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
	IL6009856	A. BUILDING: ______ B. WING ______	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

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S 000	Initial Comments Complaint Investigations: 2386629/IL00163061 2386946/IL00163455	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1010h) 300.1210b) 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 300.1010 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	S9999	Attachment A Statement of Licensure Violations	

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

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

These Regulations are not met as evidenced by:

Based on interviews and record review, the facility failed to ensure 1 (R6) a totally dependent resident was free from Injuries of Unknown Origin in a sample of 11 residents. This failure resulted in R6 sustaining left upper extremity bruising, swelling and a fracture of the Left 2nd Metacarpal.

Findings Include:

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S9999	Continued From page 2 R6 has diagnosis not limited to Dysphagia Following Cerebral Infarction, Encephalopathy, Gastrostomy, Type 2 Diabetes Mellitus, Atrial Fibrillation, Benign Prostatic Hyperplasia, Anemia, Hyperlipidemia, Essential (Primary) Hypertension, Cerebral Infarction, Vitamin D Deficiency, Morbid (Severe) Obesity Due To Excess Calories, Muscle Weakness (Generalized), Dementia, Unspecified Severity, With Other Behavioral Disturbance, Peripheral Vascular Disease, Obstructive Sleep Apnea, Herpes Viral Infection of Other Male Genital Organs, Acute Kidney Failure, Displaced Fracture of Shaft of Second Metacarpal Bone, Left Hand, Initial Encounter For Closed Fracture. R6 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 04 indicating severe cognitive impairment. R6's MDS (minimum data set) Section G Functional Status: document in part: A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture: Extensive Assistance. Two + persons' physical assist. B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet). Total Dependence, Two + persons' physical assist. A. Upper extremity (shoulder, elbow, wrist, hand) 1. Impairment on one side. B. Lower extremity (hip, knee, ankle, foot) 1. Impairment on one side. Section GG A. Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. Dependent. E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). Dependent.	S9999		

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R6's Care Plan document in part: R6 has alteration in musculoskeletal status r/t (related to) fracture of the Left 2nd Metacarpal Fracture Date Initiated: 08/25/23. R6 has an ADL (Activities of Daily Living) Self Care Performance Deficit Weakness/deconditioning. Intervention: Check skin for changes during bathing. Date Initiated: 02/16/22. R6 is at risk for falls Muscle Weakness, Unsteady gait. R6 requires the use of a mechanical lift for transfers. R6 requires tube feeding and stoma site care. R6 is at risk for abuse related to: R6 has a diagnosis of dementia, there is total dependence on staff/others for care. R6 requires a soft cast to left hand. Date Initiated: 08/24/23. R6 has Dementia and is noted with cognitive impairment. R6 has the potential for alteration in function, decrease in sensation and or circulation of extremity secondary to fracture with soft cast in place. Date Initiated: 08/25/23. R6 requires assistance from staff for bed mobility; R6 unable to turn and reposition self in bed without physical assistance from staff r/t (related to) Limitations in Range of motion weakness/deconditioning.

R6's Progress note dated 08/21/23 14:28 document in part: Nurses Note Text: Resident noted with redness and swelling to left upper extremity.

R6's Progress note dated 08/22/23 11:56 document in part: Nurses Note Text: New order given to writer to send resident to Hospital for further evaluation related to Left hand X-ray.

R6's Progress note dated 08/22/23 14:19 document in part: Nurse Practitioner Note Text: Patient seen and examined today for acute visit. Patient noted with pain, swelling, and bruising to LUE (Left Upper Extremity) with bruising/swelling

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to left shoulder, left inner elbow. Patient also with swelling and pain to left hand. XR (X-ray) revealed 2nd distal metacarpal transverse fracture. Total assist with ADLs (activities of daily living). EXTREMITIES: red/purple ecchymosis and swelling noted to anterior aspect of left shoulder, pain with ROM (Range of Motion) , small healing skin tear noted to central area of ecchymosis, baseball sized area of red/purple ecchymosis noted superior and laterally to antecubital fossa, additional area of red/purple ecchymosis noted to lateral aspect of antecubital fossa, limited ROM due to pain and guarding; patient resistant to extension of elbow; left dorsal hand edematous, point tenderness to palpation of 2nd metacarpal, pain with ROM to left wrist. ASSESSMENT/PLAN # (number) Left Upper Extremity Pain # Left Shoulder Pain # Left 2nd Metacarpal Fracture - No reported fall or injury - Patient with pain, swelling, and ecchymosis to LUE noted by staff on 8/21. Left Forearm XR (X-ray): Examination reveals mild soft tissue swelling with no evidence of recent fracture or dislocation. There is a slight transverse fracture of the distal shaft of the second metacarpal with no significant displacement. Transfer to ED (Emergency Department) for further evaluation.

