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	IL6008528	A. BUILDING: _____ B. WING _____	C 05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE SENIOR LIVING	1901 13TH STREET HERRIN, IL 62948

(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 2453869/IL173272 and 2453564/IL172832	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 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 300.1010 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	S9999		

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S9999	Continued From page 1 of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 ensure thorough assessments for changes in condition were provided and documented (R1 and R8) for 2 of 3 residents reviewed for quality of care in a sample of 21. These failures resulted in both R1 and R8 experiencing discomfort due to a delay in treatment. R1 experienced prolonged respiratory distress resulting in R1's transport to the local hospital, and R8 required transport to the local hospital with subsequent hospital stay for altered mental status, Urinary Tract Infection with hematuria, and acute pulmonary edema.	S9999		

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Findings Include:

1. R1's Facility Admission record documents an admission date of 04/19/2024, with diagnoses that include Chronic Obstructive Pulmonary Disease, unspecified cirrhosis of the liver, Heart failure, hypertension, Nonalcoholic steatohepatitis (NASH), chronic kidney disease, and Psoriasis.

R1's MDS (Minimum Data Set), dated 05/06/2024, documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R1 was cognitively intact.

R1's Weights and Vitals Summary, dated 05/14/2024, documents the following: On 05/04/2024 at 11:09pm, Blood Pressure (B/P) 126/84, pulse (P) 86, respirations (R) 16, temperature (T) 98.2. On 05/06/2024 at 05:49am B/P 126/84, P 88, R 16, T 97.7. There were no vital signs documented from 05/04/2024 at 11:09pm until 05/06/2024 at 05:49am.

A review of R1's progress notes document R1 was administered a dose of her as needed pain relief medication at 01:29pm on 05/05/2024 for left lower quadrant pain. She was later administered a dose of her as needed anti-nausea medication at 8:44pm and 10:26pm on 05/05/2024. R1's progress notes do not document any assessments, including respiratory assessments or oxygen saturation, or notes from 05/05/2024 until 05/06/2024 at 10:33am when they document the following: "Resident (R8) is being sent out to (local hospital) ER (emergency room) due to significant changes in Respiratory and responsiveness. Resident did appear lethargic at the beginning of the shift and was breathing deeply but had no complaints of pain

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and did respond "no" she wasn't hurting and when asked how she felt resident stated "fine" and shrugged her shoulders. This nurse was alerted around 10am that the patient is now not responding verbally. Resident is conscious and alert. Respirations have increased and breathing appears to be labored. Resident's urine is also discolored, and patient's vitals are BP 92/58, T=97.0, P= 99, O2= 80% on 3L (Liters) via NC (nasal cannula). V14 (NP/Nurse Practitioner) notified, and order given to send resident to the hospital. Daughter called and asked that she go to (name of larger hospital in another town) but could also go to (name of local hospital) if necessary. EMT (emergency medical technician) stated they preferred to take resident to (name of local hospital) d/t (due to) possible aspiration. This nurse attempted to call the daughter back twice to inform her of where the resident would be getting taken and got no answer from on the phone. Resident was transported via (name of ambulance service) to (name of local hospital) Hospital ER (emergency room)."

A review of a document titled "Patient Care Record" for R1 from (name of ambulance service), dated 05/06/2024, documents the following: "dispatched immediate response to (facility name) in (town name) for a female who has an altered mental status. Upon arrival staff stated that this morning she did not want to take her medicine and that is not like her. They then stated that she ate breakfast and took her meds and when they came back to check on her, she was altered, and her oxygen saturation was 80% on her normal 3 liters via cannula. They stated that her normal baseline is alert and oriented x4. Currently the patient is awake but unresponsive to voice or pain. She is moderately cyanotic with use of accessory muscles.She has a hx (history)

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of diabetes and COPD. She was placed on a capnography cannula at 6lpm (liters per minute). Her oxygen saturation was 70%. Lung sounds assessed and there was a pleural rub noted on the right side with wheezing. Her airway was suctioned, and stomach contents were removed. Her oxygen began to rise after suctioning. Her breathing began to improve, and she was given an albuterol breathing treatment. Patient was transported to (local hospital) ER without incident."

