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S 000	Initial Comments Complaint Investigation 2459621/IL181481- F686 Complaint Investigation 2459839/IL181871- F600, F677, F686	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.686f) 300.1210a) 300.1210b) 300.1210c) 300.1210d)1)2)3)5) 300.3240a) 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 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications f) Residents who use antipsychotic medications shall receive gradual dose reductions and behavior interventions, unless	S9999		

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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.

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'

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S9999	Continued From page 2 respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 3 These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure a resident was free from neglect when they failed to assess, treat, and implement interventions to prevent pressure ulcers, accurately assess for skin breakdown, discontinue psychotropic medications as ordered by the physician, and provide oral care for 1 of 5 (R12) residents reviewed for neglect in the sample of 19. This failure resulted in R12 being transferred to the local hospital on 12/01/24 for altered mental status and possible sepsis. Once at the hospital it was determined R12 had received Haldol and Clonazepam without a physician order from 11/23/24 until 12/01/24. R12 had developed 15 new wounds including a Stage 2 and Stage 3 to his buttocks, a Stage 2 to the left knee, and two deep tissue injuries to his bilateral heels. R12 also had a buildup of a hardened yellow/brown coating with cracking and fissures noted to be covering the tongue from lack of oral care. Findings Include: R12's Admission Record with a print date of 12/5/24 documents R12 was admitted to the facility on 4/29/24 with diagnoses that include fracture of left femur, hypotension, diabetes, schizophrenia (diagnosis added on 11/07/24), bipolar disorder (added on 11/07/24) difficulty walking, and muscle weakness. R12's MDS (Minimum Data Set) dated 10/17/2024 documents R12 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R12 is cognitively intact. This same MDS documents R12 required partial to	S9999		

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moderate assist for transfers, was independent for bed mobility, and was at risk for developing pressure ulcers. R12's local hospital records dated 12/01/24 documents R12 is "more confused" upon arrival to the hospital.

R12's current Care Plan documents a Focus area of "(R12) uses psychotropic medications (Escitalopram) r/t (related to) dx (diagnosis) depression, anxiety. Schizophrenia 10/9/24 Clonazepam for agitation, 10/27/24 Clonazepam increased, 10/29/24 Escitalopram decreased, 11/8/24 Haldol, Date Initiated: 05/03/2024." Interventions for this Focus area include, "Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 05/03/2024 ..."

R12's facility Progress Notes document the following:
11/17/24 - "At 0700 (7:00 AM) resident was observed to be unresponsive and weak. VS (vital signs): 97.1, 122, 32, sat (oxygen saturation) 70, bp (blood pressure) 139/75. No purposeful movement on the left side. Unable to assess pupils. Ambulance called and resident transferred to (local hospital) ER (emergency room). MD (physician) and POA (power of attorney) informed."
11/17/24 - "Called for an update on the resident. Resident will be admitted IP (inpatient) for aspiration PNE (pneumonia)."

R12's local hospital record documents R12 was admitted to the local hospital on 11/17/24 and discharged back to the facility on 11/23/24. R12's hospital record includes under Secondary Discharge Diagnosis, "bed sore on buttock." This same hospital record documents under Hospital Course, " ...Patient advised to take Augmentin

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875 for 3 days post discharge. He was also advised to stop taking Haldol and Clonazepam as the medications were held for the entirety of his admission and he had no psych issues ..." Under Active Issues Requiring Follow-up and Discharge Plan the hospital records document, " ...Please stop taking Haldol. Please stop taking Clonazepam ..."

R12's facility Progress Note dated 11/23/24 documents, "Resident's Haldol and Clonazepam discontinued by hospital at discharge. Antibiotic added.... Discharge medication list faxed to (name of pharmacy) and (V14/Physician) office. Provider notified of arrival."

