IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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August 12, 2021

Business Filing Incorporated, Registered Agent
Belleville Behavioral Health & Nursing Center, LLC
600 S 2nd St, Ste 104
Springfield, Illinois 62704

RE:	Complaint #:	IL133726, IL133807, IL133810 & IL134198
	Survey Date:	05/27/21
	Docket #	21-C0479
	Violation Type:	B Violations with fines

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Integrity HC of Belleville.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Becky S. Dragoo, MSN, RN
Deputy Director – Office of Health Care Regulation
Illinois Department of Public Health

Enclosure
cc: Administrator
File
Integrity HC of Belleville/05/27/21//RegAgent/S. Hobson

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. BELLEVILLE BEHAVIORAL HEALTH & NURSING CENTER, LLC, D/B/A, INTEGRITY HC OF BELLEVILLE, Respondent.	))))))))))	Docket No. NH21-C0479

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on 05/27/21, at Integrity HC of Belleville, 727 North 17th Street, Belleville, Illinois 62226. On 08/02/21, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Scott Hobson, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Becky S. Dragoo, MSN, RN
Deputy Director – Office of Health Care Regulation
Illinois Department of Public Health

Dated this 12 day of August, 2021.

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 05/27/2021

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 2143180/IL133726 2143252/IL133807 2143257/IL133810 2143573/IL134198	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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) These requirements were not met as evidenced by: Based on interview and record review the Facility failed to supervise, assess, and implement progressive interventions for 1 of 7 residents (R12) reviewed for elopement in the sample of 35. This failure resulted in R12 eloping the facility on 4/22/2021. R12 has not been found after she	S9999		

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S9999	Continued From page 2 eloped on 4/22/2021 and is still missing as of 5/27/2021. Findings include: R12's Face Sheet documents R12 was admitted to the facility on 7/31/2018. R12's Face Sheet also documents V34 as the Family of R12. On 5/14/2021 at 8:13 AM, the facility provided The Midnight Census Form that documents R12's room as a Bed hold (paid). R12's electronic records document R12 as being an active resident. R12's Minimum Data Set (MDS) dated 4/7/2021 documents R12 was moderately impaired with cognition with supervision and set up needed for transfers. R12's Physician Order Sheet (POS) for April 2021 documents (R12) has a diagnoses including schizoaffective disorder, bipolar type, cocaine abuse with cocaine induced psychotic disorder, epilepsy not intractable without status epilepticus, Type 2 diabetes mellitus with diabetic neuropathy, muscle weakness, complete traumatic amputation at knee level of left lower leg, and alcohol abuse. R12's POS for April 2021 also documents R12 is taking 25 milligrams (mg) of Hydroxyzine tablets two times a day for anxiety. R12's POS documents she was taking Paroxetine (Paxil) 30 mg daily for Schizophrenia, Valproic Acid 250 mg three times a day for epilepsy, Quetiapine (Seroquel) 50 mg two times a day and 200 mg once daily at bedtime. R12's POS also documents Blood Glucose Monitoring check and record at 6:00 AM, before breakfast.	S9999		

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S9999	Continued From page 3 R12's Elopement Wandering Risk Assessment dated 4/7/2021 does not identify R12 as being at risk for elopement and or wandering. On 5/14/2021 at 9:35 AM, V1 (Administrator) was questioned if any residents had attempted to elope from the facility. At that time, V1 stated, "I am not sure if we have had anyone elope in the last 3 months; let me check." R12's Care Plan, with a target date of 2/12/2021, documents, "(R12) requires healthcare monitoring related to Diabetes Mellitus." The Care Plan documents R12 received blood sugar finger sticks and insulin daily to manage symptoms. R12's Care Plan documents, "(R12) is at risk for episodes of hypo/hyperglycemic reactions." R12's Care Plan documents, "(R12) healthcare monitoring related to diagnosis of Seizure Disorder. (R12) is at risk for injury due to uncontrolled seizure activity. She is at risk for aspiration of respiratory secretions or vomiting during seizure and suffocation." R12's Care Plan documents, "(R12) is at risk for decrease of functional mobility in lower extremities related to above the knee left leg amputation, inactivity resulting from loss of limb." R12's Care Plan documents, "(R12) has a diagnosis: Schizophrenia. She is at risk for impaired social interaction, disturbed sensory perception, defensive coping and disturbed thought processes. (R12) displays conflictual, difficult behavior with peers and roommates. She likes to antagonize her peers, related to Diagnosis of Bipolar and Psychotic Disorder." R12's Care Plan does not document she was always saying she wanted to leave the Facility. R12's medical records had no documentation	S9999		

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S9999	Continued From page 4	S9999		

related to R12's elopement on 4/22/2021 in her electronic or paper chart.

