. Special Instructions: continue medihoney until santyl arrives, then discontinue order at bedtime; 3:00 p.m.- 11:00 p.m."., "03/28/2022- 04/22/2022, Cleanse wound to coccyx, pat dry, apply nickel thick layer of santyl to wound bed; if wound has low moisture/drainage follow with normal saline moist to dry gauze, cover with foam border dressing daily as needed"., "04/22/2022-04/28/2022, Cleanse wound to coccyx, pat dry, apply nickel thick layer of santyl/gentamicin to wound bed. If wound has low moisture/drainage follow with normal saline moist to dry gauze, cover with foam border dressing daily as needed"., "04/28/2022-Open ended, Cleanse wound to coccyx, pat dry, apply nickel thick layer of santyl to wound bed. If wound has low moisture/drainage follow with normal saline moist to dry gauze, cover with foam border dressing daily as needed". On 5/2/2022, at 9:00 a.m., R17 stated that he did not have a wound on his bottom when he got admitted to the facility. R17 stated that his wound on his bottom has gotten worse and has caused a lot of pain. R17 stated that he has been going to	S9999		

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a wound clinic and his son helps transport him to and from his appointments.

On 5/4/2022, at 1:45 p.m., R17's coccyx's wound treatment was performed by V6 (Registered Nurse) with assistance from V11 (Certified Nursing Assistant). Dressing was removed and was saturated with light yellow colored drainage. Wound looked like a deep, crater-like hole into the skin. Area in the crater-like hole was noted to have light yellow slough at the bottom with redness to tissue surrounding the inside of the wound.

A Resident Progress Note dated 02/05/2022, at 11:37 a.m. and entered into R17's EHR (Electronic Health Record) by V14, (Licensed Practical Nurse), documents "Body Assessment: Heels intact, toenails thick, no edema to BLEs (Bilateral Lower Extremities), multiple moles to mid/upper back, skin warm/dry. Bruising from needlesticks to RFA (right forearm) & LFA (left forearm). Coccyx has preventative bordered foam dressing, coccyx pink and not open."

A nurses note dated 2/5/2022 in R17's medical record documents R17 developed MASD (Moisture -Associated Skin Damage) to his coccyx and an order for "AF" (antifungal) cream was ordered to be applied twice per day until healed.

A nurses note in R17's medical record dated 2/14/2022 at 3:03pm documented "antifungal cream applied to coccyx wound. Redness still noted."

A nurses noted in R17's medical record dated 2/19/2022 at 10:47am, documented "resident has been yelling, upon inspection, resident has a 1cm

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(centimeter) deep bedsore on his bottom. 1.5 cm width, 3.5cm in length on his coccyx. Wound had slight yellow slough noted. Cleansed and applied dried optifoam (dressing) will pass on to inform POA (Power of Attorney) and doctor related to time."

A nurses note in R17's medical record dated 2/20/2022 at 8:40pm documented "dressing change to bottom area, slight non odorous drainage noted to dressing very little yellow/white slough noted to wound site, wound edges seemed very macerated. Cleansed wound patted dried. Zinc applied to peri-wound new Opti foam dressing applied."

A nurse's note in R17's medical record dated 2/22/2022 at 9:05pm documented "slight white/yellowish slough noted to wound, applied new optifoam (dressing) and antifungal/barrier cream to coccyx."

A nurse's note in R17's medical record dated 2/23/2022 at 8:42pm documented "made new treatment order. (doctor) okayed on 2/20/2022 when rounding was informed of what we were doing and okayed it."

A nurse's note in R17s medical record dated 2/28/2022 at 9:22pm documented "cleansed area to bottom and patted dry. Zinc/antifungal cream mixture applied to buttocks and coccyx and covered with optifoam (dressing)."

A nurse's note in R17's medical record dated 3/4/2022 at 10:11pm, "dressing changed to bottom at this time, scant amount of drainage noted, wound bed has whitish look to it, peri-wound is not macerated."

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A nurse's note in R17's medical record dated 3/10/2022 at 9:13pm documented "wound to bottom treated at this time, wound bed is completely covered in white stiff slough, peri-area around the wound looked dark in color, slightly macerated and slightly curled, applied zinc/antifungal mixture to peri-wound to help prevent maceration and covered."