R12's facility Order Summary Report Active Orders as of 11/30/24 includes the following physician orders, "Clonazepam 0.5 mg (milligrams) Give 0.5 mg by mouth three times a day for anxiety," with a start date of 10/27/24 and "Haloperidol (Haldol) oral tablet 5 mg Give 5 mg by mouth three times a day related to schizophrenia, unspecified; bipolar disorder unspecified," with a start date of 11/08/24. There is no end or discontinue date documented for either physician order.

R12's Progress Notes dated 11/24/24 at 2:57 PM signed by V18 (RN/Registered Nurse) documents, "Clonazepam Tablet 0.5 MG, give 0.5 mg by mouth three times a day for anxiety Resident's medication was dc'd (discontinued) at the hospital. Reaching out for clarification on medication."

R12's Medication Administration Record (MAR) dated 11/01/24 to 11/30/24 documents an order for Clonazepam 0.5 mg to be administered at 9:00 AM, 2:00 PM, and 9:00 PM. This MAR

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documents initials indicating Clonazepam 0.5 mg was administered at 9:00 PM on 11/23, 11/24, 11/26-11/30, at 9:00 AM 11/24-11/30/24 and at 2:00 PM 11/26-11/30/24. This same MAR documents the Clonazepam was held at 2:00 PM on 11/24 and 11/25/24. This indicates upon R12's return to the facility the Clonazepam was administered 20 times and held three times. This same MAR documents an order for Haldol 5 mg to be administered at 9:00 AM, 2:00 PM, and 9:00 PM with initials documented indicating R12 was administered Haldol at each dose time from 11/23/24 to 11/30/24.

On 12/16/24 at 12:37 PM, V18 (Registered Nurse/RN) stated she was responsible for readmitting R12 to the facility after his return from the hospital on 11/23/24. V18 stated she charted the Haldol and Clonazepam had been discontinued in the progress notes. V18 stated when she returned to work the next day, she noticed they were still active on R12's medication list so she held them waiting for clarification. V18 stated she spoke with the night shift nurse (V19/RN) who said she had taken care of it and the medications were reinstated so she assumed the physician had given an order to resume them.

On 12/28/24 at 10:00 AM, V19 (RN) stated V18 was the day shift nurse when R12 returned from the hospital, and she (V19) was the oncoming night shift nurse. V19 stated V18 reported to her R12's medications were discontinued by the hospital. V19 stated R12 doesn't have any medications ordered on night shift other than Tylenol. V19 stated she did not call the physician to clarify the medication orders from the hospital discharge. V19 stated she wouldn't have had a reason to look at those medications and/or orders since R12 didn't take medications on her shift and

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V18 had reported to her they were discontinued.

On 12/4/24 at 2:35 PM, V5 (CNA/Certified Nursing Assistant) stated mid-November, R12 stopped eating, started refusing care, and became a two person assist. V5 stated it was a change in R12's condition and it worsened when he came back from the hospital on 11/23/24. V5 stated R12 would get up for meals before he went to the hospital and when he came back, he would barely eat and/or drink and even stopped yelling down the halls. V5 stated she reported this to an unknown nurse, and she thought the nurse assessed R12 and documented it.

On 12/9/24 at 12:50 PM, V2 (DON/Director of Nurses) stated the Haldol and Clonazepam were started because R12 had extreme behaviors. V2 stated after it was discontinued at the hospital, she assumed V15 (Psychiatric Nurse Practitioner/Psych NP) had resumed the order when he returned to the facility and that was why he was still getting the medications.

On 12/9/24 at 1:02 PM, V15 (Psych NP) stated the facility did not notify her R12 had been to the hospital and/or that the medication had been discontinued by the hospital physicians. V15 stated she looked back at her communication with the facility, and she got a message R12 needed a refill on his Clonazepam but was never notified by the facility the medication had been discontinued. V15 stated she hadn't seen R12 since 10/24/24 and her expectations would be that if a medication were discontinued while the resident was at the hospital it would stay discontinued when they returned to the facility.

R12's Braden Scale dated 11/10/24 documents a score of 14, which indicates R12 is at moderate

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risk of skin breakdown. R12's Braden Scale dated 11/24/24 documents a score of 12, which indicates R12 is at high risk of skin breakdown.

