STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009336	A. BUILDING: _____ B. WING _____	C 02/09/2023

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S 000	Initial Comments Complaint Investigation 2340945/IL156029	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)2) 300.1220b)3) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were Not Met as evidenced by:	S9999		

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S9999	Continued From page 2 A- Based on interview and record review, the facility failed to provide care and follow physician orders for an indwelling urinary catheter for 1 of 5 residents (R6) reviewed for indwelling urinary catheter care in the sample of 13. This failure resulted in R6 having an indwelling urinary catheter longer than ordered and being admitted to the hospital with a diagnosis of acute cystitis with hematuria. B- Based on interview and record review, the facility failed to ensure continuity of care by failing to secure follow up appointments and testing for 2 of 3 residents (R3, R6) reviewed for quality of care in the sample of 13. This failure resulted in R6 being admitted into the hospital with a Urinary Tract Infection Findings include: 1. R6's Face Sheet, print date of 2/2/23, documents R6 was admitted on 12/09/22 with diagnoses of Acute Kidney Failure, Atrial Fibrillation, Anemia, History of Malignant Neoplasm of Prostate and muscle weakness. R6's Hospital After Visit Summary, dated 12/9/22, documents, "Discharge Instructions: Please hold Eliquis for one month - can resume first week of Jan 2023 need CT (computerized tomography) head prior to monitor resolution of bleed f/ u (follow up) with NS (neurosurgery) in 3 weeks. What's Next: Follow up with (V9, Neurosurgeon). Please call our office to schedule a follow - up in about 4 weeks with a repeat CT head prior to your follow - up to assess if the small bleed on the surface of your brain has resolved. Follow up with (V6, Urology Nurse Practitioner) in 2 weeks.	S9999		

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S9999	Continued From page 3 Our office will call to schedule (indwelling urinary catheter) removal and starting Lupron." R6's Health Status Note, dated 1/31/23 at 10:00 AM, documents, "Discharge Summary Note Text: Pt. (patient) d/c'd (discharged) with medications and belongings. Writer educated pt. on medications times, taking meds (medications) as prescribed, and some side effects to report to PCP (Primary Care Provider). Pt. given copy of order summary." R6's Electronic Medical Record (EMR) was reviewed for documentation of the care and observation of R6's indwelling urinary catheter. R6's EMR had 2 notes available for review related to R6's indwelling urinary catheter were on Admission and on 12/28/22. The catheter is not mentioned anywhere else. There were no orders regarding the indwelling urinary catheter, no care plan regarding it, and nothing on Treatment Admission Record (TAR) regarding the performance of catheter care or monitoring for R6. R6's Admission Assessment, dated 12/9/22, documents that R6 was admitted with an indwelling urinary catheter. R6's Health Status Note, dated 12/28/22, documents that R6 has an indwelling urinary catheter. R6's Hospital Emergency Department Phys (Physician) Chart, dated 2/2/23, documents R6 was admitted on 1/31/22 with diagnoses of Acute Cystitis with Hematuria (blood in urine), Dehydration and Anemia." R6's Hospital Complete Blood Count with	S9999		

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S9999	Continued From page 4 Differential, dated 1/31/23 at 4:31 PM, documents that R6 had a white blood cell count of 19.6 which is high (This is indicative of an infection). The normal range is 4.8 - 10.8. R6's Hospital Urinalysis, dated 1/31/23 at 4:17 PM, documents that R6's urine was obtained from an indwelling urinary catheter, and it was slightly turbid, had leukocytes, protein, red blood cells and white blood cells present in the urine. All of these are abnormal to be in urine. R6's Hospital Inpatient Discharge, dated 2/7/23, documents, " Diagnoses: 1. Sepsis 2' (secondary to) UTI (urinary tract infection). Specimen did not qualify for a culture. ABS (antibiotics) given anyway. SIRS (Systemic Inflammatory Response Syndrome) criteria resolved on IV (intravenous) Rocephin. No other source found." On 2/8/23, V12 (Nurse Practitioner) stated, "V13 (R6's daughter) brought R6 in to be seen after leaving the nursing home. I saw him on 1/31/23. He just looked awful. He was so weak he could not stand by himself. I did a quick assessment and took him down to the Emergency Room for an evaluation. My office is in the hospital. He then was admitted to the hospital. When I saw him, he had a very high heart rate, and I was worried he was septic. The hospital admitted him and diagnosed him as being septic with an UTI (Urinary Tract Infection). I cannot say if leaving the (indwelling urinary) catheter in longer and not getting him started on the Lupron did him harm but he was admitted to the hospital with a UTI, which is harm. I think he deteriorated from being septic from the UTI and his low Hemoglobin and Hematocrit. I did not remove his (indwelling urinary) catheter while he was in my office. I left it for the hospital to address." V12 further stated,	S9999		