Progress note dated 08/23/23 02:08 document in part: Nurses Note Text: Resident return from Hospital with a soft cast to the left hand. Resident noted with pain, swelling, and bruising to left upper extremity with bruising/swelling to left shoulder, left inner elbow. Resident also with swelling and pain to left hand.

Hospital Records dated 08/22/23 document in part: Left hand/finger, injury. Splint (Post mold applied to left hand). Patient with ecchymosis and tenderness to the left shoulder or left elbow and

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S9999	Continued From page 5 left mid hand, bruising appears to be more than a day old. after finding that left mid hand does have a fracture, CT head and C (Cervical)-spine added as clear injury occurred that was not reported, and patient is a poor historian. Primary Diagnosis: Second Left Metacarpal Fracture. Secondary Diagnosis: Unwitnessed fall. Primary Impression: Fracture of Second metacarpal bone of left hand. Secondary Impression: Fall. Patient Notes: Patient came in with H/O (History of) swollen hand. Restorative Nursing Assessment dated 07/12/23 document in part: 3. Bed Mobility: Total Dependence. 4. Transfer: Total Dependence. F. Locomotion on unit: Self performance: Total Dependence. H. Locomotion off unit: Self performance: Total Dependence. 7. Dressing/Grooming: Total Dependence. 8. Eating: Total Dependence. Initial Reportable dated 08/22/23 document in part: On 08/21/23 resident noted with redness and swelling on left hand. On 08/22/23 X-ray revealed fracture of 2nd metacarpal. R6 sent to hospital for further evaluation. Final Report dated 08/28/23 document in part: R6 is extensive assist with ADLs (Activities of Daily Living), functional transfers, and functional mobility. Staff with no reported falls or any occurrences with the resident in the facility. Resident with diagnosis of oblique mildly displaced fracture of the distal third of the second metacarpal bone. Resident readmitted with soft cast to left hand. The resident was unable to recall any accidents or incidents. On 09/19/23 at 08:31 AM V8 (R6 Family Member) stated "R6 finger was broken and bruised up. I	S9999		

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don't know how the injury happened. R6 said that he was beaten. I saw R6 hand on 08/20/23, and they did an X-ray of R6 hand. On 08/21/23 the nurse called me and told me that they took R6 to the emergency room."

On 09/19/23 at 12:52 V8 (R6 Family Member) stated "No one knows what happen to R6 during the four days that I did not come. R6 cannot move about by himself. I came in on Monday 08/21/23 and that is when I saw the bruising and swelling to R6 entire left arm. Nothing was broken but R6 index finger." R6 was observed sitting in the dining room in a reclining wheelchair with an ace wrap to the left hand.

On 09/19/23 at 01:14 PM V8 (R6 Family Member) asked R6 what happen to your hand and R6 responded "a nurse kept beating my hand." V8 asked R6 the nurse's name and R6 did not respond.

On 09/19/23 at 01:16 PM V12 (Licensed Practical Nurse) stated "when I came back to work after being off a couple of days, I was told R6 had a fracture to the left hand. R6 had an X-ray, the results were relayed to the Nurse Practitioner on 08/22/23, and I was told to send R6 to the hospital for evaluation. I observed R6 left hand was kind of swollen. I had gotten the results that it was fractured. When you touch R6's left hand R6 would make say ouch. R6 was not able to tell you what happened, R6 is confused but alert to name.

