STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INTEGRITY HC OF ALTON	**3523 WICKENHAUSER ALTON, IL 62002**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide eating assistance and showers for 9 of 14 residents (R2, R10, R20, R26, R31, R32, R39, R41 and R42) reviewed for activities of daily living in the sample of 43. Findings include: 1. On 7/20/20 at 1:25 PM, R20 was sitting in wheelchair in room, plate on bedside table. R20 was playing with her hat. No staff present. R20's care plan dated 3/31/20 documents that R20 has a nutritional problem or potential problem related to needing assistance with eating and weight fluctuation, appetite good with assistance. Interventions documents to assist with eating with hands on assistance, encourage to feed self. 2. On 7/20/20 at 1:50 PM, R2 was feeding self from plate with dividers. There was spillage of food on the floor. No staff present. On 7/20/20 at 2:34 PM, remained up in wheelchair drinking liquids from Styrofoam cup. No staff present. R2's Care Plan, dated 7/ 5/19, documents that R2 has nutritional problem or potential nutritional problem r/t (related to) [DIAGNOSES REDACTED]. He is noted to require adaptive equipment with meals of a deep sided divided plate. He does prefer to use his fingers more than the utensils even when encouraged to use the spoon. R2's Care Plan documents the following interventions: All meals received in a deep sided plate. Assist with tray set up as needed, Verbal cues to start or continue eating. Hands on assist as needed On 7/22/20 and 7/23/20, R39, R41 and R42 were all observed being served their breakfast meal trays in their rooms without staff providing assistance and / or supervision. All three residents require assistance and / or supervision with meals. 3. On 7/22/20 at 8:15 AM, R39 was served her breakfast tray in her room. No staff was present while she ate. R39 finished eating at 8:45 AM. R39 had no staff supervision through her entire meal. On 7/23/20 at 8:05 AM, R39 was served her breakfast tray. No staff supervision was provided. R39 finished eating at 8:25 AM. R39 had no staff supervision through her entire meal. R39's [DIAGNOSES REDACTED]. R39's Care Plan dated 7/9/20 documents R39 has a self care deficit in feeding related to [MEDICAL CONDITION]. Interventions include: Providing verbal cues, ensure and encourage to chew thoroughly. R39's Minimum Data Set ((MDS) dated [DATE] documents R39 requires an extensive assist of one staff with eating. R39's Diet Order dated 7/2020 documents double portions, low concentrated sweets, pureed consistency and nectar thick liquids. R39's Diet Card for 7/22/20 and 7/23/20 documents R39 requires one on one supervision with meals. 4. On 7/22/20 at 8:10 AM, R41 was served her breakfast tray. No staff supervision was provided. At 8:40 AM, R41 had finished her breakfast. R41 had no staff supervision through her meal. On 7/23/20 at 8:05 AM, R41 was served her breakfast tray. No staff supervision was provided. At 8:30 AM, R41 had finished her breakfast. R41 had no staff supervision through her meal. R41's Care Plan dated 3/12/20 documents R41 has a nutritional problem related to her medical [DIAGNOSES REDACTED]. R41's MDS dated [DATE] documents R41 requires supervision with a assist of one staff for eating. R41's Diet Order documents regular consistency and no added salt. 5. On 7/20/20 at 1:32 PM, R42 was feeding himself from a divided deep plate with pureed food on a bedside table across the bed. No staff were present. On 7/22/20 at 8:25 AM, R42 was served his breakfast tray. No staff supervision was provided. At 8:55 AM, R42 had finished his breakfast. R42 had no staff supervision through his meal. On 7/23/20 at 8:20 AM, R42 was served his breakfast tray. R42 was sleeping so it was set on the bedside table. R42 was not awoken by staff and the bedside table was not within reach. At 9:00 AM, the breakfast tray was gone, R42 was sleeping. R42's Care Plan, dated 5/7/18, documents nutritional problem related to poor to fair appetite [MEDICAL CONDITION](stroke), under hospice care. Interventions include document all meals, provide deep sided plate, assist with tray set up and eating. Monitor document report any signs of dysphagia, pocketing,choking or drooling, [DIAGNOSES REDACTED]. R42's MDS dated [DATE] documents R42 requires supervision with eating. R42's Diet Order documents pureed consistency, nectar thick liquids, divided plate and double portions. On 7/22/20 at 8:05 AM, V24, Dietary Aide, stated if a resident requires assistance or supervision, it will be printed on their diet card and the nursing staff will assist them. Dietary sets the food tray in the resident's room and staff know to assist or feed them. The dietary department does not hold the trays for those that need supervision / assistance. On 7/24/20 at 9:00 AM, V2, Regional Registered Nurse (RN), stated she would expect nursing staff to assist / supervise residents with meals that require it. The facility policy and procedure titled Assistance with Meals dated July 2017, documents facility staff will serve resident trays and will help residents who require assistance with eating in a manner that meets the individual needs of each resident. The Facility Resident Council Minutes dated 3/19/20 document complaints of no showers for one week. 6. On 7/21/20 at 10:50 AM, R10 stated that he is supposed to get two showers per week but is lucky if he gets one a week. R10's MDS, dated [DATE] documents R10 requires an assist of one staff with bathing. 7. On 7/22/20 at 10:00 AM, R26 stated she receives showers on Wednesdays and Saturdays however, she has not gotten her last two showers. Stated when she has asked staff, they tell her they can't because there is not enough staff. R26's MDS, dated [DATE] documents R26 is dependent upon staff with bathing. 8. On 7/22/20 at 8:15 AM, R31 stated that they have washed her hair in the sink one time but have refused to do it when asked since then. R 31 continued to state that she has not had a shower in several days and have asked staff multiple times to give her a shower but they have not. R31's MDS, dated [DATE] documents R31 is dependent upon staff for bathing. 9. On 7/22/20 at 8:15 AM, R32 stated that he has not had a shower in several days and have asked staff multiple times to give R32 a shower but they have not. R32's MDS, dated [DATE], documents that R32 requires an assist of one staff with bathing. On 7/22/20 at 10:00 AM, R31's and R32's hair appeared greasy and unkept. The facility Shower Log (no date) was reviewed and R10's, R26's, R31's and R32's names were on the log with their shower days designated, however, the log failed to document their last shower received. The facility Grievance Logs for the past four months was reviewed and document multiple resident complaints of not receiving their scheduled showers. The Grievance Log, dated 2/23/20, documents R10 complained he wasn't offered a shower, marked as resolved. The Grievance Log, dated 3/30/20, documents R31 and R32 complained of not getting showers, marked as resolved. The Grievance Log, dated 5/4/20, documents R31 and R32 complained regarding their shower schedule, marked as resolved. The Grievance Log, dated 5/6/20, documents R43 complained of not getting showers, marked as resolved. The Grievance Log, dated 5/13/20, documents R26 complained of not getting showers, marked as resolved. On 7/24/20 at 9:00 AM, V2, Regional Nurse, stated she would expect residents receive their showers as scheduled.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess, provide interventions to prevent new and worsening pressure ulcer for 1 of 4 residents (R19) reviewed for pressure ulcers in the sample of 43. Findings include On 7/21/20 at 10:10 AM, R19 was lying on his back with the head of bed elevated. R19's feet were wrapped with gauze dressing. R19's heels were not floated on pillows. R19's heels were black and lateral right foot was black. R19 was wearing 2 incontinent briefs that were both saturated with urine, and when removed the dressing to his coccyx pressure ulcer was wet

