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 12/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 1948812/IL117973	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 300.1210d)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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These Requirements are not met as evidenced by:

Based on interview, observation and record review, the facility failed to provide care and services for the provision of hemodialysis for 2 of 2 residents (R1, R3) reviewed for dialysis services in a sample of 9. This failure resulted in R3 missing 2 dialysis treatments within a week which resulted in hospitalization for End Stage Renal Disease (ESRD) and the need for emergency dialysis treatment.

Findings include:

1. R3's current Care Plan documented R3 was a 42-year-old male admitted to the facility on 1/6/19 with a diagnosis of Stage 5 Chronic Kidney Disease (End Stage Kidney disease).

R3's Minimum Data Set (MDS) dated 10/25/19 documents that R3 was alert and oriented, independent with bed mobility and transfers and utilized a wheelchair to independently propel

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S9999	Continued From page 2	S9999		

himself in and out of the facility.

R3's Nurse's note dated 10/25/19 at 9:38 AM entered by V7 (Licensed Practical Nurse/LPN) documents that R3 was having diarrhea and R3's Primary Care Physician (PCP) was in the building and gave a new order to send R3 to the nearest emergency room for evaluation.

R3's Hospital History & Physical (H&P) dated 10/26/19 documents that R3 presented to the emergency room with complaints of a fall, nausea, vomiting, diarrhea and chest pain. Problem list includes: Acute on chronic Renal Failure, Hyperkalemia, Lactic Acidosis, Sepsis, and Pneumonia.

R3's Hospital Discharge Summary dated 10/31/19 documents that R3 was admitted with a diagnosis of End Stage Renal Disease (ESRD) and Hyperkalemia (Potassium Level in your blood that is higher than normal) with the potassium level being 9.8 (high). The Hospital Discharge Summary documented R3 received emergency dialysis at the hospital.

R3's Dialysis (undated) Care Plan documents R3's goal will be to have no complications associated with dialysis through the next review. Interventions include: "Arrange transportation to and from dialysis center; Assess bruit and thrill every shift; Assess for edema; Check lab values as ordered - notify MD/NP/Dialysis of abnormal values; Monitor shunt site for signs and symptoms of infection or free bleeding."

R3's Nurse's Note, dated 11/6/19 at 10:10 PM entered by V2 (Director of Nurses/DON) documents R3 returned from the hospital with a diagnosis of ESRD and Hyperkalemia. The Note

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 12/17/2019

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S9999	Continued From page 3	S9999		

documented dialysis was set up for three times weekly on Tuesday, Thursday and Saturday and a new fistula was placed in R3's left arm for dialysis.

R3's Physician Order Sheets (POS) documented R3 was readmitted to the facility on 11/6/19. At that time there was no documented Physician's order for dialysis, assessment of R3's fistula/shunt site or laboratory testing upon readmission to the facility.

R3's November 2019 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documents dialysis every Tuesday, Thursday & Saturday at 10:00 AM. There is no documentation that R3 attending on those days. R3's TAR documents that the fistula site will be monitored daily during the day shift for thrill/bruit. The TAR did not document staff were monitoring R3's fistula site for thrill/bruit on all shifts.

R3's Nurse's Note dated 11/7/19 at 12:57 PM entered by V4 (LPN) documents rescheduled dialysis appointment for tomorrow (11/8/19) at 0600. Will be transported by company van. Transportation director at facility aware of appointment.

R3's Nurse's note dated 11/11/19 at 12:57 PM entered by V6 (LPN) documents that the facility received a dialysis holiday schedule for the holiday (Thanksgiving Holiday). The Nurse's Note did not document what changes were made and what days R3 would be receiving dialysis.

R3's Nurse's Notes dated 11/16/19 and 11/23/19 (Saturday) documented R3 received dialysis on these days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF BELLEVILLE	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

R3's Nurse's Note dated 11/26/19 (Tuesday) at 10:54 AM entered by V4 document that a call was received from the dialysis center and R3 had missed his dialysis appointment on Monday 11/25/19. Nurse asked if there were any available chairs for 11/26/19, there were none available. R3's next appointment was on Wednesday 11/27/19. The Nurse's Note documented R3's dialysis schedule had changed from Tuesday, Thursday, Saturday to Monday, Wednesday, Friday due to the holiday. The Note documented the transportation coordinator was made aware of situation/change in schedule and that a ride needed to be scheduled or provided so R3 could attend the dialysis appointment on 11/27/19 at 5:30 AM. The Note documented "Call made to PCP with no new orders."