On 5/14/2021 at 9:48 AM, R17 stated, "(R12) was no longer happy here in the Facility. Her room was in the basement and she was not happy here and she said she was going to leave so she crawled out of the window in the middle of the night. She crawled out of the window out of (R9's) room. They never found her; nobody knows where she went or where she is at now. She was going around checking the windows and (R9') window was open and she crawled out of it."

On 5/14/202021 at 9:59 AM, R19 stated, "(R12) used to be on our hall, but she was moved down into the basement. (R12) was not happy here; she was miserable and said she was going to leave, and she did. She went into (R9's) room and crawled out at night a couple of weeks ago. They never found her; she is still missing. I hope she is okay."

On 5/14/2021 at 10:54 AM, V34 (Family of R12) stated, "The facility called me and told me (R12) had left out of the window in the middle of the night. I have no clue where (R12) is at or if she is even safe. She does not have any money and I do not know if her medical needs are being met and if she is getting her medication. She has no access to money, and I have called the facility several times to get updates. Nobody knows nothing. I don't know if the police are even looking for her, and I am really worried about her and want to know if she is safe. I live in Kentucky and we are really sick about it."

On 5/14/2021 at 11:02 AM, R21 stated, "I am now in the room where (R12) was living. They took all of her stuff out of the room. I think it is in storage

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S9999	Continued From page 5	S9999		

because (R12) left in the middle of the night and never came back. They say she crawled through the window in the middle of the night."

On 5/14/2021 at 11:03 AM, R22 stated, "I know (R12). She was down here with us. She said she was sick of this place and in the middle of the night she crawled out of the window and that is something because she only had one leg. They never found her, and nobody knows where she is at."

On 5/14/2021 at 11:04 AM, V19 (Certified Nursing Assistant/CNA) stated, "I was not working that night. It was a Thursday and when I came into work they told me (R12) was no longer here and had went out the window in the middle of the night."

On 5/14/2021 at 11:06 AM, V20 (Licensed Practical Nurse/LPN) stated, "All I know is that (R12) got out of the facility and is no longer here and is still missing."

On 5/14/2021 at 11:07 AM, V22 (Housekeeping) stated, "When I came to work, they told me (R12) had escaped through the window in the middle of the night. (R12) was always up and down in her moods and was always saying she was going to leave."

On 5/14/2021 at 11:08 AM, V24 (Activity Director) stated, "(R12's) belongings are in storage. She eloped. I heard about it when I got to work on Friday morning; that would have been April 22, 2021 around 10 PM. I have a text, so it was 4/22/2021. (R12) crawled out of the window in (R9's) window as we think it was opened. We think she had on her prosthetic leg because we did not find it, but her wheelchair was right by the

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S9999	Continued From page 6	S9999		

window. (R12) was always saying she was going to leave the Facility."

On 5/14/2021 at 11:11 PM, V23 (Maintenance Director) stated, "(R12) crawled out of the window and broke the screen and escaped. I know we documented everything in her nurse's notes. We think she was going room to room and checking windows and found a window that was open, and she could crawl out of and left."

On 5/18/2021 at 1:32 PM, V2 (Director of Nursing/DON) stated, "I heard (R12) had some issues in the past. Staff were telling me she wanted to leave, every so often. She had had an episode that night and was threatening to leave. Later on that night, I got a call from staff telling me they could not find her and so we called the police and started looking for her. They said she crawled out of the window."

On 5/18/2021 at 2:33 PM, V35 (Hall Monitor) stated, "(R12) came up to the nurse's station that night and was talking and saying stuff like if she could do things all over again what she would do different. At 10:20 PM, I did my rounds and (R12) was in bed. Some of the windows on the 500 hall do open and I was told the next day that (R12) had left out of the window and the screen was messed up and she was no longer here. (R12) was constantly saying she wanted to leave the Facility, but I did not take her seriously. We have not found her, and she is still missing."