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) with urine. V16, Licensed Practical Nurse (LPN), stated all of R19's pressure sores were unstageable. R19 stated that he got the pressure ulcers at the facility. R19's Care Plan, dated 2/28/20, documents that R19 is at risk for impairment of skin integrity related to fragile skin, incontinent of bowel and bladder, uses low air loss mattress. R19's Care Plan documents the interventions to include: float heel on pillow, turn side to side only, turn every hour. R19's Minimum Data Set (MDS), dated [DATE], documents that R19 requires total assistance and 2 plus physical assistance for bed mobility and transfers. R19's MDS documents that R19 is totally dependent on staff, requires 2 plus physical assistance for toileting, and is always incontinent of urine and bowels. The MDS also documents that R19 is at risk for pressure ulcers, has 2 stage 1 pressure ulcers and zero unstageable pressure ulcers. The MDS does not document that R19 has an unstageable pressure ulcer to his sacrum and unstageable pressure ulcers to bilateral heels. R19's potential for skin breakdown assessment, dated 5/15/20, documents score of 12 with a score of 12 or less being high risk. The facility was unable to provide any Pressure Ulcer Logs for April or May 2020. Although, R19's MDS identifies 2 stage 1 pressure ulcers on 6/5/20, R19 was not documented on the pressure log until 6/17/20, less than 2 weeks later from 2 pressure ulcers to 4 progressed to unstageable pressure ulcers. The Pressure Ulcer Log, dated 6/17/20, documents R19's coccyx pressure ulcer measures 2.8 cm (centimeters) x 2.6 cm x U (unstageable), right heel 4.5 cm x 6 cm x U, right lateral foot 1 cm x 1 cm x U, left heel 1 cm x 8 cm x U. It also documents the treatments of Santyl and dry dressing to coccyx, [MEDICATION NAME] and dressing to right heel, [MEDICATION NAME] to right lateral foot, and [MEDICATION NAME] and dry dressing to left heel. It has no documentation of the date of onset or whether or not they were facility acquired. The facility most current pressure log, dated 7/14/20, documents R19's coccyx pressure ulcer 3.2 cm x 5 cm x 2 cm unstageable, right heel 6 cm x 7 cm unstageable, right lateral foot 1 cm x 1 cm unstageable and left heel 1.5 cm unstageable. All have increased in size. The facility's Decubitus Care/Pressure Areas policy and procedure, dated November 2019, documents, 4) Documentation of the pressure area must occur upon identification and at least once each week. The assessment may include: i) Characteristic (ie. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.). ii) Treatment and response to treatment. 5.) Reevaluate the treatment for [REDACTED]. If no improvement is seen in the time frame contact the physician for a new treatment order.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide timely incontinent care for 2 of 5 residents (R2, R19) reviewed for incontinent care, in the sample of 43. Findings include: 1. On 7/20/20 at 2:50 PM, R2 was incontinent of urine, the incontinent brief was saturated with dark yellow urine. V19, Certified Nursing Assistant (CNA), stated that R2 had been up since R2's shower this morning. R2's Minimum Data Set (MDS), dated [DATE], documents that R2 requires extensive assistance and 2 plus person physical assistance for toileting. R2's MDS documents that R2 is frequently incontinent of urine and feces. 2. On 7/21/20 at 10:10 AM, R19's incontinent brief was removed to observe R19's pressure ulcer. R19's incontinent brief was saturated with urine. R19 had 2 incontinent briefs on and both were saturated. R19's bed was also double padded. V6, CNA, stated that R19 is a heavy wetter. R19 stated that he is left in urine and feces for long periods of time. R19's Care Plan, dated 2/28/20, documents that R19 is at risk for skin integrity impairment related to fragile skin, incontinent of bowel and bladder. R19's MDS documents that R19 is totally dependent on staff and requires 2 plus physical assistance for toileting and is always incontinent of urine and bowels.
F 0693 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate nutrition for 2 of 5 residents (R8, R38) reviewed for gastrostomy tubes ([DEVICE]s) in the sample of 43. This failure resulted in R38 having a significant weight loss of 5.3 % in two weeks, and due to no additional interventions, R38 continued to lose weight, resulting in a significant weight loss of 8.3 % in 3 months. Findings include: 1. On 7/22/20 at 7:55 AM, R38 was lying in his bed, partially covered to the waist with a sheet. He had an emaciated appearance, with the bony prominences of his shoulders, elbows and knees easily evident. He had enteral nutrition formula, [MEDICATION NAME] 1.5, infusing at 55 milliliters (ml) per hour (hr) via his gastrostomy tube ([DEVICE]). The bottle of tube feeding hanging was dated 7/21/20 and was untimed. It had about 200 mls left in the bottle. There was dried tube feeding formula on the tube feeding pump and on the floor below the pump. On 7/22/20 at 11:26 AM, V25, Registered Nurse (RN), pulled R38's sheet back to uncover his [DEVICE] site, which did not have a dressing around it. V25 stated R38 should have a dressing around his [DEVICE] to protect it because he is a scratcher, and will dig at the skin around his [DEVICE] with his fingernails. R38's fingernails on both hands had dark brown debris under them, and they were long and uneven. On 7/23/20 at 8:05 AM, R38 had a different enteral nutrition formula, [MEDICATION NAME] 1.2, infusing at 55 mls/hr infusing per his [DEVICE]. On 7/24/20 at 9:55 AM, V6, Certified Nursing Assistant (CNA), and V26, CNA, used full body mechanical lift to raise R38 completely off his bed, removed his heel protectors so he was only wearing a gown, and weighed R38 with the scale on the mechanical lift, after the scale was zeroed. R38's weight was measured as 85.8 pds. V6 hit the weigh button a second time and got the same weight. R38's Progress Notes, dated 4/27/20 at 10:18 PM, document he was admitted to the facility on that date from an acute care hospital. He is N.P.O. (nothing by mouth) and he has [DEVICE] to his mid abdomen. He had [MEDICATION NAME] 1.2 @ 55 ml/hr infusing continuously with 100 ml water flushes every (q) 6 hrs. R38's Medical [DIAGNOSES REDACTED]. R38's Minimum Data Set (MDS), dated [DATE], documented he is severely cognitively impaired and dependent on staff for all Activities of Daily Living (ADLs), including eating. His MDS documents R38 has a feeding tube and he receives 51 % or greater of total calories per day via his [DEVICE]. R38's EMR (Electronic Medical Record) included the following weights: There was no admission weight until 12 days after he entered the facility. On 5/9/20 his initial weight was 99 pds; two weeks later on 5/23/20 his weight was 93.8 pds (5.3% weight loss); on 6/1/20 his weight was 93.6 pds, on 6/5/20 his weight was 93.8 pds; on 6/11/20 his weight was 96.2 pds; on 7/2/20 his weight was 98.4 pds, and on 7/27/20 his reweight was 90.8 pds (8.3% weight loss in two and a half months). R38's Initial Registered Dietician (RD) Assessment by V35, Registered Dietician, on 5/7/2020 at 9:53 PM, documented R38 is NPO and on continuous tube feeding and is receiving [MEDICATION NAME] 1.2 at 55 ml/hr and 100 ml flushes every 6 hours with no feeding intolerance noted. R38's feeding and flushes are providing a total of 1584 kcal, 73 g (grams) protein and 1465 mL fluids. The RD's assessment reviewed his labs from 4/24/20: Hgb 10.2 L (low), Hct 30.4 L, Na 142, K 3.1 L, magnesium 1.8, protein 6.2, [MEDICATION NAME] 2.7 L, BUN 3 L, Cr 0.5 L, calcium 8.4, phosphorus 3.2. V35 documented R38's height (ht) and weight (wt) taken on 4/18/20 per hospital record: ht 62 inches, Wt 114 pds, BMI 20.9-normal. Calories: 1560-1820 (30-35 kcal/kg); protein: 62 g (1.2 g/kg); fluids: 1560 mL (30 mL/kg). V35 recommended increasing R38's tube feeding to 60 mL/hr x 23 hours and flushing with 120 mL fluid every 6 hours. New orders will provide a total of 1656 kcal, 77 g protein and 1594 mL fluids. RD will monitor for tube feeding. V35's tube feeding/weight note on 5/22/2020 at 1: 23 PM documented: (R38) was just weighed and new weight reported to be 93 pds, reflecting a 6 pd weight loss (6.1%) x 2 weeks. Significant. RD (V35) spoke with the nurse who said that resident is currently getting the [MEDICATION NAME] 1.5 at 55 mL continuous to substitute for the [MEDICATION NAME] 1.2 at this time. RD will recommend continuation of the [MEDICATION NAME] 1.5 at 55 mL since the 1.5 is more calorie concentrated. If resident is on the 1.5 for awhile, weight gain likely to occur. Run at 55 mL x 23 hours daily and flush with 125 mL water every 4 hours. New orders will provide a total of 1898 kcal (45 kcal/kg), 80 g protein (1.9 g/kg) and 1711 mL fluids (40 mL/kg). RD will monitor. V35's RD weight/tube feeding note on 6/25/2020 at 8:26 PM documented, (R38) is on the [MEDICATION NAME] 1.2 at 55 mL continuous. No tube feeding intolerance noted. Weight 6/11 96.2 pds, 6/5 93.8, 6/1 93.6 pds. Resident