R12's current Care Plan documents a Focus area of "(R12) is at risk for skin breakdown r/t (related to) requires assist with bed mobility, frequently incontinent of B & B (bowel and bladder). Has left side neglect. Date Initiated: 05/16/2024." This Focus area includes the following interventions, "10/30/24 cover spokes on left side of w/c (wheelchair)...8/27/24 Pad bed frame." This same focus area includes the following interventions initiated on 5/26/24, "assist T & P (turn and position) at least every 2 hours and prn (as needed) .... Educate resident/family/caregivers of causative factors and measures to prevent skin injury .... Encourage good nutrition and hydration in order to promote healthier skin .... Follow facility protocols for treatment of injury ...Keep skin clean and dry. Use lotion on dry skin... Monitor/document location, size and treatment of skin injury, if occurs. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (physician) ....Offer toileting/check every 2 hours and prn (as needed) provide peri-care as needed ....Pressure relief mattress on bed and cushion in w/c (wheelchair) as preventative... Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface ..."

R12's Order Summary Report Active Orders as of 11/30/24 documents a physician order for weekly skin checks with no orders documented for treatments to specific areas of skin breakdown and/or orders for interventions to prevent skin breakdown from 11/23/24 to 12/01/24.

R12's Progress notes document.

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11/23/24 12:49, "Report received from (name of local hospital). Resident will be arriving today by EMS (emergency medical services). Resident is a Mechanical soft diet with thin liquids by mouth. Family declined to have resident's code status changed to comfort measures and will remain full code with current plan of care with an addition of PO (oral) abx (antibiotic)."
11/23/24 15:51, "Resident arrives at this time via EMS."

R12's Initial Skin Alteration Record signed by V18 (RN), dated 11/23/2024 documents under Site, "Resident refusing skin assessment, yelling to leave him alone. Able to assess visible skin. Resident pushing away this nurse when trying to assess. Wound founds found (sic) to BUE (bilateral upper extremities). Several bruises and skin tears present.... Comments- healing skin tears to left arm noted. no signs of infection observed. resident not in pain at this time. this nurse unable to complete a head to toe assessment as resident was screaming no and resisting with physical pushing away of this nurse. Treatment Plan...Monitor skin tears..." There are no measurements, assessments, or physician notification documented on this assessment."
R12's medical record did not document any Initial Skin Alteration Records after 11/23/24.

On 12/5/24 at 11:16 AM, V18 (Registered Nurse) stated she was working on 11/23/24 when R12 returned from the hospital. V18 stated she attempted to do a skin assessment, but he was resisting, and she didn't want to cause him distress. V18 stated she did see the dressings that had been applied at the hospital and looked under them and didn't see any open areas. V18 stated she meant to put an order in to remove and replace them every three days and just forgot

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to do it. When asked what interventions were implemented to prevent skin breakdown, V18 stated he had a pressure reducing mattress on his bed and a cushion in his chair. V18 stated they floated his heels and would try to reposition him hourly.
R12's Weekly Skin Check dated 11/24/24 not signed until 12/04/24 by V18 (RN) documents under "Site: Left antecubital- Resident refusing skin assessment, yelling to leave him alone. Able to assess visible skin. Resident pushing away this nurse when trying to assess. Wound found found (sic) to BUE. Several bruises and skin tears present.... Comments: healing skin tears to left arm noted, no signs of infection observed. resident no in pain at this time. This nurse unable to complete a head-to-toe assessment as resident was screaming no and resisting with physical pushing away of this nurse. will continue to monitor." This is the same narrative that was documented in R12's Initial Skin Alteration Record dated 11/23/24.

