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S9999	Final Observations Statement of Licensure Violations: 1 of 3 Findings 300.610a) 300.1210b)2) 300.1210d)3) 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 300.1210 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. Restorative measures shall include, at a minimum, the following procedures:	S9999	Attachment A Statement of Licensure Violations	

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2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements are not met as evidenced by:

Based on interview, observation and record review, the facility failed to prevent a decline in range of motion (ROM) by providing adequate

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services including Passive Range of Motion and splints for one of 4 residents (R5) reviewed for range of motion services in a sample of 34. This failure resulted in R5 developing a contracture left hand and declining range of motion bilateral lower extremities.

Findings include:

1. The Minimum Data Set (MDS) dated 7/4/18 documents R5 to have severe cognitive impairment with a Brief Interview of Mental Status score of 4. The MDS documents R5 to have range of motion limitations bilaterally upper and lower extremities and receives Passive Range of Motion 6 days a week.

On 9/26/18 at 11:10am, R5 was sitting in her reclining wheelchair. Both knees were contracted and laid over the side of a platform on the bottom of the wheelchair. R5's left hand appeared to have some limitations also.

On 9/27/18 at 11:11am, V18, R5's daughter, said the stiffness had just started using a sling which she picked up off a chest of drawers next to the bed. V18 stated she hadn't noticed her Mom's decline in her left hand until the CNA (certified nurse aide) told her. V18 identified the CNA as V12 who notice the decline and it was mentioned to therapy who asked if she minded if they tried the sling. V18 stated her mothers fingers had started to curl in and she also has contractures of both legs which she thought had gotten worse also. She doesn't think they do any exercises with her adding none that she's aware of or that they've talked about. V18 stated the newly developed hand contractures inhibit her mothers ability to feed herself and get her own drinks. V18 stated R5 can feed herself finger foods and drink

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from glasses if they are small enough to fit in her hand and have a straw.

The Progress Notes written by V12 CNA on 9/19/18 at 11:39am documents "Splint was placed after PROM was done. Wanted off after breakfast so splint was removed."

The Care Plan 7/4/18 documents under Focus "PROM: Dorothy is at risk for decline in functional mobility/ has contractures noted to BUE/BLE." The goal documents R5 "will maintain current level in range of motion without further decline through next review." Interventions include: Explain each procedure, Maintain good body alignment and assess skin, Provide Passive Range of Motion exercises 5-10 repetitions to BUE/BLE during AM/PM care, Perform repetitions in a slow and smooth motion, Stop range at point of pain or resistance, Inform resident when procedure is complete and Notify nurse of signs and symptoms of pain during activity. [CNA,RNA,NURS]. This care plan does not include any information regarding splint use.

An occupational evaluation dated 7/10/18 documents the reason for referral as "The pt (patient) has mild stiffness in the lt (left) digits and the contractures of the LE (lower extremities) have increased. It is difficult to place pt in the w/c (wheelchair) due to contractures. The pt will benefit from skilled OT program to establish exercises to decrease contractures." The Initial assessment also documents R5 to have pain with movement scoring an 8/10 with 10 being the worse documenting "pain limits the following functional activities: proper positioning in w/c, difficulty in repositioning in bed and in w.c identifying "remaining still" as "what relieves pain." Under Long Term Goals, it documents "The

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pt will demonstrate ability to wear the lt resting splint in functional position for 2 hours w.o (without) s/s (signs/symptoms) of discomfort to prevent contractures in the left hand from getting worse."

On 10/2/18 at 11:15am, V32 Certified Occupational Therapy Assistant (COTA) stated R5 did show decline in range of motion for her legs bilaterally and a newly developed contracture in her left hand which they ordered a splint for. V32 stated R5 does refuse the splint at times and will refuse range of motion. V32 stated R5 will wear the splint some days for only 15min and at times, 1-2 hours. V32 stated it is the CNA's responsibility to do the ROM currently because she is no longer getting skilled therapy. V32 couldn't say why R5 developed contractures of her hand and decline in her legs if the ROM services were provided appropriately.

