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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 5 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These requirements are not met as evidenced by: Based on interview and record review the facility failed to verify certification of a Certified Nursing Assistant prior to employment. This failure has the potential to affect all 90 residents residing in the facility. Findings Include: The facility's midnight census dated 4/8/24 documents 90 residents reside in the building. The Illinois Department of Public Health Health Care Worker Registry documents V16 Certified Nursing Assistant, was hired by the facility on 3/5/24. The registry check verifies V16 is eligible for work. However, under certifications "No Certifications" is documented. V16's employee record documents V16 was hired and is working as a Certified Nurse's Aide and continues to hold that position currently.	S9999		

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On 4/9/24 at 2:00PM, V19 Human Recourses Assistant provided a CNA Registry printout obtained 4/9/24 that documents V16 completed the CNA program on 4/13/22 and passed the competency on 5/25/22. V19 stated "I guess the one I have on file does not have (V16's) certification information on it. I think I must have keyed in the wrong Social Security Number." V19 verified that from 3/5/24 until 4/9/24 the facility did not have proof of V16's certification in V16's Human Resources file.

(C)

Statement of Licensure Violations 2 of 5

300.682a)1)2)4)
300.682b)
300.682c)
300.682h)
300.682i)

Section 300.682 Nonemergency Use of Physical Restraints

a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:
1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective;
2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being;
4) demonstration by the care planning

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process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act)

b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.

c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used.

h) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well being.

i) A resident wearing a physical restraint shall have it released for a few minutes at least once every two hours, or more often if necessary. During these times, residents shall be assisted with ambulation, as their condition permits, and provided a change in position, skin care and nursing care, as appropriate.

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S9999	Continued From page 3 These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to assess and care plan for the use of a physical restraint. The facility also failed to obtain a physician order and consent for the use of a physical restraint for one resident (R902) reviewed for physical restraints in the sample list of 3. Findings include: The facility's Physical Restraints policy dated January 2014 documents, "The goal of (the facility) is to maintain or increase a resident's independence and function as well as quality of life, while utilizing the least restrictive intervention possible." "Prior to restraint use, the resident will be evaluated to ascertain what events preceded the need for restraints. Causal factors will be eliminated when possible, this eliminating the need for restraints whenever possible." "If, after the trial of less restrictive measure, the facility decides that a physical restraint would enable and promote greater functional independence, then an order must be obtained from the attending physician" "If the resident, family member or legal representative agrees to this treatment alternative, then the restraining device may be used for the specific periods for which the restraint has been determined to be an enabler." "When restraints are applied, the Plan of Care for a resident will state the reason for the restraint, time frame for releasing same and allowances for skin checks, exercise, toileting, etc (etcetera), at least every two (2) hours. The use of the restraints shall be reevaluated by the interdisciplinary team and the Plan of Care will be updated on a quarterly basis and more often if needed if there is a significant change in	S9999		

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resident's condition."

R902's Order Summary Report dated 4/8/24 documents an admission date of 10/17/22 and documents diagnoses including Repeated Falls, Major Depressive Disorder, Syncope and Collapse, Unspecified Dementia Moderate, Parkinson's Disease, Unspecified Abnormalities of Gait and Mobility, Unsteadiness on Feet, Difficulty Walking and Other Lack of Coordination.

On 4/8/24 at 12:26 PM, R902 was sitting in a reclining geriatric chair next to the nurse's station with the safety belt fastened across R902's lap.

On 4/9/24 at 10:00 AM, R902 was sitting in the reclining geriatric chair next to the nurse's station with the safety belt fastened across R902's lap and an alarm on the chair. R902 was sleeping.

On 4/9/24 at 11:39 AM, R902 was sitting in the reclining geriatric chair in the dining room at a dining table eating a cracker. The safety belt was still fastened across R902's lap and the alarm was on the chair.

On 4/9/24 at 12:06 PM, R902 was sitting in the reclining geriatric chair at the dining table eating lunch with the safety belt still fastened across R902's lap.

On 4/10/24 at 11:25 AM, R902 was sitting in the reclining geriatric chair in R902's room with family and the safety belt was fastened across R902's waist.