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S9999	Continued From page 5 "R6 not getting his CT scan and follow up neurology appointment and the delay of restarting his Eliquis put R6 at risk. When I saw him, he had a very fast heart rate with the sepsis, and he has atrial fibrillation. This puts him at high risk for developing a blood clot. He was definitely at a high risk of harm, but to my knowledge, the hospital did not find a blood clot." On 2/8/23 at 2:30 PM, V3 (Interim Assistant Director of Nursing/ Interim ADON) stated, "When a resident is admitted with an (indwelling urinary catheter), orders are written for the care of the catheter like if the catheter needs to be changed because it is not working (blocked), if it needs to be irrigated or if the drainage bag needs to be changed. Those would all be prn (as needed) orders. Those orders would be placed on the TAR so the nurse know that there is a (indwelling urinary) catheter and that it needs to be monitored. The nurses should be checking and documenting on the catheter. We are a (corporation name) home, and we do not have a policy on (indwelling urinary) catheter care. We expect our nurse to follow the nursing standard practice of nursing care for (indwelling urinary) catheters." V3 was told that R6 only had documentation of R6 having an indwelling urinary catheter on 2 notes, the Admission Assessment from 12/9/22 and Health Assessment note of 12/28/22, V3 stated that R6's indwelling urinary catheter should have been charted daily in the TAR. On 2/6/23 at 2:20 PM, V8 (Transport Driver) that sets up appointments, stated that she was not aware that R6 needed an appointment for a CT of the brain or a follow up appointment for removal of an indwelling urinary catheter. V8 stated, "Usually the nurses give me the discharge	S9999		

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S9999	Continued From page 6 paperwork with all appointments on it or any appointments that need to be made for the residents, and I will call and set them up. I did not get R6's discharge paperwork with those appointments on it." 2. R3's Face Sheet, print date of 2/7/23, documents R3 was admitted 11/17/22 and has diagnoses of Acute Respiratory Distress Syndrome, Emphysema and Congestive Heart Failure. R3's Hospital After Visit Summary, dated 11/17/22, documents, "What's Next: Jan (January) 23, 2023 (Regional Hospital) Vascular Ultrasound at 8:00 AM and Follow-up with (V10), Cardiology Advanced Practice Nurse, on Monday Jan 23, 2023 at 9:00 AM." On 2/6/23 at 1:39 PM, V3 (Interim Assistant Director of Nursing/ Interim ADON) stated that when a resident is admitted to the facility, if there are any appointments that need to be made, they go to V8 (Transport Driver) and she sets up the appointments. V3 also stated that all discharge orders that document a doctor's office will call with an appointment should be followed up on to ensure that the resident gets the needed appointment scheduled. V8 (Transport Driver) stated, "R3 is too large to go in the facility van. We usually try to set him up with a bariatric transport out of Springfield. I just found an envelope in last year's book stating that R3 missed an appointment on 1/23/23 for the cardiologist. I need to talk to the Administrator and see if we can do that as a possible telehealth visit." When asked if she was aware of the appointment that R3 had for 1/23/23 at 8:00 AM	S9999		

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S9999	Continued From page 7 for a vascular ultrasound, V8 stated, "I was not aware of that. I guess I need to talk to the Administrator about getting him to Springfield. Usually, the nurses give me the discharge paperwork with all appointments on it or any appointments that need to be made for the residents, and I will call and set them up. I did not get R6's or R3's discharge paperwork with those appointments on it." On 2/6/23 at 3:15 PM, when asked about the missing appointments of R3 and R6, V3 (Interim ADON) stated that she will have to come up with a better system to track appointments and make sure they get made. On 2/7/23 at 11:35 AM, V3 stated that the facility does not have a policy and procedure on setting appointments or transcribing hospital discharge orders. (A) Statement of Licensure Violations (2 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1220b)3) 300.1810f)	S9999		

