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| | IL6007041 | A. BUILDING: _____ B. WING _____ | 07/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S 000 | Initial Comments<br><br>Annual Licensure Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>1 of 3<br><br>300.610a)<br>300.1010h)<br>300.1210b)<br>300.1210d)2)<br>300.1210d)3)<br>300.1210d)5)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1010 Medical Care Policies<br><br>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 | S9999 | | |

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|---|---|---|---|---|
| S9999 | Continued From page 1 | S9999 | | |

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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who

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|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility to report new pressure injuries. The facility failed to ensure pressure injury prevention interventions were in place. The facility failed to identify a resident's pressure injury prior to the injury becoming a Stage III injury. These failures resulted in R101 developing a Stage III pressure injury to her coccyx and Stage II pressure injuries to each of her buttocks. The facility failed to ensure pressure treatment interventions were in place and failed to complete weekly assessments on residents (R82, R24) with pressure injuries and new wounds. The facility failed to assess and monitor a resident's (R94) ankle. This applies to 4 of 11 residents (R101, R82, R24, and R94) reviewed for pressure injuries and with new wounds. in the sample of 25.

The findings include:

1. R101's Admission Record showed R101 was admitted to the facility on 5/3/24 with diagnoses of a compression fracture of her spine, morbid obesity, Type 2 Diabetes Mellitus, and congestive heart failure.

R101's care plan dated 5/15/24 showed R101 was at risk for "alterations in skin integrity." The plan showed facility staff were to monitor and

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|---|---|---|---|---|
| S9999 | Continued From page 3 | S9999 | | |

document any skin injuries on R101 and "keep skin clean and dry".

R101's resident assessment dated 6/27/24 showed R101 required staff assistance for repositioning and toileting/incontinence care.

R101's last shower sheet/skin assessment dated 6/29/24 showed no wounds, no redness, and no excoriation to R101's buttocks/lower back.

On 7/8/24 at 9:05 AM, R101 was in bed, lying on her back. A urinary catheter bag hung off the side of R101's bed. R101 complained of pain to her buttocks and lower back. At 9:09 AM, V3 Certified Nursing Assistant (CNA) repositioned R101 on her side. V3 CNA pulled down the side of R101's incontinence brief, exposing R101's buttocks. R101's buttocks appeared red with multiple open areas noted to the skin of her buttocks. A nickel-sized wound was noted to R101's coccyx area with a scant amount of bleeding noted from the wound. Large, irregular shaped wounds were noted to each of R101's buttocks. R101's incontinence brief was soiled with a small amount of stool and urine as R101's indwelling urinary catheter appeared to be leaking onto R101's brief. R101 again complained of pain to her buttocks. V3 CNA then applied zinc oxide cream to R101's buttocks and secured R101's soiled brief back in place. V3 stated, "I know I haven't been in to change you yet today. I will be back shortly to get you cleaned up." V3 exited R101's room.

On 7/9/24 at 8:27 AM, V9 Wound Care Nurse stated R101 did not have any pressure injuries. V9 stated, "Nothing new has been reported to me." V9 stated staff are to notify her and the resident's physician when any new wounds or

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|---|---|---|---|
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|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

skin alterations are found.

On 7/9/24 at 1:38 PM, V10 Licensed Practical Nurse (R101's nurse) stated, "No one has told me that (R101) has any new wounds."

On 7/9/24 at 1:50 PM, V3 CNA was asked about the cares she provided to R101 on 7/8/24. V3 CNA stated, "Yea, I saw that her catheter had been leaking a little. I didn't report her open areas (to R101's buttocks) to anyone. I'm pretty sure they already knew about it."

On 7/9/24 at 3:10 PM, V9 Wound Care Nurse stated, "I evaluated (R101) this morning. She has a new Stage III to her coccyx and Stage II's to each buttock. According to the documentation, it looks like she went from having no wounds to a Stage III and Stage II's. She did tell me she had a history of having wounds to those areas previously. She has a catheter (urinary) but if the catheter is leaking the wounds could be caused by her laying in urine and/or stool. She is one that needs to be cleaned up immediately if she is incontinent. She also can't reposition herself. Her wounds don't appear to be infected.... These should have been caught prior to becoming Stage II and III's."

