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
	IL6001275	A. BUILDING: _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

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S 000	Initial Comments Facility Reported Incident of February 26, 2024 IL170141 Complaint Investigation 2451246/IL169813	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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	S9999		

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S9999	Continued From page 1 supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to initiate a safe transfer to a wheelchair for 1 of 3 resident (R2) reviewed for safety in a sample of 5. This failure resulted in R2, during a transfer, receiving a laceration to her leg requiring an emergency room visit and a total of 16 stitches to the wound. Findings include: R2's Face Sheet documented an admission date of 7/11/23, and listed diagnoses including Bipolar Disorder, Unspecified Dementia, Diabetes Type 2, and Chronic Peripheral Venous Insufficiency. R2's Minimum Data Set (MDS), dated 1/17/24, documented a Brief Interview for Mental Status Score of 8, indicating R2 had moderate deficits in cognitive functioning. The same MDS documented R2 utilized a wheelchair for mobility and was totally dependent on staff for transfers. R2's Care Plan, dated 2/19/24, documented a problem area,"Dependent transfers," with a corresponding goal, "Transfer from chair/bed without injury, safely, using (mechanical lift). The Care Plan further documented a problem area, "Resident has impaired skin integrity due to: Chronic Lymphedema to the (bilateral lower extremities), a skin tear to left calf, a laceration to right outer calf with stitches, and a deep tissue injury to right heel," with a corresponding goal, "Resident will have skin show signs of healing," and associated interventions, "Assist with mobility and transfers," and, "Ensure proper body	S9999		

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alignment when in bed or chair."

R2's Physicians Orders documented an order for Xarelto (anticoagulant) 10 milligrams take one tablet daily in the afternoon, with a start date of 7/11/23.

R2's Facility Incident Report sent to the Department on 2/26/24 documents: "Incident date: 2/16/24...BIMS is an 8. Diagnosis Edema, unspecified. Unsteadiness on feet. Muscle weakness (generalized). Other lack of coordination. (R2) was being transferred to her w/c (wheelchair) and received skintear that she went to (Name of Hospital) ER and received stitches for. Res (resident) was 3 assisted to w/c (wheelchair) when during transfer to w/c pool noodle that was in place to w/c on area to attach foot pedals came off from r (right) side of wheel chair and res received a skintear/ laceration to RLE (Right lower extremity). Pain management in place... Therapy evaluating a carefoam chair for resident transfers."

An Event Report for R2, dated 2/16/24, documented," At 1615 (2:15pm) 3 assist for resident from toilet to wc (wheelchair). In process of transfer noted large amt (amount) blood pooling under rt (right) foot. Padding required for wheelchair in place on left, however right has fallen off. Approximately 100-150 milliliters of blood noted on floor. On call administration (staff) notified and was advised to send to ER (Emergency Room).

R2's 2/16/24 Emergency Department Report stated," 61 year old female presents to the emergency department for evaluation of a wound to her right leg. The patient reportedly was taking a shower and the patients leg got caught on a

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sharp object, causing a wound. They put a bandage on it and she was sent to the ER (Emergency Room) for evaluation. History is very limited as the patient has dementia. Most of the history was obtained from the EMS (Emergency Management System) who transported the patient to the ER. 15 centimeter 'V' shaped laceration over lateral aspect of right lower leg. The wound was irrigated and then closed without difficulty. Number of sutures: 16."

A document titled, " (R2) laceration to RLE (right lower extremity) investigation completed 2/19/24" stated,"(R2) was 3 assisted from toilet to wheelchair. She received laceration to RLE and was sent to (local ER) for treatment. She received 16 sutures r/t (related to) incident. Root cause of laceration was pool noodle was in place and became dislodged during transfer."

On 2/21/24 at 1:25pm, V2, Director of Nursing, stated when the incident occurred on 2/16/24, there were pool noodle pieces attached to both legs of the wheelchair to protect R2's fragile skin from the armature where the foot pedals attach to the frame. V2 stated, "Somehow at some point the right pool noodle piece fell off, and when they were transferring her back into the wheelchair her leg made contact with the exposed wheelchair leg, and even though the surface was not sharp, it cut her leg and she had to have 16 stitches."