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S9999	Continued From page 8 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	S9999		

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S9999	Continued From page 9 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.1810 Resident Record Requirements f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. These requirements were Not Met as evidenced	S9999		

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S9999	Continued From page 10 by: Based observation, interview and record review, the facility failed to assess for risks of weight loss by monitoring weights and failed to implement interventions to prevent weight loss for 4 of 7 residents (R6, R7, R8, R9) reviewed for nutrition in the sample of 13. This resulted in R8 losing 13.8 pounds (lbs.) in 25 days resulting in a 11.2 % weight loss, R6 losing 9.9 lbs. resulting in a 6.1% weight loss in 30 days, and R9's losing 22.46 lbs. resulting in 17.5% weight loss in 24 days. Findings include: 1.R8's out of state Regional Hospital Progress Notes, dated 11/29/22, documents, "Wt. (weight) readings from last 3 Encounters are 11/25/22 123 lb. (pounds) 7.3 oz (ounces), 10/04/22 123 lb. 7.3 oz, and 6/30/22 134 lbs. 0.6 oz." R8's Facility's Face Sheet, print date of 2/7/23, documents that R8 was admitted on 12/8/22 from an out of state Regional Hospital with diagnoses of a Stroke, Dementia and Severe Protein - Calorie Malnutrition. The facility had no documentation R8's weight was taken upon admission. R8's Physician Orders, dated 12/12/22, documents, "Weekly weight every day shift every Thur (Thursday) for 4 weeks. Stop date of 1/12/23." R8's Minimum Data Set (MDS), dated 12/14/22, documented he had severe cognitive impairment, required limited assistance of one staff for eating. R8's February 2023 Physician Orders documents,	S9999		

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S9999	Continued From page 11 "Regular diet, Mechanical Soft texture, Regular Liquid Consistency, health shakes with meals, whole milk and large portion protein with meals." R8's Dietician Nutrition assessment, dated 12/28/22, documents, "Most Recent weight 123.0 Date: 12/12/22 Scale: wheelchair. Usual body weight unknown. Goal weight 154. Comments: IBW (Ideal Body Weight) 139 - 169 lbs. Weekly weights ordered. Appearance Malnourished. Skin issues Pressure Ulcers (unstaged) R (right) Trochanter. Nutrition Summary: 72 y/o (year old) male - admitted with multiple medical issues including malnutrition, skin breakdown, kidney disease, dysphagia. He is on a Regular Mechanical Soft diet - speech therapy is ordered. Intake is reported 75-100% - occasionally eats less at times. Mechanical Soft diet (may be changed with speech therapy). Health shakes @ (at) meals along with extra foods as above. May need to make restrictions depending on renal function issues. Goal - gradual weight gain, intake >75%, wound healing. He is underweight, and extra calories and protein are warranted. Do not want to overdo the protein d/t (due to) to compromised kidney function. Suggest adding health shakes TID (three times a day) @ meals, large portions of protein and whole milk @ meals. Suggest adding a multivitamin/mineral supplement. Staff aware of food preferences. Nutrition Plan: Mechanical Soft diet (may be changed with speech therapy). Health shakes @ meals along with extra foods as above. May need to make restrictions depending on renal function issues. Goal - gradual weight gain, intake >75%, wound healing." R8's Weight and Vitals Summary documents that on 12/12/22, R8 weighed 123 lbs. (pounds) using a wheelchair scale. This same report documents	S9999		

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S9999	Continued From page 12 that on 1/6/23 R8 weighed 109.2 lbs. using a mechanical lift scale, indicating that R8 had a 13.8 lbs. weight loss, indicating that R8 has had a significant weight loss of 11.2% in 25 days. R8's Dietary Note, dated 1/14/23, documents, "Skin and weight issues - Unstageable area on medial L (left) foot and 2 areas on R trochanter - improving. Last update added health shakes TID @ meals, large portions of protein and whole milk @ meals, as well as a multivitamin/mineral supplement. Weight loss noted from admission - 123# to 109.2# - 13.8# (11/2%). Continue with current interventions and will follow." The facility had no other documented weights recorded for R8. There was no documentation that the facility implemented any additional interventions to address R8's weight loss after he lost 13.8 pounds. R8's Dietary Note, dated 2/4/23, documents, "Skin issues - Stage 4 area on medial L(left) foot and Stage 3 areas on R trochanter - improving noted on both by nursing. Recently added health shakes TID @ meals, large portions of protein and whole milk @ meals as well as a multivitamin/mineral supplement. Weight loss noted from admission - 123# to 109.2# - 13.8# (11/2%). No February wt. (weight) at this time. Continue with current interventions and will follow." There was no documentation that the facility implemented any additional interventions to address R8's weight loss or if he had experienced any further weight loss. The facility supplied document "Need w/c (wheelchair) Dec (December)" is a handwritten	S9999		