was reported to have a weight loss on 5/22 when he weighed in at 93 pds. See RD note 5/22. He is up 3.2 pds x 3 weeks-favorable. Current feeding and flush (100 mL flush every 6 hours-see 5/7 RD assessment) is providing 1584 kcal, 73 g and 1465 mL fluids. No labs in PCC (Electronic Medical Record) available to review at this time. Since resident recently had a weight loss, RD will recommend increasing feeding rate to ensure weight gain continues. Will recommend running [MEDICATION NAME] 1.2 at 65 mL x 23 hours daily and flush with 150 mL every 6 hours to provide a total of 1794 kcal, 83 g, and 1806 mL fluids. RD will monitor. On 7/24/20 at 9:15 AM, R38's Physician order [REDACTED]. There were no changes to R38's tube feeding orders since his admission to include changes recommended by V35. On 7/23/20 at 9:00 AM, V2, Director of Nursing (DON), stated she found

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F 0693 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) a dietary recommendation from 6/25/20 for R38 and was going to give it to V36, Nurse Practitioner (NP), to look at. She stated the Registered Dietician emails her recommendations to the DON, who gives them to the MD (medical doctor) or NP. She stated she does not know where any of R38's other recommendations from the RD are, or why they were not followed up on. At 9:25 AM, V2 stated V36 was agreeable with the recommendation from 6/25/20 and R38's tube feeding is now [MEDICATION NAME] 1.2 to infuse at 65 ml/hr for 23 hours a day. On 7/23/20 at 10:25 AM, V36 stated she had not been given any dietary recommendations for R38 until she was given the recommendation from 6/25/20 this morning from V2. V36 stated she did not know what the difference between [MEDICATION NAME] 1.5 and [MEDICATION NAME] 1.2 is because she is not a dietician and that writer would need to call the dietician and ask her. V36 stated she had never disagreed with any dietary recommendations she has reviewed from a Registered Dietician before. On 7/24/20 at 10:15 AM, V2, DON stated that R38's weight of 85.8 pds would be a big weight loss for him and it is the facility's policy to get a reweight, but she did not want to have the same CNAs weigh him .she would have someone else do it later. On 7/28/20 at 8:42 AM during a phone interview, V2 stated R38's reweight was done on 7/27/20 (three days after he was weighed at 85.8 pds) and his reweight was 90.8 pds. She stated the facility does not have a specific weight or weight loss policy. She stated she has requested the MD see R38 on his weekly rounds to address weight loss. 2. R8's Electronic Medical Record documents her [DIAGNOSES REDACTED]. R8's Admission Physician Orders, dated 4/5/20, does not include any order for type of tube feedings, rate or flushes. R8's Progress note, dated 4/7/2020 at 1:51 AM, documents R8's tube feeding is infusing at [MEDICATION NAME] 1.5 @ 60 ml/hr running continuously. On 4/8/2020 at 11:48 AM, R35's INITIAL RD ASSESSMENT documented: NPO (Nothing by mouth). NKFA (No known food allergies [REDACTED]. DX (diagnosis): [MEDICAL CONDITION], transient cerebral attack, [MEDICAL CONDITION] and [MEDICAL CONDITION] affecting left non-dominant side, [MEDICAL CONDITIONS], cerebral infarction, acute [MEDICAL CONDITION], NSTEMI (a type of [MEDICAL CONDITION]), gastrostomy status, hypo-osmolality and [MEDICAL CONDITION], vitamin D deficiency, HTN, [MEDICAL CONDITION], GERD, constipation, [MEDICAL CONDITIONS], [DIAGNOSES REDACTED], dysphagia, anorexia, pneumonia, pressure ulcer of sacral region-stage III. Meds: aspirin, MVI/minerals, eliquis, lactobacillus, [MEDICATION NAME], vitamin D3. Labs 4/3/20: Na 150 H, K 3.7, BUN 15, Cr 0.58, glucose 118 H, GFR >90, calcium 7.6 L, Hgb 8.8 L, Hct 31.3 L. Stage III pressure ulcer on sacrum per Initial Skin Alteration Record 4/6/20. Ht 65 in, Wt 130.0#, BMI 21.6-normal. [MEDICAL CONDITION] +1 pitting to RUE (right upper extremity) per nursing note 4/7/20. Calories: 1770-2065 (30-35 kcal/kg); protein: 77 g (1.3 g/kg); fluids: 1770-1947 mL (30-33 mL/hr). Increased protein needs raises fluid needs. Current tube feeding provides a total of 2160 kcal, 92 g protein, 2594 mL. Will recommend running [MEDICATION NAME] 1.5 at 45 mL x 23 hours daily, flush with 180 mL every 4 hours. Give 30 mL liquid protein TID (three times daily). Feeding, liquid protein and flushes will provide a total of 1852 kcal, 111 g protein, and 1866 mL fluid. Will provide a total of 2070 kcal, 88 g protein 2128 mL fluids. Meets 100% kcal, 144% protein and 100% fluid needs. RD will monitor. Review of R8's Physician order [REDACTED].