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S 000	Initial Comments Complaint #2245912/IL149508: F689	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care 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 300.3240 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 regulations were not met as evidenced by: Based on observation, interview and record review the Facility failed to supervise/monitor and prevent elopement for 1 of 3 residents (R2) reviewed for elopement in the sample of 42. This failure resulted in R2 eloping the facility, being found by local police on 7/27/22 and being hospitalized for seven days. This failure has the potential to affect 39 other residents (R1, R2, R3, R7-R42) who have been identified by the facility at risk for eloping. Findings include: On 7/28/2022 at 1:35 PM, R2 was not in the facility. R2's Face sheet documents R2 was admitted to the facility on 6/13/2022.	S9999		

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S9999	Continued From page 2 R2's July 2022 Physician Order Sheets (POS) documents diagnoses of unspecified psychosis due to a substance or known psychosocial condition, paranoid personality disorder, unspecified dementia, and depression. R2's Care Plan document with a date initiated of 6/14/2022 document, "(R2) is at high risk for elopement related to dementia, paranoid personality disorder, and psychosis. