

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/25/2024
NAME OF PROVIDER OR SUPPLIER  Integrity Hc of Carbondale		STREET ADDRESS, CITY, STATE, ZIP CODE  120 North Tower Road Carbondale, IL 62901	
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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43088</p> <p>Based on interview and record review the facility failed to administer tube feeding as ordered for 1 (R1) of 3 residents reviewed for gastrostomy tube care in a sample of 3.</p> <p>Findings include:</p> <p>On [DATE] at 9:29 AM, V12 (R1's State Guardian) said the facility was not completing R1's tube feedings as ordered. V12 said she had spoken with the facility wanting R1's tube feeding orders to be changed from bolus feeding to continuous due to R1's decline and weight loss during a hospitalization prior to R1 being admitted to the facility. V12 said the facility had told her they would speak with the dietitian to see if R1's tube feeding orders could be changed. V12 said she had been notified the dietitian had recommended R1's tube feeding orders be changed to continuous. V12 said 8 to 10 days, V12 was unsure of the exact dates, she received a call from someone visiting R1 and was told R1 was still receiving bolus tube feedings. V12 said on [DATE] she arrived at the facility and saw R1 was still receiving bolus tube feedings. V12 said she questioned V5 (Registered Nurse/ RN) about R1's tube feeding orders. V12 said V5 made a phone call and told V12 the dietitian had made the recommendation for R1's tube feeding orders to be changed to continuous but R1's Primary Care Physician (PCP) had not signed the order. V12 said V5 called R1's PCP and obtained an order for continuous tube feeding as the dietitian had recommended. V12 said V5 told her due to R1's gastrostomy tube (g-tube) being of a new design the facility did not have the tubing to perform continuous tube feedings. V12 said R5 called the hospital and the tubing that was compatible with R1's g-tube was delivered to the facility from the hospital.</p> <p>R1's Admission Record documented an admitted [DATE] with diagnoses including: dysphagia, adult failure to thrive, gastrostomy status. R1's Admission Record documented R1 expired in the facility on [DATE]. R1's [DATE] Minimum Data Set (MDS) documented no Brief Interview for Mental Status (BIMS) score due to R1 rarely/ never being understood.</p> <p>R1's Order Recap Report dated [DATE] documents, Section Enteral-Fed, Enteral feed order four times a day for enteral nutrition Bolus Jevity 1.5 270mls (milliliters). Order date [DATE], Start date [DATE], End date [DATE]. Enteral feed order every 24 hours for maintain and improve weight isosource 1.5 cal continuous at 45 mls/hour. Order date [DATE], Start date [DATE], End date [DATE]. Section Pharmacy documents, Jevity 1.2 Cal Oral Liquid (Nutritional Supplements) Give 360 ml via G-Tube three times a day for supplemental feeding take 360ml TID (three times daily) with 70cc flush after each feeding. Order date [DATE], Start date [DATE], End date [DATE].</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145757
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's [DATE] Medication Administration Record (MAR) documented the following orders:</p> <p>Start date of [DATE] Jevity 1.2 Cal (calorie) oral liquid give 360 ml via g-tube 3 times a day for supplemental feeding at 6:00 AM, 2:00 PM, and 9:00 PM with a discontinue date of [DATE].</p> <p>Start date of [DATE] Jevity 1.5 Cal give 270 ml 4 times a day at 6:00 AM, 10:00 AM, 2:00 PM, and 6:00 PM with a discontinue date of [DATE].</p> <p>R1's [DATE] MAR documented the 6:00 AM feeding for both the Jevity 1.2 cal and Jevity 1.5 cal were blank on [DATE], 16, 19, 21, 22, and 23.</p> <p>The facility's [DATE] nursing schedule documented V9 (Registered Nurse/ RN) was the only licensed nurse in the facility on [DATE], 16, 19, 21, 22, 23 at 6:00 AM.</p> <p>On [DATE] at 10:54 AM, V9 said she did recall R1 but had never taken care of R1. V9 said she had never administered any tube feeding to R1. V9 said she did not work the hall R1 resided on. V9 said she was the only nurse in the facility from 11:00 PM until 7:00 AM. V9 said another nurse cared for R1 and the other residents on that hallway from 3:00 PM until 11:00 PM. V9 said it would be the responsibility of the 3:00 PM to 11:00 PM nurse to make sure all the resident's feedings had been completed prior to them leaving the facility. When V9 was asked if the 3:00 PM to 11:00 PM nurse left the facility at 11:00 PM how would they be responsible for administering a resident feeding scheduled to be administered at 6:00 AM, V9 responded she did not know and would have to get clarification.</p> <p>On [DATE] at 11:03 AM, V2 (Director of Nursing) said she was not aware V9 was not administering R1's 6:00 AM tube feedings. V2 said it would be V9's responsibility to ensure R1's tube feedings were being completed.</p> <p>On [DATE] at 11:50 AM, V6 (RN) said on [DATE] and [DATE] she had documented she had administered the Jevity 1.2 at 2:00 PM, the Jevity 1.5 at 10:00 AM, and the Jevity 1.5 at 2:00 PM to R1. V6 said she was not sure if she administered the Jevity 1.2 or the Jevity 1.5 to R1. V6 said cases of Jevity solution are kept in the residents room when the resident has a bolus tube feeding and V6 would have used whatever Jevity was being kept in R1's room at that time.</p> <p>On [DATE] at 12:11 PM, V5 (RN) said she was unsure why nursing staff were documenting they were administering both Jevity 1.2 three times a day and Jevity 1.5 four times a day. V5 said R1 was receiving Jevity 1.5 four times a day. V5 said she knew nursing staff were giving Jevity 1.5 because she was the nurse that had placed the case of Jevity 1.5 in R1's room. V5 said when nursing staff are documenting tube feedings there are several boxes that have to be checked in the Electronic Medical Record (EMR) for g-tube flushes and other things so perhaps the nursing staff did not notice there was a difference in the two.