@ 60 ml/hr and no liquid protein was ordered. R8 was hospitalized from [DATE] to 4/28/20. Her readmission orders [REDACTED]. On 5/13/2020 at 6:36 PM, R35 documented : READMISSION RD ASSESSMENT: resident continues on the [MEDICATION NAME] 1.2 at 60 mL/hr continuous. Flush orders not available in PCC for review. Tube feeding currently providing a total of 1728 kcal, 80 g protein and 1162 mL fluids. RD spoke with nursing over the phone today (working offsite d/t COVID-19 restrictions) and there were concerns over residuals since resident has a hx (history) of this. Resident is NPO, NKFA. Family concerned over swollen tongue per nursing note 5/5/20. DX: [MEDICAL CONDITION]. cerebral infarction, [MEDICAL CONDITION] and [MEDICAL CONDITION], NSTEMI, gastrostomy status, hypo-osmolality and [MEDICAL CONDITION], vitamin D deficiency, HLD, GERD, AMS, constipation, [MEDICAL CONDITIONS], [DIAGNOSES REDACTED], UTI, dysphagia, anorexia, stage III pressure ulcer of sacral region. Med list taken from discharge orders dated 4/28/20: 1 packet protein supplement, MVI with minerals, eliquis, lactobacillus, [MEDICATION NAME], vitamin D3, [MEDICATION NAME] sulfate, [MEDICATION NAME]. No labs to review at this time. Wt 130.0 pds, Ht 65 inches, BMI 21.6-normal. Stage III pressure ulcer on coccyx per Initial Skin Alteration Record 4/28. No [MEDICAL CONDITION] noted. Calories: 1770-2065 (30-35 kcal/kg); protein: 77 g (1.3 g/kg); fluids: 1770-2065 mL (30-35 kcal/kg). Recommend running [MEDICATION NAME] 1.2 at 45 mL x 23 hours, give 30 mL liquid protein TID, and flush with 250 mL every 4 hours. These orders will provide a total of 1542 kcal, 102 g protein and 2335 mL fluids daily. RD will monitor. Review of R8's Physician order [REDACTED]. On 6/12/2020 at 4:31 PM, V35 documented: the DON contacted this RD earlier to say that the nurse practitioner ordered RD consult regarding her skin breakdown. Current orders for 60 mL/hr [MEDICATION NAME] 1.5 provide a total of 92 g protein-see RD assessment 6/11/20. Will recommend adding 30 mL Prostat once daily for an additional 100 kcal and 15 g protein. Will receive a total of 2260 kcal and 107 g protein daily. Continue MVI with minerals-noted to have an order for [REDACTED]. No Prostat was ordered during that time. On 7/28/20 at 2:50 PM, during a phone interview, V1, Administrator, stated he would expect residents to be weighed soon after they were admitted to the facility to get a baseline weight, but since that is clinical, he does not know the actual time frames during which it should be done. V1 stated residents should be weighed monthly thereafter. On 7/29/20 at 1:30 PM, V35, Registered Dietician, stated she had recommended R8 be given liquid protein 30 milliliters (ml) three times a day when she first assessed her because she was trying to ensure she get the adequate nutrition to maintain her health and to assist with healing her current pressure ulcers and prevent additional skin impairment. V35 stated the nurses had reported to her that they were getting residuals when checking R8's gastrostomy tube, and this could cause decreased calories and nutrition. She stated the liquid protein may not have brought or kept [MEDICATION NAME] level within normal range, but it certainly would have helped, and may have helped wound healing. On 7/29/20 at 2:31 PM via email, V1 stated he is unable to locate any dietary recommendations for R8. The Facility's Policy, Enteral Tube Feeding via Continuous Pump revised January 2020, documents, The purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally. The Facility's Policy,5.5 Enteral Tube Medication Administration dated December 2017, documents, Procedure: The selection of the enteral formula, equipment, route of administration and rate of flow is determined by the physician based on the nursing assessment of the resident's condition and approval by the physician. The facility dietician and consultant pharmacist may provide consultation for this assessment.