On 12/9/24 at 9:59 PM, when asked if she completed the Weekly Skin Check dated 11/24/24, V19 (RN) stated R12 was sitting in his wheelchair, and she noticed the area on his arm was healed. V19 was asked if she assessed any other skin on R12 and she stated, "No, I just looked at his arm." V19 stated they have another nurse who does all the treatments for south side. This surveyor reviewed with V19 that R12 wasn't located on that side and V19 stated she thought he was. This surveyor then asked V19 if she did a physical assessment of R12's skin from 11/23/24 until 12/01/24 and if she completed the 11/24/24 Weekly Skin Check and V19 stated, "I don't remember. I usually just ask the CNA if the residents have any skin changes."

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On 12/9/24 at 12:50 PM, this surveyor reviewed the 11/23/24 initial skin assessment and the 11/24/24 weekly skin assessment with V2 (DON) and she stated the 11/24/24 assessment looks like it was copied and pasted from the 11/23/24 assessment.

R12's Skin Monitoring: Comprehensive CNA Shower Review documents dark bruising to R12's left arm, heels as red, coccyx as dark red, a bandage to the inside of his inner right leg and a bandage on his left hip with V17's (CNA) signature dated 11/30/24. This Review documents V2 (DON's) signature with a date of 11/30/24 with no assessment of the new areas documented under "Nurse Assessment."

On 12/5/24 at 8:37 AM, V17 (CNA) stated R12's condition had declined when he returned from the hospital on 11/23/24. V17 stated R12 wasn't eating, drinking, and/or communicating as well. V17 stated she gave R12 a bed bath on 11/30/24 and found a bandage on his left hip that was "looking a little rough." V17 did not remember if there was a date on the bandage that would indicate when it was placed. V17 stated when she rolled R12 over she noticed R12's coccyx was dark red, and his right hip was splotchy in color. V17 stated she was concerned R12 was mottling and then she removed his socks and noted that both of his heels were dark red as well. V17 stated there was a bandage on R12's inner thigh that didn't look as bad as the one on his left hip, but she again didn't know if there was a date on it. V17 stated she didn't remove the bandages, so she didn't know what his skin looked like under them. V17 stated she documented the areas on the shower sheet and told V2 (Director of Nurses) who was working as her nurse that night. V17 stated she told V2 she was worried R12 was

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dying and that his family needed to be notified. V17 stated she also reported the change in R12's condition to the oncoming shift and her supervisor (V21/CNA Supervisor). V17 stated R12 was sent out to the hospital two days later so she assumed someone heard her concerns. When asked what interventions were in place to prevent the pressure injuries from worsening, V17 stated there was a pillow under his left hip that was always there because of previous skin issues but that was the only intervention in place. V17 stated R12 was clean and dry when she changed him and that he was dependent on staff for all care.

On 12/5/24 at 1:48 PM, V21 (CNA Supervisor) stated V17 told her R12's skin looked bad, but she didn't remember the date this occurred. V21 stated she asked V17 if she had reported it to the nurse and V17 told her she reported it to V2 (DON).

On 12/5/24 at 12:04 PM, V2 (DON) stated she didn't remember signing off on the 11/30/24 shower sheet that documented the new areas of skin breakdown for R12. V2 stated she was working the floor that day and was told she had to get skin assessments on all the residents. V2 stated she attempted to get other nurses to assist her with it and was not able to get anyone to assist. V2 stated V17 (CNA) helped her by doing skin assessments and documenting them on the shower sheets. V2 stated she knew R12 was declining, not getting out of bed, not eating, and not drinking. V2 stated, "I am really pi**ed off at myself and the building because I had zero help except for the CNA's who can't make calls or write orders. It can't be just me. I don't have any help at all." When asked if she ever assessed R12's skin, V2 stated, "No." V2 stated the skin assessments were done on Sunday 11/30/24 but

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she didn't sign them until Monday, December 01, 2024. V2 stated she wished V17 had told her on Friday, how bad R12's skin was. When asked to clarify if R12's skin was assessed on Friday 11/29 or Saturday 11/30, V2 stated they were working midnight shift, and she wasn't sure if it was before or after midnight. V2 stated it was miscommunicated and they missed it. V2 stated if she had done R12's skin assessment she would have notified the physician and obtained orders for treatments. V2 stated they recognized there was an issue and have put things in place to "make it better." V2 stated they are checking each morning during clinical rounds to make sure skin assessments are being done. V2 stated R12 should have had a head-to-toe assessment on 11/23/24 when he returned from the hospital and again before he went back to the hospital on 12/01/24.