V1 (Administrator) provided a copy of a November 2019 calendar on 12/10/19 at 11:14 AM for R3. This calendar documents that R3 missed dialysis appointments on 11/25/19 and 11/27/19. V1 stated the information on the calendar was compiled after reviewing transportation records, nurse's notes and staff interviews.

Review of the dialysis center's post treatment notes on R3 dated 11/25/19 & 11/27/19 confirms that R3 missed the dialysis appointments on those days.

R3's Nurse's note dated 11/28/19 entered by V5 (Licensed Practical Nurse (LPN)/Unit Manager) documents that a family member came to the nurse's station with concern about R3. The Nurse' Note documented R3's blood pressure was 110/60; Pulse 72; and Temperature 97.2 degrees Fahrenheit. The Nurse's Note documented R3 was transported to the emergency room.

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	IL6001341	A. BUILDING: _____ B. WING _____	C 12/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

R3's Hospital History & Physical (H&P) dated 11/29/19 documents that R3 was admitted to the hospital with a diagnosis of ESRD, Septic Shock with Hypotension, Cardiac Arrest, Acute Respiratory Failure, Severe Metabolic Acidosis, Hyperkalemia, Anemia, Hypertensive Renal Disease, Peripheral Artery Disease with Right Lower Extremity Amputation, Lactic Acidosis secondary to Hypoperfusion, Congestive Heart Failure and Sepsis. The H&P documented R3 had missed several dialysis sessions and his prognosis was poor. The H&P documented R3 received emergency dialysis and during dialysis R3 became unresponsive and CPR was performed. R3 was subsequently placed on a ventilator. The H&P documented on 11/29/19 at 6:21 PM, R3 continued to deteriorate.

R3 expired on 11/29/19 and death certificate documents the cause of death as Sepsis, ESRD, and Wound Infection.

On 12/6/19 at 12:12 PM, V15 (R3's sister) stated that she visits R3 2-3 times per week. V15 stated on 11/27/19, she went to the facility to take R3 shopping and to bring him food. V15 stated that after telling the nurse that R3's wound was bleeding and the nurse reapplying a dressing, she took R3 shopping. V15 stated that R3 had complained that he was sick to his stomach, so he bought some 7-up. V 15 stated that when she brought R3 back to the facility, V9 (Transportation Coordinator/Certified Nurse's Assistant/CNA) stated that R3 had missed his dialysis appointments on Monday and Wednesday because transportation wouldn't pick him up due to insurance and the facility van was broken and in the shop. V15 stated on 11/28/19, she went to the facility and upon arriving, R3 was still in bed

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	IL6001341	A. BUILDING: _____ B. WING _____	C 12/17/2019

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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S9999	Continued From page 6	S9999		

which V15 stated was unusual and his food was still on his table that was brought to him on 11/27/19. R3 stated he wasn't feeling well, had missed 2 appointments at dialysis and needed to go to the hospital to get dialysis. V15 stated that R3 was confused, slow to respond, stated he hadn't eaten, left leg was bleeding and his voice was raspy. V15 stated she went to the nurse's station and spoke with V5 regarding R3 not feeling well and he needed to be sent to the hospital. V15 then left the facility. V15 stated on 11/29/19 she received a call from her mother and was told that R3 was in the hospital. V15 visited R3 in the hospital that afternoon and she was hopeful that he would recover in a few days. On 11/29/19, V15 received a phone call from her mother stating R3 had deteriorated and she needed to get to the hospital. V15 stated that R3 was unresponsive and expired 11/29/19 at 6:31 PM. V15 stated that R3 had never refused his dialysis treatments.

On 12/6/19 at 10:58 AM, V13 (R3's Nephrologist) stated he would expect the facility to monitor a dialysis patient's blood pressure, signs of fluid overload (i.e.: edema, shortness of breath), weigh daily, monitor for any change that would warrant an office visit. V13 stated he would expect to be notified of a missed dialysis appointment or change in condition. V13 stated he was not notified of R3 missing any dialysis appointments or change of condition.

On 12/6/19 at 8:30 AM, V5 stated that he was the nurse on duty 11/28/19 when R3 was sent to the emergency room. V5 stated that R3's daughter was here and wanted him sent out. V5 stated that R3's leg was bleeding, and he wasn't "messing around with a dialysis patient" so he sent him to the hospital. V5 stated he did not assess R3 prior

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	IL6001341	A. BUILDING _____ B. WING _____	C 12/17/2019

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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S9999	Continued From page 7	S9999		

to and "it would have been a good idea, but the sister was demanding that he be sent out," and he did not notify R3's PCP or Nephrologist. V5 was unaware of how many dialysis appointments R3 had missed. V5 stated, "I almost sent him out the day before (11/27/19) because of his leg, I had to put a new dressing on it even though I don't do wounds."