R101's Wound Notes/Wound Assessment Report dated 7/9/24 showed R101 had a Stage III pressure injury to her coccyx measuring 1.51 cm (centimeters) x 0.8 cm x 0.3 cm, a Stage II to her right buttock measuring 4 cm x 3 cm x 0.1 cm, and a Stage II to her left buttock measuring 4 cm x 3 cm x 0.1 cm.

On 7/10/24 at 9:25 AM, V11 Nurse Practitioner stated, "I saw (R101) yesterday and saw the wounds to her buttocks, but I don't do any staging

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|---|---|---|---|
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|---|---|---|---|---|
| S9999 | Continued From page 5 | S9999 | | |

of wounds... I know she has a history of MASD (moisture associated skin damage) to that area. Her catheter has been leaking and we are trying to treat that. She can't move on her own. She is someone who would need frequent changing (of her incontinence brief). I would say that if she is being changed frequently and repositioned, the development of these pressure injuries most likely would not happen..."

The facility's Shower/Skin Sheets policy dated 11/2009 showed, "Report any skin alteration or reddened area(s) to the nurse immediately while the resident is still undressed so it can be clinically assessed, treated and appropriately documented..."

The facility's Perineal Care policy dated 2/2018 showed, "The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition..." The policy showed facility staff are to document "any discharge, odor, bleeding, skin care problems or irritation, complaints of pain or discomfort."

2. On 07/08/24 at 12:29 PM, R82's left, and right heels were resting on the bed while the resident was lying on his back.

On 07/08/24 at 12:30PM, R82 said, I usually wear the heel boots, they are in the closet. I had them on yesterday, the night shift did not put them on last night. I must ask for them to be put on. I ended up falling asleep before I could ask anyone to help me.

On 07/09/24 at 3:16 PM, V9 Wound Nurse said, heel boots protect the wound. When in bed R82 should have his heels off-loaded. R82's ankles

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| S9999 | Continued From page 6 | S9999 | | |

should be suspended so there is no pressure to the heels.

R82's Wound Notes dated 07/03/2024 at 10:14AM, shows, left heel stage 3 pressure ulceration 0.4 x1.0 x 0.1 centimeters.

R82's current Care Plan on 07/08/2024 shows, put protective boots on when in bed initiated: 04/15/2024.

R82's Physician's Order on 07/08/2024 shows, off-loading heel boots to be worn in bed. Every day and night shift for wound care. Initiated: 04/15/2024.

3. On 7/8/24 at 1:50 PM, V18 and V19 (Certified Nursing Assistants) provided incontinence care to R24. R24 did not have any dressings to her posterior thighs, buttock or groin area. R24's bilateral posterior thighs and buttock area was bright red with multiple open, bleeding wounds present. R24's front groin and upper thigh area was bright red and had open, bleeding areas on each upper thigh.

On 7/8/24 at 1:50 PM, V18 said that R24's thighs and groin areas have looked like that for a few weeks.

On 7/09/24 at 2:14 PM, V9 (Wound Nurse) said that according to R24's clinical records, R24 has a pressure ulcer on her left heel, a venous ulcer on her left lower leg and MASD (Moisture Associated Skin Damage) on her left thing and nothing else. V9 said that if a resident develops new skin alterations, the CNA should notify the nurse and the nurse should do an assessment, call the physician for appropriate treatments and

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|---|---|---|---|
| | IL6007041 | A. BUILDING: _____ B. WING _____ | 07/10/2024 |

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|---|---|
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|---|---|---|---|---|
| S9999 | Continued From page 7 | S9999 | | |

document their findings in the medical record. V9 said that she was not aware of any new skin alterations for R24. V9 went into R24's room to do a skin check. Multiple wounds were observed on R24's left and right posterior thighs and her left and right groin area. R24 did not have any dressings on her thighs or groin area wounds.