On 12/5/24 at 11:16 AM, V18 (Registered Nurse) stated she followed R12 closely even when she wasn't his nurse. V18 stated he wasn't eating well, and his oxygen dependence was increasing. V18 stated R12 didn't start showing skin breakdown until 11/30/24 and she was working on the other side that day. V18 stated she told his nurse she would be over there the next day and would look at him then.

On 12/9/24 at 10:18 PM, V24 (CNA) stated she provided care to R12 between 11/23/24 and 12/01/24. V24 stated R12 was incontinent of bowel and bladder and was not able to turn and reposition himself. When asked what interventions were implemented to prevent pressure ulcers from developing, V24 stated they were turning and repositioning R12 and using pillows for support. V24 stated she was aware of the areas of skin breakdown on R12, and he had

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them for "probably a couple of weeks."

R12's facility Progress Notes document:
11/30/24 - "1907 (7:07 PM) Resident has a loss of appetite and motivation. Resident continues to take medication but not showing any improvement. This nurse will continue to monitor. Reported to nightshift nurse. If not showing improvement by mid shift tomorrow, will reach out to provider for further intervention."

12/01/24 - "14:06 (2:06 PM) Resident still not doing well and declining. Despite antibiotics, resident has not eaten in two days, has crackles throughout lung fields, febrile at 102.8 F (Fahrenheit), today extreme lethargy to the point where nursing judgement is that it is not safe to give PO (oral) medication. EMS (Emergency Medical Services) called for emergent send out for possible sepsis. Provider and POA (Power of Attorney) notified. Vital signs as follows: 154/64, pulse 138, respirations 28 and shallow with crackles and wheezes, Temp (temperature) 102.8, post Tylenol, O2 (oxygen) at 91 on 4 L (liters)."

12/01/24 - 4:26 PM, "(R12) admitted IP (in patient) for AMS (altered mental status) and sepsis r/t (related to) aspiration PNE (pneumonia)."

R12's local hospital records dated 12/01/24 documents "Patient presents from the nursing home for altered mental status. He is somnolent." This hospital record documents under ED (Emergency Department) Triage notes, "Per EMS, pt (patient) was recently discharged with pneumonia. Pt had a temp of 103.6 F, Tylenol was given at nursing home. Heart rate 130's and more confused this morning. Pt localizing to pain

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and shaking head to questions. Labored breathing. skin warm, Dry. mouth is extremely dry...." The physical exam dated 12/01/24 documents R12 is ill appearing and lethargic. Under Clinical Impression it documents, "Altered mental Status, unspecified altered mental status type. Sepsis without acute organ dysfunction, due to unspecified organism...." Under Physical Exam R12's hospital record includes, "...Skin: General skin is warm and dry. Comments: Sacral decubitus, multiple wounds left buttocks, left hip, heels, left arm - see photos...." R12's hospital records document under Wound Nurse Note, "Wound care: Wound consult completed w/(with) dressings applied to the following POA Pis (present on admission pressure injuries): right medial heel: DTPI (deep tissue pressure injury) & (and) left lateral heel.: DTPI & coccyx: Stage 3 PI and Left buttock: Stage 2 PI and left lateral knee: Stage 2 PI; and skin tear located on the left elbow previously dressed per assigned RN (Registered Nurse)." R12's hospital records document the following assessments of the pressure areas all dated 12/01/24. 1. DTPI right heel- measured 4.5 cm (centimeters) x 3.8 cm described as purple, painful, dry, intact, non-blanchable. 2. Pressure injury of left lateral heel measured 2 cm x 1.5 cm and described as non-blanchable, purple, dry, intact. 3. Stage 2 pressure injury left buttocks measured 0.6 cm x 0.7 cm x 0.1 cm and described as partial thickness, red moist, painful, blanchable with scant serous drainage. 4. Stage 3 pressure injury to midline coccyx measured at 1.5 cm x 0.9 cm x 0.2 cm and described as full thickness, moist, painful, with scant amount of serosanguinous drainage, and 5. Stage 2 pressure injury to left lateral knee measured at 0.9 cm x 0.5 cm x 0.1 cm and described as red, moist, with scant amount of serous drainage. Under Adult Neglect Assessment and Plan, R12's