R1's hospital record ,dated 05/06/2024, documents, "71 yo (year old) wf (white female) is brought to er (emergency room) for medical eval. Patient was found unresponsive, blue in color, patient has low sat on 70% at 3 liters. As per EMS (emergency medical services), patient vomited last night. Patient got better after suctioning and breathing treatment." Under Vital Signs it documents the following: temperature 94.7, heart rate 91, respiratory rate 26, blood pressure 91/63. R1's hospital record documents, "Clinical Impressions" 1. Acute on chronic respiratory failure with hypoxia and hypercapnia (HCC), 2. Pneumonia of left lung due to infectious organism, unspecified part of lung, 3. Mucus plug in respiratory tract, 4. Renal failure, unspecified chronicity, 5. Respiratory acidosis 6. Metabolic acidosis.

R1's "ED (Emergency Department) Triage Note" from the local hospital dated 5/6/23 at 10:53 am, documents "Pt (patient/R1) unresponsive to painful stimuli. Doctor in room on arrival. Pt (R1) has foley which has turbulent appearance in drainage bag." The "Patient Expiration Pronouncement" from R1's local hospital records documents a date of death of 5/6/24 and time of death of 9:34pm.

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A review of an incident report from the local police department documents a statement from V27 (Medical Doctor/MD performing autopsy) on 05/10/2024. This document states V27 confirmed the NASH (Nonalcoholic steatohepatitis) diagnoses and stated that R1 had end stage liver disease. V27 noted that most of R1's internal organs appeared to have been failing. V27 attributed the amount of fluid R1's body was retaining due to R1's organs failing and her lack of mobility. V27 attributed R1's death to be as a result of the poor condition of her organs.

On 05/14/2024 at 10:01 am, V9 (Licensed Practical Nurse/LPN) stated R1 had some discomfort in her left lower quadrant on 05/05/2024. V9 stated she believed R1's vital signs were within normal limits for her. V9 stated R1 takes quite a few pills in the evening and on 05/05/2024, R1 was really having difficulty getting them down. V9 reported R1 always struggles with them, but that it was worse that night. V9 denied R1 had any episodes of emesis but stated R1 felt nauseated. V9 reported she administered a dose of R1's anti-nausea medication that was ordered as needed. V9 stated R1's nausea was resolved within an hour. V9 stated R1 requested her bed to be reclined more because V9 had R1 sitting straight up in bed. V9 stated she checked on R1 multiple times throughout her shift and did not notice anything abnormal about her. V9 stated she reported to the day shift nurse about R1's condition because she had never had this experience with her, and V12 (day shift LPN) said that it was a common occurrence for R1 on day shift. V9 reported she took R1's vital signs, but was not sure if she documented them. V9 further elaborated R1's blood pressure and pulse were typically pretty low on her shift, but does not

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specifically recall what they were on the night of 05/05/2024 going into the morning of 05/06/2024. V9 stated she does not recall if she did any assessments on R1. V9 stated she did not document assessment or vitals because she was not required to.

On 05/14/2024 at 2:04pm, V13 (Certified Nurse's Assistant/CNA) stated she was not very happy when she came in and saw the condition R1 was in on the morning of 05/06/2024 at the start of her shift at 06:00am. V13 stated she could see R1's chest was going up and down hard before even entering her room. V13 reported R1 was lying flat in bed, her head was not elevated at all, and no one had given her any report. V13 noted R1 had brown stuff on her shirt and vomit in the basin that was also dark brown in color. V13 stated she reported all of this to V12 (Licensed Practical Nurse/LPN), and V12 stated she would keep an eye on her. V13 stated she gets R1 up for breakfast often and she knows that her feet can lay flat on the ground, but that morning her feet were so stiff, they wouldn't move, which she reported to V12, and V12 she stated it was just foot drop. V13 stated she was not able to take R1's vital signs because equipment is kept on the nurse's cart so they can take it. V13 stated she sat in R1's room with her and fed her breakfast in bed at approximately 08:00am. V13 reported R1 was not a big eater, but only took a few bites that morning. V13 did note that morning the little dots on R1's fingers and she reported it to V12. V13 reported she did provide incontinence care for R1 that morning and the "stuff in her catheter was not a good color". V13 stated she reported it to V12 as well. V13 stated she was very concerned, and she continued to report it to V12, and she felt that it took hours for someone to do something. V13 stated she did have concerns about being

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brushed off or heard by some nurse's when they report concerns with residents to them. V13 stated R1 was communicating with simple yes or no responses that morning until around the time she took her tray away. V13 stated at that point, she started to check on R1 constantly, in between caring for other residents, and continued to report her concerns to V12 who was passing medications at that time. V13 said as soon as V15 (Infection Control Nurse) saw her standing at R1's door, she went and looked at R1 and got her vital signs.