On 12/6/19 at 10:00 AM, V9 stated that she is responsible for setting up the initial transportation for dialysis patients. V9 stated she was aware of the holiday schedule for dialysis and had set up transportation for 11/25/19 & 11/27/19. V9 stated she was notified by dialysis on 11/27/19 that R3 had missed his appointment on 11/25/19 and V9 contacted R3's insurance company regarding the transportation. V9 stated that if she been notified that transportation didn't come, she would have taken R3 in the facility van. V9 stated the facility van's lift was broken; however, R3 could have gotten into the van without the lift and the facility could have borrowed a sister facility's van if necessary.

On 12/5/19 at 1:15 PM, V6 (LPN) stated that R3 had not missed any dialysis appointments prior to 11/25/19. V6 stated that the hospital or dialysis center will set up the initial transportation and once it is set up the facility transportation person lets the insurance company know of any changes. V6 stated the transportation company will not make any changes until the insurance company approves it. V6 stated the facility is not notified if the change has been approved, the transportation company just doesn't show up or shows up at the regularly scheduled time. V6 stated that R3 missed his dialysis appointment on 11/25/19 and the facility attempted to reschedule him for 11/26/19 but the dialysis facility did not

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	IL6001341	A. BUILDING: _____ B. WING _____	C 12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 8	S9999		

have a chair time available.

On 12/10/19 at 9:10 AM, V4 (LPN) stated she would monitor R3's shunt/fistula for thrill and bruit at the beginning of the shift and when R3 would return from dialysis. V4 stated the facility would send a communication form with R3 to dialysis but he wouldn't return with it. V4 stated there was no communication between the facility and dialysis regarding R3's condition before or after the dialysis treatments.

On 12/11/19 at 9:45 AM, V1 stated she was not notified that R3 had missed dialysis appointments or of any transportation issues until Wednesday (11/27/19). V1 stated V1 was notified that R3 missed Wednesday and it was rescheduled for Saturday and "no one knew about him missing Monday (11/25/19)."

On 12/6/19 at 2:15 PM, V11 (Registered Nurse/RN/Regional Nurse) stated the facility does not have a policy and procedure for Dialysis. V11 stated they would follow the standard of practice.

The facility contract with the dialysis center, last signed on 4/22/15 stated that "The facility shall have the responsibility for arranging suitable transportation of the Designated Resident to and from Center, including the selection of the mode of transportation, qualified personnel to accompany the Designated Resident and transportation equipment usually associated with this type of transfer. The facility shall ensure that all appropriate information accompany all Designated Residents at the time of transfer including any information that will facilitate the adequate coordination of care."

The facility policy titled "Change in a Resident's

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	IL6001341	A. BUILDING: _____ B. WING _____	C 12/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

Condition or Status" dated 2015 stated the "facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status." The policy continues to state that the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition; A need to alter the resident's medical treatment significantly, and a need to transfer the resident to a hospital/treatment center. The policy defines a "significant charge" as "a condition that is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more that one area of the resident's health status, requires interdisciplinary review and/or revision to the care plan and is ultimately based on the judgement of the clinical staff."

2. The MDS dated 10/9/19 identifies R1 to be a 66-year-old male admitted to the facility on 9/1/17 with diagnoses of Hyperkalemia, End Stage Renal Disease Stage 5 and Schizophrenia.

R1 was identified on 12/5/19 as receiving Dialysis treatments off campus by V1 (Administrator).

R1's December 2019 Physician's order sheet (PO) did not document an order for the Dialysis or identify when he is scheduled to go.

The Care Plan (undated) documents R1 has "end stage Renal Disease and receives hemodialysis 3 times per week" but fails to document when those times are. The Care plan documents his dialysis access/shunt is located on his right upper

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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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S9999	Continued From page 10	S9999		

extremity and identifies which dialysis center he attends. The care plan also documents R1 has a "history of refusing to go to dialysis at times. He will state that he doesn't feel like it." The goal is for R1 to have no complications associated with dialysis thru next review with interventions being: arrange transportation to and from dialysis center, assess for edema, dressings to be changed at dialysis, encourage resident to rest upon return, in case of bleeding hold pressure until EMS (emergency medical services) arrive, make sure resident is ready to go to dialysis, monitor shunt site for signs and symptoms of infection or free bleeding, staff are to encourage to attend all dialysis appointments, nurses to educate resident on the risk of missing dialysis treatments, utilize communication form and phone conversation to optimize coordination of care and limit complications related to treatments in part.

On 12/5/19 at 1:10 PM, R1 was out of the building at Dialysis per V5. V5 stated they "always send information with the resident" but they do not always come back with information or they do not give it to the nurses.

