STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007868	A. BUILDING: _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT SOUTH HOLLAND, THE	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

(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 2298868/IL153039 2299047/IL153251 2299047/IL153251	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.690 a) 300.690 b) 300.690 c) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to report to IDPH (Illinois Department of Public Health) regional office an incident where a resident (R1) expired in the facility after bleeding from a dialysis catheter, and failed to report a fall where a resident (R3) suffered a forehead laceration requiring tissue adhesive for two out of three residents reviewed for incidents and accidents in a total sample of eight. Findings Include: 1. R1 is a 73 year old with the following diagnosis: end stage renal disease with dependence on renal dialysis and heart failure. R1 was admitted to the facility on 08/02/21. On 11/15/22 at 12:11PM, V2 (Director of Nursing/DON) stated, "This was just a bizarre incident but during my investigation, I didn't see that anything problematic occurred so I did not report it. It was more like a freak accident." A Nursing note, dated 11/8/22, documents R1 was observed resting comfortably in the bed with the head of the bed elevated around 11:45 PM.	S9999		

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S9999	Continued From page 2 R1 was easily aroused and denied any complaint of pain or discomfort at this time. A pressure dressing was noted to the left arm fistula site that was dry and intact. The CNA (Certified Nursing Assistat) was observed providing ADL (Activity of Daily Living) care at approximately 2 AM. R1 appeared alert, oriented, and verbally responsive at this time. Upon making round at 3:20 AM, R1 was observed resting in the bed with the head of the bed elevated. At approximately 5:10 AM, the CNA called the nurse to R1's room and upon entering the room, R1 was observed unresponsive with no pulse or respirations. CPR was immediately initiated, and the CNA was instructed to call code blue as well as 911. The paramedics arrived and took over. At 6:15 AM, the paramedics informed the writer that R1 expired. The Patient Care Report from the EMS (Emergency Medical Services), dated 11/8/22, documents EMS were contacted to come to the facility for a cardiac arrest at 5:20AM. R1 was found unresponsive, not breathing, and lying in a supine position. The EMS crew noticed some blood on the ground and on the patient about 1000 ML in total. A pulse was checked and not present. CPR was continued by the EMS crew. The monitor continued to show asystole. More blood was noticed on the ground under a blanket and towel which appear to be 1000-2000 ML in addition to the blood found on the R1's bed. The blood that was on the ground was already coagulated which led the crew to discontinue resuscitation due to the excessive amount of blood in total. There was also blood on R1's right side on the table and on the left side on the curtains. Staff were not sure where all of the blood came from and did not know any further details. Police arrived on scene to get her	S9999		

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S9999	Continued From page 3 information and time of death was given at 5:50 AM. 2. R3 is a 84 year old with the following diagnosis: altered mental status, dementia, unsteadiness on feet, and heart failure. R3 was admitted to the facility on 09/29/22 and discharged on 10/02/22. A Nursing note, dated 10/2/22, documents R3 was found on the floor by V15 (Activity Aide) at 8AM. V15 notified V14 (Nurse). Upon assessment, R3 was sitting on the floor at the foot of the bed. R3 stated, "I fell get out of bed and hit my head on the floor." R3 was transferred to the hospital for further evaluation. R3 was admitted to the hospital later that day with a diagnosis of congestive heart failure and forehead laceration. The Hospital Records, dated 10/2/22, document R3 presented to the emergency department for evaluation status post fall. R3 was found on the ground. R1 has a 1 cm forehead laceration that was repaired with tissue adhesive. On 11/15/22 at 12:11PM, V2 stated, "I did not report this fall to IDPH. R3 only had a small laceration to R3's head that I found out about when I called to get an update. I was not told that it needed any sutures or staples so I didn't report it. We only report deep lacerations that require sutures or staples. This was not considered a serious injury. When I called to get the status update, I always ask if they needed any sutures or staples to close the laceration because this way I will know if I have to report it. I was not told about any glue." There was no documentation or investigation report made to the Illinois Department of Public	S9999		

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S9999	Continued From page 4 Health regional office reporting either incident with R1 or R3. (C) 2 of 2 300.610 a) 300.1210 b) 300.1210 d)2) 300.1210 d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999		