On 2/22/24 at 8:20am, R2 was lying in bed and was alert only to herself. R2's wheelchair was in the room and the foot pedals were not attached. Taped on each side of the frame to the armature where the pedals attach were pieces of pool noodle approximately 6 inches in length. R2's right leg was visible and the shin was covered with an elastic bandage. The Surveyor asked R2

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if she remembered her leg getting hurt and she said,"Yes", but the rest of her responses were non sensical.

On 2/22/25 at 2:05pm, V17, Licensed Practical Nurse, was observed providing wound care for R2. R2 was noted to have a v-shaped laceration, approximately 3.5 inches long on each angle, to the right outer shin. The wound had multiple stitches and appeared to be healing well, with no drainage, redness, or odor.

On 2/22/23 at 2:20pm, V15, Certified Nursing Assistant (CNA) stated she, V16, CNA, and V8, Registered Nurse, were transferring R2 from the toilet in the shower room to R2's wheelchair. V15 stated during the transfer, the piece of pool noodle on the right side of the wheelchair fell off and R2's shin made contact with the frame of the wheelchair where the foot pedal attaches on that side, causing a skin tear and profuse bleeding. V15 stated the pool noodle had a slit so it could be slid over the part of the frame where the leg support/foot pedals attach, but it was not secured on.

On 2/22/24 at 245pm, V16 stated V15 and V8 had R2 on the shower room toilet and asked V16 for help transferring R2 to her wheelchair. V16 stated V15 and V8 stood on either side and lifted R2 while V16 pulled up R2's pants. V16 stated as they were pivoting R2 into the wheelchair, the pool noodle on the right side came off and they saw R2 was bleeding. V16 stated she had never previously witnessed the pool noodles come off. V16 stated both the pool noodles were on the wheelchair when V16 entered the shower room. V16 stated she thought the pool noodles were taped on, but she was not sure. V16 stated after the incident, staff were educated that they need to

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be more careful with R2's legs during transfers and to make sure the pool noodles are attached prior to transfers.

On 2/23/24 at 8:10am, V8 stated she, V15, and V16 transferred R2 from the toilet to R2's wheelchair when suddenly they saw blood pooling on the floor and determined it was coming from R2's right leg. V8 stated she immediately put pressure on the leg and was not paying attention to the wheelchair, but found out later the pool noodle came off the wheelchair on the right side. V8 stated R2's skin is very fragile and additionally she is on Xarelto. V8 stated she did not personally witness it, but had heard R2 had previously been injured in identical circumstances. V8 stated after the incident, staff used ductwork tape to secure the pool noodles on. V8 stated staff have also been discussing the possibility of getting a different wheelchair for R2.

An Event Report for R2, dated 1/10/24, documented, "Skin tear to left lower extremity. Activity during skin tear: Repositioning." A Nursing Progress Note dated, 1/10/24, documented, "Resident received skin tear to lower left extremity when repositioning resident in wheelchair. Skin tear measures 7.5 centimeters by 0.1 centimeter. Foot pedals were not in place at time of transferring resident from bed to chair, (new intervention added is) placing pool noodle on foot pedal area."

On 2/23/24 at 10:00am, V2 stated on 1/10/24, R2 received a skin tear while being repositioned in her wheelchair and her leg came in contact with the part of the chair where the foot pedals attach. V2 stated the intervention of placing the pool noodles was added after the 1/10/24 incident. V2 stated initially, the pool noodles were not

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attached, but slid over the armature and were to be used when the resident was self propelling and did not need the foot pedals. V2 stated at some point, V2 attached the pool noodles semi permanently using medical grade tape. V2 stated she believes she notified the therapy department of this intervention, "And they were OK with it." V2 stated she was not sure if therapy had evaluated R2's wheelchair. V2 stated on 1/29/24, R2's transfer status went from 3 staff assist to mechanical lift due to progressive weakness in R2's legs.