On 09/19/23 at 01:37 PM V13 (Certified Nurse Assistant) stated "R6 is a two person assist and a little confused. I looked at R6's arm to see what they were talking about. R6 was feeling pain if you tried to lift the left arm up. Near the left shoulder area, I saw a dark red area larger than a

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quarter. I worked with R6 on 08/17/23 and did not see anything."

On 09/19/23 at 01:46 PM V7 (Certified Nurse Assistant) stated "I did not work with R6 a few days before the injury, but I am the one that reported the injury. I was assigned to R6 on 08/21/23 and reported the bruising to V23 (Registered Nurse). I was about to start patient care, was wiping R6 face and attempted to take off R6 gown. I observed bruises on the outer area of R6 left arm and left shoulder. I reported the skin abnormality. R6 is transferred with the mechanical lift."

On 09/19/23 at 02:02 PM V6 (Certified Nurse Assistant) stated "when I take care of R6 I wash him up, dress and transferred with a mechanical lift. I was assigned to R6 on 08/18/23 day shift. I did not see any bruises or swelling."

On 09/20/21 at 12:20 PM V21 (Restorative Nurse) stated "I never saw any bruising on R6 body, and I am not aware of any falls. I was told that R6 had a fracture, and R6 had the splint to his left hand like a half cast mold with an ace wrap holding it in place. The mold is to stabilize R6 hand. 09/21/23 at 11:12 AM V21 (Restorative Nurse) stated "R6 is a restorative patient. R6 can grasp the side rails but cannot turn himself."

On 09/20/23 at 12:49 V41 (Certified Nurse Assistant) stated "on 08/20/23 I gave R6 patient care and bed bath and R6 remained in bed. There was no bruising or swelling."

On 09/20/23 at 12:56 V23 (Registered Nurse) stated "the certified nurse assistant came to me. R6 left arm and hand was red and swollen. I assessed it then notified the Nurse Practitioner

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who gave new orders, and I followed up on them. There was an X-ray of the left shoulder, hand, arm and a doppler. I did not see any swelling to R6 left arm prior to this. I worked 08/17/23 and 08/18/23 and did not come back until 08/21/23. R6 is able to turn with assistance, transfers with a mechanical lift and gets a g (gastric)-tube feeding."

On 09/20/23 at 01:46 PM V30 (Registered Nurse) stated "when I worked with R6 on 08/19/23 and 08/20/23 R6 had no bruising and swelling. R6 has a gastric tube feeding and I had to lift up R6 gown. There was no swelling or abnormalities to the skin. R6 really can't move."

On 09/20/23 at 01:35 V19 (Certified Nurse Assistant) stated "on 08/19/23 I did not see any bruising or swelling to R6 left arm."

On 09/20/23 at 03:24 PM per telephone interview V32 (Registered Nurse) stated "On 08/17/23 I did not see R6 with any redness or swelling. I only saw the redness and swelling to R6 left hand and arm on 08/21/23 when I came back to the floor. It was redness and swelling to the left upper shoulder and swelling to the left hand."

On 09/20/23 at 03:54 PM per telephone interview V33 (Registered Nurse) stated "the care that I provide for R6 is medications and the feeding tube. I work the night shift and days shift as well. I did not notice any swelling or redness to R6 arm. R6 has not had any recent falls and there were no reported skin issues. I was still there on 08/21/23 when they saw R6 left arm/hand redness and swelling. It was a couple hours into the day shift when I saw it. The redness was under the sleeve of R6 gown and R6 was in bed when I got there."

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On 09/20/23 at 04:13 PM Per telephone interview V34 (Certified Nurse Assistant) stated "I only had R6 one day on the weekend on the 3-11 shift. The care that I provided because R6 was in bed we just changing R6 once. R6 had no bruising to body or arm, and I did not look for that. We are looking more of what is going on in the bottom. I noticed the redness and swelling when I put R6 to bed on 08/21/23. I took the mechanical lift and when I looked at R6 left arm, I saw the color and I did not like this. They said they were going to do and x-ray. A few hours later they came and did the X-ray. I came the next day, and I went to R6 room looking for him. I asked the nurse where R6 was, and I found out that he went to the hospital. I only saw the left arm bruising and swelling when I was putting R6 to bed."

