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INTEGRITY HC OF HERRIN	1900 NORTH PARK AVENUE HERRIN, IL 62948

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3300a)b)e)j) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 1 Section 300.3300 Transfer or Discharge a) A resident may be discharged from a facility after he or she gives the administrator, a physician, or a nurse of the facility written notice of his or her desire to be discharged. If a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of his or her guardian or if the resident is a minor, his or her parent unless there is a court order to the contrary. In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being. (Section 2-111 of the Act) b) Each resident's rights regarding involuntary transfer or discharge from a facility shall be as described in subsections (c) through (y) of this Section. e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. j) The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's	S9999		

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S9999	Continued From page 2 clinical record. (Section 3-408 of the Act) Based on interview and record review, the facility failed to serve an appropriate non-emergent involuntary discharge and allow the resident and resident's family time to appeal the notice for 1 of 1 resident (R185) reviewed for discharge in the sample of 32. This failure resulted in R185 being removed from her environment and suffering psychosocial harm that any reasonable person would after being placed over two hours away from her family and friends without notice. The findings include: R185's Face sheet, dated 09/19/24, documents R185 was admitted to the facility on 10/22/21 and discharged on 06/18/24 with diagnoses including cerebral infraction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified dementia severe with other behavioral disturbances, vascular dementia unspecified severity with other behavioral disturbances, anxiety, schizoaffective disorder, wandering in diseases classified elsewhere, bipolar II disorder, major depressive disorder recurrent, and cognitive communication deficit. R185's Minimum Data Set (MDS) dated 06/18/24 documents in Section C a Brief Interview for Mental Status (BIMS) score of 00, indicating R185 has severely impaired cognition. Section E documents no hallucinations or delusions, no physical behavioral symptoms directed towards others, no verbal behavioral symptoms, other behavioral symptoms not directed towards other (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like	S9999		

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screaming, disruptive sounds) occurred 1 to 3 days out of the 7 day look back period, did not reject evaluation or care, and wandering 1 to 3 days out of the 7 day look back period. Section GG documents R185 was dependent for toileting, dressing, and personal hygiene and set-up and clean up for transfers.

R185's Care Plan, with a "cancelled date" of 06/18/24, documents focus areas of: 1. (R185) is disoriented to place and time. (R185's) memory is similarly impaired. Consequently. (R185) has problems with decision-making, insight, logic, calculation, reasoning, planning, and judgement. (R185) is known to be impulsive at times. This problem it related to Dementia. Strengths and abilities include her ability to be easily redirected. 2. (R185) has a behavior problem r/t (related to) (R185) is known to wander and lacks safety awareness. (R185) is easily redirected by staff most of the time. (R185) has a hx. (History) of agitation r/t dementia. (R185's) son reports (R185) has a known trend of doing bad things out of defiance then laughing when confronted. Recently (R185) has started to defecate in inappropriate places. (R185) appears to like attention even when it is negative attention for doing wrong as reported by (R185's) son. 3. (R185) has no discharge potential r/t poor safety awareness, cognition, and inability to care for self. A documented goal for this focus was "(R185) will remain in the facility long term."

R185's Physician Orders document no order for discharge on 06/18/24 to another facility.

R185's Progress Notes dated 06/14/24 at 8:16AM (Late entry) documents in part "Called Her (R185's) son (V13) and left message that she (R185) was being moved." R185's Progress Note

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dated 06/18/24 at 7:01AM documents in part "Resident (R185) discharged via facility transporter with personal clothing et (and) medications to receiving facility." R185's Progress Note dated 06/18/24 at 10:05AM documents "SSD (Social Services Director/V3) mailed a letter to (R185's) son (V13) telling him where (R185) has been sent to and the address and phone number where (R185) can be reach [sic]."

R185's Care Plan Summary/Participation record, dated 03/28/24, documents that R185 and V13 did not attend the meeting. Goals for care document "D/C (Discharge) is feasible, but resident/responsible party goal remains for long term placement." Other changes/Updates document no family attended and "Res (R185) will be looking at discharge to another facility when their lock down wing is complete."

R185's Discharge Planning Review/Summary documents in part under Discharge Goals/General Information 1. Who initiated discharge? Resident (box checked). 2.Reason for discharge: She (R185) went to other facility. 3. Recap of resident's stay: The resident was a long-term resident that needed a locked down unit, and we transfer her to the other facility for better care ...5. Initial discharge goals- remain in facility (box checked) ... 8. Resident's goals of care and treatment preferences: to be able to stay in the facility." Under Medication Reconciliation it documents " ...2. Has post-discharge medication list been discussed with resident/family? Resident (box checked). Under Activity Summary, 1. Social Service it documents "the Resident was excited that she was going to the [sic]." Under the section "2. Nursing Service" it documents "1. Medical Summary-Medication was sent with her (R185)."