On 2/23/24 at 11:00am, R2's wheelchair was again observed. The pool noodle pieces were taped to the armature where the foot pedals attach, but the one on the left leg was loose and able to be spun around, exposing the metal armature.

On 2/23/24 at 12:05pm, V14, Physical Therapy Assistant/Director of Therapy Services, stated she was aware of the intervention involving the pool noodles for R2. V14 stated the therapy department has evaluated R2 several times since her admission, but not since the 1/10/24 or 2/16/24 incidents. V14 stated they have tried changing R2's wheelchair several times, but R2 refuses them by not wanting to sit in a new chair or trying to get out of it. V14 stated a custom chair could be ordered, but it would cost thousands of dollars, R2's insurance might not cover it, and R2 might still refuse to use it. V14 stated, " I guess we could get permission (from insurance) to do another evaluation and call in a wheelchair specialist." The Surveyor notified V14 the pool noodle on the left side was loose, potentially exposing R2 to injury. V14 stated, "I guess we could try something more secure."

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On 2/23/24 at 12:30pm, V2 stated after the 2/16/24 incident, staff were educated to always use a mechanical lift to transfer R2. V2 stated it was determined in addition to the issue with the pool noodle coming off, the skin tear might have been avoided by using a mechanical lift, which at the time staff were supposed to be using. V2 stated she has now discussed the issue with the therapy department, and therapy is going to evaluate R2 for the use of a pressure reducing mobile specialty chair. V2 stated they already have such a chair which had belonged to another resident and is no longer being used.

An Inservice Sign In Sheet dated 2/19/24 documented," Topic: Use of (trade name mechanical lift). When someone is recommended to be a (mechanical lift), we need to follow through and use the (lift)."

(B)

2 of 2

300.610 a)
300.1010 h)
300.1210 b)
300.1210 c)
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

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policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and

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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 assess for risk of dehydration, to contact a medical provider to report lack of food and fluid intake, and to implement in a timely manner orders for labs to identify dehydration for 1 of 3 residents (R1) reviewed for hydration in the sample of 5. This failure resulted in R1 requiring hospitalization from 2/4/24 through 2/14/24 for a diagnosis of dehydration and requiring IV (Intravenous) fluid replacement.

Findings include:

R1's Face Sheet documented an admission date of 1/19/24, and listed diagnoses including Huntington's Disease, Unspecified Dementia, Unspecified Psychosis, and Moderate Protein-Calorie Malnutrition.

R1's Minimum Data Set(MDS), dated 1/31/24, documented R1 requires substantial/maximum assistance from staff for eating, defined as," The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident,"and a BIMS (Brief Interview for Mental Status Score) of 99, indicating R1's cognition is so impaired that the examination could not be completed. This MDS documented R1's admission weight as 123lb (pounds) and height as 62 inches.

R1's Care Plan, dated 1/31/24, documented a

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problem area,"Resident is at risk for alteration in weight due to Huntington's Disease and Malnutrition," with a corresponding goal, "Encourage fluids with meals and in between."

R1's Initial Nutrition Assessment, dated 1/23/24, authored by V11, Registered Dietician, documented R1's diet order was for a regular diet with mechanical soft texture and thin liquids. This Assessment further documented R1 was experiencing swallowing problems, R1's 1/23/24 weight was 125.5 pounds, and R1 required 1500ml (milliliters) of fluid intake per day.

R1's 1/31/24 Dietary Progress Note authored by V12, Dietary Manager, documented,"How many full meals does resident eat daily: Less than one full meal. Does resident consume 2+ servings of fruit or vegetables per day?: No. How much fluid (water, juice, coffee, tea, milk) is consumed per day?: 3-5 cups."

A 1/23/24 Speech Evaluation documented, "Reason for Referral: 51 year old female resident of the (facility) who was referred for Speech Therapy related to difficulty chewing and swallowing. She also has difficulty communicating related to Huntington's disease. Diet recommendations: Solids, puree consistencies. Liquids, thin liquids."