On 05/14/2024 at 12:27pm, V12 (LPN) stated she was working on 05/06/2024, and sent R1 out to the Emergency Room. V12 stated it was reported to her R1 was not taking her medications, which was unlike her. V12 reported that V13 (CNA) told her that she did not look good and she was not herself, but her vital signs were fine, so V12 told V13 there was nothing she could do. V12 stated her shift started at 6:00 AM, she stated that it was probably around 7:00 AM, R1 was breathing deeply with no pain and lethargic. V12 noted at that point in time, "(R1) was not in respiratory distress, but was breathing deep. Not rapid, just looked comfortable and lethargic." V12 stated that is when she took the vitals and checked on her. V12 reported R1 was responding verbally. V12 recalled vital signs were within normal range; R1's blood pressure was on the lower end of normal, but within the normal range. V12 stated R1's blood pressure was on the lower end of normal for parameters, maybe not for her individually. V12 reported she was only R1's nurse twice, so she couldn't really say what was normal for her. V12 stated around 10:00am, V15 (Infection Control Nurse) grabbed her and said there were people in R1's room and she needed to check her out. So V12 went in there and R1

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was alert and conscious. V12 stated she wouldn't say R1 had an altered level of consciousness, because she was awake, but not responsive. V12 reported she took vital signs on R1 and decided to send her out. V12 stated she did obtain vital signs on R1 at the beginning of the shift, but she did not document them as she was busy with her medication pass. V12 denies any concerns with the care R1 was provided the previous shift. V12 stated the previous shift had told her R1 wasn't herself and hadn't taken her meds as normal and she was nauseous. V12 denied anyone had told her R1 had an emesis. V12 stated on 05/06/2024, she didn't have an opportunity to put in any assessments on R1 because she was doing her medication pass. V12 denied having suctioned R1 on 05/06/2024. V12 stated she gave R1 medication that morning, and she was taking them a few at a time. V12 stated R1 shook her head "no" the last time, tried a few more drinks of water, said they went down, but V12 noted they were on her tongue. V12 reported she removed them with a spoon. V12 reported she made the hospital aware, she recalled she thought there were four pills. V12 stated R1 was responding by shaking her head, but not verbally responding.

On 05/14/2024 at 4:11pm, V15 (Infection Control Nurse) stated when leaving morning meeting on 05/06/2024, she noticed a few Certified Nursing Assistants standing outside of the room of R1 and she asked them what was going on. They said R1 didn't seem to be doing well. V15 said she asked if they told their nurse and they said yes, they told V12 (LPN). V15 asked V13 (CNA) if R1 had any changes over the weekend and she said no, but she noticed it when she came on shift that morning. V15 reported V13 was really concerned and pretty upset. V15 stated she went in to check on R1 and you could tell something

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was wrong. V15 stated when she went to speak to R1, her eyes were open, but she wasn't responding. V15 noticed R1's urine didn't look good. V15 reported she went to V12 and asked about vital signs, V12 said she had done them, and they were within normal limits. V15 called V14 (On-call Nurse Practitioner) at 10:06 AM. V15 denied knowing whether V12 obtained vital signs at that time or not.

On 05/14/2024 at 3:35pm, V14 (On call Nurse Practitioner) stated V15 called her at some point that morning (5/6/24) and told her R1 was less responsive and not herself. V14 told V15 to send R1 to the Emergency Room. V14 stated if someone has a change in condition that isn't emergent, they leave notes in her book so she can see the patient when she is at the facility. V14 stated she would expect staff to check vital signs. V14 stated there isn't anything in writing as to how often they should be assessing a resident or their vital signs with a change in condition, but V14 would expect they should just be using nursing judgement.