A nurse's note in R17's medical record dated 3/17/2022 at 3:45pm documented "wound to buttock shows some sign of decline. Wound edges are red/purplish in color with some maceration. Darker yellow, immovable slough noted to wound bed. Updated (doctor's) office and asked for referral to wound clinic. Stated would call back with orders."

A nurse's note in R17's medical record dated 3/17/2022 at 4:01pm documented "signee assessed unstageable wound to coccyx. Slough to wound bed has decreased however still obscuring wound bed. Resident complains of mild pain with cleansing. Edges have appearance that resembles DTI (Deep Tissue Injury). Son in room. Signee explained meaning of unstageable wound and that facility would like to make referral to wound clinic. Signee spoke with resident about having cushion in recliner when he is sitting and will have staff place air mattress for bed at this time."

A nurse's note in R17's medical record dated 3/18/2022 at 2:59pm documented "appointment at wound clinic is on 3/28/2022 at 11:00am ..."

A facility document printed from R17's EHR (Electronic Health Record) titled Wound Management Detail Report created on 3/11/2022 documents the following: Wound type:

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Unspecified Ulcer, Wound location: Coccyx, Date/Time identified: 003/11/22 10:30 am, Present on Admission/Re-entry: No.

Observation History:

On 5/4/2022 at 2:10PM, Length 5cm (centimeters), Width 3cm, Depth 1.5cm, Exudate: Moderate, Exudate color and consistency: Serosanguineous (pale red to pink, thin and watery), Wound odor present: Yes. Tissue type: Slough, Percent of wound cover by slough tissue: 20, Wound edges/margin: Macerated/soft.

On 4/29/2022 at 10:36 PM, Length 5.5cm, Width 2cm, Depth 1.5cm. Exudate: Moderate, Exudate color and consistency: Seropurulent (yellow or tan, cloudy and thick), Wound odor present: No. Tissue type: Slough, Percent of wound cover by granulation tissue: 25, Percent of wound covered by slough tissue, 75. Wound healing status: Declining.

On 4/20/2022 at 2:05 PM, Length 5cm, Width 3cm, Depth 1.5cm. Exudate: None, Wound odor present: No. Tissue type: Slough, Percent of wound covered by slough tissue, 90.Wound healing status: Stable.

On 4/15/2022 at 10:27 AM, Length 3.5cm, Width 2cm, Depth 1.6cm. Exudate: Light, Exudate color and consistency: Serous (clear, amber, thin and water), Wound odor present: No. Tissue type: Slough, Wound healing status: Stable.

On 3/30/2022 at 9:28 PM, Length 4cm, Width 2.2cm, Depth 1.8cm. Exudate: Moderate, Exudate color and consistency: Serosanguineous (pale red to pink, thin and watery), Wound odor present: No. Tissue type: Slough, Tissue type:

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Slough, Percent of wound cover by granulation tissue: 10, Percent of wound covered by slough tissue, 90. Wound healing status: Stable.

On 3/25/2022 at 8:56 PM, Length 3.7cm, Width 2cm, Depth 1.2cm. Exudate: None, Wound odor present: Yes. Describe: foul, Tissue type: Slough, Tissue type: Slough, Percent of wound cover by granulation tissue: 10, Percent of wound covered by slough tissue, 50. Percent of wound covered by eschar tissue: 40, Wound healing status: Declining.

On 3/16/2022 at 9:54 PM, Length 3.5cm, Width 1.2cm, Depth: could not be measured. Exudate: None, Wound odor present: No. Tissue type: Slough, Tissue type: Slough, Percent of wound cover by granulation tissue: 10, Percent of wound covered by slough tissue, 90. Wound healing status: Stable.

On 3/11/2022 at 10:31 AM, Length 3.2cm, Width 1cm, Depth: could not be measured. Exudate: None, Wound odor present: No. Tissue type: Slough, Tissue type: Slough, Percent of wound cover by granulation tissue: 10, Percent of wound covered by slough tissue, 90.

The bottom of R17's Wound Detail Management Report documents: Wound type: Abrasion, Wound location: Coccyx, Date/Time Identified: 2/19/2022 11:44 AM, Present on admission/Re-entry: No, Healed/Discontinued Date/Time: 3/11/22 at 10:29 AM.

