Illinois Department of Public Health

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 07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF BELLEVILLE	727 NORTH 17TH STREET BELLEVILLE, IL 62226

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S 000	Initial Comments Complaint Investigation 2045875/IL125177 2045871/IL125180	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220)b)3) 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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S9999	Continued From page 1 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 300.1220 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on observation, interview and record review the Facility failed to supervise, reassess, and implement progressive interventions for 1 (R2) of 23 residents reviewed for elopement in the sample of 43. This failure resulted in R2 eloping the facility on 5/26, 6/25 and 7/8/20. R2 has not been found after he eloped on 7/8/20. This failure has the potential to affect 22 other residents (R1, R5, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, and R29) who have a risk of eloping and require medications and medical monitoring. Findings include: R2's Face Sheet document R2 was admitted to the facility on 7/18/2018. R2's Face Sheet also document V26 (R2's mother) is the guardian of R2. R2's Care Plan, initiation date 7/24/2018, documents "(R2) has a diagnosis of schizophrenia. He is at risk for impaired social interaction, disturbed sensory perception, defensive coping and disturbed thought process." R2's Care Plan documents R2 is at risk for changes in his cognition and behaviors related to his use of psychotropic medication. R2's Clerk of the Circuit Court Guardianship papers dated 7/7/2020 documented R2 was a disabled adult and V26 was authorized as R2's Court Appointed guardian.	S9999		

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R2's Physician Order Sheet (POS) dated July 2020 documents R2 with a diagnosis of Schizophrenia. R2's POS document R2 was taking 30 milligrams (mg) of Seroquel (an antipsychotic), 1 tablet by mouth at bedtime and Haloperidol Decanoate injections (long-acting antipsychotic) 100 mg/milliliters inject 150 mg intramuscular every 4 weeks.

R2's Elopement Risk form, dated 3/4/2020, document R2 was at risk for elopement, ambulated independently and was cognitively impaired with poor decision-making skills. The Risk Form documented R2 had a wandering behavior or pattern or routine, history of elopement, history of leaving without informing staff and recent change in the resident's status or routine.

R2's Care Plan Problem, initiation date of 3/4/2020, documents, "History of exit seeking." The intervention documented "Divert resident's attention to another subject or activity. Place resident's picture in elopement book and keep at nurses' station, and redirect resident when he is exit seeking."

On 7/24/2020 at 12:20 PM, at the 400-hall nurse's station there was no elopement book present. V20 (Licensed Practical Nurse/LPN) stated she was not sure where the book was at.

On 7/24/2020 at 12:23 PM, at the 200-hall nurse's station there was no elopement book present. V7 (LPN) stated the elopement book was usually kept at the nurse's station but she was not sure where it had gone to.

R2's Progress Notes dated 5/27/2020 at 11:59 PM, document, "This writer asked if anyone from

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the facility had contacted her (V26) to inform her that her son the resident (R2) had eloped from the facility on yesterday evening (5/26/20) around 8:00 p.m. She replied 'No'."

There is no documentation or investigation in R2's medical record prior to the 5/27/20 Progress Note regarding R2's elopement. There is no documentation as to when R2 was found to have eloped and what was done.

R2's Progress Note Text dated 5/28/2020 at 4:47 PM documents, "This writer received a call from this resident's mother (V26). This writer expressed that she wants to know why she was not notified."

R2's Progress Notes dated 5/30/2020 at 2:36 PM, document, "Resident walked up to the front door by himself; no visible sign of injury noted; no distress." R2 returned to the facility after 4 days.

On 7/28/2020 at 2:40 PM, V17 (Police Officer) stated, "We were called in on 5/27/2020 at 8:37 PM, because (R2) was missing. The facility reported to us (R2) had been missing for about 30 minutes; they were unable to find (R2) so they contacted us because they did not know where he was at. He had eloped."

R2's Care Plan was not updated to address R2's elopement on 5/26/2020. There were no new progressive interventions to address his elopement or address his need for increased supervision after he returned on 5/30/20.