On 05/15/2024 at 10:08pm, V2 (Director of Nurse's/DON) state, after a quick review of the events of the night of 05/05/2024 into the morning of 05/06/2024, she would expect to see documentation of reassessment and vital signs after administration of as needed medication for nausea and R1's reported symptoms and change in condition. V2 stated it would be her expectation staff would document vital sign values and assessments on residents for each encounter with them, and not in just one note. V2 stated it is her expectation staff would continue to reassess a resident that was in the condition that R1 was in, especially if staff continued to voice concerns about them. V2 said she would expect staff to

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assess a resident whether an assessment was scheduled or not if there were concerns and contact the physician even if vital signs were within normal limits. V2 recalled V12 (LPN) stopping her the morning of 05/06/2024 and asking if V14 (Nurse Practitioner) would be in house that day. V12 was hoping to have V14 take a look at R1 because she had been nauseous the night before, had spit her meds out and was lethargic that morning. Then at around 10am, V13 (CNA) stopped V15 (Infection Control Nurse) and asked her to take a look at R1. V2 couldn't say for sure if waiting until V14 came into facility was appropriate or not for R1's change in condition. V2 denied knowing if there was a facility protocol or standing order about the management of respiratory distress while waiting for an ambulance. V2 noted V14 would have given an order if she wanted any changes in the amount of oxygen R1 was receiving.

On 05/15/2024 at 09:05am, V16 (Paramedic) stated when they walked into R1's room, she was blue. V16 stated R1's eyes were open, but she was not alert or responsive; he was told by someone there her baseline was A&O (alert and oriented) x4. V16 believes R1 was slightly moaning, but was working extensively to breathe. V16 stated he believed there was a delay in care, and R1 had likely been in distress for several hours. V16 reports he was almost certain they would be working a cardiac arrest before they arrived at the Emergency Room. V16 reported they received the call through the Ambulance service private number, and the report they received was R1 had an altered level of consciousness. V16 stated the report they received in no way depicted an accurate report of the condition R1 was in. V16 stated R1 was lying pretty flat in bed, with her normal dose of three

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liters of oxygen being delivered via nasal cannula.

On 05/15/2024 at 09:05am, V17 (Paramedic) stated the facility reported R1's oxygen saturation was 80%, when they arrived, it was 73%. V17 stated R1 was still receiving her normal dose of oxygen of three liters via nasal cannula. V17 stated she suctioned R1, and she sounded a little better, but they also gave her a breathing treatment because she was still kind of restricted. V17 stated she absolutely believed there was a delay in care. V17 recalled she was really concerned this call was about to turn into a cardiac arrest. V17 denied R1 was alert when they arrived; "her eyes were open, but she was not there."

On 05/16/2024 at 2:06pm, V13, Infection Control Nurse, stated she did not see V12 take R1's vital signs at any point during the morning of 05/06/2024. V13 denied having taken her concerns to anyone besides V15 later that morning. V13 stated administration always tells them it is important for them to follow their chain of command. V13 commented she did not have this issue with all nurses, just two in particular, V12 being one of them.

On 05/16/2024 at 02:07pm, V26 (Emergency Room Physician) confirmed from his progress note that R1 presented to the Emergency Room unresponsive, hypothermic, and hypotensive. V26 reviewed his clinical impression and agreed with his diagnosis of R1. V26 stated it is possible for someone in R1's poor condition of health to have normal vital signs and to decline so much from 06:00am to 10:00am. V26 stated he could not confirm or deny if R1 would have had a different outcome had she arrived at the hospital earlier. V26 stated he did not think it would have changed

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R1's outcome, but that it is really hard and dangerous for a practitioner to say in this situation. V26 further commented when diseases become more advanced, the ability to call for help becomes less and less. V26 further stated it is also not known if R1's vital signs were truly normal at 06:00am, and he cannot base his assessment on everything being normal at 06:00am and abnormal at 10:00am.

A review of a facility policy titled "Notification of Resident Change in Condition" documents it is the policy of this facility to promptly notify the resident, their legal representative(s) and attending physicians of changes in the resident's health condition. Under the section titled "Standards" it documents in part the following: The licensed nurse is to use professional judgment in determining changes in condition based on assessment and findings or signs and symptoms of change which could lead to deterioration if not treated. Following assessment, observing signs and symptoms, and obtaining vital signs, the attending physician, family/guardian will be promptly notified of significant findings.