On 09/20/23 at 04:33 PM Per telephone interview V48 (Certified Nurse Assistant) stated "R6 is on a gastric tube and the main care provided if R6 is in the day room, I get help to put R6 in bed and clean R6 up. R6 is transferred using the mechanical lift.

On 08/20/23 R6 did not fall and there was no redness or swelling. I noticed the redness and swelling when R6 returned from the hospital. I saw the swelling to the left ankle and the left shoulder had some redness."

On 09/21/23 at 08:51 AM V2 (Assistant Administrator) stated "V8 (R6 Family Member) called me that day when she noticed discoloration on R6 left hand. I made the nurse aware, and the nurse followed protocol calling the doctor. The doctor placed orders."

On 09/21/23 at 09:02 AM V1 (Administrator) stated "The nurse called the Nurse Practitioner

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and R6 was sent to hospital. There has a fracture to the left finger."

On 09/21/23 at 09:20 AM V36 (Certified Nurse Assistant) stated "I was there Monday 08/21/23 or Tuesday 08/22/23. I went to get R6 up and when I went to pull up the pulled gown, I saw the bruising. Prior to that R6 had no bruises."

On 09/21/23 at 09:30 AM V18 (Nurse Practitioner) stated "on 08/21/23 there was noted redness and swelling to R6 left upper extremity. I saw R6 the next day. The X-ray of the left hand showed a transverse fracture of second metacarpal bone of left hand. It could be from turning or trauma, but I can't say if R6 was hitting his hand on the side rail."

On 09/21/23 at 10:01 AM V12 (Licensed Practical Nurse) stated "R6 bed has always had the bilateral upper side rails. R6 can turn and hold the side rail with assistance. R6 right side is the stronger side."

On 09/21/23 at 12:22 PM V21 (Restorative Nurse) stated "each resident is scheduled for a bath/shower twice a week." V21 reviewed the bathing sheet with the surveyor and stated "the number 4 stands for total assist with bathing. The number 3 stands for 2 people assistance because R6 is a mechanical lift for transfers. If there are any skin issues reported to nurse n/a means R6 did not have any skin issues for 08/16/23. On 08/19/23 the number 4 stands for total assist with bathing. The number 3 stands for 2 people because R6 is a mechanical lift for transfers. The number 2 is for follow up questions and stands for no new skin abnormalities."

Policy:

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Titled "Incident/Accident Reports" dated 09/20 document in part: Policy: The Incident/Accident report is completed or all unexplained bruises or abrasions, all accidents or incident where there is injury or the potential to result in injury. Procedure: an accident refers to any unexpected or unintentional incident, which may result in injury or illness to a resident. 4. all situations requiring they emergency services of a hospital. 8. any condition resulting from an accident requiring first aid, physician visit, or transfer to another healthcare facility. Note: physical harm would include a broken bone, or blood flow not stopped by a band aid or hospital or emergency room treatment that involves more than diagnostic evaluation. 15. facility must ensure that the resident environment remains as free of accident hazard as is possible; and each resident receives adequate supervision and assistance devices to prevent accident.

Titled "Abuse Policy" dated 09/20 document in part: Policy: The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its resident and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. 3. establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. This facility is committed to protecting our residents from abuse by anyone. Prevention: The facility desires to prevent abuse, neglect, and theft by establishing a resident sensitive and

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resident secure environment.

(B)

Statement of Licensure Violations 2 of 2:
300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210c)

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.

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Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

These Regulations are not met as evidenced by:

Based on interviews and record reviews, the facility failed to follow their policies and

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procedures to (a) evaluate and monitor a high-risk resident's (R5) nutritional status, (b) obtain weights monitoring, and (c) implement nutritional interventions, monitor the effectiveness of interventions and revising them as necessary. These failures resulted in a severe weight loss [more than 9% over 2 months] for 1 (R5) of 5 residents reviewed for nutrition.

Findings Include:

R5's clinical records show an admission date of 5/20/23 with listed diagnoses not limited to abnormal weight loss, personal history of Malignant Neoplasm of Prostate, Hyperlipidemia, Essential Hypertension, Pulmonary Embolism, And Functional Dyspepsia. R5 was discharged to the hospital on 7/12/23 for complaint of rectal pain.

