| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000496 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/15/2025 |
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| S0000 | Initial Comments<br><br>Complaint Investigation:<br><br>2544059/IL191863 | S0000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br><br>300.1210b)<br><br>300.1210c)<br><br>300.1210d)3)<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 300.1210 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 | S9999 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>These Regulations are not met as evidenced by:<br><br>Based on interview, observation, and record review the facility failed to monitor a resident's enteral nutrition needs, monitor a resident's weight, identify severe weight loss of a resident, provide needed interventions to prevent further weight loss, and re-assess a resident's nutritional needs when the resident was not tolerating enteral nutrition for 1 (R11) of 3 residents reviewed for enteral nutrition. This failure resulted in R6 experiencing a 11.98% weight loss in 6 weeks of being admitted to the facility.<br><br>Findings Include:<br><br>R11's clinical census sheet, print date of 5/13/25, documented R11 was admitted to the facility on 4/2/25.<br><br>R11's medical diagnosis form, print date of 5/12/25, documented R11 has diagnoses including laceration of esophagus, history of anaphylaxis, gastrostomy status, hypertension, depression, anxiety, and anemia.<br><br>R11's MDS (Minimum Data Set), dated 4/9/25, documented R11 is cognitively intact and dependent on staff for all ADLS (activities of daily living). | S9999 | | |

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| S9999 | Continued from page 2<br><br>R11's weights and vitals document, print date of 5/12/25, documented R11 was weighed 2 times between admission date of 4/2/25 through 5/8/25. R11's documented weights are 206.9 pounds on 4/2/25 and the next recorded weight is 182.1 pounds on 5/8/25.<br><br>R11's gastroenterology progress note, dated 3/12/25, documented R11 presented to local hospital with concerns for angioedema (anaphylactic reaction) thought to be related to shellfish and found to have pneumothorax. Patient was intubated in the ED (Emergency Department) after multiple failed attempts in the field, ICU (Intensive Care Unit) concerned for possible traumatic esophageal perforation. CT (computed tomography) scan reveals diffuse accumulation of contrast in the right chest cavity believed to be caused from mid esophageal perforation. Underwent EGD (esophagogastroduodenoscopy) on 3/3/25 which confirmed diagnosis. Then underwent thoracotomy with decertification, repair of esophagus, and intersection of PEG (percutaneous endoscopic) tube on 3/11/25.<br><br>R11's progress note, dated 4/2/25 at 1:40 PM, documented (local hospital) nurse called with report. Resident is an 80-year-old female. Resident had an allergic reaction to shrimp. It continues, IV (intravenous) ABT (antibiotic) for pneumonia. Resident is alert and oriented x4. NPO (nothing by mouth) G-tube with tube feeding 5x/times day.<br><br>R11's provider progress note, dated 4/4/25, documented dietician to eval and treat free water flushes and tube feeds.<br><br>R11's progress note, dated 4/5/25 at 12:44 PM, documented resident nauseated and declined feeding at this time.<br><br>R11's progress note, dated 4/5/25 at 6:54 PM, documented enteral feed order, resident refused due to being nauseated and dizzy.<br><br>R11's progress note, dated 4/6/25 at 5:46 AM, documented resident expressed clear refusal to receive morning G-tube medications, stating "I don't want anything through my tube right now." Reported feeling | S9999 | | |

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| S9999 | Continued from page 3<br>"extremely dizzy and nauseated since yesterday." No emesis or pain reported. Resident requested transfer via ambulance to local ER (Emergency Room) for further evaluation. Resident insisted on the need for a higher level of medical care. Notified POA (Power of Attorney) and charge nurse. EMS (emergency medical services) initiated, transported via gurney to local hospital at 0430 per wishes.<br><br>R11's local emergency room progress notes, dated 4/6/25, documented reason for visit: vomiting, diagnoses: low sodium levels, dizziness, nausea and vomiting, medications given Antivert (for vertigo), Zofran (for nausea), and sodium chloride 0.9% (for low sodium).<br><br>R11's progress note, dated 4/8/25 at 1:33 PM, documented resident complained to writer she is having loose stools after every tube feeding. Writer sent an email to the dietician to evaluate resident's tube feeding.<br><br>R11's dietician recommendation, dated 4/8/25, documented recommend (enteral nutrition supplement) at 35 ml/hour continuous with water flushes every 4 hours to provide adequate nutrition.<br><br>R11's progress note, dated 4/8/25 at 7:11 PM documented resident refused tube feeding due to having constant diarrhea.<br><br>R11's progress note, dated 4/10/25 at 11:20 AM, documented resident refuses to have feeding through pump and would like to have feedings administered via bolus as previously ordered, will notify dietician as well.<br><br>R11's progress note, dated 4/10/25 at 8:51 PM, documented resident states she "doesn't want the feeding and would like to talk about other options."<br><br>R11's progress note, dated 4/12/25 at 4:27 PM, authored by V25, R11's physician, documented patient states that she cannot tolerate tube feeding and frequently refuses continuous tube feedings she prefers boluses not only allows small amount of bolus. It continues, patient is NPO (nothing by mouth) and is getting tube feeding | S9999 | | |