2. R8's Admission Record, with a print date of 5/20/24, documents R8 was admitted to the facility on 3/7/23 with diagnoses that include unspecified dementia, Alzheimer's disease, diabetes, hypertension, chronic kidney disease, arthritis, and history of falls.

R8's MDS (Minimum Data Set), dated 3/4/24, documents R8 has a BIMS (Brief Interview for Mental Status) score of 10, which indicates a moderate cognitive impairment.

R8's current Care Plan documents a Care Area of

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"(R8) requires assist with ADL's (activities of daily living) r/t (related to): Activity Intolerance, Pain, confusion, non-compliant with asking to help." The interventions for this Care Area document R8 requires assist of one for bathing and toileting, requires assist with bed mobility, dressing, eating, grooming, and hygiene.

R8's Weights and Vitals Summary, dated 5/20/24, documents R8's vitals on 5/12/24 at 11:09 PM as blood pressure (B/P) 115/70, temperature (T) 98.3, pulse (P) 80, and respirations (R) 20. This same report documents R8's vital signs on 5/16/2024 at 1:49 PM as B/P 189/106- T- 97.4, P 95, R 16. There are no vital signs documented from 5/12/24 at 11:09 PM until 5/16/24 at 1:49 PM.

R8's Progress Notes, dated 5/13/24, documents an assessment by V24 (Nurse Practitioner/NP) with no significant findings. R8's Progress Notes do not document any assessments or notes from 5/13/24 until 5/16/24 at 1:44 PM when V30 (LPN) documented the following. "Res (R8) observed drooling from L (left) side of mouth. Res (resident) c/o (complains of) dizziness, lethargy, nausea/vomiting, some increased confusion, coughing, and congestion. Res (R8) B/P was taken twice. First time it was 175/108, second time it was 189/106. Pulse 95. This nurse notified (V14 Nurse Practitioner) who gave orders to send res to hosp (hospital). This nurse called (name of ambulance service) at 1315 (1:15 PM). Report was called to (name of local hospital) ER (emergency room) and given to (name of hospital staff), (Name of POA/Power of Attorney) was notified at 1320 (1:20 PM). (Name of ambulance) arrived at 1330 (1:30 PM)."

R8's hospital record, dated 5/16/24, documents,

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"Pt (patient) arrives via EMS (Emergency Medical Services) with c/o (complaints of) cough, congestion, and "periods of increased altered mental status ...." Under Impression and Disposition R8's hospital record documents, "Clinical Impression: 1. Altered mental status, unspecified altered mental status type. 2. Urinary tract infection with hematuria, site unspecified. 3. Acute pulmonary edema ..."

R8's facility Progress Notes, dated 5/19/24, document, "Pt readmitted from (name of local hospital) discharge r/t UTI. Nurse reported medication addition of ABT (antibiotic) of Levaquin 250mg (milligrams) PO (by mouth) BID (twice daily) and Coreg 3.125mg PO BID for HTN (hypertension). Nurse from (name of hospital) reports pt has not been ambulating since admission to (name of hospital). Pt arrived via BLS (Basic Life Support) ambulance and stretcher. Pt vital signs as follows blood pressure of 140/86, pulse regular 106, respirations 18 and non-labored on room air, temp 97.4 temporal, and weight of 120.6 lbs (pounds). Pt able to make needs known. Alert to self and place. Pt denies any pain at this time. Pt voids with clear amber urine. Pulse, movement and sensation noted to all extremities. Pt skin intact. No redness or open area noted. Call light within reach. Orders processed per policy. Dietary advised of pt return and order given. Will monitor. MD (physician) and on-call management advised."

On 5/20/24 at 1:30 PM, R8 was in bed, appeared clean and well-groomed with no obvious signs of distress. R8 stated she did go to the hospital recently, and when asked if the facility sent her to the hospital in a timely manner, R8 stated, "so-so." R8 was not able to tell this surveyor how long she was sick before the facility sent her to the

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hospital.

On 5/20/24 at 10:09 AM, V33 (Family Member) stated she didn't have concerns with the care R8 received at the facility. V33 stated the nurse at the hospital told her R8 had "advanced fluid in her lungs like it had been going on for a while." V33 stated she spoke with the physician at the hospital, and the physician said there was a little fluid in R8's lungs, but the physician was more worried about R8's blood pressure and the bad urinary tract infection R8 had.