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Under signatures 1. Resident signature and date documents R185 name typed in with date of 06/18/24. 3 staff signature documents V3 (Social Service Director) with typed in name and date of 06/18/24.

On 09/18/24 at 8:50AM, V13 (Family Member) stated that the facility never contacted him about R185 moving to another facility. V13 said he received a phone call from an unknown number stating that it was a new facility, and they were admitting R185 and wanted to review R185's medication with him. V13 stated that he asked the new facility if R185 was at the other facility she had been at, and they stated no that R185 was transferred to them today from the other facility on 06/18/24. V13 said he was very upset and mad. V13 said that he told the new facility that no one had notified him that R185 had been discharged and moved. V13 said the new facility that she was transferred to was around 2 hours away from his house. V13 said the facility that R185 was in was only 15 minutes away from his house. V13 said he hasn't been able to visit often and that with covid and the fact that R185 doesn't know who he was most of the time was upsetting to him. V13 stated the facility did not notify him about R185 being transferred and there were no messages left regarding a transfer. V13 said the facility did talk to him about 3 or 4 months ago about maybe moving R185 to another facility, but they never said they were for sure moving her. V13 said the facility never mentioned any other facilities that they were thinking about moving R185 to that he could remember. V13 said they talked about discharging R185, but it was brief and nothing definite. V13 said the facility could of at least called him to let him know that R185 was moving. V13 said the facility calls him for all kinds of other things like when she has eloped,

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medication changes, and other stuff; why not when they transferred R185? V13 said that he did not receive any paperwork from the facility other than a bill and no information on where R185 went or information on her moving at all. V13 said that he would have preferred for R185 to stay at the facility, because it was closer to him.

On 09/18/24 at 10:16AM, V14 (Facility Administrator at R185's new facility) stated that they did receive R185 as a new resident at their facility. V14 said that R185's old facility contacted them about 3-4 months ago and wanted to admit R185 to their facility. V14 said at that time they didn't have any beds available for R185. V14 said that they were in the middle of construction at that time for their locked unit and would have beds available soon. V14 doesn't remember off hand who she spoke to. V14 said they called the facility to let them know they had a bed available for R185. V14 said the facility worked on discharging R185 right away. V14 said when R185 was transferred to the new facility they did give all of R185's medical information. V14 said that R185 was admitted to a locked memory care unit at their facility. V14 said they did call V13 to verify R185's medications. V14 said that V13 was very upset and stated that he didn't know that R185 was discharged from the facility, and he knew nothing about R185 being admitted to a new facility. V14 said that V13 was very angry when they were talking to him because he was not made aware of any transfer or discharge. V14 said that R185 has seemed to adjust well to the new facility. V14 said that R185 did have some increased behaviors and some crying episodes at first, but that was expected some with her current diagnoses. V14 said that she didn't have a lot of concerns with R185 discharge and transfer other then V13 not knowing anything about the transfer

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S9999	Continued From page 7 and discharge. On 09/18/24 at 12:30PM V3 (Social Service Director/SSD) stated that the facility initiated R185's discharge. V3 said the facility initiated the discharge because they were unable to care for R185. V3 said R185 needed a locked facility because she kept trying to elope every day. V3 said the facility sent R185 to another facility that had a locked unit. V3 said they do have other resident that are elopement risks, but they don't usually get out like R185 did. V3 said they tried to do one on ones and extra activities but none of that worked. V3 said the one on one's didn't work, because R185 kept getting away from staff. V3 said R185 wouldn't stay with the person providing one on one's. V3 said the new facility has a locked unit and all we had was a medical alert device that the resident wears and locks the doors when she goes up to the door, but she would take off the medical alert device all the time. V3 said they determined the capability for care prior to admission by reviewing hospital or discharge records and talking to the family. V3 said she was not employed by the facility when R185 was admitted. V3 said that R185 has wandered since she has been employed by the facility. V3 said all of the elopement risk residents they have now have never actually eloped. V3 said the facility reviews discharge planning every three months on all residents, but most residents are long term. V3 said that R185 was sent to another facility that had a locked unit. V3 said R185's son V13 didn't have much to do with her. V3 said that she did try to contact V13 but was unable to get ahold of him. V3 said she tried several times to get a hold of V13 but was unable to get ahold of him to tell him that R185 was moving. V3 said that she did not document all the times she tried to get a hold of V13. V3 said she	S9999		