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S9999	Continued From page 13 notebook piece of paper that documents R8 weighed 109.6 lbs. On 2/7/23 at 9:30 AM, V3 (Interim Assistant Director of Nursing/ Interim ADON) stated that the weight aide found a handwritten notebook piece of paper with weights on it that had been taken in December, but they had not been documented. On 2/7/22 at 2:01 PM, R8 was observed eating lunch with the assistance of V11 (Certified Nursing Aide/CNA). R8 was not served a health shake with the noon meal. 2. R6's Face Sheet, print date of 2/2/23, documents R6 was admitted on 12/09/22 from a Regional Hospital with diagnoses of Acute Kidney Failure, Atrial Fibrillation, Anemia, History of Malignant Neoplasm of Prostate and muscle weakness. The facility had no documented admission weight for R6. R6's MDS, dated 12/15/22, documents that R6 is cognitively intact and requires set up for meals. R6's Weight and Vital Summary, printed on 2/7/23, documents, R6's weight was 159.8 lbs. on 12/15/22. R6's Care Plan, dated 12/22/22, documents, "Diet to be followed as prescribed. Interventions. Food dislikes are: none noted at this time. I prefer snacks between meals. I would like anything for a snack. My favorite beverages are: variety of beverages. My favorite foods are: none noted at this time." R6's Treatment Administration Record (TAR),	S9999		

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	IL6009336	A. BUILDING: _____ B. WING _____	C 02/09/2023

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S9999	Continued From page 14 dated 12/1/22 - 12/31/22, documents, "Weight every day shift every Sat (Saturday) for 4 weeks. Start date of 12/10/22." This TAR fails to document R6's weight on 12/10/22, 12/17/22 and 12/23/22. R6's Weight and Vital Summary dated 12/31/22 documents R6 weighed 161.6 lbs. R6's Physician Orders, dated January 2023, documents, "Regular Diet Regular texture, Regular Liquid Consistency, 2000 cc (cubic centimeters) fluid restriction avoid ham, bacon, sausage, sauerkraut, salted crackers, chips, oj (orange juice), bananas, baked potatoes, tomatoes juice, avoid saltshaker and salt at table." R6's Hospital Emergency Department Phys (Physician) Chart, dated 2/2/23, documents that R6 was admitted to the hospital on 1/31/23 and R6's initial weight at the Emergency Department presentation was 151.7 pounds. This indicates R6 lost 9.9 lbs. in 30 days resulting in a 6.1 % weight loss which is classified as a significant weight loss. 3. R9's Hospital Progress Note, dated 12/18/22, documents that R9 weighed 58.3 kg (128.6 lbs.) R9's Face Sheet, print date of 2/7/23, documents that R9 was admitted on 12/19/22, with diagnoses of Parkinson's Disease, Dementia and limitation of activities due to disability. There was no documentation the facility obtained R9's weight upon admission. R9's MDS, dated 12/25/22, documents R9 is severely cognitively impaired and requires limited	S9999		