On 5/20/24 at 9:31 AM, V30 (LPN) stated she administered medications to R8 on the morning of 5/16/24. V30 stated later that same day, V32 and V37 (CNA's) reported to V30, R8 had a change in condition. V30 stated R8 had increased weakness, altered mental status, and was drooling. V30 stated she assessed R8, called the Nurse Practitioner (NP), and called an ambulance to transfer R8 to the local hospital. V30 stated R8 was admitted to the local hospital with a diagnosis of hematuria, altered mental status, and acute pulmonary edema. V30 stated R8 did not have any respiratory symptoms when she administered medications in the morning but was congested and had a cough when the CNA's reported the change in condition to her later in the day.

On 5/20/24 at 9:55 AM, V32 (CNA) stated she provided care to R8 on 5/16/24. V32 stated R8 refused her shower and didn't want to wake up to eat breakfast. V32 stated that was normal for R8. V32 stated R8 didn't exhibit any symptoms until right after lunch when she vomited. V32 stated she reported it to V30 who assessed R8 and sent her to the hospital. When asked if she had any concerns with the care R8 received at the facility, V32 stated later, on 5/16/24, she was told by V34

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(CNA) he had reported to his nurse on the evening of 5/15/24 that R8's skin color was not right and R8 wasn't acting her normal self.

On 5/20/24 at 10:22 AM, V34 (CNA) stated he worked on 5/15/24 and 5/16/24. V34 stated he provided care for R8 on 5/15/24. V34 stated he reported to an unknown nurse on 5/15/24 that R8 was not looking like her normal self. V34 stated the unknown nurse asked what was wrong with R8, and he told her R8 was pale. V34 stated then V36 and V38 (CNA's) stated they thought R8 was having a stroke. V34 stated R8 wasn't eating and wasn't putting words together. V34 stated they all went to V35 (LPN) and V35 didn't really say anything and "more or less pushed it to the back burner." V34 stated V35 told them she would get to it and would monitor R8. V34 stated this occurred between 2:00 PM and 3:30 PM. When asked if he checked R8's vital signs, V34 stated V35 didn't tell him to. V34 stated he is still new to the facility and didn't know where they kept everything.

On 5/20/24 at 12:57 PM, V36 (CNA) stated she worked on 5/15/24 and provided care for R8. V36 stated she remembered R8 laying in her bed, not doing much. V36 stated she took R8 her dinner and she didn't eat it. V36 stated she gave this information to V35 (LPN) because R8 just wasn't her normal self. V36 stated V35 went into R8's room with V36 present, and asked R8 if she was alright. V36 stated V35 didn't check R8's vital signs or perform an assessment on R8. V36 stated V35 just stood and talked to R8.

On 5/20/24 at 4:08 PM, V38 (CNA) stated she was working on 5/15/24 and provided care for R8. V38 stated R8 didn't seem to be her normal self on that night. V38 stated R8 was more confused.

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V38 stated they reported it to V35 (LPN). V38 stated V35 went to R8's room and looked at her and said R8 was ok and to just keep an eye on her. V38 stated V35 didn't check R8's vital signs and didn't have them check them. V38 stated she didn't recall V35 doing a physical assessment on R8. When asked if she had any issues with nurses not following up or doing assessments when she reports concerns to them, V38 stated, "Yes, V35 doesn't seem to follow up."

On 5/20/24 at 12:23 PM, V35 (LPN) stated she didn't remember if she provided care to R8 on 5/15/24 or 5/16/24. V35 stated she hadn't had any CNA's report a change in R8's condition to her. V35 stated the last time she saw R8, she was ok. V35 stated she didn't remember working with V34, V36, or V38. On this same date at 12:48 PM, V35 came back to this surveyor and stated she spoke with V30 (LPN), and now she remembered providing care to R8 on 5/15/24. V35 stated she thought V36 reported to her R8 wasn't feeling good. V35 stated she checked on R8, and she was up in her room, wheeling about in her wheelchair. V35 stated R8 was not coughing, and she didn't notice any concerns. When asked if she checked R8's vital signs, V35 stated, "Probably because I usually do." When asked where she charted them, V35 stated, "If they were fine, I wouldn't have." V35 stated if R8 was in distress she would have documented the vital signs.