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S9999	Continued From page 5 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. 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 evidenced by: Based on interview and record review, the facility failed to report R4's poor oral intake for 24 days, and failed to implement further interventions to prevent weight loss and dehydration. This affected 1 of 3 (R4) residents reviewed for unplanned weight loss and dehydration. This failure resulted in R4 having a significant weight loss of 9.8% in 10 days, and resulted in R4 needing to be hospitalized for an acute kidney injury due to being severely dehydrated. Findings Include: R4 is a 88 year old with the following diagnosis: adult failure to thrive, anorexia, dysphagia, cognitive communication deficit, cerebral infarction, and hemiplegia to the left side. R4 was admitted to the facility on 10/25/22. The Admission Hospital Records, dated 9/17/22, documents R4 was admitted to the hospital from home for feeling dizzy and having a 20 pound weight loss over the past six months. R4 reported not feeling like eating. R4 was in acute renal	S9999		

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S9999	Continued From page 6 failure with a BUN (Blood Urea Nitrogen) of 45 and a creatinine of 3.2. R4 reported not having an appetite for the past month. The Dietitian reported believing R4 is not eating due to weakness. The acute kidney injury resolved during the hospitalization with hydration. R4 was sent to a skilled facility for rehab. A Nursing note, dated 9/30/22, documents R4 was admitted from the hospital. R4 does not have any nutritional risk factors. The Hydration Evaluation, dated 9/30/22, documents the score as a four. Any score 14 or higher indicates the resident is at risk for dehydration. It is documented R4 has no risk factors for becoming dehydrated. R4 has a documented weight on 9/30/22 of 137.5 pounds taken via a mechanical lift. The next weight taken was on 10/10/22, and R4 weighed 124 pounds. The weight was taken also via the mechanical lift. R4 lost 13.5 pounds in 10 days. This was a 9.8% change from the previous weight. The Laboratory Report, dated 10/3/22, documents R4 had normal sodium, potassium, blood urea nitrogen, and creatinine levels. Normal sodium is 135-145 mEq/L, normal potassium is 3.5-5.1 mEq/L, normal blood urea nitrogen is 5-28 mg/dl, and normal creatinine is 0.5-1.4 mg/dl. The Laboratory Report, dated 10/20/22, documents R4 had an elevated sodium level of 149 mEq/L, an elevated blood urea nitrogen level of 76 mg/dl, and an elevated creatinine level of 2.6 mg/dl. There is no documentation that any interventions were implemented at this time. The Laboratory Report, dated 10/25/22, documents an elevated sodium level of 155 MEQ/L, an elevated	S9999		

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S9999	Continued From page 7 potassium level of 5.3 mEq/L, a critically elevated blood urea nitrogen level of 102 mg/dL, and an elevated creatinine level of 3.6 mg/dl. The Minimum Data Set (MDS), dated 10/6/22, documents a Brief Interview for Mental Status score as 12 (moderate cognitive impairment). Section K of MDS documents R4 has a loss of liquids/solids from the mouth when eating or drinking. It is also documented R4 does not have a weight loss of 5% or more in the past month or 10% or more in the last six months. A Nurse Practitioner note, dated 10/6/22, documents R4 presented to the hospital on 9/16/22 with poor appetite, history of falls, dizziness, and 20 pound weight loss in 6 months. A Nursing note, dated 10/6/22, documents R4 is alert and oriented times 1 - 2. R4 requires a set up assistance with meal times. The Comprehensive Nutrition Assessment, dated 10/10/22, documents R4 is on a regular general diet within liquids. R4 needs supervision when eating it is currently eating 26 - 50% of meals. R4's general appearance is described as thin, muscle and fat wasting. R4 is documented as having moderate fat and muscle loss. R4's ideal body weight is 154 pounds. It is documented that it is unknown whether R4 had a significant weight loss in the past month, 3 months, or 6 months. The physician was not consulted for weight loss. R4 has a diagnosis of anorexia and adult failure to thrive. Oral intake is variable and at times in adequate to meet nutritional needs with or for eating less than 50% of meals. R4 received a medication which may increase the oral intake. The house supplement was added to increase calories and protein needs. This supplement	S9999		