A nurse's note in R17's EHR dated 4/8/2022 at 4:23pm documented "Received orders from the wound clinic for Bactrim DS 800-160mg BID (twice per day) x 10 days r/t (related to) green drainage from wound ...."

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A nurse's note in R17's EHR dated 4/30/2022 at 9:45pm documented "Changed wound dressing to coccyx per order. Noted yellowish saturation to old dressing, strong odor noted. Noted wound bed 25% slough, wound depth 2.5cm, 3cm width and 5.5cm length. Wound edges macerated. Surrounding wound tissue irritated and red ....res voiced pain to site.""

A nurse's note in R17's EHR dated 5/5/2022 at 1:31pm documented "dressing to coccyx soiled and removed at this time ...some purulent (pus) drainage noted ..."

On 5/05/2022 at 12:30pm, V2, (Director of Nursing) said R17 should have had an air mattress applied to his bed and chair before 3/17/2022 when she asked staff to apply it and documented her request. V2 said it should have been applied when R17 was assessed to be at moderate risk for developing pressure wounds. V2 said she could not find where R17's care plan had been updated when R17 developed the open area on his coccyx. V2 said the nursing staff are responsible for the weekly assessment of wounds and are responsible for measuring and pursuing new treatments if current wound treatments were not working. V2 said per the facility's pressure injury prevention and treatment protocol if the pressure injury is showing no improvement, the physician will be notified so change of treatment may be obtained. When V2 was asked when R17's coccyx ulcer did not show improvement after several weeks of decline, would she expect her nursing staff or R17's physician to try a different treatment then antifungal cream, V2 would not give an answer.

On 5/10/2022 at 10:16am, V17 (Advanced

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S9999	Continued From page 11 Practice Wound Nurse) said she has been treating R17 since R17 was referred to the local wound clinic. V17 said AF (antifungal) cream is not an appropriate treatment for a pressure ulcer like R17's. V17 said she first seen R17's coccyx wound at his first wound clinic appointment on 3/28/2022 and R17's wound was classified as a stage 3. V17 said R17 reported to her that the nursing home was not limiting his time up in his wheelchair so V17 wrote orders for R17 to only be out of bed for meals. V17 said on 3/28/2022 R17's coccyx wound measured 4.2cm (Centimeters) long by 2.4cm wide and 1cm deep and adipose (fat) tissue was visible, pain was rated by R17 as 5 on a scale of 10 and was surgically debrided. V17 said on 4/8/2022 she saw R17 at his weekly wound clinic appointment where R17 reported a pain rating of 5 on a scale of 10. V17 said R17's wound again was debrided and now measured 5cm long by 2.4 cm wide and 1.3cm deep, had green drainage so a wound culture was obtained and a broad spectrum antibiotic was ordered for the green wound drainage because the wound was now infected. V17 said at R17's 4/15/2022 appointment, R17 reported pain of 5 on a scale of 10, R17's wound was debrided again and post debridement wound measurements were 5cm long by 2.4cm wide and 2.2cm deep.V17 said when R17 came to his next wound clinic appointment on 4/28/2022, R17 did not have any dressing on his coccyx wound and wore an adult diaper without any underwear on. V17 said R17's coccyx wound was making great progress but that no longer was the case. V17 said R17's wound had turned black and no longer looked as good as it had previously. V17 said R17's stage 3 coccyx pressure ulcer remained unchanged in size and developed slough. R17's Progress Note Details report by V17 dated	S9999		

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3/28/22 documents in part, " Wound Assessment(s)" Wound #1 Coccyx is a chronic Stage 3 Pressure Injury Pressure Ulcer and has received status of Not Healed. Initial wound encounter measurements are 4.2 cm length x 2.4cm width, x 1cm depth, with an area of 10.08 sq (square) cim and a volume of 10.08 cubic cm ...Procedures: Wound #1. .A skin/subcutaneous tissue level excisional/surgical debridement with a total area debrided of 10.5 sq com was performed by V17. Subcutaneous was removed along with devitalized tissue: biofilm and slough ...Post debridement measurements: 4.7 cm length x 2.5 cm width x 1.1 cm depth, with an area of 10.5 sq cm and a volume of 11.55 cubic cm."