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| S9999 | Continued from page 4<br>through G-tube not able to tolerate G-tube feeding well. Will ask dietician to see patient continue with fiber to prevent diarrhea, advised patient to do tube feeding as much as possible.<br><br>R11's progress note, dated 4/12/25 at 8:29 PM, documented resident refused tube feeding.<br><br>R11's progress note, dated 4/12/25 at 9:16 PM, documented resident refused her feeding this shift, stated it gives her diarrhea. Doctor (V25) aware.<br><br>R11's physician progress note, dated 4/15/25 at 2:28 PM, documented patient is NPO (nothing by mouth) and is getting tube feeding through G-tube not able to tolerate G-tube feeding well. Will ask dietician to see patient, continue with fiber to prevent diarrhea, advised patient to do tube feeding as much as possible. C-diff (clostridium difficile) negative.<br><br>R11's progress note, dated 4/16/25 at 10:09 AM, documented continues tube feeding at 35ml/hour, requests bolus feedings.<br><br>R11's progress note, dated 4/17/25 at 2:27 PM, documented nurse practitioner in facility to visit resident. Dietician to eval for possible different tube feeding as this once causes her significant diarrhea.<br><br>R11's provider progress note, dated 4/17/25, documented dietician to eval for possible different tube feeding as this one causes her significant diarrhea.<br><br>R11's progress note, dated 4/17/25 at 9:28 PM, documented resident refused tube feeding this shift. Resident educated on the importance of her ordered feedings as well as the impact not receiving these feeding can have on her overall health. Resident is aware and acknowledges understanding. MD (Medical Doctor) and NP (Nurse Practitioner) are aware of this as well. Plan of care continues.<br><br>R11's progress note, dated 4/18/24 at 10:42 PM, documented resident's feeding refused this shift. Resident expressed concerns to writer regarding her feeding order. Resident is currently NPO and has an | S9999 | | |

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| S9999 | Continued from page 5<br>order for (enteral nutrition) via g-tube however she has expressed to MD and NP (Nurse Practitioner) that the (enteral nutrition brand) gives her diarrhea and she would like order changed to a new type of feeding. As of now dietitian has been contacted and resident is awaiting word from dietitian about this matter. She states to writer that this has gone on for too long and she feels that her concerns are not being taken seriously by her MD at this time. She is asking to be seen by a new doctor. Writer explained that she will make managers aware of this.<br><br>R11's progress note, dated 4/19/25 at 4:56 AM, documented resident continued to have an order for continuous tube feeding at 35ml/hour 24 hours a day. It continues, resident chose to take 60ml of (nutritional supplement) at this time, she stated that the (nutritional supplement) gives her severe diarrhea and wants to ease into talking the (enteral nutrition brand) feeding supplement.<br><br>R11's progress note, dated 4/22/25 at 4:56 PM, documented received email from dietician regarding feeds. Continue (enteral nutrition brand), however, instead of being ran at 35 ml/hr she is requesting 45 ml/hr. Nursing staff as well as resident made aware; all agreeable to plan.<br><br>R11's progress notes by V24, Registered Dietitian, dated 4/23/25 at 12:33 PM, documented current weight 206.9, diet: NPO, (enteral nutrition brand) at 45ml/hr x 24 hours. It continues, resident admitted 4/2/25, NPO with TF's (tube feeding) for nutritional support. TF's meeting low end of calorie needs. Unable to assess weight history as resident was recently admitted. Resident previously on (enteral nutrition supplement) however not tolerating it. Staff states resident tolerates (enteral nutrition brand). No pressure injuries, skin is intact. Plan: Recommend continuing current TF regimen. Will continue to monitor TF tolerance and weight changes. RD is available for consult PRN (as needed).<br><br>R11's physician progress note authored by V26, thoracic surgeon, dated 4/24/25, documented patient may now start a full liquid diet. All further diet recommendations will come from (local) GI (gastrointestinal) clinic. | S9999 | | |