R24's Skin/Wound Note dated 7/10/24 shows that R24 has a broken blister on her right medial thigh near her groin measuring 1 centimeter (cm) x 2.2 cm x 0.1 cm, a broken blister on her left medial thigh measuring 0.5 cm x 0.4 cm x 0.1 cm, a superior right posterior thigh trauma measuring 1.3 cm x 1.2 cm x 0.1 cm, a right distal posterior thigh trauma measuring 0.5 cm x 6.5 cm area of redness with a 0.5 cm x 1.2 cm wound with a firm yellow wound bed and a left superior posterior thigh reddened area measuring 7.5 cm x 8 cm with scattered open areas with pale pink wound beds.

R24's Wound Assessment Details Report dated 6/19/24 shows that she has a facility acquired left heel pressure ulcer measuring 5 centimeters (cm) x 4.5 cm x 0.2 cm that was identified on 6/13/24. No additional wound assessments of R24's left heel pressure ulcer after the 6/19/24 assessment was documented until 7/10/24 (21 days later). It also shows that she has MASD (Moisture Associated Skin Damage) to her left back thigh measuring 15 centimeters (cm) x 9 cm x 0.1 cm. No wound notes were documented regarding R24's right posterior thigh or groin/thigh areas until 7/9/24. V2 (Director of Nursing) verified that no additional assessments after 6/19/24 of her left heel pressure ulcer were in R24's clinical records.

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|---|---|---|---|
| | IL6007041 | A. BUILDING: _____ B. WING _____ | 07/10/2024 |

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|---|---|---|---|---|
| S9999 | Continued From page 8 | S9999 | | |

R24's Physician's Order Sheet (POS) printed on 7/9/24 shows an order initiated 6/19/24 for, "Clean wounds left posterior thigh with wound cleaner, apply xeroform (petroleum dressing), then cover with bordered foam gauze dressing, change daily and as needed." The POS did not contain any additional orders for wounds on her posterior thighs or groin area. The order shows an order for an air mattress dated 6/14/24.

R24's Skin Integrity Care Plan shows that she has a blister pressure injury of her left heel with an intervention added of an air mattress on 6/14/24.

On 7/9/24 at 11:44 AM, R24 was lying in bed. R24 did not have an air mattress in place.

On 7/10/24 at 12:07 PM, V2 (Director of Nursing) said that wound assessments including measurements should be done weekly on all pressure wounds to ensure the pressure wound is getting better and not getting worse.

4. R94's Minimum Data Set Assessment dated 6/9/24 shows that her cognition is intact.

On 7/8/24 at 9:27 AM, R94 was self propelling down the hallway in her wheelchair. R94's right lower leg was swollen. There was a gauze wrap around her ankle. Above the wrap, R94's skin was reddened and had dry peeling skin present. R94 said that her right ankle is very painful because she has a screw sticking out of her ankle that has been "like that for a while" and she is waiting to see an orthopedic doctor.

On 7/9/24 at 12:00 PM, R94 was lying in bed. R94 did not have a dressing on her right ankle. R94 had a surgical screw protruding through her

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|---|---|---|---|
| | IL6007041 | A. BUILDING: _____ B. WING _____ | 07/10/2024 |

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|---|---|---|---|---|
| S9999 | Continued From page 9 | S9999 | | |

skin on her right medial ankle. The screw was protruding out 1 centimeter (cm). R94's right leg was swollen and had a 9.5 cm x 7.5 cm reddened area around the screw.

On 7/9/24 at 12:16 PM, V21 (Registered Nurse-RN) said that she did a dressing change to R94's ankle yesterday along with V20 (RN). This surveyor asked V21 if R94's ankle was like that yesterday as well and she responded with, "yes".

On 7/10/24 at 2:32 PM, V21 said that when she did the dressing change on 7/8/24 with V20, R94's leg was swollen and there was redness present. V21 said that she did not report the findings to anyone because she was just following the treatment order and wounds have redness. V21 said that she had not seen R94's ankle before so she is not sure if it was red in the past. R94's Nursing Notes documented for 7/8/24 as a late entry by V20 shows, "This nurse with a second RN completed treatment to right ankle. No swelling or redness present. pt (patient) had no CO (complaints of) pain."