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left messages, but V13 never returned her calls. V3 said she doesn't know why other staff were able to get a hold of V13 at times. V3 said V13 never called her back so she mailed him information telling him, where we sent R185 along with address and phone number of the new facility on the day R185 was discharged to other facility. V3 said that 3 months ago they did start talking about sending R185 to another facility. She said that V13 and R185 were invited to Care Plan and V13 never showed up. V3 said they had started working on the discharge then. V3 said she was not able to get ahold of V13 since the Care Plan meeting on 03/28/24. V3 doesn't remember how many times she attempted to call V13, but that she did leave him a message. V3 stated the discharge summary was not completed until 09/17/24. She stated that she did not know she had to complete a discharge summary when they transfer to another facility. V3 said she had started one on paper but got rid of it. V3 said she didn't know if there was a physician's order or not because that is something she doesn't deal with. V3 said it states on the discharge summary that R185 initiated discharge. V3 said R185 does have a BIMS score of 00 which indicates that R185 has severely impaired cognition, but that R185 is able to understand. V3 said that the BIMS score is 00 because R185 is nonverbal most of the time. V3 said she knows R185 understands, and she seemed happy about transferring to another facility. V3 said she believes that R185 was capable of making her own decisions. V3 said that she never attempted to contact any other family members on R185's contact list because they weren't the POA (Power of Attorney), and she was only told to get ahold of the POA. V3 said that she did not try to contact V13's wife who is also listed on R185's contact list. V3 stated that she thinks V1 (Administrator)

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or V2 (Director of Nursing) might have gotten ahold of V13 on the day R185 transferred, but she wasn't sure. V3 doesn't know if any forms were sent to V13 other than the information about the new facility she sent on the day of discharge on 06/18/24.

On 09/18/24 at 12:40PM, V1 (Administrator) stated that the facility did initiate R185's discharge when they sent her to a facility with a locked unit. V1 said that R185 was always escaping and trying to elope. V1 stated they do have other resident who are at risk for eloping, but that they have never gotten out. V1 said they have been planning the discharge for several months. V1 said that they were waiting for the other facility to have a room available for R185. V1 said that the other facility called and told them they had a bed available. V1 said that she did believe that a notice was sent to V13, but she didn't know when that was. V1 said that they did try to keep R185, she was placed on one on ones, but we couldn't do that forever. V1 said that R185 actually got out of the facility several times. V1 said they did do extra stuff like extra activities, small groups, one on ones, and a medical alert device that locks the doors. V1 said R185 was at the facility when she started. V1 said she knows that they did talk about notifying the son and she thought V3 took care of that. V1 said that V3 worked on R185's discharge planning. V1 doesn't know if there were any discharge orders or not, but she would look and see if she could find any orders. V1 said that she did call around to different facilities that are closer, but no one around could take her because they were full or just wouldn't take R185. V1 doesn't know if it was documented all the places that they tried to get ahold of to take R185. V1 said that they did notify R185 that they were transferring her to another

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facility. V1 said that R185 could understand and answer appropriately at times. V1 knows that R185 has a low BIMS score which indicates severely impaired cognition but V1 said that R185 knows what is going on. V1 said she would expect V13 to be notified of the discharge and transfer before it was made. V1 said that she didn't know what the policy was for involuntary facility-initiated discharges.

On 09/19/24 at 7:55AM, V1 stated that they did not complete a notice of involuntary transfer form or notify the ombudsman concerning R185 involuntary facility-initiated discharge. V1 said at the time they were discharging R185 she wasn't thinking of it as an involuntary facility-initiated discharge. V1 stated that she does see that it was now. V1 stated that she does not know why V13 wasn't notified other than they could not get a hold of him. V1 said that they should have documented all the attempts the facility made to get a hold of V13, but she said they didn't. V1 agreed that V13 could not have done an appeal since he didn't know about the discharge. V1 said that she never told V3 that she could not call any of the other contact on R185's contact list other than the POA. V1 stated that V3 is still learning the Social Service Director job and probably didn't know she could have contacted others on R185's contact list.

The Facility Policy titled "Transfer or Discharge, Preparing a Resident for Discharge" with a revision date of 12/2016 documents under Policy Statement "Residents will be prepared in advance for discharge" Policy Interpretation and Implementation documents in part 1a. "Obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment. 1c. Providing the resident or

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representative (sponsor) with required documents."

The Facility Policy titled "Transfer or Discharge, Emergency" revised 12/2016 documents in part under Policy Interpretation and Implementation "2. If a resident exercises his or her right to appeal a transfer or discharge notice he or she will not be transferred or discharged while the appeal is pending unless the failure to discharge or transfer would endanger the health and safety of the resident or other individuals in the facility. 3. If the resident is transferred or discharged despite his or her pending appeal, the danger that failure to transfer or discharge would pose will be documented. 4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, home, or other setting our facility will implement the following procedures. 4a. Notify the resident's attending physician ... 4e. Notify the representative (Sponsor) or other family member."

The facility policy titled "Discharge Summary and Plan" revised 12/2016 documents under Policy Statement "When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new environment." Under Policy Interpretation and Implementation it documents "12. A member of the IDT (Interdisciplinary Team) will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. 13. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge

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