R1's Daily Vitals Log documented the following:
1/27/24: No fluid intake documented.
1/28/24: No fluid intake documented.
1/29/24: 1900ml fluid consumed.
1/30/24: 975ml fluid consumed.
1/31/24: 1000ml fluid consumed.
2/1/24: 475ml fluid consumed.
2/2/24: 400ml fluid consumed.
2/3/24: No fluid intake documented.

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2/4/23: 920ml fluid consumed.
2/5/24: "Fluids not taken."
2/6/24: "Fluids not taken."

A General Order for R1 with an order received date of 1/26/24 documented,"Physician order: Order Description: CBC with diff (Complete Blood Count with Differential), (vitamin) B12 (level), vitamin D (level), Folate (level), Depakote level." There was no corresponding Nursing Progress Note and no Physicians Progress Note to indicate why this lab order was given. A Lab Report with a specimen collected date of 2/5/24 and a specimen reported date of 2/5/24 documented,"Sodium-greater than 180 (no reference range listed). Blood Urea Nitrogen: 117 (reference range 7-25). Creatinine 2.2 (reference range 0.6-1.2)."

Nursing Progress Notes for R1 documented the following:
2/4/24: "No behaviors noted from resident all weekend. Resident with poor appetite and fluid intake. Will only take 3-4 bites each meal and sometimes will spit it out. Residents front teeth appear to have caries. Dentist appointment may be necessary. Will pass on to night nurse to inform day nurse tomorrow. Labs to be drawn in a.m. No signs or symptoms of distress. Has taken medications all weekend."
2/6/24: "Writer obtained lab results from (local lab), noted many abnormal lab results and high critical BUN (Blood Urea Nitrogen) of 117. Writer faxed results to (V9, Physician) office and reported to on call (Physician). Writer notified (V9) of (R1) refusing bedtime medication and also other medications as well. (R1) is refusing to eat and drink. Writer requested if (V9) would like to place her on comfort care."
2/6/24: "Labs were faxed to (V9) earlier this am

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for review. Call received from (V13, Nurse Practitioner) at office for orders to contact family concerning future plan of care as resident has commented to staff that "she wants to die" and has refused any oral fluids, food and some medications when offered. Administration is unable to contact family at this time with numbers provided. Order also received for ERD (Emergency Room Department)(transfer) for IV fluids related to abnormal labs if family and/or resident are in agreement to this course of treatment. PSR(Psychosocial Rehabilitation Staff) and Social Service were at bedside to talk with resident. She has agreed to hospital and has taken most of her medications at all times throughout day. Has eaten approximately 2 ounces with Occupational Therapy at bedside today. Resident rests comfortably in padded bed. Noted sporadic uncontrolled movements, especially of all extremities continues. Resident has very unwell appearance with waxen skin tone, bruises (as a result of self-injurious behavior) are healing."
2/6/24:" EMS (Emergency Medical Services) transported resident to (local hospital) as directed with report given to EMS team. Resident is cooperative with a calm demeanor at time of leaving facility."
2/6/24: "Verified status of resident and is admitted to (local hospital) for observation due to abnormal labs."
2/14/24: "Readmit from (local hospital) per EMS on cart. Responsive and aware of staff at bedside. Transferred from cart to padded bed with EMS and staff support. incontinent of small amount soft tan stool and clear urine, skin care per staff and barrier cream applied as preventative. No skin impairment of back or buttocks. no paperwork was provided with transfer. Report was received from (nurse) at

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RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

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(local hospital). Admission discharge for hospital was increased sodium, dehydration and failure to thrive. IV(Intravenous Fluid infusion) was removed from right lower extremity at discharge. Resident is NPO(Nothing by Mouth) with no swallow reflex. Edema to bilateral lower extremities. Family have been contacted by hospital and have made decision for Hospice/Comfort Care at this time. Daughter is POA(Power of Attorney)."
Nursing Progress Notes from 1/27/24 through 2/3/24 contained no documentation related to R1's poor fluid intake nor of any attempts to contact R1's Physician. Nursing Progress Notes from 1/26/24 through 2/4/24 contained no documentation about labs being drawn.