R94's Hospital History and Physical dated 7/9/24 shows, "The patient states that her pain started about 4 days ago when she noticed her right medial ankle red and with a screw poking out of the skin..." R94's Orthopedic consult dated 7/9/24 shows, "Presents from [local extended care facility (ECF)] with several day complaint of worsening right ankle pain...Patient states she noted worsening redness and pin-point prominence over her medial ankle. 4 days ago, she states she informed ECF a screw had popped through the skin. Patient notes global pain and erythema around her medial ankle and hardware is exposed.... ankle diffusely tender, noted medial screw with purulence (pus-like

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|---|---|---|---|---|
| S9999 | Continued From page 10 | S9999 | | |

drainage), induration and erythema along medial ankle.... Plan for operative intervention-Incision, irrigation and excisional debridement of right ankle, removal of hardware, bone biopsy, possible antibiotic bead placement, possible wound vac by [orthopedic surgeon] 7/10/24."

R94's Operative Report dated 7/10/24 shows, "Procedure...Removal of plate and screws distal medial tibia in contact with obvious purulent infection. Irrigation and debridement skin subcutaneous tissues muscle fascia and bone associated with chronic postoperative infection and likely osteomyelitis."

The last Wound Assessment Details Report of R94's right medial ankle was from 6/20/24 that showed that her vascular wound that was present on admission on her right inner ankle had closed. R94 still had swelling of her bilateral lower legs with no redness and stated, "my ankle is painful, when she moves it..." The last shower sheet that was provided was from 7/1/24 that showed no skin alterations.

R94's Nurse Practitioner Note dated 6/21/24 shows, "X-ray to right foot/ankle? Septic arthritis/osteomyelitis of lateral malleolus with recommendation for joint aspiration. Ortho (Orthopedic) consult for possible aspiration and cultures."

R94's Nurse Practitioner Note dated 6/26/24 shows, "She has chronic intermittent aching pain to right foot that worsens with therapy, Norco (narcotic pain medication) and rest helps relieve...Plan. Norco started per physiatry on 6/12/24.scheduled ES (extra strength) Tylenol BID (twice a day). Diclofenac (anti-inflammatory drug)."

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|---|---|---|---|---|
| S9999 | Continued From page 11 | S9999 | | |

R94's Physiatry Notes dated 7/6/24 shows, "She reports continued right ankle pain. She reports that her BLE (bilateral lower extremities) has gotten very swollen.

On 7/10/24 at 10:43 AM, V7 (Physiatry-Nurse Practitioner) said that he saw R94 on 7/6/24. V7 said that when he saw R94 on 7/6/24 she had [rolled gauze] wrapped around her right ankle and her leg was swollen. V7 said that R94 always had swollen legs but when he saw her that day, her right leg was a little more swollen than usual and she was still having pain in her right ankle.

On 7/10/24 at 12:52 PM, V30 (Hospitalist) said that he saw R94 in the emergency room on 7/9/24. V30 said that based on the way R94's right ankle looked (screw sticking out with yellow crusted drainage around it, redness and swelling) that he would estimate that it has been protruding out of the skin anywhere between 48 hours to a week. V30 said that R94 gave him a pretty good history and said that she noticed it about 4 days ago.

The facility's Pressure Ulcer/Skin Breakdown Clinical Protocol revised April 2018 shows, "Treatment/Management-The physician will order pertinent wound treatments, including pressure reduction surfaces...."

The facility's Measurement of Alterations in Skin Integrity Policy dated January 2017 shows, "At first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and/or describe skin condition in the clinical record.... Skin conditions such as bruises, skin tears, abrasion, rashes, and moisture/incontinence associated dermatitis will

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| | IL6007041 | A. BUILDING: _____ B. WING _____ | 07/10/2024 |

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| PA PETERSON AT THE CITADEL | 1311 PARKVIEW AVENUE ROCKFORD, IL 61107 |

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|---|---|---|---|---|
| S9999 | Continued From page 12 | S9999 | | |

be described upon initial observation and documented in the clinical record ..." "All wounds/ulcers (i.e., pressure, arterial, diabetic, venous) will be measured weekly and results recorded in the clinical record."

The facility's Perineal Care Policy revised February 2018 shows, "The purpose of this procedure are to.... observe the resident's skin condition.... documentation...any discharge, odor, bleeding, skin care problems or irritation.... Report other information in accordance with facility policy and professional standards of practice.