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S9999	Continued From page 8 should be taken twice a day. Staff should monitor weight, labs and oral intake. A Nursing note, dated 10/18/22, documents R4 refused to eat dinner despite several attempts. The Documentation Survey Report for 10/01/22 - 10/25/22 documents R4 needs set up of only or one person physical assist when eating. The percentage of food eaten for R4 is variable each day. For breakfast, R4 ate 0 - 25% for 10 meals, 26 - 50% for 7 meals, 51% - 75% for 1 meal, and 76 - 100% for 3 meals. For lunch, R4 ate 0 - 25% for 10 meals, 26 - 50% for 5 meals, 51% - 75% for 1 meal, and 76 - 100% for 5 meals. For dinner, R4 ate 0 to 25% for 2 meals, 26 - 50% for 2 meals, 51 - 75% for 16 meals, and 76 - 100% for 4 meals. The Physician Order Sheet dated 11/12/22 documents an order for a nutritional health supplement 2 times a day was ordered on 10/10/22. There is also an order for weights one time for day one and every day shift for 3 days and every dayshift for 7 days for 3 weeks and every day shift starting on the 1st and ending on the 7th every month. This order was placed on 9/30/22. There was an order placed on 10/3/22 for a medication that stimulates appetite. The Medication Administration Record dated 10/2022 documents weights were only taken on 10/1/22. There is no other documentation of weights. On 10/8/22, it is documented R4 was not available. On 10/15/22, it was documented as not applicable. There are no care plans in relation to weight loss prevention or dehydration prevention for R4.	S9999		

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S9999	Continued From page 9 A Nurse Practitioner note, dated 10/24/22 at 3:44 PM, documents R4 has been eating less than 25% of meals served for a couple days now. R4 is alert and oriented times 2. Plan to get laboratory work and a swallow eval. Continue appetite stimulant medication. A Nursing note, dated 10/24/22 at 10:48 PM, documents the primary physician came in to review the previous lab results. R4 was examined and an order for a midline was placed with IV fluids to run at 150 mL for 2L. Will recheck labs after the 2L are infused. A Nursing note, dated 10/25/22, documents R4 is resting in bed with the 1st bag of IV fluid running at the rate ordered. Critical labs were relayed to the physician this morning. A Nursing note, dated 10/25/22 at 11:20 AM, documents R4 is in bed awake with IV fluid infusing as ordered. An order for IV antibiotics were put in place for pneumonia. R4's oxygen saturations were at 86% of 3 L via nasal cannula. An order was placed to transfer R4 to the hospital. 911 was called. A Nurse Practitioner note, dated 10/25/22 at 4:12 PM, documents R4 has a history of adult failure to thrive it is receiving IV fluids for hypercalcemia and declining kidney function. R4 has had 1.5 L of fluid with no urinary output. The brief is dry. A urinary catheter was inserted with 75 mL of urinary output. The chest x-ray showed right side of pneumonia so IV antibiotics were ordered. R4 begin to saturate in the 80s despite supplemental oxygen administration. R4 does not respond verbally to questions asked. R4 was sent to the ER for further evaluation.	S9999		

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S9999	Continued From page 10 A Nursing note, dated 10/25/22 at 10:20 PM, documents R4 was admitted to the hospital for alert mental status change and hypernatremia. The Hospital Records, dated 10/25/22, document R4 presented to the emergency room for altered mental status. R4 is relatively nonverbal and history is limited. R4 is thin appearing with dry mucous membranes. Screening labs are concerning for dehydration. The kidney function labs are the blood urea nitrogen and creatinine. The blood urea nitrogen level four or four is 98 mg/dL and the creatinine level is 3.67 mg/dL. R4 is also in acute on chronic kidney disease. R4 was given 1 L IV fluid bolus. IV fluids were started at 125 mL after the bolus per nephrology recommendations. R4 had elevated troponins which may be secondary to kidney failure. The electrocardiogram was nonischemic. R4 was admitted to the hospital with a diagnosis of hyponatremia, hyperglycemia, dehydration, and failure to thrive in adult. R4 ended up developing acute hypoxic respiratory failure and was intubated on 10/26/22 due to septic shock from right lower lobe aspiration pneumonia. R4 continued to decompensate while in the intensive care unit developing worsening shock, worsening hypoxemia, hyponatremia, and thrombocytopenia. R4 was made a do not resuscitate by family. R4 expired on 11/5/22. The Physician Order Sheet dated 11/12/22 documents an order for a nutritional health supplement 2 times a day was ordered on 10/10/22. There is also an order for weights one time for day one and every day shift for 3 days and every dayshift for 7 days for 3 weeks and every day shift starting on the 1st and ending on the 7th every month. This order was placed on 9/30/22. There was an order placed on 10/3/22	S9999		