R902's Order Summary Report dated 4/8/24 documents an order for a bed and chair alarm every shift related to repeated falls. This Order Summary Report does not document an order to

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use the safety belt for R902.

R902's medical record does not contain a Physical Restraint assessment for the safety belt for R902 nor does the medical record contain a signed consent from R902's representative for the use of the physical restraint.

R902's Care Plan does not document the use of the Physical Restraint and does not direct staff when to release and how to monitor the use of the safety belt.

On 4/10/24 at 12:25 PM, V3 Assistant Director of Nursing confirmed that there was no assessment completed prior to the use of the safety belt and they only completed an assessment after being asked to provide one. V3 confirmed there was no Physician's Order for the safety belt, no consent signed for the use of the safety belt by R902's representative and confirmed it was not on R902's Care Plan with interventions until prompted to add it to the Care Plan. V3 confirmed the seat belt was added to help prevent falls.

(C)

Statement of Licensure Violations 3 of 5

300.686a)8)
300.686b)
300.686d)1)3)4)
300.686f)
300.686g)
300.686h)1)

Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications

a) For the purposes of this Section, the

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following definitions shall apply:
8) "Informed consent" - documented, written permission for specific medications, given freely, without coercion or deceit, by a capable resident, or by a resident's surrogate decision maker, after the resident, or the resident's surrogate decision maker, has been fully informed of, and had an opportunity to consider, the nature of the medications, the likely benefits and most common risks to the resident of receiving the medications, any other likely and most common consequences of receiving or not receiving the medications, and possible alternatives to the proposed medications.
b) State laws, regulations, and policies related to psychotropic medication are intended to ensure psychotropic medications are used only when the medication is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. (Section 2-106.1(b) of the Act)
d) A resident shall not be given unnecessary drugs. An unnecessary drug is any drug used:
1) In an excessive dose, including in duplicative therapy;
3) Without adequate monitoring;
4) Without adequate indications for its use;
f) Residents who use antipsychotic medications shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue these medications in accordance with Appendix F. In compliance with subsection 2-106.1(b-3) of the Act and this Section, the facility shall obtain informed consent for each dose reduction.
g) Except in the case of an emergency, psychotropic medication shall not be

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administered without the informed consent of the resident or the resident's surrogate decision maker. (Section 2-106.1(b-3) of the Act) Additional informed consent is not required for changes in the prescription so long as those changes are described in the original written informed consent form, as required by subsection (h)(12)(A). The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome, pursuant to subsection (h)(12)(A). The most common side effects of the medications shall be described. In an emergency, a facility shall:
h) Protocol for Securing Informed Consent for Psychotropic Medication
1) Except in the case of an emergency as described in subsection (g), a facility shall obtain voluntary informed consent, in writing, from a resident or the resident's surrogate decision maker before administering or dispensing a psychotropic medication to that resident. When informed consent is not required for a change in dosage as described in subsection (h)(12)(A), the facility shall note in the resident's file that the resident was informed of the dosage change prior to the administration of the medication or that verbal, written, or electronic notice has been communicated to the resident's surrogate decision maker that a change in dosage has occurred. (Section 2-106.1(b-3) of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to attempt a recommended dose reduction for an antipsychotic medication, document behaviors to justify the use of antipsychotic medication, obtain consents for psychotropic

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medications, and complete assessments for psychotropic medications for three of three residents (R900, R901, R902) reviewed for Unnecessary medications in the sample list of 3.

Findings include:

The facility's Psychotropic Drug Policy and Procedure with a revised date of March, 2024 documents, "It is the policy of (the facility) that psychotropic drugs are not to be used if avoidable and never as a chemical restraint. They are to be used with a physician's order, written permission of the resident or legal representative, and an appropriate diagnosed indication need. Behavior Monitoring will document specific behavior that indicates the need for administration of the medication. There will be an assessment on admission and quarterly concerning the resident's response and progress while receiving the medication."

1.) R900's Order Summary Report dated 4/8/24 documents diagnoses including Encephalopathy, Parkinson's Disease and Cognitive Communication Deficit. This Order Summary documents an order for Seroquel (antipsychotic) 25 mg (milligrams) at bedtime.