On 10/2/18 at 10:30am, V12 Restorative Certified Nurse Aide (CNA) confirmed that she was the restorative aide and does all the ROM in the building on a daily basis. However, V12 stated she would not be doing ROM today since she'd been scheduled to do the monthly weights instead. V12 was unable to provide any progress notes written that gives information such as R5's compliance or lack of with the PROM's but did provide daily documentation that PROM were done 15 minutes daily. V12 stated R5 does remove her own splint at times making it difficult to meet the time frames suggested by OT.

On 10/3/18 at 10am, V12 Restorative Certified Nurses Aides (CNA) was asked to do PROM's on R5 and couldn't recall whether R5 got ROM on all four extremities but thought she just got them on her lower with the splint on her one wrist/hand.

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S9999	Continued From page 5 On 10/3/18 at 1:21pm, V12 entered R5's room and explained that she was going to do her exercises. R5 was laying in bed, her legs were bent with knees laying to the left. V12 did 5 repetitions on the joints she ranged. V12 failed to do flexion/extension, abduction/adduction, and opposition of her thumb, failed to do flexion/extension of her finger joints, failed to do internal/external rotation and hyperextension of the hip joints, abduction/adduction of the toe joints (did range of motion while R5's socks were on,) failed to do supination/pronation of the elbow joint, and internal/external rotation and hyperextension of the shoulder joint. V12 stated R5 had her splints on from 6:05am until right before lunch around 11:10am or so. R5 resisted a little during some of the exercises which caused V12 to move to the next joint. A care plan dated 10/19/17 documents R5's risk for debility and limited range of motion to Bilateral Lower Extremities but fails to address her upper extremities. The care plan documents R5 was to receive PROM's am and pm 5 repetitions per joint. A revised care plan was provided on 10/3/18 which identifies R5's focus area as "requires the use of splint to left hand rt contractures and immobility but fails to address her refusal or ability/history of removing the splint at times. The revised focus area for PROM's also failed to identify her refusals for ROM to be done fully and on all joints. The facility failed to develop a effective functional plan that address R5's needs in an effort to ensure that ROM services are provided to prevent further contractures and limitations.	S9999		

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S9999	Continued From page 6 The facility's policy/procedure entitled "Resident Mobility and Range of Motion" dated 7/2017 documents the "resident with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM." The policy interpretation and implementation documents "During the resident's assessment, the facility will attempt to identify any underlying factors that contribute to his or her range of motion or mobility problems." The policy also documents "Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs." (B) 300.610a) 300.1210b)4) 300.1210d)3) 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.	S9999		

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S9999	Continued From page 7 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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	S9999		

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S9999	Continued From page 8 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on interview, observation and record review, the facility failed to develop an appropriate resident focused plan to prevent further weight loss and failed to provide adequate supervision and assistance to prevent weight loss for 3 of 6 residents (R4,R5,R44) reviewed for weight loss in a sample of 34. Findings include: 1. The Minimum Data Set (MDS) dated 7/6/18 documents R5 to have severe cognitive impairment with a Brief Interview of Mental Status score of 4. The MDS dated 7/6/18 documents a decline in eating from set up with minimal assist of one on 10/23/17 to extensive assist of one staff currently. On 9/26/19, R5 was propelled to the dining room table at 11:30am. R5 remained in her reclining wheelchair at a 45 degree angle back as she sat at the table awaiting her meal. R5 was served at 12:20pm. No set up assistance was provided	S9999		

