STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013106	A. BUILDING: _____ B. WING _____	C 10/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF COLUMBIA	253 BRADINGTON DRIVE COLUMBIA, IL 62236

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S9999	Continued From page 1	S9999		

meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 300.2900 General Building Requirements

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S9999	Continued From page 2 d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to prevent unsupervised wandering outside the facility for 1 of 3 residents (R3) reviewed for wandering in the sample of 11. This failure led to R3 being found outside the facility sustaining a hematoma on the forehead and sent to the Emergency Room (ER) for evaluation. Findings include: R3's Quarterly Minimum Data Set (MDS) dated 7/27/18 documents R3 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documents R3 needs extensive assist for transfers but independent with the use of a wheelchair on and off unit. The MDS document no wandering behavior or history of falls. R3's Nurse's Notes dated 8/6/18 at 6:50 PM,	S9999		

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S9999	Continued From page 3	S9999		

documents, "Res (Resident) eloped out main doors into the parking lot, assisted back to facility per this nurse, 15 minute checks initiated, care plan made aware. Nurse's Note documents, "8/6/18 at 7:00 PM Message left for POA to call facility." Nurse's Note dated 8/7/18 9AM documents," MD made aware of elopement."

R3's Care Plan dated 9/13/18 documents, "Resident has potential to demonstrate verbally abusive behaviors and resist care related to Dementia, Mental/Emotional Illness. She will become impatient quickly if staff do not respond immediately to all her requests. She has also been delusional in that she does not seem to know where she is and has entered other residents' rooms and has attempted to leave the facility. She has exit seeking behaviors and often will transfer self without assistance." There are no interventions/approaches addressing R3's wandering/elopement in the care plan. There was no update on the care plan about R3's elopement on 8/6/18.

R3's Incident/Accident Report dated 9/15/18 at 8:10 PM documents, "Resident found outside exterior door lying on her back. Hematoma to forehead." R3's Investigation Conclusion documents,"9/15/18. Found on ground assisted up by one (CNA) Certified Nursing Aide and two nurses after being assessed by nurse. Resident had no complaint of pain or discomfort, moves all extremities without difficulty. Resident alert with no change in cognition noted. MD (V8) and (V7, Power of Attorney) POA notified. Resident obtained hematoma to right forehead. Resident sent to ER for evaluation. Resident was observed by staff at dining room door at 7:45 PM as staff were on break."

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S9999	Continued From page 4	S9999		

R3's Nurse's Notes dated 9/15/18 at 8:09 PM documents, "This nurse found resident outside near maintenance door, on ground, lying on her back in the grass, wheelchair on the sidewalk facing the grass. Noted hematoma to right forehead. This nurse assessed resident's range of motion. No complaint of pain when all extremities were moved. Alert, and talking, knows names of staff present. One CNA and 2 nurses assisted back to wheelchair and wheeled into facility. Nurse phoned 911, doctor's exchange, Administrator. Ice applied to forehead. Resident refused all vital signs, talking to this nurse, laughing, complained of pain only when forehead was assessed."

R3's Post Fall CNA Report dated 9/15/18 documents, "What happened? (Answer) Resident was outside and fell from wheelchair. Is this resident on the Fall Program? (Answer) No. If Safety Interventions not in place, please explain: (Answer) No interventions necessary. Resident is not a fall risk. In your opinion, is there anything we could have done to prevent fall? (Answer) No alarms on door sounded."

R3's Hospital History and Physical dated 9/15/18 documents, "Patient presents with a hematoma to the right side of forehead after an unwitnessed fall today. Patient was sitting outside in her wheelchair and was found on the ground by staff later. LOC (level of consciousness) is unknown. Pt is on aspirin daily. HPI (History of Present Illness) limited due to dementia. Unable to open her eyes and there is a large hematoma on the right forehead."