R900's Nurse's Notes dated 3/6/24 at 6:01 PM document that R900's POA (Power of Attorney) refused the request to decrease R900's Seroquel dose from 25 mg to 12.5 mg.

On 4/8/24 at 12:42 PM, V2 Director of Nursing stated that resident's behaviors are documented in the Nurse's Progress notes.

R900's Nurse Progress Notes dated from 10/27/23 to present only document three

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behaviors and two were on the same day.

R900's Psychoactive Medication Monitoring assessment dated 11/22/23 documents R900 had zero behaviors exhibited in the last 90 days. R900's Psychoactive Medication Monitoring assessment dated 2/21/24 documents R900 has zero behaviors exhibited in the last 90 days.

2.) R901's Order Summary Report dated 4/8/24 documents a diagnosis of Depression. This Order Summary Report documents an order for Lorazepam (antianxiety) 2 mg (milligrams)/ml (milliliters), give 0.25 ml by mouth twice a day for agitation/anxiety with a start date of 4/3/24.

R901's medical record does not document an assessment for the use of Lorazepam and does not contain a signed consent for the use of the Lorazepam.

On 4/10/24 at 2:32 PM, V1 Administrator confirmed there is no consent or R901's Lorazepam.

3.) R902's Order Summary Report dated 4/8/24 documents diagnoses including Major Depressive Disorder, Unspecified Dementia Moderate and Parkinson's Disease. This Order Summary documents orders for Lorazepam Intensol Oral 2 mg/ml give 0.25 ml twice a day with a start date of 3/5/24, Lorazepam Oral Concentration 2 mg/ml give 0.25 ml every one hour as needed for agitation/anxiety with a start date of 2/16/24, Seroquel 50 mg give two tablets at bedtime for Dementia with a start date of 1/3/24, Xanax (antianxiety) 0.25 mg one every 12 hours as needed for Anxiety/Agitation with a start date of 3/12/24, Xanax 0.25 mg twice a day for Anxiety with a start date of 12/5/23 and Zoloft

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(antidepressant) 100 mg every day for Major Depression Disorder with a start date of 9/20/23.

R902's medical record does not document a consent for R902's Xanax or R902's Seroquel 100 mg at bedtime.

On 4/10/24 at 2:32 PM, V1 Administrator confirmed there is no consent for R902's Xanax or Seroquel in R902's chart.

(C)

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300.1210d)6)

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to supervise a resident on the toilet resulting in a fall for one of one resident (R901) reviewed for falls in the sample list of 3.

Findings include:

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The facility's Clinical Protocol for Falls documents, "While many falls are isolated individual incidents, a few individuals fall repeatedly. These individuals often have an identifiable underlying or root cause for their falls." "The nurse will review each resident's risk factors for falling and document in the medical record." "Based on assessments and observations, the staff, with assistance from the practitioners, will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling." "If the individual continues to fall, the staff and practitioner will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or addition to those that have already been identified) and reconsider the current interventions."

R901's Order Summary dated 4/8/24 documents diagnoses including Muscle Weakness, Unspecified Abnormalities of Gait and Mobility and Abnormal Posture.

R901's Nurse Progress Notes document falls on 12/14/23, 12/17/23, 1/3/24 and 3/13/24. On 12/14/23 and 12/17/23 R901 was found on the floor in R901's room due to having to use the bathroom. The fall on 1/3/24 happened in R901's bathroom and the fall on 3/13/24 happened in R901's bathroom. The current Care Plan documents the intervention developed on 1/3/24 was to not leave the resident alone in the bathroom. On 3/13/24 the fall investigation documents that the CNA (Certified Nursing Assistant) stepped away to get assistance and R901 fell off the toilet and sustained a hematoma on the right forehead and skin tears to the Right Lower Extremity, Left Knee and Right Shoulder.