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S9999	Continued From page 9 when the tray was delivered by V5. R5 was served one cup of coffee, no straws R5 was served spaghetti/meatballs, bread, a bowl of cut up peaches, and broccoli stems. R5's tray also had a carton of chocolate health shake. R5 remained in a reclining position when V5 CNA sat R5 up to approximately 30 degree. V5 then sat down to assist her to eat. R5 lifting her head to take sips. R5 was given a cup of coffee but no water with her meal. There was no conversation between V5 and R5 as V5 slowly gave R5 bites of food. At 12:35pm, V5 got up from feeding R5 and went to the other side of the table to assist her tablemate. At 12:38pm, V5 again got up and walked to the kitchen. At 12:50pm, V5 gave R5 a bite of peaches and at 12:56pm, V5 got up and left R5's table. R5 had only eaten bites of spaghetti, no bread, 50% of her broccoli and only sips of her chocolate health shake. No further assistance was given R5 before taking her back to her room nor were any substitutions offered for foods uneaten prior to her leaving the table. Tables were observed being cleared without meal intake recorded. R5 was not offered/encouraged any substitutes for foods uneaten before removing her from the table. On 9/27/18 at 11:40am, R5 was assisted with her lunch meal by V18, daughter. R5's plate had plate guard on it which was not on it the day before. R5 was served tea and a health shake which she drank well with a straw independently. R5 was handed a buttered piece of bread which she fed herself with no problems. R5 ate approximately 50% of her total meal. The monthly weight records documents a gradual weight loss for R5 whose weight was recorded as 112.8 pounds 2/2/18 and on 9/10/2018, it was recorded as 102.5 Lbs.	S9999		

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On 9/27/2018 at 2:03pm, the Nurses Notes document "Dietary recommendation received to add super cereal to breakfast tray. POA and Dietary notified", after a discussion regarding R5's difficulty in eating.

On 9/25/2018 11:14 Dietary Note documents "Weight progress note: resident has been noted to eat bites of her food and dietary manager is concerned that family bringing in candy and other snack foods is causing her to get too full for meals. CBW 102.5#, down 4.3# x 3 weeks. Weight normally runs in upper 110s. BMI 20.7-lower than optimum for age. Staff reports that resident gets a health shake at meals. Physician order sheet reports 30 mL Prostat bid which provides an additional 30 g protein. RD went to resident's room to help offer some suggestions to resident but she was asleep and did not stir when name was called. RD will suggest adding super cereal at breakfast. RD will monitor for additional weight changes."

The Dietary Slip provided by V7, Dietary Manager on 10/2/18, documents R5 receives as General Mechanical Soft diet with adaptive equipment (plate guard) and for lunch is to receive a house shake 4 ounces, plate guard and "may offer finger foods." Drink of choice is identified as "tea." On 09/27/18 at 11:08 AM, V18, R5's daughter, stated she comes almost daily to visit and was here last night to feed her. V18 stated her mom is able to feed herself if she is positioned properly and given some finger foods. V18 also said R5 needs straws in her fluids. V18 stated R5 has lost weight this past month so she tries to come feed her when she can as she thinks staff don't take enough time with her during meals.
The facility failed to identify R5's gradual weight

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loss over the past 7 months and failed to develop a plan based on her needs and ability to feed herself to prevent further weight loss. The current care plan fails to reflect the weight loss, her need for finger foods and straws. Nor does the care plan identify the need to properly position R5 at the table to maximize her ability to feed herself or for staff to take time for R5 to eat.
The facility provides the health shake but fails to document it's consumption amount.
Meal Intake records provided on 10/2/18 fails to document intake for all three meals daily. For example, R5 has only one meal documented on 9/8/18 at 17:15 (5:15pm), two meals documented on 9/10/18, one at 10:23am and the other at 17:15 (5:15pm.) Incomplete intake records also occurred on 9/12, 9/13, 9/15, 9/16, 9/20, 9/22, 9/24-9/28 (no documentation for 9/25, 9/26 at all), and only included one meal documented on 9/27/18. Of the days documented, R5 consumed 0-25% for 13 of 60 days and 25-50% for 27 of those days.
There is no evidence the dietician fully assessed R5's needs and addressed them.
The current care plan dated 7/6/18 fails to document R5's current needs including her need for finger foods, straws and being fed. The current care plan documents as a focus R5 "takes her meals in the dining room. Is assisted with meals, with set up and supervision. She is on a Mech (mechanical) Soft Diet. Appetite poor-fair, eats 25-50% of most meals. Family chooses meals from a selective menu for her." The goal is documented as "Alb. (albumin) level will be WNL (within normal limits)," R5 "will eat 50% or more of meals" and "Wt. (weight) will remain within 2# (pounds) of present wt (weight.)" Interventions include "Assist with tray set up and encourage her to eat 50% or more of meals. Assist with feeding as needed. Offer alternates for foods