On 5/18/2021 at 2:38 PM, V33 (Pharmacist) stated, "Looking at (R12's) diagnoses and medications, (R12) has 2 significant medications that could cause her harm by not receiving them. The Paxil 30 milligrams (mg) daily one time a day which could cause her withdrawals and the

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S9999	Continued From page 7	S9999		

valproic acid 250 milligrams three times a day which would increase her likelihood of having seizures. Both of these drugs could be harmful to (R12) if she was not taking them."

On 5/18/2021 1t 4:31 PM, R9 stated, "(R12) came into my room and I did not see or hear her, but (R12's) wheelchair was by my bed and they told me she had crawled out of my window. The next day my window was broken, and the screen was missing."

On 5/19/2021 at 4:45 PM, V5 (Assistant Director of Nursing/ADON) stated, "I was new to this position and had only been here for a few days. I came to do a follow up and (R12) was in a frenzy and was all upset and was belligerent and said she wanted to leave the facility. I told her, 'Look it is 9:00 PM at night.' I talked with her for about 30 minutes and I thought she was fine, and I left about 9:40 PM. Then I got a call later about 11:00 PM telling me (R12) was gone and we (V5, V1 and V6 Assistant Administrator) went out looking for her. I did not get home until about 2:00 AM."

On 5/18/2021 at 10:40 PM, V30 (LPN) stated, "(R12) was upset that night and was screaming and hollering. V5 (ADON) was talking to her. (R12) was saying that she wanted to leave the facility."

On 5/18/2021 at 10:43 PM, V38 (Hall Monitor) stated, "I was just coming into work the night (R12) escaped from the building. We were changing shifts and the CNA called upstairs and asked us to look for (R12) because she was missing. I started at 10:30 PM, and (R12) was already gone. We went outside and did a perimeter check but could not find her. I had received a report from (V35, Hall Manager) that

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S9999	Continued From page 8	S9999		

(R12) had been acting up all night and to keep an eye on her. (R12) has good days and bad days. We found (R12's) wheelchair next to (R9's) window and the window was opened, and the screen had been off, so we think that is how (R12) got out."

On 5/18/2021 at 10:44 PM, V39 (Hall Monitor) stated, "As I was coming in and starting my shift (R12) was already gone. We were looking for her, but she had already left."

On 5/18/2021 at 10:46 PM, V40 (CNA) stated, "(R12) always had something to say and was always saying she wanted to leave. She had good days and bad days."

On 5/18/2021 at 10:47 PM, V41 (LPN) stated, "(R12) has her moments; she was up and down and sometimes she would say she wanted to get out of here."

On 5/18/2021 at 11:45 PM, V42 (Police Officer) stated (R12) was still missing and had not been found and the case was still active.

On 5/18/2021 at 1:32 PM, V2 (Director of Nursing) stated, "I heard (R12) had some issues in the past. Staff were telling me she wanted to leave every so often. She had had an episode that night and was threatening to leave. Later on that night I got a call from staff telling me they could not find her and so we called the police and started looking for her. They said she crawled out of the window."

R12's paper and electronic records were reviewed and there was no documentation related to her being upset, stating she wanted to leave the facility and/or any documentation

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S9999	Continued From page 9 related to her eloping on 4/22/2021. There was no assessment or interventions related to stating she was unhappy with placement. R12's Elopement Investigation, undated, documents the following: R12 was last seen by V35, Hall Monitor, at 10:20 PM on 4/22/21. The Investigation documented at 10:40 PM, the night Shift CNA reported for shift. At that that time, CNA noted that R12 was not in her room and she/he continued to search the remainder of the rooms on 500-hall searching for R12. The Investigation documents that at 10:55 PM, the nurse and physician were notified R12 was missing. The facility staff were notified, and all completed a facility wide search including the facility outside grounds. The Investigation documented during the search it was discovered that R12's wheelchair was found in (Room XXX) next to the window. In this room the window was opened, and the screen was pushed outward, R12's wheelchair was noted to be in the room next to window. R12's prosthesis was not in the room nor in any of the rooms of the facility. R12's Behavior Tracking for April 2021 does not document R12 wanted to go home, leave the Facility or was exit seeking. The Facility's Elopement Policy dated March 2015 documents, "Staff shall investigate and report all cases of missing residents." (B) (Violation 2 of 2) 300.610a)	S9999		