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S9999	Continued From page 12 On 4/10/24 at 12:25 PM, V3 Assistant Director of Nursing stated that on 1/3/24 the CNA took R901 into the bathroom and assisted R901 onto the toilet and left the bathroom to gather R901's clothing. When the CNA returned R901 was on the floor. V3 stated at that time they implemented the intervention to not leave R901 alone on the toilet. V3 stated on 3/13/24 the CNA assisted R901 onto the toilet and stuck her head out to get assistance and R901 fell off the toilet sustaining the hematoma and skin tears. V3 confirmed that the CNAs knew they were not supposed to leave R901 alone on the toilet. (B) Statement of Licensure Violations 5 of 5 300.1010h) 300.1210a) 300.1210b) 300.1210d)2) 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. 300.1210	S9999		

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S9999	Continued From page 13 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. 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.	S9999		

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	IL6009922	A. BUILDING: _____ B. WING _____	04/10/2024

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S9999	Continued From page 14 These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide feeding assistance, implement nutritional recommendations, evaluate nutritional supplement intakes, notify the physician of significant weight loss, and ensure significant weight loss was evaluated by a dietitian for two (R5, R21) of two residents reviewed for nutrition in the sample list of 31. These failures resulted in R5 experiencing a severe weight loss of 16.65% (percent) in six months and R21 experiencing a 15.6% severe weight loss in two months. Findings include: The facility's Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol dated September 2017 documents the physician will be notified of significant weight loss including persistent changes in baseline appetite/food intake, and the physician will help identify medical conditions that may cause the weight change and will consider if any additional diagnostic testing is indicated. This policy documents the staff and physician will identify and implement appropriate interventions to address weight loss and will monitor the resident's nutritional status including response to interventions. 1.) R5's Minimum Data Set (MDS) dated 3/5/24 documents R5 has moderate cognitive impairment, requires setup assistance for meals, and has had a significant weight loss of 5% or more in one month or 10% or more in six months that was not prescribed.	S9999		

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R5's Weight Log documents R5's weight as follows:
107.1 lbs (pounds) on admission of 9/7/23
105.8 lbs on 9/17/23
101.5 lbs on 10/1/23 (5.2% loss since 9/7/23)
100.5 lbs on 11/1/23
96.0 lbs on 12/1/23 (10.4% loss since 9/7/23)
95.2 on 1/1/24 (11.1% loss since 9/7/23)
92.6 lbs on 2/1/24 (13.5% loss since 9/7/23)
90.5 lbs on 3/1/24 (15.5% loss since 9/7/23)
85.7 lbs on 4/1/24 (5.3% since 3/1/23)
84.6 lbs on 4/3/24 (16.65% since 10/1/23)

R5's Care Plan dated 1/15/24 documents an intervention for supervision/touching assistance for eating with the helper providing verbal cues/touching/steadying trunk. R5's Care Plan dated 9/20/23 documents R5 is at risk for malnutrition, is underweight, and has a Body Mass Index (BMI) of less than 19. This care plan includes interventions to assist with feeding as needed, encourage oral intake, offer snacks between meals and document acceptance, nutritional supplement 120 ml (milliliters) three times daily (TID), frozen nutritional supplement PRN (as needed), obtain weights as ordered, and notify the physician of significant weight loss. There is no documentation in R5's medical record that any new nutritional interventions were implemented after 12/18/23.

R5's Meal Intake with date range 3/12/24-4/10/24 documents of the 88 meals 11 meals had 0-25% consumed, 28 meals had 26-50% consumed, and two meals were refused. R5's March and April Medication Administration Records (MARs) document to administer the frozen nutritional supplement PRN and does not document that R5 was offered this supplement.

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R5's Nutrition/Dietary Notes document R5 was evaluated by V20 Registered Dietitian (RD) on 9/13/23, 12/18/23, and 3/15/24. On 9/13/23 V20 recommended adding nutritional supplement 60 ml three times daily and a frozen nutritional supplement PRN. On 12/18/23 V20 documented R5's weight loss is likely secondary to decreased appetite and oral intake, and behaviors of refusing meals, supplements, and medications. V20 recommended to increase the nutritional supplement to 120 ml three times daily, continue with the frozen nutritional supplement PRN, and R5's family will encourage the frozen nutritional supplement in the afternoon. On 3/15/24 V20 documented R5 requires varying levels of feeding assistance including independent, supervision, and fully dependence on staff. V20 did not document new recommendations to address R5's continued significant weight loss.