The facility's Shower/Skin Sheets Policy revised on November 2009 shows, "Body inspection is to begin at the head and with the feet. Look at all areas of the body. Pay special attention to back, buttocks, peritoneal area, feet and between the toes and heels.... Report any skin alteration or reddened areas to the nurse immediately while the resident is still undressed so it can be clinically assessed, treated and appropriately documented.... When appropriate, the family and doctor are to be notified. If applicable, treatment orders are obtained from the physician."

(A)

2 of 3

300.610a)
300.1010h)
300.1210b)
300.1210d)2)

Section 300.610 Resident Care Policies

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S9999 | Continued From page 13<br><br>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.<br><br>Section 300.1010 Medical Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. | S9999 | | |

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|---|---|---|---|---|
| S9999 | Continued From page 14 | S9999 | | |

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.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident (R121) was assessed, in-person, by a Certified Dietary Manager or Registered Dietician, upon admission to the facility. The facility failed to obtain and monitor a resident's (R121) weight as per physician order. These failures resulted in R121 sustaining a significant weight loss of 20.3 % (49.4 pounds) in 25 days. This applies to 1 of 10 residents (R121) reviewed for weight loss in the sample of 25.

The findings include:

R121's hospital record dated 5/20/24-6/14/24 showed R121 was admitted to the hospital with a diagnosis of a GI (gastrointestinal) bleeding on 5/20/24. While hospitalized, R121 underwent radiologic imaging which revealed a new, malignant mass in R121's colon. R121 subsequently underwent surgery to remove the mass in her colon as well as to have a colostomy placed. Post surgery, R121's records showed R121 required an appetite stimulant medication and TPN (intravenous nutritional feeding) due to her poor appetite and diagnosis of severe protein malnutrition and caloric deficit. R121's hospital discharge medical records showed R121 weighed 243 pounds (lbs) on 6/13/24. R121 was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| S9999 | Continued From page 15 | S9999 | | |

discharged to the facility on 6/14/24 for skilled therapy services and rehab.

R121's admission care plan dated 6/15/24 showed R121 was at risk for weight loss. The plan showed R121 "will not have unplanned significant weight loss/gain through next review." The plan showed R121 was cognitively intact.

A physician order for R121 dated 6/15/24 showed, "On admission, weekly weights x 4 (weeks) and then per protocol."

On 7/8/24, R121's Weights and Vitals Summary was reviewed and showed R121 weighed 243 lbs upon admission to the facility on 6/14/24. The record showed no documented weights for R121 from 6/15/24-7/8/24.

On 7/8/24 at 1:01 PM, R121 was asleep in bed. An uneaten roast beef sandwich was on the table in front of R121.

On 7/9/24 at 7:55 AM, R121 was seated in bed. R121 was asked if she had ever been weighed in the facility. R121 stated, "They have never weighed me here. They have never asked if they could weigh me." The uneaten roast beef sandwich remained on the table in front of R121. R121 pointed at the sandwich and stated, "My son brought that in. I haven't been hungry."

On 7/9/24 at 9:44 AM, this surveyor asked V3 Certified Nursing Assistant (CNA) to weigh R121. R121 was weighed by V3 CNA, with this surveyor present. The facility's scale showed R121's weight as 193.2 (lbs).

On 7/9/24 at 10:13 AM, V4 Registered Dietician (RD) and V5 Certified Dietary Manager (CDM)

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|---|---|---|---|---|
| S9999 | Continued From page 16 | S9999 | | |

