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	IL6012322	A. BUILDING: _____ B. WING _____	C 12/09/2024

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S 000	Initial Comments Complaint Investigation 2459773/IL181742	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010)h) 300.1210 b) 300.1210 d)3) 300.1220 b)2) 300.1220 b)7) 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	S9999		

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S9999	Continued From page 1 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: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 7) Coordinating the care and services provided to residents in the nursing facility.	S9999		

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These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide a residents' dietary recommendations to the physician, notify the Registered Dietician and physician of continued weight loss, obtain weights as ordered, follow dietary orders, report a residents' peg tube (gastric tube) placement to the Registered Dietician upon readmission to the facility, and monitor and document a residents' tube feeding administration amounts, gastric tube placement, residuals, feeding complications, and consultation to ensure adequate nutritional intake was being administered via the tube feeding. These failures affect one (R3) of three residents reviewed for nutrition on a total sample list of eight residents. These failures resulted in R3 losing 13.5% of his body weight in three and a half months, resulting in malnutrition, dehydration, and peg tube placement due to nutritional insufficiency, and R3 experiencing nausea and vomiting with tube feeding administration, and the tube feeding being shut off without a physician order/consultation.

Findings include:

R3's progress notes, dated 8/16/24, document R3 was admitted to the facility with a history of intellectual disability, hematuria, hydronephrosis, genitourinary surgery, depression, chronic leukemia, spondylosis, osteoarthritis, persistent atrial fibrillation and a need for assistance with personal care.

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R3's weight summary, dated 8/16/24, documents: R3 weighed 149 pounds on 8/16/24, 131.6 pounds on 10/2/24 (12% weight loss in 17 days), 130 pounds on 11/27/24 and 128.9 pounds on 12/2/24. No weight was documented in September 2024.

R3's admission nutritional assessment, dated 8/29/24, documents an order for R3 to have regular, soft, bite sized foods.

R3's progress notes, dated 10/2/24, document R3 weighed 131 pounds, having lost l2% of his body weight. At this time, recommendations for weight gain were made by V4, Registered Dietician, to provide twice daily supplements and an appetite stimulant, neither of which were implemented.

R3's medical record does not document the implementation of any Dietician recommendations or physician notifications of Dietician recommendations from admission throughout R3's entire facility stay.

On 10/31/24, R3 was sent to the hospital for blood in the urine and a penile abcess. R3's hospital notes, dated 11/3/24, document a potassium level of 3.3milligrams (mg) compared to R3's potassium level, dated 7/18/24, of 3.8mg and R3's magnesium level dated 11/3/24 of 1.8mg, indicative of malnourishment, dehydration, and weakness to the degree that a feeding tube was placed for supplemental nutrition and fluids. R3's body mass index was documented on this date at 17.3, severely malnourished.

On 11/3/24, hospital physician progress notes document "a gastric tube placement will be discussed with the guardian given severe malnutrition which appears to have been going on

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for some time."

R3's hospital discharge records, dated 11/27/24, document R3 returned to the facility with orders for oral intake of soft and bite sized food on a dysphagia three diet, with supplemental peg tube feedings. The formula included Osmolite 1.5 at 90 milliliters ml per hour, starting at 6:00PM and stopping at 8:00AM, and 50ml flushes with tap water every four hours.

R3's intake records document the facility failed to provide R3 with the Osmolite 1.5 at 90 ml per hour for 14 hours, and instead provided it for 12 hours. Additionally, they did not provide R3 with oral nutrition from 11/27/24 until 11/30/24, when they obtained a nothing by mouth order until a speech consultation is obtained, due to weakness and inability for R3 to eat.

R3's intake summary, dated 11/28/24 to 12/7/24, documents the first time oral nutrition is provided to R3 was on 12/5/24.

R3's weight summary, dated 12/2/24, documents R3's weight measured 128 pounds, a loss of 13.5 percent of R3's total body weight in 3.5 months.

R3's physician progress notes, dated 12/3/24, documents V5, Physician, was asked to review R3's situation regarding poor oral intake, deconditioning, and weight loss. R3's notes document that the peg tube feeding is running from 6:00PM to 6:00AM, 12 hours at a time, and another two pound weight loss has occurred.

R3's physician orders, dated 12/3/24, document a change in tube feeding formula from Osmolite 1.5 at 90cc per hour to Jevity 1.5 at 50cc per hour to increase in 10 cc increments until reaching 70cc

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per hours for twelve hours, from 6:00PM to 6:00AM.

On 12/3/24 at 9:15AM, R3 was laying in bed, with blood and feces covering his sheets. R3's left arm was covered with a bandage, and his fingernails were caked with dark, thick, dough-like matter. R3's teeth were black and brown, with some teeth missing. R3 appeared severely underweight, with bones protruding from his translucent skin, and both legs contracted.