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S9999	Continued From page 15 assistance of 1 staff member for eating. R9's Dietician Nutrition Assessment, dated 12/28/22, documents, "Most Recent Weight: 134.0 (Lbs.), Date: 12/5/2022, Scale: Wheelchair. BMI 20.4. Goal weight 154. IBW - 139-169 lbs. Weight was obtained from hospital admission record. Appearance: Well nourished. Comments on appearance: thin. Nutritional Plan: 92 y/o male - admitted after hospitalization for UTI (Urinary Tract Infection) - has Parkinson's and dementia. On a Pureed diet - eats with assistance. He is below IBW standards. Suggest adding calories to promote some wt. gain. Suggest super cereal and double protein @ breakfast, whole milk @ meals, ice cream and extra dessert @ lunch and supper. Need to obtain a current wt. on facility scale. Nutritional Goal: Provide extra foods as above. Goal - intake >75%, gradual wt. gain." R9's Health Status Note, dated 1/1/23, documents, "New diet order received per dietary recommendation add super cereal whole milk ice cream and extra dessert." R9's Weight and Vital Summary documents that R9 weighed 105.8 lbs. on 1/11/23. R9's weight calculations of 12/18/22 at 128.6 lbs. and 1/11/23 at 105.8 lbs. document a 22.46 lbs. weight loss or 17.5% weight loss in 24 days, indicating R9 sustained a significant weight loss. R9's Dietary Note, dated 1/14/23, documents, "Weight loss noted - 105.8# BMI-16.09. Admission wt. was recorded as 134 (taken from hospital admission records. He is on super cereal & 2x protein @ breakfast, whole milk @ meals, ice cream & extra dessert @ lunch and supper.	S9999		

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S9999	Continued From page 16 He has been working with ST (Speech Therapy) -to be advanced to Mechanical Soft - waiting on MD (Medical Doctor) order to confirm. Yesterday at lunch, he was given some ground chicken and ate about 50% of it with supervision. Dietary staff will check with nursing before providing anything other than pureed foods for now and if he gets this, it must be with close supervision. He does need additional calories - will suggest adding Health shake or 2.0 supplement at med pass - 90 ml TID (milliliters three times a day)." R9's Physician Orders Summary, dated 2/7/23, documents, "Regular diet Mechanical soft texture, Regular Liquid Consistency, offer Kennedy cups only when shaking with straws, return to regular silverware. Continue ice cream x (extra) dessert lunch and supper offer 2 x protein @ Breakfast offer super cereal @ breakfast whole milk with meals with assist with feeding." R9's Physician Orders fails to document, Health shake or 2.0 supplement at med pass - 90 ml TID that was recommended on 1/14/23." On 2/8/23 at 12:50 PM, R9 was not served milk or ice cream with the noon meal. 4. R7's Face Sheet, print date of 2/7/23, documents that R7 was admitted on 1/17/23 from a Regional Hospital with diagnoses of Orthopedic aftercare following surgical amputation (left below the knee amputation). R7's Physician Orders, dated 2/7/23, documents, "Regular diet Regular texture, Regular liquid consistency. R7's MDS, dated 1/22/23, documents that R7 is cognitively intact and R7 is independent with eating.	S9999		

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S9999	Continued From page 17 R7's facility Weights and Vitals Summary, documents R7 was only weighed one time and that was on 2/6/23 and his weight was 289.6 Lbs. R7's Hospital Discharge Plan, dated 1/17/23, documents on 1/10/23 R7 weighed 152.3 kg (kilograms) or 304.6 lbs., and R7 had a left below-the-knee amputation. On 2/7/23 at 2:30 PM, R7 stated, "I had my surgery on 1/14/23. I do think I am losing weight, and my shorts are a little looser." On 2/6/23 at 1:45 PM, V3 (Interim ADON) stated, "New admissions are weighed upon admission and then once a week for 4 weeks. If the resident's weight is stable, then they will be weighed once a month, if not, then the weekly weights will continue. Residents that are experiencing weight loss will be weighed weekly until they stabilize. I do not know why R9's updated dietary recommendation is not in the system." On 2/7/23 at 9:02 AM, V3 stated, "I have figured out what happened with the dietary recommendations, the Administrator walked out about January 8th, 9th or 10th. I just got all these recommendations that V1 (Administrator) just got yesterday afternoon via email. I think what happened is they were going to the old Administrator, and they were not getting forwarded to the new Administrator. The process is the Dietician will make a note in the computer about recommendations. She then goes back to her office and makes up the orders, which is then emailed to the Administrator. The Administrator then forwards them to me to put into place."	S9999		

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S9999	Continued From page 18 The facility Weight Assessment and intervention policy, dated 1/2017, documents, "Weight Assessment. 1. The nursing staff will measure resident's weights on admission, and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly. 2. Weights will be recorded in the individual's medical record. 3. The threshold for significant unplanned and undesired weight loss will be based on the following criteria." It continues, "a. 1 month 5% weight loss significant; greater that 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10 % weight loss is significant; greater than 10% is severe." (B)	S9999		