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uneaten. Allow ample time for her to eat each meal. Record % eaten at meals.[CNA (certified Nurses aide,)ALL,DIET,NURS, Plate guard at meal time[DIET,NURS], Provide with Regular diet per orders. Honor food pref (preferences) and dislikes. Offer selective menu to family to assist in choosing her meals.[DIET] , Refer to RD for possible dietary supplement.[FSS (Food service supervisor),Diet], Weigh monthly and per facility protocol. If wt. loss is determined, weigh weekly and re evaluate. Notify Dr. and responsible party of any sign of wt. changes. Record wt. in chart." There is no evidence the facilty fully assessed R5 current needs which included her decline in eating ability, need to be fed, have straws/finger foods, and the need for proper positioning and developed a plan to meet these needs in an effort to prevent further weight loss.

2. The MDS dated 8/28/18 documents R44 to be cognitively intact with a BIMS score of 14. The MDS documents she requires set up and supervision to eat.

The Physician Order Sheet (POS) for October 2018 documents R44's date of birth as 5/12/49 with diagnoses of dysphagia in part.

On 9/26/18 at 11:27am, R44 exited her room with her wheeled walker to go to Dining room for lunch.. R44 sat at the table waiting to be served until 11:50am when she was served chicken rice (single portion), bread, broccoli stems and a health shake. The broccoli was pale and overcooked. R44 was independent in eating and had no staff approach after her meal was delivered. At 12:45pm, R44 left the dining room with no staff intervention. R44 had eaten only a few bites of her meal. R44 had given her health

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	IL6009534	A. BUILDING: _____ B. WING _____	10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF WOOD RIVER	393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095

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shake to her table mate who drank it. There were no offers of substitutions for food uneaten.

On 9/27/18 at 11:45am, R44 received her noon meal which was salisbury steak, carrots and potatoes and gravy. R44 ate only bites of her meal. R44 gave her health shake away to her tablemate who drank it and handed back the carton. R44 had a cup of coffee.

On 09/27/18 at 2:26 PM, V 16 LPN stated R44 does not eat at times and sometimes she does.

A telephone order dated 9/27/18 documents R44's house shake as discontinued.

The POS for October 2018 documents R44 receives a regular diet, high cal snacks every 4 hours while awake and Remeron 7.5mg at HS added 8/7/18 and Remeron as an appetite stimulant.

The last Registered Dietician note dated 8/7/18 documents R44's weight loss could be due to depression, refuses snacks offered, going to try Remeron, maybe adjusting Zoloft, RD suggests weekly weight times one month but there is no evidence the facility further identified/assessed and monitored R44's weight loss.

The monthly weight logs document a gradual weight loss for R44 from 12/6/17 at 122.8 pounds to 111.5 pounds on 9/10/2018.
R44's care plan dated 8/29/18 only documents R44 requires set up and supervision for eating under Activities of daily care and fails to identify R44's gradual weight loss and her increased risk for more weight loss. The care plan also fails to address her giving food away off her plate.

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S9999	Continued From page 14 A telephone order dated 9/27/18 documents R44's health shake was discontinued. POS regular diet, high cal snacks every 4 hours while awake, Remeron 7.5mg at HS added 8/7/18. The diet slip documents R44 is to get tea for lunch and double portions which she received neither on 9/26/18 or 9/27/19. Meal Intake Records for September 2018 document R44 ate 50-75% of her lunch meal on 9/26/18 and 9/27/18 which conflicted with observations made of the actual meal. On 10/3/18 at 9:35am, R44 was standing in the doorway of the dining room with her room mate, R15. The dining room lights were off and a barrier was in front of the door to prevent residents from going onto the wet floor. R44 was asked if she had breakfast and responded "no, I'm waiting for it. " R15 stated "well, we've already had breakfast." There is no evidence the facility developed a plan to prevent further weight loss that included accurate assessment, monitoring and effective interventions. The facility's policy/procedure entitles "Nutrition/unplanned weight loss policy" dated 1/2016 documents under Assessment and Recognition, documents "As part of the initial assessment, the staff and physician will define the individual's current nutritional status and identify individuals who are at risk for impaired nutrition." Under Cause Identification, it documents "The physician will review possible causes of weight loss with the nursing staff and/or Dietician before ordering interventions. a. The Dietician will estimate calorie, nutrition and fluid	S9999		

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needs and, with the physician, will identify whether the resident's current intake is adequate to meet his or her nutritional needs." The policy continues "The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and treatment wishes." Under Monitoring, the policy documents "Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals will be done."