On 5/20/24 at 12:07 PM, V37 (CNA) stated she worked on 5/15/24 and 5/16/24. V37 stated she was not R8's primary CNA on those days but did see her. V37 stated R8 appeared more tired than normal. When asked if she had any issues with nurses responding or following up when they report changes in condition to them, V37 stated,

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"sometimes." V37 was not able to provide this surveyor with any specific situations that this has occurred. V37 stated they (CNA's) get vital signs when they are asked to. When asked if they had access to vital sign equipment, V37 stated, "No." V37 stated if they (CNA's) have to get vital signs, they get the equipment from the nurses who keep them on the medication carts. V37 stated they aren't always on the carts though and then they have to go find them on another cart on a different hall.

On 5/20/24 at 4:44 PM, V30 (LPN) stated she had CNA's report to her other nurses were not following up when they reported concerns related to a resident's condition to them. V30 stated CNA's will get V30 when they report a concern to V12 (LPN) and/or V35 (LPN) and they don't do anything about it.

On 5/20/24 at 4:34 PM, V2 (DON) stated if a resident had a change in condition, she would expect the nurse to assess them, see if it was a valid change in condition, document the assessment, and if there was a finding notify the nurse practitioner.

On 5/20/24 at 5:01 PM, V1 (Administrator) stated after she spoke with this surveyor she talked to some CNA's, and they told her V12 and V35 don't respond when they take concerns to them.

On 5/21/24 at 8:44 AM, V1 stated if there is a change in condition she would expect the nurse to assess the resident, address the concern, do vital signs if necessary, and document their assessment of the resident including the vital signs.

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S9999	Continued From page 19 On 05/14/2024 at 10:01 AM, V9 (LPN) stated she did not recall any remarkable skin condition beyond the normal. V9 stated =R1 had some discoloration to lower extremities and genitals. V9 stated it is normal for someone with her liver conditions. V9 stated =R1 required quite a bit of assistance with turning and repositioning as she was very weak. On 05/14/2024 at 04:26 PM, V11 (CNA) stated she was working on 05/04/2024 and 05/05/2024. V11 stated =she did provide care for R1. V11 stated R1 scratched a lot. V11 stated R1 came in with some areas where she had previously scratched her skin open. V11 denied that she noticed any of the areas were actually open during her time caring for R1, but they were still there and not resolved. On 05/14/2024 at 12:27 PM, V12 (LPN) denied seeing any bruising or open areas on R1's skin, she just scratched a lot and they said that was something she did at a prior facility. V12 stated she was not aware of any treatments without looking back at the TAR (Treatment Administration Record). V12 recalled the first day she worked with R1, she helped to turn her, she denied noticing any skin breakdown. V12 stated R1's bottom was a little pink, she assumed it was from being wet. V12 reported they put powder or cream on R1 when they cleaned her up. On 05/14/2024 at 02:04 PM, V13 (CNA) reported no open areas to R1's skin that she was aware of. V13 did note that morning the little dots on R1's fingers and that she reported it to V12 (LPN). V13 confirmed R1 required assistance with bed mobility, but she did a lot of it herself once you gave her a little push. V13 stated R1 was incontinent of bowel all the time.	S9999		

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S9999	Continued From page 20 On 05/14/2024 at 04:11 PM, V15 (Infection Control Nurse Manager) denied having seen R1's skin. V15 reported she only knew by word of mouth that nothing was on R1's skin when she arrived. V15 did recall R1 had a little bit of redness from the loose stools from the cirrhosis medications. On 05/15/2024 at 10:08pm, V2 (DON) denied knowing of any open areas, pressure sores or any other alterations in skin, and commented that she would know since she is the wound nurse. A review of the facility policy titled, "Pressure Ulcers and Skin Breakdown - Clinical Protocol" documents the following: "Assessment and Recognition", The nurse shall assess and document/report the following: a. Full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width and depth, presence of exudates or necrotic tissue. b. Pain assessment c. Resident's mobility status d. Current treatments, including support surfaces. e. All active diagnoses. 3. Examine the skin of a new admission for skin conditions or indications of a Stage I pressure area that has not yet ulcerated at the surface. Cause Identification 1. Identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer, or sepsis causing a catabolic state, and macerated or friable skin. (A)	S9999		