There is no documentation that R5's weight is monitored more frequently than on a monthly basis, R5's October significant weight loss was evaluated by V20 Registered Dietitian or that any new nutritional interventions were implemented after 9/13/23 until 12/18/23. There is no documentation that V20 evaluated R5 after 12/18/23 until 3/15/24. There is no documentation that R5's trending significant weight loss that began on 10/1/23 was reported to or evaluated by a physician.

On 4/08/24 at 11:53 AM R5 was sitting in the dining room and had not taken any bites of food from the meal which consisted barbecued ground beef sandwich, mashed potatoes with gravy, peas, and lemon dessert bar. No staff was sitting with R5 to provide cueing or assistance. At 12:14 PM V24 Certified Nursing Assistant sat next to R5 and offered assistance/cueing. R5 only accepted

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a few bites of food from V24. V24 asked R5 if R5 wanted something else to eat and R5 did not respond. V24 did not offer R5 a frozen nutritional supplement. At 12:19 PM V13 Registered Nurse (RN) sat down beside R5 and fed R5 bites of food. At 12:26 PM R5 ate half of R5's sandwich and 75% of the mashed potatoes with V13's assistance.

On 4/9/24 at 11:30 AM R5's Family (V12) stated R5's family visit often at meal time to feed R5, as R5 eats better when someone assists R5 with meals. V12 stated R5's family are concerned that staff may not be assisting R5 with meals. R5 ate 75% of the noon meal on 4/9/24, with V12's assistance.

On 4/10/24 at 11:40 AM R5 was sitting in the dining room with a small cup of the nutritional supplement and a plate of ground meat, green beans and mashed potatoes with gravy. R5 was able to use the fork to take bites of mashed potatoes, but had difficulty getting bites of the ground meat and green beans as they fell off of R5's fork. No staff was sitting with R5 to provide cueing or assistance. V11 Certified Nursing Assistant (CNA) was asked if any residents require eating assistance in this dining room (where R5 was eating). V11 stated there are no residents who require help with eating on a consistent basis. At 12:00 PM V11 began giving R5 bites of food, after it was pointed out that R5 was having difficulty eating. At 12:30 PM V11 was asked how much of the noon meal R5 consumed and V11 stated "I don't know, I walked away."

On 4/10/24 at 2:15 PM V14 (R5's Family) stated R5 typically does better if someone assists R5 with meals and R5 eats better with a spoon instead of a fork. V14 stated R5 does not show

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interest in the frozen nutritional supplement and asked if there were alternative options to this supplement and if R5 could be weighed weekly instead of monthly.

On 4/10/24 at 10:18 AM V2 DON (Director of Nursing) stated V20 RD reviews the weights monthly and V20's recommendations are given to the physician to review, which is how the physician is notified of weight loss. V2 stated the frozen nutritional supplement is given by the nurses and signed out on the MAR when given. At 12:55 PM V2 confirmed R5's weight loss has not been reported to or evaluated by a physician. At 1:31 PM V2 stated staff should offer assistance if R5 is not eating or having difficulty eating, but R5 does not always accept assistance. V2 stated maybe we should schedule R5's frozen nutritional supplement to be given routinely.

On 4/10/24 at 11:57 AM V20 RD stated if there isn't a nutrition note, then V20 likely did not see R5 during the months that were not documented in R5's dietary notes (October 2023, November 2023, January 2024, and February 2024). V20 stated V20 runs a weight report monthly to see if there are any significant weight changes and then V20 follows up on those weight changes. V20 stated V20 originally spoke with R5's family and they were going to give R5's frozen nutritional supplement in the afternoons, and R5 refuses R5's supplements at times. V20 confirmed staff should offer the frozen nutritional supplement at meals if R5 has poor appetite or isn't eating, and this supplement could prevent further weight loss. V20 stated V20 talks with the nurses to determine if supplements are given and accepted. V20 stated the nutritional supplement 60 ml TID was ordered in September 2023 and increased in

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December 2023 to 120 ml TID. V20 confirmed there were no other nutritional interventions implemented between September 2023 and December 2023. V20 stated V20 gives V20's recommendation forms to the nurses to follow up with the physician. V20 stated a big part of R5's weight loss is R5's poor intakes and poor appetite, and confirmed staff should offer assistance when R5 is having difficulty eating or poor appetite. V20 confirmed if staff do not assist R5 when needed, this could contribute to R5's weight loss. On 4/10/24 at 12:55 PM V20 confirmed there were no new nutritional interventions recommended or implemented for R5 after 12/18/23.