R5's electronic medical records (EMR) show no weights were obtained from R5's admission date of 5/20/23 until R5's discharge from the facility on 7/12/23. The only weight documented on R5's weight record was 182.6 lbs dated 7/15/23. On 9/20/23 at 2:33 PM, V21 (Restorative Nurse) stated that V21 entered the wrong date and the weight recorded on 7/15/23 was taken the week before July 10th. R5's hospital records prior to R5's admission to the facility printed on 5/20/23 shows R5 weighed 213.3 lbs on 5/12/23.

R5's Admission Minimum Data Set (MDS) dated 5/24/23 shows R5 weighed 201 pounds (lbs). R5's Discharge MDS dated 7/12/23 shows R5 weighed 182 lbs.

The facility's 2023 "Documentation Survey Report v2" for R5's amount eaten shows R5 ate 50% or less on multiple occasions from 5/21/23 to

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7/12/32 with some days of refusals.

R5's care plan initiated on 5/26/23 shows R5 requires nutritional support with one intervention that reads, "Nutritional assessment initially and quarterly. Obtain food preferences and update at least annually."

R5's EMR (electronic medical record) do not show any dietary notes or nutritional assessments were completed from 5/20/23 to 7/12/23. R5's progress notes from 5/20/23 to 7/12/23 show no documentation R5's weight loss and poor appetite were communicated to V22 (R5's Physician) and V18 (Nurse Practitioner).

R5's progress notes dated 5/22/23 at 5:18 PM written by V18 (R5's Nurse Practitioner) reads in part, "Patient seen and examined today. [R5] expresses [R5] is not satisfied with the food [R5] has been receiving in the facility. [R5's] diet preferences have been reported to dietary services."

R5's physician order sheet (POS) shows a diet order of "General diet Regular texture, Thin Liquids consistency" ordered on 5/20/23. R5's POS does not show any other nutritional interventions ordered for R5.

On 9/19/23 at 11:30 AM, V12 (Licensed Practical Nurse) stated that R5 was having diarrhea at least twice during V12's shift but does not remember when it started. V12 stated that R5 had very poor appetite ever since R5 came to the facility. V12 stated that V43 (R5's Wife) would come and bring R5 something to eat. V12 stated that R5 only ate breakfast and every other day V43 would bring food for R5. V12 stated that R5 was a picky eater. V12 stated that R5 would only

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eat less than 50% or nothing at all. V12 stated that R5 would try to eat and if R5 did not like the meals, staff would offer substitutions, but R5 did not eat the substitutions either. V12 stated that V12 thought V27 (Registered Dietitian) was aware because V27 is in the facility twice a week. V12 stated that nurses did not monitor R5's weights because it was the restorative department's responsibility to obtain all residents' weights.

On 9/19/23 at 1:25 PM V20 (Restorative Aide) stated that residents' weights are taken within 24 hours upon admission and re-admission, weekly weights on Thursdays, and monthly weights are taken the last 5 days of the month. V20 stated, "We record the weights on the weight sheet that's given to us by the Restorative Nurse [V21] then we give it back to [V21]."

On 9/19/23 at 1:35 PM, V21 (Restorative Nurse) stated that the restorative aides get the weights. V21 stated, "When the resident gets admitted we try to get the weight within 24 hours. We try to ask the admitting nurse to get the admission weight, but restorative follows up the next day. Upon admission weight is taken within 24 hours, then weekly for 4 weeks, and then monthly. We enter the weights in the resident's electronic record." V21 stated that restorative notifies the nurse if there are some weight changes, and the Dietitian (V27) also monitors the weights in the residents' electronic medical records (EMR). V21 stated, "They have access to the EMR. [V27] comes in once a week." Surveyor reviewed R5's weight records in R5's EMR with V21, and V21 confirmed R5's admission weight and weekly weights were not obtained.