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S9999	Continued From page 11 for a medication that stimulates appetite. The Medication Administration Record dated 10/2022 documents weights were only taken on 10/1/22. There is no other documentation of weights. On 10/8/22, it is documented R4 was not available. On 10/15/22, it was documented as not applicable. On 11/12/22 at 3:31PM, V10 (Nurse) stated, "I did send (R4) out to the hospital for mental status changes. (R4's) appetite was very, very poor. (R4) did require you to set up the tray and (R4) needed constant reminders to eat. (R4) would just refuse to eat. (R4) had a medication to help his appetite, but that even didn't help. (R4) had a diagnosis of failure to thrive also. I know we did lab work and they came back with some issues so (R4) was starting on IV fluids. I was never told that (R4) lost weight when (R4) transferred up to the third-floor. Restorative CNAs (Certified Nursing Assistants) will do the weight and report it to the restorative nurse or management. It was never brought to my attention that (R4) had lost that much weight. I'm only seeing now in the computer for the first time. If they're not drinking much, then you try to encourage more fluids. If they still aren't drinking, then you will call the doctor or nurse practitioner and they will normally get labs. I know because (R4) was not drinking. (R4) needed IV fluids. When a resident has weight loss, the Dietitian will evaluate the patient and the nurse practitioner should know because they will also help put in orders to prevent weight loss. Normally (R4) was verbally responsive; by the end of the day, (R4) was getting worse. (R4) became verbally unresponsive and was not eating at all. The IV fluids were started the day before. The last week or two I took care of (R4), (R4) was only eating maybe 10 to 25% of meals. I	S9999		

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S9999	Continued From page 12	S9999		

don't know how much (R4) was drinking. After about a week of not eating well, then I would let the doctor know."

On 11/12/22 at 4:07PM, V12 (Nurse) stated, "If (R4) came in with failure to thrive, then we would monitor eating at meal times. We would also make sure we are taking down his likes or dislikes to see if there was anything else we could give him that he would enjoy eating. Usually when a resident is not eating well, the house supplement is the first to always be given. We also will add on a high calorie shake. If there is a couple days where the resident is not eating well, then we will let the nurse practitioner know. If (R4) came in with poor eating and it's already started while R4's there, it's probably going to continue, so you need to let someone know. The resident isn't going to just decide to start eating. Every time we go into the room we try to encourage them to take a drink. If they are not drinking well or are having less urinary output, then the nurse practitioner should be notified within a day or two. Signs of dehydration would be lethargy, confusion, and dry mouth. You don't want to wait on telling the nurse practitioner or doctor if they aren't drinking because if you had the ability to rehydrate them in the facility, it's better to do that they are than a hospital."

On 11/14/22 at 3:33PM, V14 (Restorative Aide) stated, "When a resident is a new admit, I get their weight and their height. Usually it's monthly after that unless there is a doctor order for more. If a resident has a significant weight loss, then I have to report it to the DON (Director of Nursing). It will usually tell me once I put the weight in the computer if it was a significant weight loss. It will give me a percentage of weight that was lost, and if it was significant or not. I don't remember (R4)

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having any significant weight loss. I know (R4) did have some weight loss, but it wasn't significant. I can't remember exactly what it was but if it was significant, then I would've told someone. The CNAs said that (R4) was just a slow eater and (R4) never really wanted to eat too much. The only thing that (R4) was at risk for weight loss was because (R4) didn't eat much. I don't know what interventions they put in for (R4) for weight loss. If any new interventions are put in, then I will look at the Kardex to see what was put in place."