2.) R21's Physician Order dated 3/9/24 documents to administer (nutritional supplement) twice daily (does not specify "Original" or "Plus" version) and may substitute with (comparable alternate nutritional supplement) 120 ml (milliliters) TID (three times daily). R21's March and April 2024 MARs document administration of this order, but do not document if or when the alternate supplement was given or the amount of (nutritional supplement) given.

R21's Weight Log documents R21's weight as follows:
81.5 lbs (admission weight) on 12/12/23
78.4 lbs on 12/31/23
75.6 lbs on 1/1/24 (7.2% loss since 12/12/23)
74.1 lbs on 1/14/24
68.8 lbs on 2/1/24 (15.6% loss since 12/12/23 and 9% loss since 1/7/24)
69.8 lbs on 3/1/24
74.6 lbs on 4/1/24 and 70.1 lbs on 4/3/24

R21's Dietary/Nutrition Note dated 12/19/23 documents R21's BMI is 15.1, R21 is

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underweight related to inadequate oral intake and poor appetite. This note documents V20's recommendation of (nutritional supplement) "Plus" twice daily that is provided by R21's family, and give (comparable alternate nutritional supplement) 120 ml TID when unavailable. This note documents R21's family requested to be notified when supplement is running low. R21's Dietary/Nutrition Note dated 3/7/24 documents R21 accepts the comparable alternate nutritional supplement when the ordered supplement is unavailable. This note documents R21's meal intakes average 50-75%, but vary with occasional poor intakes and refusal of meals. This note documents the recommendation to continue with the same supplement amount and frequency noted on 12/19/23.

There is no documentation in R21's medical record that R21's trending weight loss that began on 12/31/23 was reported to or evaluated by a physician.

On 4/08/24 at 11:48 AM R21 was eating independently in the dining room. At 12:26 PM R21 ate approximately 75% of R21's meal.

On 4/08/24 at 12:35 PM R21 stated R21's weight was down to 62 lbs at one time, and R21 didn't like that. R21 stated R21 has difficulty gaining weight and last week R21 weighed 70 lbs. R21 stated R21's appetite is "pretty good" and R21 has an upcoming doctor appointment to have R21's esophagus stretched, which usually helps with R21's eating. R21 stated the nurses give R21 a nutritional supplement that R21 likes.

On 4/10/24 at 9:44 AM V7 Registered Nurse stated R21 gets (nutritional supplement) per orders and (comparable alternate nutritional

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supplement) can be given if the (nutritional supplement) is unavailable. V7 entered the medication room and showed the nutritional supplement bottles that are administered to R21. This supplement was not the "Plus" version of the (nutritional supplement) as ordered.

On 4/10/24 at 1:31 PM V2 confirmed there is no documentation that R21's physician was notified of R21's weight loss.

On 4/10/24 at 11:57 AM V20 RD stated there is a difference in the "Original" and "Plus" versions of (R21's ordered nutritional supplement). V20 stated (nutritional supplement) "Plus" is R21's preferred supplement that R21 was taking at home, and R21 should receive one bottle (237 ml) twice daily. V20 confirmed (nutritional supplement) "Plus" is ordered for R21 and provided by R21's family. V20 stated V20 was not aware that R21 was not receiving the ordered supplement and V20 will need to follow up on this right away as the "Original" and "Plus" supplements do not have equivalent nutritional content. V20 stated more of the "Original" will need to be given to equal the amount of "Plus" ordered. V20 confirmed the order should specify "Plus", and not receiving the ordered supplement could have contributed to R21's weight loss.

(B)