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S9999	Continued From page 10 300.1210b) 300.1210d)3) 300.1210d)6) 300.1220b)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 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: 3) Objective observations of changes in a	S9999		

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	IL6001341	A. BUILDING: _____ B. WING _____	C 05/27/2021

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S9999	Continued From page 11 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. 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. These requirements were not met as evidenced by: Based observation, interview, and record review the facility failed to treat, assess or provide services to address and treat behaviors related to	S9999		

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S9999	Continued From page 12	S9999		

mental disorders for 2 (R6, R8) of 5 residents reviewed for behavioral health services in the sample of 35. This failure resulted in R6 and R8 displaying self-injurious behaviors resulting in hospitalizations.

Findings include:

1. R6's Face Sheet documents he was admitted to the facility on 5/1/20 with diagnoses of paranoid schizophrenia, schizoaffective disorder, vascular dementia with behavior disturbances, and major depressive disorder, recurrent with severe psychotic symptoms.

R6's Care Plan, dated 3/30/21, documents, "(R6) has a dx (diagnosis): Paranoid Schizophrenia, depression with psychotic symptoms, and schizoaffective disorder bipolar type. He is a risk for impaired social interaction, disturbed sensory perception, defensive coping and disturbed though processes." R6's Interventions, dated 3/30/21, document, "As resident allows introduce strategies that can minimize anxiety and behaviors such as meaningful activities replacing negative thoughts with constructive thoughts, deep breathing exercise, seeking support from families and outside agencies and listening to music or other activities that assist resident in staying calm." The Interventions document, "Offer supportive group therapy."

R6's Care Plan, dated 4/9/21, documents, "(R6) has history of suicidal ideations. He is at risk for self-harm." The Interventions, dated 4/9/21, document, "Assess seriousness of suicidal ideation, noting behaviors such as gestures, threats, giving away possessions. Conduct appropriate interdisciplinary assessments upon admission. Review transfer forms, including

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S9999	Continued From page 13	S9999		

screening material to determine any history of self harm." The Care Plan did not address any interventions to prevent R6 from self harming.

R6's Progress Note dated 5/3/21 at 10:48 AM documents R6 was sent out to the hospital for drinking body wash.

R6's Care Plan, dated 5/4/21, documented, "When res (resident) wants to go out to the hospital, he will conduct abnormal behavior. 05/4/21, res drank soap because he wanted to go out to the hospital." The Interventions documented, "Soap was taken out of resident room and res was sent out to hospital for exam."

There was no documentation in R6's medical record that facility reassessed R6 upon readmission to the facility to determine appropriate behavioral health services and interventions to address his wanting to be sent out to the hospital using self-injurious behavior to do so.

R6's Progress Note dated 5/7/21 documents Resident complained of his chest hurting and he was sent out to the hospital.

R6's Progress Note dated 5/8/21 at 3:24 PM documents R6 complained of chest pain and wanted to be sent out to the hospital.

R6's Progress Note dated 5/8/21 at 3:58 PM documents R6 drank some soap to kill himself. He was sent out to the hospital.

R6's Care Plan, dated 5/20/21, documents, "Resident has behaviors such as drinking soap." The Interventions, dated 5/20/21, document, "Educate resident on the importance of not