The Medication Administration Records (MAR) and the Treatment Administration Records (TARs) for October, November and December 2019 were reviewed and found to have no information regarding when R1 is scheduled to go to Dialysis and when he went.

The progress note dated 10/16/19 entered by V7 (LPN) at 11:32 AM documents R1 returned from Dialysis and "starting on 11/5/19 dialysis will move to Tuesday, Thursday and Saturday at 11:20 AM."

Progress notes dated 11/9/19 entered by V8 (Psychiatric Rehab Service Director) at 1:17 PM

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	IL6001341	A. BUILDING _____ B. WING _____	C 12/17/2019

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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S9999	Continued From page 11	S9999		

documents 11/9/2019 13:17 (1:17PM) a Social Service Note text "Due to transportation issues, resident was unable to go to dialysis on this date." The note continues "This writer phoned (Dialysis Center) to inquire of transportation and or to gain knowledge if dialysis social worker (SW) arranged, however SW was off on this date. This writer spoke w (with)/Nurse who shared information on chair-time. Residents' chair-time is from 11:20-1:20p on T-TH-Sa (Tuesday-Thursday-Saturday) Nurse shared would leave a message for SW to return call on Monday, 11/11/19. This writer attempted to contact (Transportation Service) (per resident this is his transportation) to no avail. Will continue to follow up on res and offer supportive services." There is no follow-up to this conversation documented in the progress notes or Social Service Notes.

Progress notes dated 11/11/19 at 1:52 PM, written by V6 (LPN) documented "waiting dialysis holiday schedule up ad lib no s/s (signs/symptoms) distress, denies discomfort, shunt positive bruit/thrill, no abnormal bleeding."

Progress Notes dated 11/23/19 documents at 10:22 AM, R1 was picked up by (transportation service) to transport to Dialysis.

There are no further notes in the progress notes regarding the holiday schedule or problems with Dialysis following this entry.

On 12/5/19 at 11:00 AM, V4 (LPN) stated R1 was out of the building at Dialysis. At 5:10 PM, R1 was walking up to the building after being let out by transportation following dialysis.

On 12/6/19 at 8:30 AM, V1 was unable to provide

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 12/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

any documentation as to when R1 went to Dialysis and when he did not. V1 stated they were checking their transportation book and with Dialysis to determine how many sessions he attended and had dialysis. V1 also stated the facility does not currently have a policy/procedure on Dialysis.

On 12/6/19 at 12:11PM, V14 (Dialysis Clinical Manager) stated R1 usually comes "empty handed" when asked about if he brought any information with him from the facility. V14 stated R1 usually makes his appointments but confirmed that he did not make the appointment on 11/9/19 and that the facility was going to call back to tell them why but never did. V14 also stated R1 missed his appointments during the holiday week between 11/23 and 11/30. V14 stated the Dialysis center provides the holiday schedule well in advance to the facility and the transportation company so arrangements can be made. V14 stated after R1 missed 11/25/19 and 11/27/19, they notified the facility again but didn't get any explanation back. V14 stated they notified V16 (R1's nephrologist) of the missed appointments.

On 12/10/19 at 11:10 AM, V1 provided a calendar of Dialysis treatments that R1 received which she stated she compiled from nurses' notes, transportation notes and 24-hour report sheets. The Dialysis treatment calendar shows R1 missed his dialysis session on 11/25/19 with a notation "transportation wouldn't wait for him to come" and on 11/27/19 it documents "transportation did not come and p/u (pickup.)" The Calendar documents R1 also did not attend his dialysis on 11/9/19. There is no documentation in the clinical record or that V1 could provide that shows the facility notified, V16

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 12/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

and/or the dialysis team of any of R1's missed Dialysis treatments.

On 12/6/19 at 2:15 PM, V11 (Nurse Consultant) confirmed the facility has no policy/procedure, but they would expect nurses to follow standards of practice and send a sack lunch with them if they are there over a mealtime.

The Contract dated 5/2009 entitled "Nursing Home Outpatient Dialysis Agreement" which was written under another ownership documents it was written 5/5/2009. The agreement documents the facility agrees to provide dialysis treatments to those patients as ordered by each patient's nephrologist. The contract continues under "services" to document "Nursing Home shall schedule dialysis treatments for designated residents as mutually agreed by the parties. Nurse Home shall have sole responsibility for transporting or arranging transportation of the designated residents to and from the above referenced clinic." The policy documents "The RAI (Resident Assessment Instrument) with cooperation from the nursing home, will for its use, develop, implement, and maintain appropriate care plans for each designated resident."

(AA)