R17's Progress Note Details report by V17 dated 4/8/22 documents in part, "Wound Assessment(s)" Wound #1 Coccyx is a chronic Stage 3 Pressure Injury Pressure Ulcer and has received status of Not Healed. Subsequent wound encounter measurements are 5 cm length x 2.4cm width, x 1.3 cm depth, with an area of 12 sq cm and a volume of 15.6 cubic cm. Wound covered with a thick layer of slough, with greenish-drainage. Procedures: Wound #1. .A skin/subcutaneous tissue level excisional/surgical debridement with a total area debrided of 12 sq com was performed by V17. Subcutaneous was removed along with devitalized tissue: slough ...Post debridement measurements: 5 cm length x 2.4 cm width x 1.3 cm depth, with an area of 12 sq cm and a volume of 15.6 cubic cm."

R17's Progress Note Details report by V17 dated 4/15/22 documents in part, "Wound Assessment(s)" Wound #1 Coccyx is a chronic Stage 3 Pressure Injury Pressure Ulcer and has received status of Not Healed. Subsequent

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wound encounter measurements are 5 cm length x 2.4cm width, x 1.3 cm depth, with an area of 12 sq cm and a volume of 15.6 cubic cm. Procedures: Wound #1. .A skin/subcutaneous tissue level excisional/surgical debridement with a total area debrided of 12 sq com was performed by V17. Subcutaneous was removed along with devitalized tissue: biofilm and slough ...Post debridement measurements: 5 cm length x 2.4 cm width x 2.2 cm depth, with an area of 12 sq cm and a volume of 26.4 cubic cm."

R17's Progress Note Details report by V17 dated 4/28/22 documents in part, "When he (R17) arrived today from Nursing Home he had no dressing in wound or on wound. Son report he doesn't feel they are limiting his time in chair ...30 day follow up visit for Stage 3 pressure ulcer to coccyx. We have been treating wound with Santyl daily. We added Gentamycin at last week visit as well for added coverage from positive tissue culture from 4/8/22. He has been making good progress with wound healing until this week. He arrived today to visit with no dressing inside of wound base or cover dressing to wound. Increase in slough with some induration noted to edge of ulcer. Santyl ointment sent with patient from (Facility) was dated 4/22/22 and had never been open. I called and spoke with his nurse from nursing home. She told me she did not know why wound was not covered with dressing. Sharp debridement performed at the beside to remove devitalized tissue ... Will consider general surgery consult next week if ulcer shows no improvement."

A facility policy titled Pressure Injury Prevention and Treatment Protocol (revision date of 07/16) documents "A skin risk assessment is completed on all residents upon admission and weekly for

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the first four weeks after admission ... An individualized plan of care will be developed for the resident following the guidelines of the assessment ... All high and moderate risk residents may have the following and if so, they will be addressed on the care plan.

a. Special mattress and wheelchair cushions
b. PROMS (Passive Range of Motion)
c. Protein and/or nutritional supplements
d. Turning and repositioning schedule
e. Skin checks
f. Elbow and heel protectors

When a resident is admitted to the facility or develops a pressure injury in the facility, the following will occur: Assess the pressure injury for location, size, wound bed, drainage, odor, tunneling, undermining or sinus tract, wound edges/surrounding tissue and pain at the site. Notify physician of assessment and obtain orders for treatment of pressure injury. If pressure injury is showing no improvement, physician will be notified so change of treatment may be obtained. The pressure injury will be care planned. For pressure injury with drainage the physician will be notified, and culture obtained.

(B)

2 of 2
300.610a)
300.1210b)4)
300.1210d)2)

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

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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.

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:

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S9999	Continued From page 16 2) All treatments and procedures shall be administered as ordered by the physician. These requirements are not met as evidenced by: Based on interview, observation, and record review the facility failed to provide prescribed nutritional supplements and weight loss interventions for 1 of 7 residents (R18) reviewed for weight loss in a sample of 37. The failure resulted in R18 experiencing a 14.3% weight loss in 5 months. Findings Include: R18's Face Sheet documents R18 is a 99 year old female with an admission date of 01/30/18 and the following diagnoses: Encounter for other orthopedic aftercare, Dementia in other diseases classified elsewhere without behavioral disturbance, Abnormalities of gait and mobility, Essential hypertension, Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, Unspecified Osteoarthritis, Unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing, pain in right arm, Ventral hernia without obstruction or gangrene, Abnormal weight loss, Other specified eating disorder, Major depressive disorder, Generalized anxiety disorder, history of falling, Heartburn, Other chronic pain, Dry eye syndrome of bilateral lacrimal, Vitamin B12 deficiency anemia, Gastro-esophageal reflux disease without esophagitis, and Vitamin deficiency. R18's Minimum Data Set (MDS) dated 04/27/22, documents R18 has a Brief Interview for Mental Status (BIMS) score of 00 denoting R18's cognitive status as: severely impaired. Section G	S9999		