F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly handle soiled linens, follow isolation precautions, screen and place residents in the facility to prevent the spread infection. This failure has the potential to affect all 79 residents residing in the facility. Findings include: 1. On 7/20/20 at 2:55 PM, V17, Housekeeping, wearing only a mask, entered and came through the COVID-19 quarantine area, located on 200 hall, through the Yellow Zone, then through the Red Zone, where R16, R17 and R18 reside, testing positive with COVID-19. V17 entered a empty room and donned personal protective equipment (PPE)(gown, gloves, mask and shoe covers). On 7/20/20 at 3:00 PM, V17 stated that V14, Registered Nurse (RN), just informed V17 that she was to have had all PPE on prior to entering the COVID unit and V17 stated, I (V17) know, to apply all PPE before entering the quarantined hall, that's why I (V17), ran into the room to hurry and put it on, and get the housekeeping cart ready. On 7/20/20 at 12:53 PM, V14, RN, stated any staff entering from the within the facility into the COVID quarantine 200 hall are to apply a mask, gown, gloves and shoe coverings, remove soiled PPE and exit the COVID hall through the outside door. 2. On 7/20/20 at 1:00 PM, a large pile of soiled linens (bed sheets, towels, washcloths, bed pad protectors) were stacked in a pile, on the floor behind a closed empty room door, within the room a housekeeping cart, mop and bucket were stationed. On 7/20/20 at 3:00 PM, V8, Certified Nurse Aide (CNA), stated she was not sure what to do with the soiled linen on the floor or why it was piled on the floor. V8 continued to state that the laundry department does not come back here since this is a COVID unit and the laundry chutes utilized are located outside the COVID unit within the facility. On 7/20/20 at 3:10 PM, V17 stated she was not sure what to do with the soiled linens, as the facility has a laundry chute located outside the COVID hall, or why it was piled on the floor however, she would immediately notify her Housekeeping Supervisor. On 7/20/20 at 3:35 PM, V18, Housekeeping Supervisor, standing outside the COVID exit door, stated she was informed by V17 that their was a large pile of soiled linen on the floor, V18 stated possibly related to the toilet leak that occurred on this unit early this morning. V18 continued to state the linen will be bagged and transported outside the exit door to the laundry facility. On 7/28/20 at 5:02 PM, V29, Corporate Administrator, stated that V37, Maintenance replied that there was a toilet leak between the rooms of 210 and 212 early on 7/20/20. The facility's policy and procedure, dated as reviewed 2020, documented, The purpose of this procedure is to provide a process for the safe and aseptic handling and storage of linen, place any linen with body fluids into a leak-resistant bag, if laundry chutes are used, only closed and leak-resistant bags will be put into the chute. 3. On 07/20/2020, R34 did not have contact/droplet isolation precaution cart or signage on the door for COVID19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	A. BUILDING _____ B. WING _____	**08/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INTEGRITY HC OF ALTON	**3523 WICKENHAUSER ALTON, IL 62002**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) precautions. R34's face sheet dated, 07/29/2020, documents that R34 was admitted to the facility on [DATE] from an acute care facility. 4. On 07/20/2020, R35, did not have contact/droplet isolation precaution cart or signage on the door for COVID19 precautions. R35's face sheet dated, 07/29/2020, documents that R35 was admitted to the facility on [DATE] from home. 5. On 07/20/2020, R36 did not have contact/droplet isolation precaution cart or signage on his door for COVID19 precautions. R36's face sheet dated, 07/29/2020, documents that R36 was admitted to the facility on [DATE] from home. 6. On 07/20/2020, R37 did not have contact/droplet isolation precaution cart or signage on his door for COVID19 precautions. R37's face sheet dated, 07/29/2020, documents that R37 was admitted to the facility on [DATE] from home. 7. On 07/21/2020 at 7:14 am, V7, Licensed Practical Nurse (LPN), entered R1's room with his medication and gave him his medication. V7 did not perform hand hygiene, don gloves, gown or face shield prior to entering the room. V7 exited R1's room without performing hand hygiene. V7 returned to the medication cart and retrieved medications for R5. V7 entered R5's room. V7 did not perform hand hygiene prior to donning gloves and administration of R5's medications through