were interviewed. V4 RD stated new admissions (residents) are weighed once a week for the first four weeks, after admission, to monitor residents for any weight changes. V4 RD stated she does not see all new admissions to the facility but "only the resident's that have wounds, are on dialysis, or are at high risk for weight loss." V4 RD stated, "All residents are to be assessed by me or (V5 CDM) within 72 hours of their admission. (V5) sees and does the nutritional assessments on the new admissions that are non-high risk for weight loss." V4 stated she had never seen or evaluated R121 in the facility. V4 stated she was not aware of R121's medical history or diagnoses. R121's weight record, showing only R121's weight of 6/14/24, and R121's recent hospital records were then reviewed with V4 RD. V4 RD was also informed R121 was weighed by facility staff that morning which showed R121's weight as 193.2 lbs. V4 RD stated, "I don't see where her weekly weights were done. She should have had weights done weekly. I had no idea what her history was. I should have assessed her upon admission." R121's nutritional assessment, documented as being completed by V5 CDM on 6/15/24, was then reviewed with V4 RD and V5 CDM. V5 CDM stated, "I didn't actually see (R121) in-person and assess her myself. I had one of my dietary aides go see her to see if she had any concerns. I completed the (dietary) assessment on (R121) based on what I read in her nurses notes and what the dietary aide told me." V5 CDM stated, "I should be doing the dietary assessments on new admissions myself, but it just depends on my workload. If the resident doesn't have any concerns, I don't always do see them in-person." V5 stated he was aware R121 had a diagnosis of protein calorie malnutrition upon admission to the facility but stated he was not aware that R121 also had

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|---|---|---|---|
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|---|---|---|---|---|
| S9999 | Continued From page 17 | S9999 | | |

diagnoses of colon cancer and colostomy placement.

On 7/9/24 at 12:45 PM, V4 RD stated R121 had been reweighed by V4 and facility staff. V4 stated R121's re-weight was 193.6 lbs which confirmed R121 had sustained a significant weight loss of 20.3 % (49.4 lbs) in 25 days (6/14/24-7/9/24). V4 stated she had just completed her evaluation on R121. V4 stated R121's significant weight loss was "likely avoidable" if she had assessed R121 upon admission and had R121 been weighed weekly. V4 stated, "I should have assessed her upon admission based on her diagnoses." V4 stated if R121 had been weighed weekly, her weight loss could have potentially been caught sooner. V4 stated, "It is not okay for a dietary aide to do any assessments on residents. I wasn't aware that (V5 CDM) was not assessing all new admissions in-person." V4 stated she had just spoken with R121's son who stated he had been bringing in food for R121 because R121 had not been eating well in the facility and he was trying to get her to eat.

On 7/9/24 at 2:26 PM, V11 Nurse Practitioner (NP) for R121 stated R121 should have been weighed weekly for the first four weeks she was in the facility. V11 NP stated it was the expectation that each newly admitted resident was seen and assessed by either a registered dietician or certified dietary manager. V11 NP stated that R121's weight loss was "substantial" however, she stated the cause of R121's significant weight loss was "multi-factorial" as it was related to R121's cancer diagnosis, prolonged hospitalization, poor appetite, and R121 not being weighed weekly as ordered. V11 NP stated had R121 been weighed weekly, "they

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|---|---|---|---|---|
| S9999 | Continued From page 18 | S9999 | | |

could have seen her weights trending down and intervened."

The facility's Weight Assessment and Intervention policy dated 12/2009 showed, "The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents ...The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month- 5% weight loss is significant; greater than 5% is severe. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. 6 months- 10% weight loss is significant; greater than 10% is severe ..."

(B)

3 of 3

300.2100

Section 300.2100 Food Handling Sanitation

Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750).

This REQUIREMENT was not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure dietary staff had a food handlers certificate. This applies to all 127 residents.

The findings include:

The CMS 671 Long-Term Care Facility

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|---|---|---|---|
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|---|---|---|---|---|
| S9999 | Continued From page 19<br><br>Application for Medicare and Medicaid dated July 8, 2024 shows, there are 127 residents residing in the facility.<br><br>On July 8, 2024, during the initial kitchen tour, V25 Cook was making chili for the noon meal. Other kitchen staff were doing dishes and prepping for the noon meal.<br><br>On July 8, 2024 at 10:58 AM, V5 Dietary Manager stated, he was the only one working in the kitchen at that time that was certified with their food handlers certificate.<br><br>The facility's food certification policy (no date) shows, "Purpose: Food handler training certificate is required by IDPH (Illinois Department of Public Health). Individuals working in food preparation and food service areas prepare food for a highly susceptible population. 1. Employees working in dietary will be required to obtain a food handler training certificate..."<br><br>(C) | S9999 | | |