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S9999	Continued From page 14 drinking soap. Notify the nurse on hall. Remove soap from residents view." On 05/21/21 at 8:15 AM V5 (Assistant Director Nurses/ADON, stated, "He complains of chest pain to leave the facility. He knows how to play the system. He knows we have to send him out if he complains of chest pain. He was on his way back to the facility in the ambulance and he complained of chest pain. He was rerouted to another hospital." R6's Behavior Care Plan/Behavior Tracking Record dated 5/21 documents R6 has behaviors of drinking soap. R6's interventions were documented as "1). Notify the nurse on the hall" and "2) Remove soap from the resident's view." R6's Behavior tracking dated 5/3/21 documents frequency 1, with the use of their intervention remove soap from the resident's view. The behavior stopped. R6 drank soap on 5/8/21, but his behavior tracking did not document any behaviors. The Care Plan/Behavior Tracking Interventions did not address what behavioral health services or interventions the facility staff should implement to prevent R6 from self-injurious behavior. R6's Self harm Care Plan/Behavior Tracking Record dated May 2021 documents R6 has a history of Suicidal Ideation and is at risk for self-harm. R6's interventions were documented as "1. Assess the seriousness of the suicidal ideation through the next review date" and "2. Conduct appropriate interdisciplinary assessment upon admission." R6's Interventions did not address what types of behavioral health services the facility staff should implement to prevent R6 from attempting self-harm/injurious behavior.	S9999		

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S9999	Continued From page 15 R6's Elopement Care Plan/Behavior tracking Record dated 5/21 documents R6 is at risk for elopement. The Care Plan documents R6 voices desire to leave facility and has a history of leaving the facility unescorted. On 03/09 the resident attempted to leave the facility. The care plan did not document the year in which he (R6) left the facility. R6's interventions for this problem was documented as " allow the resident to vent concerns frustrations when exhibiting exit seeking behaviors. Divert the resident's attention to another subject or activity. Follow the facility protocol should the resident exit the facility. Notify the family and physician as needed." R6's Interventions did not address what types of behavioral health services the facility staff should implement to prevent R6 from attempting to elope. R6's undated SAD (Sex Age Depression) Scale documents R6 scored a 5 which means strongly consider follow-up. On 5/13/21 at 8:50 AM V8 (Social Service Director/SSD) stated, "For him (R6) we took the soap out of all the residents' rooms. Even their personal soap. They are given soap when they are going to use it, because (R6) will get it and drink it. During his one to one counseling (R6) stated that he wants to live on the streets. He does not want to be here, and he thinks going to the hospital will help him get to the streets. He likes being homeless, because he can do whatever he wants. He has a guardian, and his guardian will not allow him to be homeless. We have had meetings with him and his guardian." There was no documentation in R6's medical record he received any one-to-one counseling regarding his use of self-injurious behavior to	S9999		

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S9999	Continued From page 16 leave the facility and his desire to leave the facility. There is no documentation in R6's medical record he is currently receiving mental health services to address those behaviors. On 5/21/21 at 12:43 PM R6 was lying on his bed in his room watching television. R6 stated, "I'm getting out of here. I'm going to another facility. That's my plan. I've got to go and get out of here." The facility policy Behavioral Assessment, Intervention, and Monitoring revised May 2021 documents, "1. Behavioral symptoms will be identified using facility approved behavioral screening tools. 2. Residents who do not display symptoms of or have not been diagnosed with a mental, psychiatric, psychosocial adjustment or post-traumatic stress disorder will not develop a pattern of decreased social interaction or increased withdrawn, angry, or depressive behaviors that cannot be explained or attributed to a specific clinical condition that makes the pattern unavoidable. Residents will have minimal complications associated with the management of altered or impaired behavior. The interdisciplinary team (IDT) will thoroughly evaluate new or changing behavioral symptoms to identify underlying causes and address modifiable factors that may contribute to the residents change in conditions. The Interdisciplinary Team (IDT)will monitor the progress of individuals with impaired cognition and behavior until stable." 2. R8's Face Sheet, undated, documents she was admitted on 3/20/2017 with the following diagnoses: borderline personality disorder, major depression recurrent moderate, pain disorder, generalized anxiety, complete traumatic amputation knee level lower leg, sequela,	S9999		

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S9999	Continued From page 17	S9999		

post-traumatic stress disorder, suicidal ideations, muscle weakness, pain in right hand, other lack of coordination, cognitive communication deficit, other abnormal gait and mobility, mixed hyperlipidemia, schizoaffective disorder depressive type, GERD, hypothyroidism, other psychoactive substance abuse.

R8's Minimum Data Set, dated 4/20/21, documents she has no cognitive impairment.