On 12/3/24 at 9:17AM, V7 and V11, Certified Nursing Assistants, were cleaning R3's fingernails and body. V7, CNA, stated they were cleaning feces from underneath R3's nails. Both stated when R3 came to the facility in August of 2024, R3 was able to feed himself, they only supervised, and was able to wheel himself throughout the facility in a wheelchair, but now he is too weak to do anything for himself.

R3's medical record does not document an attempt to obtain dental services for R3.

On 12/4/24 at 10:45AM, V2, Corporate Nurse, stated R3 should have been offered dental services in light of his rotting teeth and weight loss.

On 12/3/24 at 11:15AM, V3, Nurse Practitioner (NP), stated R3's tube feeding order from the hospital was intended to be a supplement to oral feedings, and did not contain enough calories to help with weight gain, which is why an additional oral feeding was ordered. V3, NP, stated R3 is malnourished and needs more calories, and the failure on the part of the facility to feed R3 and to notify V4, Registered Dietician, of R3's new tube placement and feeding order, as well as the

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failure to notify V5, MD, of the recommendations for weight gain by V4, RD, all contributed to R3's increased weight loss.

On 12/3/24 at 2:51PM, V5, Medical Doctor (MD), stated he was not made aware of R3's significant weight loss or of V4, RD's, recommendations. V5, MD, stated he was called on 11/30/24 and told R3 was so weak that he couldn't eat. He said he told them not to feed R3 until a speech consult was obtained to make sure he was safe to eat. V5, MD, said he would have utilized the recommendations of (V4, RD), had he known about them, and he was accustomed to collaborating in other facilities with Dieticians.

On 12/3/24 at 12:06PM, V4, Registered Dietician (RD), stated she was not aware the facility didn't implement the supplements and other recommendations she made on 10/10/24, and she wasn't notified R3 returned to the facility on a tube feeding until today. V4, RD, stated, "I should have been notified of a new resident with a tube feed. (R3's) weight loss was preventable had they implemented supplements, provided me with regular weights, let me know what his oral intake looked like, and communicated with me so that I might have been able to help. He should have had an assessment when he returned. He just continues to lose weight and hyponatremia and hypomagnesemia are indicative of malnutrition and dehydration."

On 12/4/24 at 10:15AM, V4, Registered Dietician (RD), stated she calculated R3's current tube feeding order, and it is insufficient to meet R3's caloric needs. "(R3) is currently only receiving 990 calories and 42 grams of protein. This is why we have to be involved in all tube feedings from the start so that they get the nutritional support

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that they need and don't continue to lose weight."

R3's progress notes document R3 vomiting once on 12/4/24 and three times on 12/7/24 with feedings stopped on 12/4/24 and 12/7/24. R3's physician orders do not document an order to stop feedings, nor any consultation with the Dietician.

R3's medical record does not contain documentation of verification of tube placement, amount of enteral feeding administered, or that all episodes of vomiting were reported to the physician and supervisor.

On 12/9/24 at 10:20AM, V22, Registered Nurse/RN stated on 12/6/24 at 2:00AM, R3 vomited after dinner, and after his tube feeding was started, he vomited twice more. V22 stated she turned off R3's tube feeding and did not notify anyone. "On December 7, 2024, I saw that he ate about 25% of his meal and then threw it up. The on call physician was then notified by the other nurse. At one point, we discussed talking with the Dietician, but it just didn't go anywhere."

On 12/9/24 at 10:06AM, V4, Registered Dietician (RD), stated she was unaware the MD did not accept her recommendations for the tube feeding formula amounts and she was not made aware of R3 vomiting, so that another type of formula could be tried. "Stopping the feedings was not the right choice in someone with malnourishment, we could have tried different formulas."

On 12/9/24 at 12:00PM, V3, Nurse Practitioner stated she was never provided V4's, RD, recommendations. "If I had gotten them, I would have communicated them to the doctor and definitely considered them, but neither I nor the

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S9999	Continued From page 8 physician were made aware of them." On 12/9/24 at 12:15PM, V2, Corporate Director of Nursing, stated when caring for residents with tube feedings, staff should be documenting intake and output incuding flushes and tube feedings, verification of placement and any complications. "If they don't (document), you don't know if they are receiving all of the nutrition that they need. I would expect the Dietician would be involved at admission, weekly, and when there is a change of condition. Certainly the physician and Director of Nursing should be notified with any complications related to the feeding." The facility weight assessment and intervention policy, dated 12/2024, documents the nursing staff will measure residents weight on admission, weekly for four weeks thereafter, and then monthly, if no weight concerns are noted. The undated facility tube feeding skills checklist documents to monitor resident for feeding intolerance, document the verification of tube placement, amount and time of enteral feeding and amount of flush and report complications to the supervisor and medical practitioner. (B)	S9999		