Hospital Ultrasound of Forehead Soft Tissue Mass Report dated 9/15/18 documents, "Impression: Large frontal scalp hematoma

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S9999	Continued From page 5	S9999		

without drainable component." Hospital CT (Computerized Tomography) Head without (WO) contrast Report dated 9/15/18 documents, "Frontal Scalp Hematoma without intracranial hemorrhage or skull fracture." Hospital CT Cervical Spine WO contrast Report dated 9/15/18 documents, "Advanced multilevel lumbar spondylosis without fracture."

On 1010/18 at 11:18 AM, V4, CNA, stated at 8:15 PM, she went to R3's room to put R3 to bed but could not find her. V4 stated she searched the 400 hall and alerted the nurses when she could not find R3. V4 stated she did not hear the exit door alarms sounding. V4 stated she and V6, Licensed Practical Nurse (LPN), reached R3 at the same time. V4 stated R3 was lying on the grass on her back and her wheelchair was upright facing the grass.

On 10/10/18 at 12:15 PM, V5, CNA, stated R3 wheels herself around the hallways saw her a couple times coming down 300 hall trying to get out. V5 stated she redirected R3 away from the exit door and told R3 her husband is coming to visit her. V5 stated she did not hear the alarm doors sounding.

On 10/10/18 at 12:28 PM, V6 stated the last time she saw R3 was in the dining room at 7:45 PM and at 8:00 PM she was alerted that staff could not locate R3. V6 stated she went out the maintenance door and found R3 lying on her back in the grass and her wheelchair positioned towards grass. V6 stated no alarms on doors sounded. V6 stated she has never seen R3 attempt to go out of the building but has seen her by the door.

On 10/10/18 at 11:34 AM, V3, Maintenance

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S9999	Continued From page 6	S9999		

Director, stated he received the call R3 was found outside and when he arrived at the facility, the ambulance was there to pick up R3. V3 stated he was told R3 was found outside near the sidewalk between the 500 side door and the 500 front door. V3 stated he checked the 500 hall front door and the 500 hall back door alarms and both alarms were working. V3 stated he or maintenance staff checks all door alarms daily. V3 stated he checked all the door alarms in the facility on 9/15/18 and all were working. V3 stated nobody ever uses the back exit by the 500 nurse's station, it was for evacuation purposes.

On 10/10/18 at 9:18 AM, V1, Administrator, stated R3 was found outside on the grounds and there were two possible doors R3 could have gone out: the back exit door by the 500 Hall Nurse's Station entrance or the 500 Hall front entrance. V1 stated there are no cameras installed on any of the exit doors. V1 stated the only way it could have happened was R3 was sitting by the 500 Hall entrance and a visitor was leaving, punched the code and opened the door and R3 followed them that's why no alarm sounded. V1 stated "The facility has installed those delayed egress doors with the 14 second alarm system and is pretty much the intervention for wandering/ elopement risk residents."

On 10/16/18 at 1:08 PM, V14, Nurse Practitioner, stated there was one other occasion R3 was able to get out of the double doors into the parking lot and this happened about 5 weeks ago. V14 stated it is unacceptable that it happened again and this time R3 sustained an injury and had to be sent to the hospital. V14 stated she expects for all residents to get the very best care and be safe where they are. V14 stated R3 was pleasantly confused. V14 stated there were days

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S9999	Continued From page 7 with lucid conversations and other days when she would not make any sense at all. V14 stated she does not think R3 understood the safety issue when getting out of the building. V14 stated R3 has mild to moderate dementia. The Facility Policy on Wandering Resident dated 3/2015 documents, "Policy Statement: The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. Interpretation and Implementation: 1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). 2. The staff will assess at risk individuals for potentially correctible risk factors related to unsafe wandering. 3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. 4. Interventions to try to maintain safety will be included in the resident's care plan. 5. Staff will institute a plan of care, as indicated for residents who are assessed to have a high risk of elopement. 6. Staff will notify the Administrator and Director of Nursing immediately, and will institute appropriate measures (including searching) for any resident who is discovered to be missing from the unit or facility." (B)	S9999		