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S9999	Continued From page 17 documents R18's Eating status as: independent with set up help only. R18's Physician Order Report: dated 04/05/22 - 05/05/22 documents a Diet - Regular, HCHPS (High Calorie High Protein Supplement) Continuous, Continue, with a start date of 03/11/2022 with an end date of "open ended" listed. R18's Care plan dated 06/10/21 and last reviewed 3/25/22 documents: Category: Nutritional Status: R18 may be at risk for nutritional deficit related to decreased appetite related to dementia, eating disorder, with a problem start date of 09/17/2020. A goal target date of 03/09/2022 documents a goal of; R18 will not have any significant weight changes through review. An Approach Start Date of 01/27/22 documents: provide Supplement: High Calorie High Protein, an Approach Start Date of 02/12/21 documents: House Shakes BID (twice a day), an Approach start date of 09/17/2020 documents: Staff assist with eating/drinking as needed. On 05/02/22 at 11:45 AM, R18 received her lunch tray which contained her meal and her beverage, no fortified milk shake or fortified pudding was given. R18 ate less than 10% of her lunch with no encouragement or cueing noted from staff. On 05/03/22 at 11:42 AM, R18 received her lunch tray which contained her meal and her beverage, no fortified milk shake or fortified pudding was given. R18 ate less than 10% of her lunch with no encouragement or cueing noted from staff. On 05/04/22 at 11:06 AM, R18 received her lunch tray which contained her meal and her beverage, no fortified milk shake or fortified pudding was	S9999		

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given. R18 ate less than 10% of her lunch with no encouragement or cueing noted from staff.

R18's Lunch card dated 05/04/22 documents: Fortified Pudding - 1 each, Fortified Milkshake - 1 each with Notes: HCHP (High Calorie High Protein) Pudding and HCHP Milk Shake.

On 05/04/22 at 4:40 PM, R18 received her supper tray which contained her meal and her beverage, no fortified milk shake or fortified pudding was given. R18 ate less than 10% of her lunch with no encouragement or cueing noted from staff.

The Facility document titled, "Vitals Report" documents: on 12/02/2021 at 10:23 AM R18's weight was documented as 92 pounds. On 01/04/22 at 2:56 PM R18's weight is documented as 91 pounds. On 02/04/22 at 10:50 AM R18's weight is documented as 88 pounds. On 03/07/22 at 10:06 AM R18's weight is documented as 77 pounds. On 04/07/22 at 2:20 PM R18's weight is documented as 80 pounds. On 05/04/22 at 8:56 AM R18's weight is documented as 78.8 pounds. When calculated this shows R18 had a 14.3 % weight loss in 5 months.

R18's Progress Notes document on 03/09/2022 at 11:23 AM, titled,"Dietary Assessment by V15 (Licensed Dietician Nutritionist): "On a Regular diet with High Calorie High Protein Supplement. Prefers Fortified milk at breakfast only. Also gets fortified pudding at lunch and supper. Fortified Milk Shakes at lunch and supper. Intakes 50-70%. Weights: (3/7): 77 (pounds), (2/24): 80, (2/16): 82(pounds), (2/9): 85(pounds), (2/7): 88(pounds), (12/2): 92(pounds), and (9/2): 90 (pounds), . Current weight is down 3# (pounds), (3.8%) x 11days, down 5# (pounds), (6.1%) x 19