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hospital record document, "Patient has over 15 new wounds since last admission, he received Haldol and benzos (benzodiazepine) in the nursing home which were discontinued by our team at the time of the discharge (11/23/24), patient became somnolent due to this and stopped eating and was readmitted this time. Patient's son does not want him to go back to (name of facility) and is looking at other nursing home options."

On 12/4/24 at 8:55 AM, V16 (Registered Nurse-hospital) stated he was familiar with R12. V16 stated R12 was admitted to the hospital on 11/17/24 and discharged back to the facility on 11/23/24. V16 stated R12 had three wounds when he left the hospital on 11/23/24 that had dressings on them. V16 stated when R12 returned to the hospital on 12/01/24, R12 had 15 wounds and still had the same dressings on the original three wounds that was on when he was discharged on 11/23/24.

On 12/5/24 at 2:08 PM, V14 (Physician) reviewed R12's hospital records and stated the pressure areas on R12's hip deteriorated from 11/23/24 to 12/01/24. V14 stated the area on R12's trochanter increased in size from 11/23 to 12/01/24. When asked if the pressure ulcers/injuries were avoidable, V14 stated the areas on R12's heels would have been preventable. On 12/09/24 at 1:29 PM, V14 (Physician) stated if R12 was immobile from somnolence then it could precipitate him developing pressure ulcers.

According to the Medical Dictionary located at the website Somnolency | definition of somnolency by Medical dictionary the definition of somnolent is "1. Drowsy; sleepy; having an inclination to sleep.

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S9999	Continued From page 17 2. In a condition of incomplete sleep; semi-comatose." On 12/4/24 at 4:00 PM, V1 (Administrator) stated R12 had new areas identified on his 11/30/24 shower sheet. V1 stated there were no assessments, treatment orders, physician notification, or physician orders documented in R12's record related to the new areas. V1 stated her expectation would be for any new area of skin breakdown to be assessed and the physician notified for treatment orders. R12's hospital records with an admission date of 12/01/24 documents under Dehydration-Assessment & (and) Plan Note, "Nursing staff reported pt (patient) has had decreased PO (oral) intake since last admission, especially for the last 2 days during (sic) pt has had only a few bites to eat. Pts oral mucus membrane appeared dry with yellow crusts on tongue and palate." R12's local hospital records with an admission date of 12/01/24 documents a photograph of R12's mouth that shows R12's tongue that is covered in a dry scaly cracking with fissures, with a thick residue that is yellow/white/brown in color. On 12/11/24 at 10:04 AM, V23 (RN/Hospital Shift Supervisor) stated when R12 was admitted to the hospital on 12/01/24 his mouth looked like the bottom of the Sahara dessert. On 12/4/24 at 2:35 PM, V5 (CNA) stated they offer oral care, but residents have the right to refuse it and they don't offer it to someone who is alert and oriented since they can ask for it if they want it. When asked if she provided anyone with oral care today (12/4/24) while she was working, V5 stated she did not. V5 stated one of the	S9999		

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nurse's was wanting to set up a cart for them so oral care would be offered when the residents got up. When asked if she ever provided oral care for R12, V5 stated she didn't. V5 stated it was hard to provide care for R12 because he would refuse.

On 12/5/24 at 11:16 AM, when asked about oral care, V18 (RN) stated it was an issue. V18 stated for Christmas she bought rolling carts and was going to have them put their morning care supplies on the cart. V18 stated she had a concern oral care wasn't being provided but it had been identified as an issue and a plan was in place to attempt to improve it.