R8's Care Plan, dated 4/14/2017 with revisions on 9/3/20, documented, "(R8) has self harm behaviors and utilizes her personal items to hurt herself. i.e. earrings, CD cases, tack, pen, pencil, etc. Her guardian is in approval of parameters to remove personal items from (R8's) possession in order to assist in assuring her safety. 2/18/19 Guardian expressed desire to continue keeping items out of resident's room. 9/2/20 res used her nails to self harm herself. Personal items were removed from her room per guardian." R8's Intervention, dated 9/25/17, documented, "Discuss positive influences/coping skills." R8's Care Plan Intervention, dated 8/26/17, documented, "Social Service to meet 2 times weekly to discuss coping skills and handling stressful situations."

R8's Nurse's Notes dated 5/11/2021 at 2:40 PM, documents R8 was readmitted to the facility from the hospital with a diagnosis of major depression.

R8's Care Plan, Behavior Tracking Record, dated May 2021, documents, "Resident has a history of self harm behavior, and will use her personal items to hurt herself." The Interventions documented, "One to one to understand why resident wants to self harm and validate resident's feelings." The Intervention

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S9999	Continued From page 18	S9999		

documented, "Encourage socialization through participating in an activity and/or psychosocial groups."

On 5/18/2021 at 9:00 AM, R8 stated, "I do not want to be here anymore. I want them to tell my guardian that I want to be sent out to the hospital. They have a television there and I can pick my own food. It's better there at the hospital than here at this place. My room has bugs and mice and it's a dump here. I want to be sent to the hospital because I am bulimic, and I threw up my lunch. Please tell them to ask get approval from my guardian to go out to the hospital. My guardian has to approve for me to go out to the hospital and she will not let me have anything in my room. I only have one set of clothes and one pair of underwear."

R8's Nurse's Note dated 5/18/2021 at 5:56 PM stated, "Feelings of depression and bulimia no vomit noted, upon assessment will not answer questions. Notified (Psychiatrist) of the above, no orders received to send out; stated 'will follow-up on Friday with resident.'"

No one on one was documented as being provided to R8 and no interventions were documented regarding R8's feelings of depression and/or bulimia.

No SAD scale was documented for being completed for R8 on 5/18/2021.

R8's Nurse's Notes labeled "draft" dated 5/18/2021 at 7:22 PM, documents, "7:05 PM, resident attempted suicide by stealing a knife off another resident tray and cut wrist and left forearm; one on one initiated STAT (instantly)."

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S9999	Continued From page 19 On 5/19/2021 at 10:00 AM, V14 (Licensed Practical Nurse/LPN) stated, "(R8) is not here anymore. She went out to the hospital because she took out a plastic knife and tried to cut herself." On 5/13/21 at 8:50 AM V8 (Social Service Director) stated, "(R8) cannot have anything in her room. I spoke with her and her guardian and the guardian does not want anything in her room, because she will use almost anything to try and kill herself. She can have crayons during her one to one only, because of safety." V8 stated, "According to her guardian she once used (Name brand) chips to cut her wrist." There is no documentation in R8's medical record she is receiving any ongoing behavioral health service to address her bulimia and self-injurious behavior related to her mental illness. Statement of Education Training dated 5/6/2021 document, "Interventions for resident behaviors are located on the care plan and on the resident behavior/tracking. These interventions are in place to help decrease behaviors. If a resident stating that they are feeling down or depressed a SAD scale shall be conducted to determine the safety of a resident; it is not just social service responsibility to conduct a SAD scale and all staff can do a sad scale. How to conduct a SAD (if further education please see SSD). After a staff member has conducted a sad scale and resident exhibits alarming behaviors, then social service and/or nursing should be notified immediately. Sad scales are kept at each nurse's station in the social services office." (B)	S9999		

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LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: INTEGRITY HC OF BELLEVILLE COMPLAINT #: 0133726
LIC. ID #: 0051342
DATE COMPLAINT RECEIVED: 05/11/21 08:19:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: INTEGRITY HC OF BELLEVILLE COMPLAINT #: 0134198
LIC. ID #: 0051342
DATE COMPLAINT RECEIVED: 05/24/21 16:34:00

IDPH Code	Allegation Summary	Determination
211	SAFETY PROBLEMS	1

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

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