STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 09/30/2020

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INTEGRITY HC OF BELLEVILLE	727 NORTH 17TH STREET BELLEVILLE, IL 62226

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S 000	Initial Comments Complaint Investigation 2046320/IL125654	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.3240a) 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide supervision and progressive interventions to prevent falls for 1 of 5 residents (R3) reviewed for falls in the sample of 23. This failure resulted in R3 having multiple falls and sustaining a fracture to the maxillary and nasal bones. The facility also failed to provide supervision to prevent elopement for 1 of 3 residents (R1) reviewed for elopement in the sample of 23. Findings include: 1. The Physician's Order Sheet (POS), dated 08/01/20, documented R3 had the following diagnoses, in part as, paranoid schizophrenia, chronic obstructive pulmonary disease, diabetes mellitus type II, congestive heart failure, history of falling and epilepsy. The Minimum Data Set (MDS), dated 08/14/20, documented R3 was moderately cognitively impaired and required extensive assist of one for bed mobility, transfers, walking, dressing, toileting and hygiene. The MDS, dated 06/08/20, documented R3 required limited assist of one for walking, dressing, hygiene and bathing and was independent with transfers, bed mobility and toileting. The care plan, dated 08/19/20, documented R3 was identified as a fall risk. It documented R3 had a fall on 08/01/20 resulting in maxillary and nasal	S9999		

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S9999	Continued From page 2	S9999		

fractures. On 02/03/20, it documented to remove tube socks from R3's room and replace with gripper socks. On 02/04/20, it documented to instruct R3 to look at surroundings before walking and stepping. On 08/12/20, the care plan documented R3 placed in wheelchair for safety, therapy evaluating and treating as per physician orders, monitored for transferring/walking on own. There were no orders or assessments provided by the facility that R3 was evaluated or being treated by therapy services.

The Fall Risk Assessment, dated 01/02/20 was 10, indicating high risk. On 04/04/20, it was 7, indicating at risk. On 05/24/20, there were two separate scores of 17 and 9, one indicating high risk and the other at risk. On 07/29/20, the score was 8, indicating at risk.

From 12/16/19 to 08/01/20, nurse's notes, incident/accident log and Situation Background Assessment Recommendation (SBAR) reports documented R3 had eight falls. On 07/29/20 and 08/01/20, R3 was sent to the hospital due to falls where he hit his head. On 08/01/20, the fall resulted in maxillary and nasal fractures. There were no new interventions put into place after the falls on 12/26/19, 01/13/20, 04/04/20, 05/24/20 or 06/30/20. There were no immediate interventions put into place after the fall on 07/29/20 to prevent the fall on 08/01/20. There were no incident/accident reports presented by the facility for 12/16/19 or 01/13/20. All of these falls were documented as R3 self-ambulating in his room, in hallway or at the nurse's station. Multiple nurse's notes documented R3 was impulsive and had an unsteady gait.

On 08/28/20, a nurse's note documented R3 had "seizure activity" and was subsequently sent to

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S9999	Continued From page 3	S9999		

the hospital. On 09/02/20, R3 was discharged from the facility.

On 09/18/20 at 12:20 PM, V21 (Regional Director of Operations) stated R3 was discharged from the hospital to another facility and had not returned to this facility after the seizure activity on 08/28/20.

On 09/24/20 at 10:10 AM, V13 (Licensed Practical Nurse/LPN) stated R3 was impulsive and had an unsteady gait at times. V13 stated he was alert and oriented and could make his needs known. V13 stated R3 mostly kept to himself and slept a lot during the day. V13 stated staff tried to keep a close eye on him while he was up and moving around to try to prevent him from falling.

On 09/24/20 at 10:20 AM, V6 (Certified Nursing Assistant/CNA) stated R3 was independent with care and at times was unsteady on his feet. V6 stated R3 was quiet and stayed in his room most of the day. V6 stated R3 would walk around without shoes and socks on sometimes and staff would remind him to put some on.

The policy and procedure titled, "Fall Management" was reviewed. It documented under, "Policy: It is the policy of the facility to have a Fall Prevention Program to assure the safety of all resident in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions which include any assistive devices are utilized as necessary.

2. R1's face sheet, dated 9/22/20, documents R1 was admitted to the facility on 4/12/19 with diagnoses of Bipolar Disorder, Psychosis,

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S9999	Continued From page 4 Diabetes and Schizophrenia. R1's MDS, dated 7/23/20, documents R1 has severe cognitive impairment. R1's Elopement/Wandering Risk Assessment, dated 9/4/20, documents R1 is at risk for elopement. R1's Care Plan, dated 7/30/20, documents R1 is at risk for elopement and has a history of leaving the facility unescorted. R1 is alert and oriented to name only. Interventions include providing 1 on 1 and redirection if attempting to exit. It further documents that on 9/14/20, "resident eloped from the building, there was an all staff search and (R1) was brought back to the building" (revision date of 9/17/20). Intervention for this occurrence was social services to provide 1 on 1 for 3 days and R1 was moved to a different room. R1's Behavior Tracking, dated 9/14/20, documents R1 eloped from the facility and the intervention attempted was 1 on 1 with social services for increased monitoring. R1's Progress note dated 9/14/20 at 5:20 AM, documents V32 (Hall Monitor) went to "check lower level" and heard the door alarm sounding, V32 went out the door and saw no one. V32 then checked on R1 and noticed she was missing. A search of the building and surrounding area was completed and R1 was not found. V21 (Regional Director of Operations/RDO) was notified. Staff continue to search outdoors by foot and car. Police arrived, took resident information and began searching for R1. R1's Progress note dated 9/14/20 at 5:40 PM, documents R1 was found by an employee and is	S9999		

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S9999	Continued From page 5 safe without "noted harm or acute distress." The facility's timeline, dated 9/14/20, documents the following: 3:30 AM - Hall monitor completing walking rounds on high risk elopement residents, entered 500 hall and heard exit door alarm sounding. Hall monitor immediately went to area, searched outside area with no one seen. He completed a room search and noted R1 was not in her room. Hall monitor informed nurse and the facility was searched but R1 was not found. 4:08 AM - Charge nurse notified RDO, police and family. 5 AM - R1 located by V11 (Housekeeping Supervisor). On 9/24/20 at 1:40 PM, V11 stated he found R1 on 9/14/20 at 4:45 AM on "28th Street." V11 stated R1 was standing on the side of the road. On 9/29/20 at 8:43 AM, V32 stated on 9/14/20 at 3:50 AM, he heard the 500 hall alarm sounding and he "stuck his head out the door but did not go outside." V32 stated he did not see anyone, so he did a head count on the 500 hall where R1 resided and noticed she was not in her room. V32 stated he notified the nurse and the other halls were searched but R1 was not found. V32 stated he last saw R1 in her bed on 9/14/20 at 2:50 AM. V32 stated he checks on all residents at risk for elopement hourly. On 9/18/20 at 1:15 PM, V2 (Director of Nurses) stated R1 was on the 500 hall when she eloped. R1 was moved to the 100 hall after the elopement to be "monitored closer." On 9/24/20 at 12 PM, V2 stated the facility is ensuring the floors are adequately staffed and they have hall monitors on each shift to ensure adequate supervision is provided to prevent	S9999		

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S9999	Continued From page 6 residents from eloping. The facility policy titled "Elopements" dated March 2015, documents to initiate a search of the entire building, premises and surrounding area. (B)	S9999		