On 11/15/22 at 12:11PM, V2 (DON) stated, "Yes, (R4) was a high risk for losing weight. (R4) came to us for a lack of appetite and a diagnosis of failure to thrive. (R4) did end up losing weight while he stayed with us, but (R4) did not have a change in appetite. (R4) did have poor PO intake, which was what (R4) was admitted with. The Dietitian did see (R4) on 10/10. (R4) was weighed that day and had some weight loss, so the Dietitian added a supplement twice a day. (R4) was never weighed again after that. Usually residents are weighed monthly, and (R4) was already weighed twice that month. I don't believe there is any orders for (R4) to be weighed more frequently. The CNAs document the amount of food that is eaten with each meal. If a resident eats less than 50%, they should report that to the nurse and to me. (R4) could eat with set up help only, but (R4) did need encouraging. A couple days before (R4) left, (R4) did have labs due to mental status change, and we gave (R4) some IV fluids before (R4) was sent out. (R4) didn't respond to the IV fluids, so we had to send (R4) out. I know they repeated the labs after the IV fluids, and the BUN and creatinine were elevated even more."

On 11/15/22 at 1:26PM, V19 (Nurse Practitioner)

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S9999	Continued From page 14 stated, "I know (R4) went to the hospital this time from home, and when (R4) came to us at the end of September, (R4) only weighed 137 lbs. That was a significant weight loss that (R4) had from the previous admission. (R4) weighed over 200 pounds when (R4) was previously admitted to the facility in 2015. I know there was a Dietitian consult for (R4), and the house supplement was added to help with weight gain or maintaining (R4's) weight. We added that on because two weeks after (R4) had come to the facility, (R4) had lost weight. (R4) went from 137 pounds to 124 pounds; that would be considered a significant weight loss. Staff never told me that (R4) was not eating well. I did not find that out until a couple days before (R4) went out to the hospital. We ended up doing labs on (R4) when I found this out, and (R4's) BUN and creatinine were elevated. There was an order to start IV fluids. We did give (R4) almost 2 bags of IV fluids, and (R4) still had not had any output (urine). I went and I checked (R4's) brief, and (R4's) brief was bone dry. We inserted a urinary catheter to see if we could get any output and to monitor it, but barely anything come out. I believe it was under 100 ML. We drew labs again, and the BUN and creatinine did not go down. (R4) then began desaturating, so I sent (R4) out to the hospital for an evaluation. I gave (R4) IV fluids to try to help (R4's) kidneys recover, but (R4) started to develop pneumonia as well, so that was not something we could manage and facility any longer. If a resident is not eating well or drinking well, I tell the staff after two consecutive meals to let me know so we can avoid dehydration. If I was notified before that (R4) was not eating, we could have sent (R4) out in a better condition, or we could have managed better in house and (R4) might not have even need to go out."	S9999		

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S9999	Continued From page 15 On 11/15/22 at 2:23PM, V20 (Dietitian) stated, "I did a full assessment on (R4) a couple weeks after (R4) came to the facility. That day I started (R4) on a house supplement that provides extra calories and protein for a resident. I ordered 60 ML of that twice a day. (R4) was also taking Remeron which is an appetite stimulant. That was ordered on 10/3. I also ordered a swallow evaluation, but I was talking with speech, and that came back with no issues. (R4) came to us with a diagnosis of failure to thrive and anorexia. (R4) had already had a lack of an appetite when (R4) was admitted. I was notified of the weight loss for (R4), which is why I assessed (R4). There are no further weights after the 10th, so I'll have no further adjustments. If (R4) were to lose more weight and it would've been documented, then I would have probably made more adjustments to prevent that. (R4) just needed encouragement eating. (R4) would just let the tray sit in front of (R4). I know at times (R4) was still refusing to eat even with staff encouragement. (R4) was ill appearing when I saw (R4). (R4) had a moderate amount of muscle and fat wasting. That is where you are supposed to see muscle is that a normal healthy person you would not see it on him. Specifically around his temporal area you could see more bone. Residents that are at risk of losing weight or they have had a significant weight loss weight are usually done weekly. I'm not sure why more weights weren't taken it after the 10th. I know there were moments where (R4) was eating about 50% of (R4's) meals, but a lot of other times (R4) was eating only a couple bites to about 25% of the meal. I am in the facilities monthly to review resident weights. If no weight loss is brought to my attention and no weights are taken then I would not know if a resident needs more interventions added."	S9999		