An 1/24/24 R1's "Rehabilitation evaluation status post functional decline," note, authored by V10, Nurse Practitioner (collaborating with V9, Physician), stated,"Patient to be seen today for rehab evaluation status post functional decline. Patient is a 51 year-old female admitted to skilled facility from a sister facility. Patient admitted to behavioral health unit with plan to remain on unit long term. Current diagnosis of Huntington's disease with past medical history of generalized anxiety, unspecified dementia, psychosis, depressive disorder, iron deficiency anemia, disorder of the eye and adnexa, protein calorie malnutrition, and specified abnormal involuntary movements, chest pain, vitamin deficiency, and hypercalcemia. (R1) will be receiving speech services for cognition and dysphasia. Patient evaluated today in hallway with staff present period staff reports patient arrived recently was transferred here from sister facility. Staff state patient has been very active and wandering throughout unit, and says patient has been very inconsistent and impulsive. Noted to have head

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helmet on for protection. Staff report she has had anger outbursts and has put herself on the floor. Awaiting orders for medication to calm patient down. Patient allowed staff to assess her in hallway and in her room. Patient sat outside a bed calm but quickly wanting to get up. Able to move all extremities appropriately. Does not appear to be in any pain currently. Speech has no concerns for their ability to work with the patient at this time. No further issues voiced." There was no documentation to indicate V10 had assessed R1's hydration status during this visit, and there was no documentation V10 had evaluated R1 after 1/24/24.

A Hospital Discharge Summary, dated 2/14/24, documented, "Active hospital problem (on admission): Diagnosis: Principal problem: Hypernatremia. Hypokalemia, Acute Kidney Injury, Thrombocytopenia, Functional Quadriplegia, Dehydration, Huntington's Disease. Labs (on admission): Sodium: 146 (reference range 136-145). Blood Urea Nitrogen: 40. (reference range 10-20). Potassium: 3.1(reference range 3.5-5.1. Chloride: 123 (reference range 98-107). R1 is a 51 year old female with a history of Huntington's Disease who presented to the hospital for dehydration. She was admitted through the emergency room with severe dehydration, she was started on IV fluids, she did respond to this, it did take quite some time to rehydrate her as her sodium level was quite elevated and she was able to be brought back to nearly normal levels. We made attempts to try to feed her, and she was seen by speech therapy, unfortunately she was not safe to be fed. Discussed with her family about a possible feeding tube, they did not wish for her to have a feeding tube, and wish for her to be made hospice care. Will discharge her back to the

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nursing home under hospice care."

On 2/21/24 at 1045am, V4, Certified Nursing Assistant (CNA), stated prior to returning from the hospital on hospice, R1 required extensive feeding and fluid assistance from staff. V4 stated she would estimate R1's daily fluid requirement to be about 2000 ml daily. V4 stated CNA and nursing staff had all discussed among them R1's decline and refusal to take in food and fluids and decrease in urine output. V4 stated R1 had difficulty swallowing as well as physical acting out behaviors and movements due to Huntington's Disease which made feeding R1 food and fluids difficult. V4 stated when R1 was first admitted, she had almost constant behaviors including self-injurious behavior, but she was eating and drinking pretty well and could ask for fluids. V4 stated staff tried specialty cups and utensils when feeding R1 but R1 began spitting out food and fluids. V4 stated R1 continued to decompensate and required hospitalization in early February 2024. V4 stated CNA and nursing staff are responsible for documenting residents fluid intake in the medical record. V4 stated if the resident consumes no fluid or refuses fluid, there are menu options in the system to indicate that.

On 2/21/24 at 11:05am, V5, CNA, stated she started working at the facility on 1/26/24. V5 stated when she first started taking care of R1, R1 was able to ask for a drink and her fluid intake was pretty good. V5 stated she would estimate R1's fluid needs to be about 64 ounces (approximately 1856 ml) per day. V5 stated she does not remember exactly when, but R1 began refusing food and fluids. V5 stated her approach to keep R1 hydrated was to ask her often if she wanted a drink. V5 stated unless residents have congestive heart failure, fluids should always be

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encouraged. V5 stated the CNA and nursing staff were all aware R1 had decompensated and was not taking in adequate fluids and had a decrease in urine output. V5 stated there were days when R1 had no fluid intake at all. V5 stated she communicates with nursing staff multiple times per day about the status of the residents she is responsible for, including R1. V5 stated CNA staff is responsible for charting fluid intake in the medical record. V5 stated there is a drop down option for residents refusing fluids but the record should not be left blank. V5 stated, "There are days we are so busy it's possible things weren't charted the way they should have been."