On 12/5/24 at 11:47 AM, V20 (Family Member) stated he had concerns about the care R12 was provided at the facility. V20 stated he was told by the nurse at the hospital R12's bandages/treatments were not changed after he left the hospital on 11/23/24 and the areas were worse. V20 stated he also had concerns R12 wasn't getting good oral care because every time he would go to the facility his lips were always dry and chapped and R12 was always thirsty.

On 12/5/24 at 12:48 PM, V1 (Administrator) stated she had access to the pictures of R12's mouth that were taken at the local hospital during his emergency room evaluation on 12/01/24. V1 stated she was very disappointed with the way his mouth looked. When asked what her expectations were for oral care, V1 stated, "I mean that it is to be done routinely."

On 12/5/24 at 2:08 PM, V14 (Physician) V14 stated oral care is "pretty darn important." V14 stated the stuff on his tongue could be food or cancer but he wasn't able to tell from the pictures and did not elaborate further on why oral care

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was important.

On 12/18/24 at 3:00 PM, V39 (Physician) stated she provided care to R12 during his hospital stay beginning on 12/01/24. V39 stated R12 had been discharged from the hospital about a week (11/23/24) prior and when he returned to the hospital on 12/01/24, he had more pressure ulcers that had developed while at the facility. V39 stated when R12 was discharged from the hospital on 11/23/24 they had discontinued the Haldol and Clonazepam. V39 stated the facility continued to give R12 those medications. V39 stated those medications caused somnolence which in turn caused R12 to not eat and/or drink the way he should have. V39 stated this caused R12 to end up back in the hospital with dehydration. V39 stated R12 wasn't turned and repositioned while at the facility which led to R12 developing more pressure ulcers. V39 stated R12 was not provided oral care for probably 5-6 days leading to R12's tongue having the crusty build up on it that is evidenced in the photos that were taken at the hospital. V39 stated she considered these failures by the facility to be neglect.

According to the National Library of Medicine found at A preventive care approach for oral health in nursing homes: a qualitative study of healthcare workers' experiences - PMC "
...Studies have reported that poor oral health affects older adults' wellbeing and is associated with issues pertaining to pain and problems with eating, swallowing and social interactions [3]. Impaired oral health can also have a negative impact on general health conditions such as cardiovascular disease and diabetes, and it can lead to malnutrition and aspiration pneumonia ...."

The facility Decubitus Care/Pressure Areas policy

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dated 9/2024 documents, "The facility Decubitus Care/Pressure Areas policy dated September 2024 documents, "Policy: To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified. Procedure: Upon identification of skin breakdown, the following will be completed; 1) The pressure area will be assessed and documented. 2) Complete all areas of a wound assessment following NPUAP (National Pressure Ulcer Advisory Panel) guidelines i) Document size, stage, site, depth, drainage, color, odor, and treatment (once obtained from the physician) ....3. Notify the physician for treatment orders ....4. Documentation of the pressure area must occur upon identification and at least once each week ....8) Initiate problem area on care plan."

The facility Change in a Resident's Condition or Status policy dated 2021 documents, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) ...."

The facility Adverse Consequences and Medication Errors policy dated 2023 includes, " ...5. A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medications errors include: a. Omission ...b. Unauthorized drug-a drug is administered without a physician's order ..."

The facility Administering Medications policy

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S9999	Continued From page 21 dated January 2024 documents, "Medications shall be administered in a safe and timely manner, and as prescribed ....3. Medications must be administered in accordance with the orders, including any required time frame ..." The facility Abuse Prevention Policy dated 2022 documents, "residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Purpose: ...The facility prohibits abuse, neglect, misappropriation of property, and exploitation of its residents, including verbal, mental, sexual or physical abuse; corporal punishment; and involuntary seclusion. The facility has a "no tolerance" philosophy; persons found to have engaged in such conduct will be terminated ....Neglect is a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident ...Neglect is also the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. (A)	S9999		