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S9999	Continued From page 16 The policy titled, "Hydration Management," dated 10/16/17 documents, "Purpose: To provide each resident with sufficient fluid to maintain proper hydration. Guideline: The elderly have a diminished sense of thirst and decreased kidney function. The amount of fluid needed to maintain health and prevent dehydration is specific to each resident and may fluctuate as resident conditions fluctuate. Therefore, healthcare staff will ensure adequate fluid intake by: licensed staff observation of hydration status every shift during meals, medication pass, and other staff/resident interactions, keeping food accessible, and cueing to drink with meals and medications and assisting and/or cueing drinking as needed. Interventions: may include one or more of the following based on clinical observation: ... Develop a care plan based on evaluations and when possible, specify fluid preferences ... evaluation by a dietitian, intake and output monitoring to evaluate as determined by the interdisciplinary team. Fluid monitoring: Fluid monitoring should be considered when an evaluation of the following is identified, ordered fluid restrictions or other instances in which fluid volume may potentially be affected: acute changes in condition or illness in which 25% or less of meal intake is consumed, conditions which result in excessive sweating or fever, vomiting, nausea or diarrhea, or involuntary weight loss ... Nurses will monitor the total intake each shift and communicate during shift change report the resident intake and progress towards the goal. The night shift charge nurse will calculate the previous 24 hour total by running the intake and output report at the end of each shift and pass along to the oncoming dayshift charge nurse. The dayshift charge nurse will follow up with the assessment and the physician notification unless medically necessary to	S9999		

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S9999	Continued From page 17 address sooner. The unit manager will review the total intake and discuss at morning meeting with the IDT to ensure all follow-up assessments are completed. Any trends in deficiencies of fluid that need requirement will be discussed and further assessment/monitoring, residents/families and doctor consultation shall be completed." The policy titled, "Nutritional Status Management," dated 4/2/18 documents, "Purpose: It is the practice, in accordance with advanced directives to provide interventions to maintain, improve and respond to nutritional needs. Measures will be taken to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range electrolyte balances, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. The facility will both evaluate and record meal and take a document within the medical record. The interdisciplinary team together with the resident and/or resident representative will identify, evaluate risk factors, and individualized interventions to meet the nutritional needs of the resident and determine through monitoring of health status effectiveness ... Guideline: ...6. Development and implementation of individualized interventions based on interdisciplinary valuations, resident and/or resident representative goals to promote the highest level of function and dignity which may include but not limited to: encourage consumption of food and fluids during meals, ... offer and encourage fluids with meals, medication passes, snacks and while awake, monitor meal consumption, lab values, determination of more frequent weight monitoring, nutritional supplementation, additional fluids, enhanced foods, liberalize diet, finger foods, restorative	S9999		

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S9999	Continued From page 18 program, and additional non-food fluid items. 7. Dietitian consultation should follow a trend indicating a 5% weight gain or loss, modify with the interdisciplinary team including the resident and resident representative the plan of care with interventions to address risk factors and restore desired weight goals, and monitor the effectiveness of the modified care plan. 8. Care planning: must address the extent possible, identified causes of impaired nutritional status, reflect the resident's personal goals, preferences and identify specific interventions, time frames and parameters for monitoring. There should be a documented clinical basis for any conclusion that nutritional status or significant weight change are unlikely to stabilize or improve (e.g. physicians documentation to why weight loss is medically unavoidable) and the resident and/or resident representative involvement to ensure goals and preferences. Examples of goals include: a target weight range, desired fluid intake, the management of underlying medical conditions, and the prevention of unintended weight loss or gain ... monitoring: interviewing, observing, reviewing specific factors, and evaluating." (B)	S9999		