On 2/21/24 at 11:45am, V8, Registered Nurse, stated CNA staff were keeping her appraised of R1's poor fluid intake and urine output. V8 stated R1 was not getting anywhere near 1500ml of fluid per day at any point when V8 worked with her. V8 stated R1's jaw was really lax and food and fluids would drain out of her mouth. V8 stated she remembers R1 at some point going two days without any fluid intake. V8 stated she did not recall contacting R1's medical provider until she reviewed R1's labs on her night shift from 6pm to 6am on 2/5/24 and 2/6/24,and she recalled the sodium level being was extremely high. V8 stated V13, one of the Nurse Practitioners who collaborates with V9, gave the order to send R1 to the hospital, which was done immediately. V8 stated before R1 went to the hospital, she was not hospice or comfort care. V8 stated the idea had circulated among staff, but they couldn't get ahold of the family to discuss those options. V8 stated on 2/6/24, R1 said, "I want to die." V8 stated if V9 or V10, Nurse Practitioner who collaborates with V9 and is present in the facility Monday through Friday, saw R1 during her stay at the facility, she was not aware of it.

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On 2/21/24 at 1:25pm, V2, Director of Nursing, stated when R1 was first admitted to the facility, she could ambulate and at times self feed. V2 stated R1 was very unhappy about being placed in a facility, and had maladaptive behaviors in addition to her issues with Huntingtons Disease. V2 stated they sent R1 to the Emergency Room on 1/21/24, but they sent R1 back with no new orders. V2 stated the facility then attempted to get R1 hospitalized in a behavioral medicine unit, but the ones they checked either had no beds or would not accept R1. V2 stated after a couple days, R1 was calmer and exhibited fewer behaviors. V2 stated to her knowledge, neither V9 nor V10 evaluated R1 from her admission until she went to the hospital on 2/6/24. V2 confirmed it is the CNAs responsibility to document residents fluid intakes. V2 stated her staff did not keep her updated about the fact that R1 was not eating or drinking. V2 stated if labs are routine, the lab will come and draw them on Mondays, Wednesdays, and Fridays, but R1's labs should have been drawn as soon as possible upon receiving the order, and V2 stated the facility has been having problems with this issue of late, and she has been providing staff retraining.

On 2/21/24 at 1:45pm, V10 stated she evaluated R1 on 1/22/24 for a new resident history and physical. V10 stated to her knowledge, the facility did not attempt to contact her about R1 not eating or drinking. V10 stated she counts on the staff to contact her if there is a change in a resident's condition.

On 02/23/2024 at 12:58pm, V2 was asked if there is a routine screening for assessing a residents hydration. V2 stated a Dehydration Evaluation is done when staff notice the resident is not eating

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S9999	Continued From page 18 and drinking or is losing weight. V2 acknowledged a Dehydration Evaluation had not been done for R1. A Hydration Policy, dated December 2016, documented, "It is the policy of (the facility)to provide residents with adequate fluids, including water and other liquids that are consistent with resident needs and preferences, and are sufficient to maintain resident hydration." A Change in a Resident's Condition or Status Policy dated November 2016 documented,"A facility must immediately inform the residents, consult with the residents Physician, and notify, consistent with his or her authority, the residents representative when there is (example given changes in level of care, resident rights, etcetera.) 1. The Nurse Supervisor/Charge Nurse will notify the residents Attending Physician or on-call Physician when there has been: D A significant change in the residents physical/emotional/mental condition/psychosocial status to either life-threatening conditions or clinical complications. 2. A significant change of condition is a decline or improvement in the resident's status that: A. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self limiting')." (B)	S9999		