his gastrostomy tube. On 07/23/2020 at 9:30 am, V2, Regional Nurse, stated that all new and readmissions to the facility should be placed on 14 day contact/droplet precautions because of COVID19 pandemic. The facility's policy, COVID19 IDPH Interim Guidance: Accepting Transfers from Acute Care Setting to LTCF, dated 5/11/2020, documents, New admissions or returning residents where the COVID19 status is unknown (this could be someone new to the facility, a returning resident that went to the hospital or transferred from somewhere and was not tested or the test result is pending.) TBP (Transmission Based Precautions) for 14 days. Have passed since last exposure (which is date of admission). It continues, Patient Placement: single room is ideal. Cohort like-illnesses. Single room on transition area. If asymptomatic after 14 days, can go to regular floor. The facility's policy, Visitation and Infection Control Policy, undated, documents, Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible infection with coronavirus disease 2019 (COVID19) and therefore have an increased risk of exposure to this virus. HCP's can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control guidelines, including use of recommended personal protective equipment (PPE). It continues, g. Employees are educated and reminded to clean their hands according to CDC guidelines, including, before and after contact with residents, after with contaminated surfaces or equipment and after removing personal protective equipment (PPE). It continues, post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE. 8. On 7/20/20 at 1:00 PM, V18, Housekeeping Supervisor, walked from the far end of 300 hall towards the nurse's station carrying soiled laundry without wearing a mask, took soiled laundry into soiled laundry room. When came out of the room, he was wearing a mask. 9. On 7/20/20 at 1:15 PM, there was an Isolation cart outside of R1's room. There was no sign for isolation on the door. V13, LPN, stated that she did not know why R1 was on isolation. A few minutes later, V13 stated that R1 was on isolation because he was an admission from the hospital. V13 stated it was policy of the facility for readmissions or admissions from the hospital to be in isolation for 14 days for COVID precautions. 10. On 7/20/20 at 1:35 PM, V13 stated R3 was admitted to the facility from the hospital today. There was no sign on the door indicating that R3 in isolation or any type of isolation cart set up outside R3's room. Still no sign or isolation at 3:15 PM. 11. On 7/20/20 at 1:35 PM, V22, Medical records, was passing ice water on the 300 hall. V22 walked into R22's room. A sign was posted outside the door that documents to perform hand hygiene before entering a before leaving room and wear gown before entering room. V22 did not sanitize hands, put on gown or gloves prior to entering R22's room. V22 picked up large cup emptied in sink, came out of the room with cup, filled with ice, took back in the room, and exited the room. V22 said that she was aware that it was an isolation room that she just exited, but stated it was contact only. 12. On 7/20/20 at 2:00 PM, V29, Corporate Administrator, was walking down 300 hallway without a mask on to the DON office. At 2:30 PM, V29 was walking at the end of 300 hall from the DON Office towards the front of building without mask on. V19 stated that she cannot wear a mask and has a doctors note. 13. On 7/21/20 at 10:15 AM, V32, Nurse Practitioner, and V33, Nurse Practitioner, were at the facility doing COVID testing by performing throat swabbing. V32 and V33 both had masks, gowns and gloves on. Prior to entering R19's room V33 did not sanitize hands or don new gloves. V33 then entered room with swab and culture tube. V33 bent over bed had R19 open his mouth took swab and swabbed R19's throat. V33's gloves did touch R19's lips. V33 then put swab into culture tube, walked to R19's doorway and placed culture in plastic bag that V32 was holding. V33 did not remove gloves, or gown. V33 then went back into R19's room with another culture and swab to swab R19's room mate. 14. On 7/22/2020 2:25 PM, V2, Regional Registered Nurse, stated that if residents are not wearing a mask they should be reminded to wear a mask. V2 stated in regards to staff they are expected to wear a mask at all times. V2 stated if staff could not wear a mask due to medical reasons they would be asked to provide that information. V2 stated the facility would try to accommodate the staff, but they would not be able to provide direct care. V2 stated she would not want the staff walking up and down resident halls.