3. On 09/26/18 11:10 AM, R4 was observed seated in a wheelchair in the dining room. At 11:50 AM, R4 told another surveyor "If she didn't get her lunch tray she was going to leave." The surveyor then went to V15, CNA who then told the kitchen staff. At 12:00 PM, R4 still didn't have her tray and propelled herself toward the exit. V15, CNA asked her where she was going and said you haven't eaten yet and took her back to her table. At 12:15 PM, R4 did not have her tray and propelled herself out saying "I'm full." V5, CNA removed her clothing protector and R4 left. R4 appeared lethargic and unable to focus or speak clearly. There was no tray taken to her in her room. There was a glass of water at her table, no health shake was observed. On 09/27/18 at 9:00 AM, R4 was observed propelling herself slowly down the hallway from the dining room. When her plate was observed, R4 had dropped a lot of her food on the floor and had not touched her health shake. R4 had eaten approximately 25% of her meal, and no fluids.

The POS, dated 09/01/18, documented R4 had the following diagnoses, in part as, Dementia, Insomnia, history of Traumatic Brain Injury, right

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side Hemiparesis and recurrent Urinary Tract Infection. It also documented R4 was on a regular general diet.
The MDS, dated 07/02/18, documented R4 had a BIMS of 5 out of 15, moderate cognitively impaired and required extensive assist of one staff for bed mobility, transfers, dressing, toilet use, hygiene and bathing. It also documented R4 required assist of two for ambulation and required supervision during meals.
On 09/11/18 at 1:38 PM, a dietary note documented "Dietary manager weighed resident yesterday (09/10/18) at her Current Body Weight (CBW) and reports that her CBW is in line with her July weight 105.1 lbs., and does not believe the 105.1 lbs. weight to be accurate. Intake continues to vary between 0-50% at meals with few consumed greater than 50%. She is on a regular diet, NAS restriction was d/c per RD request last month. Will ask physician to d/c NAS from order sheet. Continue snacks bid and health shakes tid. RD will continue to monitor for hospice." The weight for R4 on 03/06/18 was 115.8 lbs. and R4's weight for 09/10/18 was 100.1 lbs.

The Care Plan dated, 09/28/18, documented R4's Height 62 in. and Weight 105.3 lbs. R4's Ideal Body Weight Range (IBWR) ranges from 131.0-159.0 BMI of 19.3. R4's appetite is usually poor 25% or less at meals. It documented R4 "required some assistance with feeding self in the main dining area and is able to make likes and dislikes known. No noted difficulty swallowing. No noted difficulty chewing a regular consistency diet. She gets health shakes 3 times a day and snacks 3 times a day to help with weight loss and maintain weight. She was placed on hospice care per change in condition. She uses a divided plate at meals. Assist with tray set up as needed or

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S9999	Continued From page 17 requested. Encourage her to eat a well balance diet and to eat 75% or more of meals. Offer alternates for foods uneaten. Record % eaten at each meal." Also, "Honor food preferences and dislikes. Offer selective menu. Refer to Registered Dietician for weight loss and possible interventions. Weigh monthly and per facility protocol. If significant weight loss is determined, weigh weekly x's 4 weeks and re eval. Notify Dr. and responsible party of any significant weight loss. Record weight in chart." The intake record for September was reviewed and on 09/26/18 documented R4 scored a 3 meaning 51% to 75% was consumed at 12:45 PM. R4 was observed at 12:15 PM to leave the dining room and at 12:45 PM, R4 was observed in her wheelchair propelling down the 500 hall. On 09/27/18, the intake record had nothing marked for the 0745 or 1245 meals. There was a 10% weight loss in one month with no weekly weights or re-evaluation documented. On 09/06/18, 09/16/18 and 09/20/18, there were missing intake numbers for 0745, 1245 or 1715. (B)	S9999		