On 9/20/23 at 11:13 AM, a phone interview

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S9999	Continued From page 17 conducted with V27 (Registered Dietitian). V27 stated that V27 started working in the facility on May 15, 2023, and comes in to see the residents twice a week. V27 stated that it is important to monitor the resident's weights to see if there have been any critical changes like decrease in intake, any wounds, any fluid shift, and if there is anything new going on or critical going on in general. V27 stated that the resident's nutritional status needs need to be assessed to see the resident's eating patterns, if they need additional help, and their dietary preferences. V27 stated that some of the potential things that could happen if a resident's nutritional status is not monitored are weight loss, wound development, altered labs, and general health decline. V27 stated that a resident with diagnosis of cancer is at high nutritional risk and interventions to meet the resident's nutritional needs should be implemented. V27 stated that a resident with poor intake and having diarrhea could put a resident for higher risk for malnutrition because of their gastrointestinal tract being compromised. V27 stated that if a resident is eating 50% or less that could potentially put the resident for dehydration, weight loss, and possible altered nutritional intake and absorption. V27 stated that generally, if a resident is eating 50% or less, V27 would put interventions in place such as liquid supplements. V27 stated that a decrease in intake of 50% or less, decrease in weight of 5% in the last 30 days or even 3% within the last 7 days are some of the criteria to determine malnutrition with the resident. V27 stated that the nurses and the nursing managers should communicate to V27 who are the residents losing weight and who are at high nutritional risks. However, V27 stated that V27 has not gotten a lot of communication from the nurses in the facility. V27 stated that V27 has not heard of R5 until 9/19/23 when V2 (Director of	S9999		

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Nursing) mentioned to V27 that R5's nutritional assessment did not get completed. V27 stated, "Unfortunately I didn't get to assess [R5]. The staff did not communicate to me about [R5]." V27 stated that R5 was never assessed by a dietitian from admission until R5's discharge from the facility.

On 9/21/23 at 9:50 AM, a phone interview conducted with V18 (Nurse Practitioner). V18 stated, "I can't remember off the top of my head if they notify me about (R5's) poor appetite and weight loss. Usually, I would document it and put in some kind of intervention like a three-day calorie count, and a dietary evaluation." V18 stated that if a resident has poor appetite and the weights were not taken and their nutritional needs were not assessed, the resident could potentially lose weight and get weak. V18 stated, "What we would do if someone is not eating as long as they are eating above 25% we would order the oral supplements and dietary monitoring, protein supplement, and honoring food preference. If they are eating less than the 25% over the three-day calorie count, I would send the resident to the hospital for evaluation." V18 stated that it's important to monitor the resident's weight. V18 stated, "If we see a decline, then interventions need to be put in place what I mentioned earlier, and we would get the dietitian involve."

The facility's policy titled; "WEIGHTS" dated 9/2020 reads in part:
POLICY:
Residents will be weighed to establish weights and identify trends of weight loss or weight gain.
PROCEDURE:
1. A baseline weight will be established upon admission. The resident will be weighed weekly for 4 weeks after admission and monthly

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thereafter.
3.Report to nursing supervisor, physician/NP, dietary supervisor, RD consultant and family/responsible party of any weight loss or gain greater than 5% within one (1) month, 7.5% within three (3) months or 10% within six (6) months.
4.Notification to the attending physician/NP and family/responsible party in regard to the above will be documented in the medical record.

The facility's policy titled; "NUTRITION ASSESSMENT" dated 12/17 reads in part:
POLICY
A nutrition assessment will be completed for each resident admitted into the building.
PURPOSE
To reduce the risk of malnutrition.
PROCEDURE
1. A trained and designated representative from the FNS Department will review each resident to determine if at low or high nutritional risk. This representative is responsible for assessing the low risk residents and providing a referral list to the LDN of high nutritional risk residents.
2. The LDN is responsible for developing a nutrition assessment for each high risk resident admitted to the facility.
3. The in-depth nutritional assessment must be developed within fourteen (14) days of the resident's admission and include at least the resident's
a. Anthropometrics
b. Diagnosis, condition, or disease affecting nutrition
c. Abnormal laboratory values
d. Clinical observation of the resident
e. Nutrition intake and any significant change in overall intake and cause
f. Eating habits

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S9999	Continued From page 20 g. Dietary restrictions h. Psychological, social or functional limitations affecting nutrition i. Use of medication with potential for drug/nutrient interactions that may affect appetite j. Diet; if therapeutic diet, indicate if this is warranted and identify the need for these restrictions (B)	S9999		