R2's Elopement Risk form, dated 6/3/2020, documented R2 continued to be at risk for elopement. The form documented the same information provided in the 3/4/20 Elopement

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S9999	Continued From page 5 Risk form. R2's Social Service Notes dated 6/8/2020 document, "QUARTERLY NOTE: This resident eloped from the facility and was gone for about three or four days. Resident stated he was at his sister's." R2's Emergency Room Visit and General History Notes, dated 6/15/20, documented he was sent to the Emergency Department after making homicidal threats to staff and residents. R2's Progress Notes dated 6/16/2020 at 5:58 PM, documented R2 returned to facility via stretcher. R2's Situation Background Assessment Recommendation Communication Form (SBAR) dated 6/25/2020 at 11:42 AM, documents "(R2) was transferred to hospital via ambulance; resident was located by local police. Resident was found on (street name). Resident was in distress and was transported via ambulance to the hospital." There was no other documentation in R2's medical record as to when staff found R2 missing, what time R2 was last seen and what facility staff did when they noted he was gone. On 7/28/2020 at 4:14 PM, V18 (Licensed Practical Nurse/LPN) stated, "Yes, I remember (R2) eloping and I filled out the SBAR for 6/25/2020. (R2) has a history of eloping and always wanting to leave the facility. I remember working that night and the alarms going off. We did room checks and discovered (R2) was missing. He had eloped. We searched the building and could not find (R2) so we called the police. The police later found him downtown. He was missing for about a half an hour before we called the police. The police found him later that	S9999		

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S9999	Continued From page 6 same night a couple hours later." R2's Care plan was not updated after his 6/25/20 elopement with progressive interventions to address his need for increased supervision to prevent him from eloping. R2's Police Report dated 7/8/2020 at 8:46 AM, documents, "On the above date at 8:46 AM, I (V17, Police Officer), responded to the facility in reference to a missing adult male (R2). Upon arrival I made contact with (V4 - LPN). (V4) stated she discovered (R2) had not been seen by staff as of 8:00 AM on 7/8/2020. (V4) believes (R2) could have been missing since the night before around 11:00 PM on 7/7/2020. (R2) does suffer from mental illness and is unknown where he goes when he leaves." R'2s Progress Notes dated 7/8/2020 at 11:42 AM, "Guardian mother is aware of resident leave of absence (LOA) from facility...police aware of resident LOA from facility." This Progress Note did not document that R2 eloped from the facility and the facility was not aware of leaving the premises. R2's Investigation Report dated 7/8/2020 did not document that the facility attempted to search outside of the facility for R2 when this incident occurred. No time was documented as to what time the facility was unable to find R2. On 7/17/2020 at 12:50 PM, V1 (Administrator) stated, "I spoke with (R2's) mom regarding (R2) eloping." V1 stated the facility has not been able to confirm where R2 is or if he is safe or injured. V1 stated, "No, we are not sure how he got out of the building or what time he exited."	S9999		

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On 7/17/2020 at 12:58 PM, V3 (Social Service Director) stated, "(R2) eloped in July. The family has called about it and the mom (V26) is his guardian and she is upset." V3 stated V26 thinks R2 is at a family member's house. V3 stated, "V26 keeps calling the facility saying 'We have to find him.' She has called 3 times last week." V3 stated R2 has eloped before but he usually comes back within a day or two. V3 stated the last time R2 eloped he returned to the facility. V3 stated this was during the COVID-19 outbreak, so the facility sent him to the hospital to get tested. V3 stated the facility does not know where R2 is or where he went. V3 stated "We think it was in the wee hours of the morning. I clock in and check the halls and when I had already clocked in the nurse told me he had eloped, and they had called the police."

On 7/17/2020 at 12:41 PM, V6 (Minimum Data Set Coordinator) stated, "(R2) would be okay for a while, then he would start to get anxious and say he has business he would need to take care of. He has a history of drugs." V6 stated, "Yes, he has left before, this is not the first time he has just left. Yes, this is the longest he has stayed away. No one is sure where he is at."

On 7/17/2020 at 1:34 PM, V7 (LPN) stated, "(R2) liked to stay in his room; he did not come out much." V7 stated, "He has left before, but he came back. This is the longest he has been away. I think he has left 2 times maybe. I can't say where he goes. I know he came back during COVID outbreak, so we had to get him tested but I am not sure of the exact date."

On 7/17/2020 at 1:40 PM, V8 (Training Nurse Assistant) stated, "(R2) stays in his room. He will wave back at you if you wave at him. He came up

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here the other day, he was short-fused and angry. It was not like him at all. One day he would be fine, the next day he would not be okay and short tempered. I have only been working here for about 6-8 weeks, but something was bothering (R2) right before he went missing."