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S9999	Continued From page 19 days, down 8# (pounds), (9.4%) x26/days, down 11# (pounds), (12.5%) x /1 month, down 15# (pounds), (16.3%) x /3months, and down 13# (pounds), (14.4%) x /6 months. Below IBW Range 90-110 (pounds). Body Mass Index:16.09 (Underweight). Awaiting M.D. orders for U.A. results. Skin free of open areas. Labs (2/17/22): Glucose 80, Sodium 145, Potassium 3.4(L), Blood Urea Nitrogen 10, Creatin 0.6, Total Protein 4.9(L), and Albumin 2.8(L) ....Plan: to stabilize weights. 1). Add: Butterball at breakfast 2). Add: Double meat at breakfast." R18's Progress Notes document on 04/13/2022 at 12:02 PM, titled, "Dietary Assessment" by V15 (Licensed Dietician Nutritionist): "On a Regular diet with High Calorie High Protein Supplement. Prefers Fortified milk, Butterball, and Double meat at breakfast. Also gets fortified pudding at lunch and supper. Fortified Milk Shakes at lunch and supper.... Monitor." R18's Progress Notes document on 04/27/2022 at 5:23 PM, titled, "Dietary Assessment" by V15 (Licensed Dietician Nutritionist): "On a Regular diet with High Calorie High Protein Supplement. Prefers Fortified milk, Butterball, and Double meat at breakfast. Also gets fortified pudding at lunch and supper. Fortified Milk Shakes at lunch and supper.... Monitor." The Facility document titled, "Observation Detail List Report" Nutritional Assessment dated 01/05/22 documents R18's current diet order as: Regular diet with High Calorie High Protein Supplement. Prefers Fortified milk at breakfast only. Also gets fortified pudding at lunch and supper. Fortified Milk Shakes at lunch. House Shakes BID (twice a day). The category titled, "Nutritional Risk Indicator" documents weight	S9999		

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S9999	Continued From page 20 status as: no weight change, Feeding Capabilities as: Independent, Supervised and Vision impaired and Oral/Nutritional Intake is documented as 50-75% intake. The section titled, "Notes" by V15 (Licensed Dietitian Nutritionist) documents: Dietitian/Readmit Assessment: "99 year old female readmitted (12/31) On a Regular diet. Dietary Intakes 50-75%. Resides on Garden Court, additional snacks available between meals. Weights: (1/4): 91, (12/31): 90.8, (12/2) 92, (10/04): 91, and (7/6): 91. WNL of IBW Range 90-110. Body Mass Index: 19.02 (Normal/Healthy weight). On antibiotics for Cholecystitis. Has enlarged gallbladder but so wants no further treatment. Skin free of open areas and no new labs to review. Estimated Needs: 1230 calories (30 kilo-calories per kg), 1230 cc fluids (1 cc per kilo-calories), and 41-49 gram protein (1.0-1.2 injury factor). Plan; restart Supplements. 1). High calorie High Protein Supplement. 2). Prefers Fortified milk at breakfast only. Also gets fortified pudding at lunch and supper. Fortified Milk Shakes at lunch. House Shakes BID (twice a day)." The Facility document titled, "Observation Detail List Report" Nutritional Assessment dated 04/27/22 documents R18's current diet order as: Regular diet with High Calorie High Protein Supplement. Prefers Fortified milk, Butterball and Double meat at breakfast. Also gets fortified pudding at lunch and supper. Fortified Milk Shakes at lunch and supper. Reason for Assessment is documented as: Quarterly. Body Mass Index is documented as: 16.51 (Underweight). Weight status is documented as 7.5% weight change in 90 days and 10% Weight change in 6 months. Oral/Nutritional Intake - Food as: Intake Meets 26-50% of Estimated Needs. R18's Feeding capabilities are	S9999		

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documented as Independent and Assisted.

On 05/05/22 at 1:05 PM, V5 (Dietary Manager) stated, residents that are supposed to be given supplements including fortified puddings or health shakes, should receive them. R18 is supposed to receive nutritional supplements, they are listed on her meal card.

On 05/05/22 at 12:30 PM V16 (Dietary Assistant) stated, the nutritional supplements are listed on the meal cards and are put on the resident's trays by the kitchen staff that is serving at that time.

On 05/05/22 1:20 PM V15 (Licensed Dietitian Nutritionist) stated, R18 has had weight loss, she is to receive fortified pudding and fortified milk shakes.

The Facility policy titled, "Supplementation" with a revised date of 07/18 documents: Procedure: 6. The Food Service Supervisor or designee will update resident's meal tray ticket to include supplementation.

"B"