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| S9999 | Continued from page 6<br>R11's physician progress note authored by V25, dated 4/26/25 at 3:55 PM, documented based on last esophagogram there was not leak, started on CLD (clear liquid diet), does not do tube feeding any more, continue protein supplement and monitor weight.<br><br>R11's provider progress note, dated 4/30/25, documented dietician eval as patient on liquid diet until 5/20/25.<br><br>On 5/12/25 at 9:27 AM R11 stated she is no longer receiving nutrition through her g-tube and she is now on clear liquids with a protein supplement. R11 stated when she was first admitted she could not tolerate the feeding and feels the lactose was upsetting her stomach resulting in her to experience nausea and diarrhea. R11 stated she has lost over 30 pounds since she was admitted to the facility.<br><br>On 5/12/25 at 9:38 AM V7 LPN stated R11 is receiving her medications and a protein supplement through her g-tube. V7 stated R11 started refusing her g-tube feeding because it caused her to have diarrhea, so the doctor put her on clear liquids and the protein supplement until she follows up with her surgeon.<br><br>On 5/12/25 at 2:42 PM V7 LPN stated R11 could not tolerate the supplement, so the NP was notified and discontinued the supplement on 5/6/25 and started her on a protein supplement twice a day. V7 presented the protein supplement to surveyor and stated R11 gets 30ml of this twice a day. The supplement bottle documented 1 - 30ml dose of the protein supplement consists of 100 calories, 15 grams of protein, and 0 fat.<br><br>On 5/12/25 at 2:46 PM V23 Unit Manager stated it is the facility policy to weigh residents every week for the first 4 weeks of admission, (R11) did get missed, we have no weights for her between 4/2/25 to 5/8/25. V23 then stated there is no documentation that the RD was notified of R11's weight loss nor was RD notified of (brand name) supplement being dcd.<br><br>On 5/12/25 at 2:52 PM V24, Registered Dietitian, stated there was a miscommunication with the facility staff and her, that the facility was messaging her through a system that she does not have access to, and the facility nurses did not realize she was not receiving the messages. V24 stated she was not aware R11's (brand | S9999 | | |

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| S9999 | Continued from page 7<br>name) supplement was discontinued, was not notified of R11's 24.8-pound weight loss since admission to the facility until 5/8/25 and was not aware nor notified R11 had been placed on a liquid diet. V24 stated she recommended V24 be started on a fortified juice on 5/8/25 after she learned of her weight loss. V24 then stated, "I also recommended they increase the (liquid protein supplement) from BID (twice a day) to TID (three times a day) on 5/9/25, and I see they have not increased it yet."<br><br>On 5/13/25 at 9:55 AM R11 stated no facility staff including the Registered Dietitian have talked with her about her diet, that all she is receiving is a bowl of broth three times a day at meals. R11 stated she went over a month here at the facility without being weighed, she asked them to weigh her recently, and the has lost about 30 pounds. R11 stated she has not received any speech therapy since she was admitted to the facility.<br><br>On 5/13/25 at 10:18 AM V25, R11's Medical Doctor, stated R11 had a perforated esophagus, it was repaired then developed a leak, she developed more complications including pneumonia, then inserted g-tube, she was receiving bolus feedings 6 times a day in the beginning of her stay. R11 refused the tube feeding because she said it was causing her to have diarrhea. Stated he personally had conversations with her regarding her weight and need for tube feeding, she was then put on clear liquid diet. Stated he was notified of her weight loss and made referrals to RD.<br><br>On 5/13/25 at 2:55 PM V3, Regional Nurse, provided an email, dated 4/24/25 at 1:52 PM documenting the facility RD, V24, was notified of R11's new order to change her diet from NPO to clear liquid. V24 replied "Thanks for the update" on 4/24/25 at 2:07 PM. V3 stated the facility does not have any documentation from the RD, V24, regarding R11's diet change to clear liquid from enteral nutrition on 4/24/25 and she would have expected V24 to complete a new nutritional assessment. V3 stated the facility does not have any weekly weights documented for R11 between her documented weight of 206.9 on 4/2/25 and the next documented weight of 182.1 on 5/8/25. V3 stated R11 should have been weighed every week and V24 RD should have been monitoring R11's nutritional status. Surveyor requested a nutritional calculation of R11's daily caloric and protein needs and V3 stated the facility does not have anything documented. | S9999 | | |