</p> <p>On [DATE] at 11:03 PM, V2 said R1 was receiving the Jevity 1.5 four times a day. V2 said she knew R1 was receiving Jevity 1.5 because the facility did not have Jevity 1.2. V2 said she did not know why there were two different orders in R1's EMR for Jevity but the nursing staff should have noticed they were documenting and administering the wrong Jevity.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's [DATE] Request for Diet Change PCP (Primary Care Provider) FAX Report documented in part . (Registered Dietitian Tube Feeding) Change note. Family would like continuous feedings. Recommend Jevity 1.5 45ml hour continuous rate, 180ml flush every 6 hours . Will adjust as needed . This document was not signed or dated by R1's PCP.</p> <p>On [DATE] at 3:13 PM, V10 (Regional Nurse Consultant) said R1's Physician signed [DATE] Request for Diet Change PCP FAX report could not be found and R1's PCP's office had no note of it. V10 stated I guess R1's [DATE] Request for Diet Change PCP FAX Report was never sent to R1's PCP.</p> <p>On [DATE] at 3:05 PM, V5 said on [DATE] V12 had asked her why R1 had not been changed to continuous tube feeding from bolus tube feeding. V5 said she told V12 she was not sure and would find out. V5 said she called V7 (MDS Coordinator/ Licensed Practical Nurse) and was told V4 (Dietitian) had made the recommendation for R1's tube feeding order to be changed to continuous, but an order had not been received from R1's PCP to change the order. V5 said she called R1's PCP and obtained a verbal order to change R1's tube feeding to V4's recommendation. V5 said due to R1's g-tube being of a new design the facility did not have the tubing required to complete a continuous feeding. V5 said she called a local hospital to see if they had any of the tubing R1 required and the hospital had delivered some tubing to the facility that day on [DATE]. V5 said she changed R1's tube feeding order to continuous on [DATE] and discontinued R1's bolus tube feeding.</p> <p>R1's [DATE] MAR documented an order with a start date of [DATE] for Isosource 1.5 Cal continuous at 45 ml per hour every 24 hours.</p> <p>On [DATE] at 9:36 AM, V4 said she was told by the facility on [DATE] R1's State Guardian had requested to change R1's tube feeding from bolus to continuous and V4 had made that recommendation. V4 said when V4 has completed the resident reviews in a facility and has made her recommendations she emails a copy of the recommendations and the Diet Change PCP FAX Report to V1 (Administrator), V2, and V7. V4 said it is V2 or V7's responsibility to ensure the resident's PCP receives the Diet Change PCP FAX Report in 24 hours and the PCP responds with in 24 to 48 hours. V4 said V2 is responsible to follow up on any unanswered Diet Change PCP FAX Reports. V4 said V4 would follow up the next month when she was in the facility to verify if the resident's PCP had agreed or disagreed with her recommendations. V4 said the facility should have a system to track when recommendations are being sent to resident's PCPs and when they are returned to the facility. V4 said the same calorie intake could be achieved by bolus and continuous tube feeding. V4 said bolus tube feeding was preferred by most residents due to the increase in mobility. V4 said the facility had notified her on [DATE] they could only administer Isosource 1.5 to R1 due to the tubing they had on hand. V4 said Isosouce 1.5 and Jevity 1.5 are comparable in calorie intake and the main difference is Jevity has more fiber. V4 said she had told them Isosource 1.5 would be ok to give R1.</p> <p>On [DATE] at 10:22 AM, V2 said she did not recall V4's [DATE] recommendations and did not know if they had been sent to resident PCP's or not. V2 said due to working as a floor nurse so often she does not have time to complete all the Director of Nursing duties. V2 said V4 would send the recommendations through an encrypted email that required a password to open and V2 did not have the password to open them or to print them. V2 said the previous Dietary Manager had printed V4's recommendations and Diet Change PCP FAX Reports and would give them to V2 or V7 to be sent to the resident PCPs. V2 said the current Dietary Manager was new and was not sure if V11 (Dietary Manager) had printed V4 [DATE] recommendations.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 9:20 AM, V11 said she did get a copy of V4's recommendations but relied on nursing staff to bring the signed copy of the Diet Change PCP FAX Report to her to change the resident's diet. V11 said she would not have received any Diet Change PCP FAX Report for R1 due to R1 being a resident who relied on tube feeding.</p> <p>On [DATE] at 11:22 AM, V13 (Chief Executive Officer) said she was not aware V5 was not caring for residents on R1's hall from 11:00 PM to 6:00 AM when V5 was the only licensed nurse in the facility but would investigate further.</p> <p>The facility's Revised [DATE] Dietitian policy documented in part . A qualified Dietitian will help oversee clinical nutritional Dietary Services in the facility . Our facility's Dietitian is responsible for, but not necessarily limited to: . a. Assessing nutritional needs of residents; b. Developing and planning regular and therapeutic diets; . d. Collaborating effectively with other direct care staff and practitioners to assess and address nutritional issues in the facility's population; .</p> <p>The facility's revised [DATE] Charting and Documentation policy documented in part .The medical record should facilitate communication between the interdisciplinary team regarding the residence condition and response to care . 2. Following information is to be documented in the Resident medical record: . b. Medications administered; . 3. Documentation in the medical record will be objective . complete, and accurate .</p>		