STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007116	A. BUILDING: _____ B. WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF SMITHTON	107 SOUTH LINCOLN SMITHTON, IL 62285

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S 000	Initial Comments Annual Licensure and Certification Survey F689G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 300.1210d)6) 300.3240a) 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 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	S9999	Attachment A Statement of Licensure Violations	

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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 agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on record review and interview the facility failed to provide supervision to prevent an elopement for one of one resident with dementia (R27) reviewed for elopement. This failure resulted in R27 leaving the facility unsupervised for approximately 2 hours, attempting to gain unauthorized access to a home, and being apprehended by local police which resulted in R27 sustaining facial abrasion and skull fracture.

Findings Include:

R27's Minimum Data Set (MDS), dated 10/01/19, documents R27 was unable to complete the interview to determine his level of cognition. R27's cognitive skills for daily decision making is documented as independent. The MDS dated 10/01/19 also documents R27's active diagnoses

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are Non-Alzheimer's, Dementia and Schizophrenia.

R27's Care Plan Interventions, all initiated on 04/10/19, documents R27 was to be one on one with staff as needed, and R27 was to be on 15-30-minute checks as needed. There was no documentation provided of 15-30-minute checks being completed and/or monitoring of R27 after 7 pm on 11/15/19.

R27's Cognition Care Plan, dated 10/01/19, documents R27 was alert but disoriented related to the diagnosis of Schizophrenia and Dementia. R27 has long and short-term memory loss, which requires R27 assistance with recalling things. When asked questions, R27 was too confused to answer appropriately.

R27's Incident Description Form, dated 11/15/19, documents R27 exited facility and was brought back by ambulance and Sheriff's Officers. Then R27 was transported to local hospital

The County Sherriff's Department Offence/Incident Report, dated 11/15/19, "Received a call of a home invasion at 4:47 AM, V29, Sheriff's Officer, arrived at the residence at 5:00 AM, where R27 was attempting to enter V28's residence. This address of V28 was approximately 2.2 miles from the facility where R27 lived, per google maps. V29, Sherriff's Officer, arrived at address of V28, to find a white male wearing sweat pants and a jacket. The caller, V28, reported the residential alarm was sounding and she could see the person outside her front door. Suspect, R27, was then seen by V29, V30, and V31, Sherriff's Officers, walking through a field east of the V28's residence, which has a large body of water that surrounds the

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residence. Deputy, V31, gave R27 several commands to show his hands and R27 refused. V31, Deputy, then tackled R27 and took him into custody.
The suspect had abrasions to his face and Emergency Medical System was called.
The suspect was identified as R27 by surrounding City Municipal Police Department, who were familiar with the suspect and reported he lived at the (facility) and suffers from Dementia. R27 was transported to the (facility) where V31 was met by the (facility) staff. Notified of the situation and the suspect was transported to local hospital."

R27's Local Hospital Emergency Room Visit Report, dated 11/15/19, documents, "R27 with Schizophrenia and Dementia. (R27) was brought to Emergency Department, (ED), by Emergency Medical Service, (EMS), as the result of a physical assault that occurred. (R27) had reportedly escaped from the Nursing Home Facility. The Sheriff's Officer (V31) had tackled him (R27) while he was attempting to enter a home down the street from the facility he lived. (R27) is nonverbal and Cognitively Impaired, (R27) was found by EMS to be covered with his own feces and multiple laceration to his (R27) face and shoulders, after being taken down by police. (R27) was absent from his facility for an unknown duration". Written witness statements noted last time seen by staff was approximately 2:30 AM on 11/15/19.

R27's Local Hospital Room Report, dated 11/15/19 at 6:17 AM, also documents a laceration, 3 centimeters to right ear which needed 4 sutures. Superficial abrasion to the right side of the nose, right shoulder, collar bone area and both knees on arrival.

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R27's Radiology Report, dated 11/15/19, documents Nondisplaced left occipital Condyle fracture (fracture at the base of the skull, beginning of the neck).

R27's Elopement Wandering Risk Assessment Form, dated 10/01/19, documents R27 was at risk for elopement and wandering at this time, and preventative measures should be taken.

R27's Elopement Care Plan, dated 10/08/19, documents R27 was a risk for elopement, related to his diagnosis of Dementia. R27 becomes confused and disoriented resulting in R27 trying to elope and then wonder. Care Plan Goal is for R27 is for him to remain free from making elopement attempts.

R27's Health Status notes, dated 05/26/19, documents, "(R27) went out of the front door and was walking around. (R27) was brought back into the facility."

R27's Health Status notes, dated 11/10/19 documents, "(R27) was exit seeking at the front door, (R27) preceded to exit the door 5 times and was brought back in each time"

V17's CNA written Witness Statement, dated 11/15/19, documents around 2:30 AM she saw R27 in the dining room. She did not hear any door alarms.

V18's CNA written Witness Statement, dated 11/15/19 documents R27 was seen about 12:30 AM, along with R157. Both were up and walking back and forth by the door. This was the last time V18 saw R27.

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V19's CNA written Witness Statement, dated 11/15/19, documents R27 was last seen around 2:00 AM. V19 saw R27 and R157 walking around the dining room. V19 did not hear any door alarms.

V20's CNA written Witness Statement, dated 11/15/19, documents at approximately 1:30 AM, R27 was seen sitting at a table in the dining room.

On 11/22/19 07:54 AM, V23, Medical Director/Physician, stated "Yes, I was notified. The alarm system needs to be revamped. It's a punch system by the door and if someone enters from the outside, the resident can just walk out. They have Dementia residents now and I will strongly suggest a different system, at our next meeting."

The facility policy entitled Elopements, dated December 2007, documents staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. If an employee observes a resident leaving the premises he/she should attempt to prevent the departure in a courteous manner. If an employee discovers that a resident is missing from the facility, he/she shall initiate a search of the building and premises.

(B)