STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145863	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INTEGRITY HC OF MARION	**1301 EAST DEYOUNG MARION, IL 62959**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 brush the teeth of a resident unable to brush their own teeth for 1 of 3 residents reviewed for oral hygiene (R2) in a sample of 4. The findings include: According to the electronic health record, R2 is [AGE] years old, and has a [DIAGNOSES REDACTED]. According to the Quarterly Minimum Data Sets (MDS) assessment dated [DATE] R2 has a Brief Interview for Mental Status score of 15 indicating R2 is cognitively intact. This same MDS lists no behavioral symptoms or rejection of care, and requires the extensive assistance of one person to physically assist with personal hygiene which evaluates how a resident maintains the brushing of their teeth. This MDS also specifies R2 has functional limitation in range of motion that interferes with daily functions of both upper extremities. On 9/10/20 at 4:22 PM, V1, Administrator, said R2 was admitted into their facility after a local consumer advocate agency requested they admit him on an emergency basis, due to him living in a bad situation of his care giver leaving him and not caring for him. He was at the local hospital and needing a place that could care for him. V1 said she accepted him for admission since she felt he had no where else to go. On 9/10/20 at 12:02 PM, R2 said the staff at the facility tell him to do things he cannot do for himself, and said the staff will not help him brush his teeth. R2 also said when he asks for help the staff asks him how did he do that before he came into the facility. During this interview, R2 was observed to have severe tremors of upper extremities where his arms and hands were swinging back and forth in a jerking motion three or four swings prior to stopping when he lay his arms on the bed indicating that during this observation, R2 would be unable to put tooth paste on a tooth brush, or complete any task that required fine motor skills for a period of time. Also at the time of this observation, R2's teeth were not discolored; there appeared to be a thick clear coating on both upper and lower teeth. On 9/15/20 at 9:23 AM, V11, Certified Nursing Aide/CNA, said R2 needs assistance brushing his teeth. On 9/15/20 at 10:15 AM, V13, Restorative Aid, said R2 needs assistance with grooming and can brush his teeth if you put the tooth brush in his hand. Staff need to put the toothpaste on the toothbrush for him, he does not have the coordination for that. V13 said R2 uses a rounded wooden toothbrush, and doesn't know if that assists him, or if he brought it into the facility because he liked it. V13 said sometimes she will brush R2's teeth for him, but that would be up to the Certified Nurses Aids (CNA's) discretion. On 9/15/20 at 9:30 AM,V12, CNA, said if R2 indicates he needs assistance with brushing his teeth, she will hand him his toothbrush. V12 stated R2 can put the toothpaste on the toothbrush and brush his own teeth. An Occupational Therapy Evaluation and Plan of treatment for [REDACTED].

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.