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| S9999 | Continued from page 8<br><br>On 5/14/25 at 10:55 AM V3, Regional Nurse, stated the facility does not have any Registered Dietitian documentation for R11's daily nutritional needs other than the 3 dietitian recommendation notes dated 4/7/25, 4/8/25, and 4/22/25. V3 agreed that these 3 documents do not calculate R11's calorie, protein, and nutrient needs based on R11's current health condition. V3 stated the facility does not have any documentation showing the facility RD V24 received and responded to V25's referrals to RD on R11.<br><br>On 5/14/25 at 12:02 PM V3, Regional Nurse, stated V26, R11's thoracic surgeon, is who ordered R11's clear liquid diet and she has a call out to his office for those progress notes. V3 stated she has no documentation showing the facility RD was notified and intervened of R11's ongoing enteral nutrition intolerance, weight loss, nor of R11 being placed on a liquid diet. V3 then provided surveyor with the progress note by V26 from R11's consultation with him on 4/24/25 and surveyor noted the order documented full liquid diet not clear liquid diet as the facility documented on R11's EMR physician orders. V26 also documented all further diet recommendations will come from (local) GI clinic.<br><br>On 5/14/25 at 1:42 PM V3, Regional Nurse, agreed V26's order documented liquid diet on 4/24/25 and that the facility put R11 on a clear liquid diet rather than a full liquid. V3 stated there is a difference between those two diets and the facility will call for verification. Surveyor asked if V26 or R11's GI specialists were notified of R11 starting back on the continuous tube feeding yesterday, 5/13/25, and V3 stated there is no documentation noting this but R11's primary physician is aware of R11 being back on the continuous tube feeding.<br><br>On 5/14/25 at 2:05 PM V7 LPN stated R11 was started back on her continuous tube feeding yesterday. Surveyor asked what physician gave the order and V7 replied "you will have to ask the unit manager, V23, because she got the order."<br><br>On 5/14/25 at 2:07 PM V23, Unit Manager, stated she received the order from the facility's RD, V24, yesterday for R11 to start the continuous tube feeding again. Surveyor asked if R11's primary physician, | S9999 | | |

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| S9999 | Continued from page 9<br>surgeon, or GI specialist approved that order and V23 stated she has no documentation showing they were notified or approved of the order.<br><br>On 5/14/25 at 2:10 PM R11 stated she was started back on the continuous tube feeding yesterday, she does not know if a doctor approved it, the nurse just came in and said I was starting back on it. R11 stated the only issue she has had since it was restarted was one loose stool this morning, but the tube feeding has been shut off since 8 AM and not restarted. Surveyor observed the bottle of (enteral nutrition brand) hanging in R11's room, the bottle was labeled as being started on 5/13/25 at 12:30 PM, rate of 35ml/hr, observed 600ml remaining in bottle, not connected, and not running. Surveyor asked R11 if V26 (R11's thoracic surgeon) ordered a clear liquid diet or a liquid diet when she saw him on 4/24/25 and R11 replied "I assumed it was clear liquid."<br><br>On 5/14/25 at 2:17 PM V24, Registered Dietitian, stated she recommended R11 be started back on her continuous tube feeding yesterday, 5/13/25. Surveyor asked if she was aware R11's thoracic surgeon recommended R11 be on a liquid diet when she saw him on 4/24/25 and that all further dietary recommendations needed to come from (local) GI (gastrointestinal) specialist and V24 replied she was not aware of that and does not know if a physician approved for R11 to go back on full enteral nutrition. Surveyor then asked V24 if there is a difference between a full liquid diet (as noted by V26) and a clear liquid diet. V24 replied yes, and that a liquid diet would provide more nutrients and calories than a clear liquid diet. Surveyor asked if V24 was aware V26 ordered a liquid diet for R11 and not a clear liquid diet on 4/24/25 and V24 replied she was not aware.<br><br>The facility's Significant Weight Gain or Loss Policy, dated 2/2024, documented Purpose: to ensure that insidious/significant weight gain or loss will be identified so that nutritional needs can be evaluated, and appropriate intervention provided. Guidelines: 1. Dietary/Nursing team will obtain weights from nursing, 2. Dietician/Nursing will determine significant weight changes: a. Gain or loss of 5% in the last month, b. Gain or loss of 7.5% in the last three months, c. Gain or loss of 10% in the last six months. 3. Dietician will review these clients and document the change. 4. If recommendations are indicated will be communicated to nursing to notify the provider of the significant | S9999 | | |

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| S9999 | Continued from page 10<br>weight changes and recommendation.<br><br>The facility's Dietitian Referrals and Recommendations policy, dated 2/2024, documented Purpose: To ensure high risk resident's nutritional needs/goals are met or maintained within acceptable parameter for resident. Responsibility: Dietitian/Licensed Nursing/Dietary Manager. Guidelines: Director of Nursing or designee will determine high risk residents and send referral to Dietitian. Dietitian will complete referrals in a timely manner. Dietitian will complete a nutritional assessment and document in the resident's EMR. Dietitian recommendations will be communicated to the medical provider on a timely basis to provide appropriate intervention if necessary. It continues, Dietitian will complete nutritional assessments on residents according to annual MDS or significant changes. Dietitian will complete assessment on all referrals and document in resident's EMR. High risk criteria examples but not limited to unintentional weight loss of more than 5% in one month, more than 7.5% in three months, and more than 10% in six months, and enteral feeding dependent residents.<br><br>(B) | S9999 | | |