On 7/22/2020 at 2:44 PM, V4 (LPN) stated, "I worked the night shift on 7/7/2020 and day shift on 7/8/2020. My co-worker gave his medication on 7/7/2020 at around 7:00 PM on 7/7/2020." V4 stated, "Around 8:00 AM, the next morning as I walked the hall I realized (R2) wasn't in his room. We searched the building and we couldn't find him. We called the police and reported (R2) gone. The CNAs are supposed to check on all the residents at least every 2 hours." V4 stated, "I know no alarms went off on the night shift on 7/7/2020. The doors are all alarmed." V4 stated again, "I don't know how he would have got out of the building. I guess the door alarm may not have worked. I don't know. No, I never heard any alarms going off alerting us that he had left the building."

On 7/23/2020 at 10:28 AM, V14 (CNA) stated, "Yes I know (R2). I work the night shift. I come in at 10:30 PM. I saw (R2) that night (7/7/20) about 10:50 PM or 11:00 PM pacing the halls. I was not assigned to his hall that night. (R2) did seem distressed and had an angry look on his face. I went to the nurse and let her know you better check on (R2) because he is pacing, and he is about to go off. I think the nurse was either (V7, LPN) or (V18, LPN). We are supposed to go to the charge nurse when anything unusual is going on. (R2) is usually quiet but sometimes he will get an angry look, and pace when he is about to go out the door. I didn't hear any door alarms go off that night. If the door alarm goes off everybody

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runs to see what is going on. I heard about (R2) missing the next day by another CNA. No one from the facility asked me any questions about him. We do bed checks every 2 hours to make sure all the residents are dry. We check and make sure they are accounted for. I would check at 12:00 AM, 2:00 AM, 4:00 AM and 6:00 AM. (R2) did not need to be checked frequently unless he was having some behavioral issues. He was usually quiet and stayed in his room."

On 7/23/2020 at 11:00 AM V16 (CNA) stated, "Yes, I know (R2), and I worked his hall on the 7/7/2020. I came in and worked at 2:30 PM until 6:30 AM. The last time I saw (R2) was about 5:00 AM or 6:00 AM and (R2) was laying down in his bed. There were not any alarms going off letting us know a resident had left the building. I am not sure when he went missing."

On 7/28/2020 at 3:30 PM, V26 stated, "(R2) can't make his own decisions, that's why I have guardianship of him. He lived with me, and he would get himself beat up on the street, he wouldn't pay his bills, and he wouldn't take his medication. He became combative and I couldn't take care of him anymore. That is why we put him at the facility. I have court appointed Guardianship." V26 confirmed R2 eloped on 6/25/20. V26 stated, "He has eloped at least 4 times this past 3 months. I believe they sent him to the hospital that time because he was so upset, and he had hit someone."

On 7/23/2020 at 3:20 PM, V19 (Physician/Medical Director) stated, "I go the facility every Saturday and that facility in particular has a population that has a lot of psych patients and they have tendency to run out the door, but I was never informed that (R2) had eloped from the facility

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and was still missing and could not be found. I was never informed of (R2) leaving the building and missing. (R2) needs supervision and especially with his history of eloping the facility should have something in place. The facility should have a working alarm system in place so no one can get out of the facility without staff knowing about it. They should be checking on (R2) and monitoring him. (R2) has behaviors and I do not believe he can make good judgements about his surroundings and environment. No, I do not believe (R2) can make good decisions. I was never contacted regarding (R2) becoming agitated, was distressed and/or angry. I would expect the facility to notify me of his behaviors and of his elopement."

As of 7/24/2020 at 12:00 PM an onsite was made to the facility and R2 was not in the facility. R2 had not returned to the facility and his whereabouts were still unknown.

On 7/25/2020 at 4:35 PM, V1 (Administrator) stated there was no policy on how to address elopement behaviors and she had already given this surveyor everything on their elopement policy.

Facility's Elopement Policy Statement, dated March 2015 documents, "Staff shall investigate and report all cases of missing residents." Policy Interpretation and Implementation documents, "1. Staff shall promptly report any resident who tries to leave premises or is suspected of being missing to charge nurse or Director of Nursing." The Policy documented "If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if resident is authorized to be out on leave or pass. b. If the resident was not authorized to leave, initiate a

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S9999	Continued From page 11 search of the building(s). c. If the resident is not located, notify the Administrator and Director of Nursing Services, Residents legal Representative (sponsor), the attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e. emergency management, rescue squads, etc.). d. Provide search teams with resident's identification information; and e. Initiate an extensive search of the surrounding area." On 7/24/2020 at 1:00 PM, V3 provided the Elopement book to surveyor. Inside the book was a list of residents at risk for elopement and the following residents were documented as being at risk for elopement R1, R2, R5, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, and R29. (A)	S9999		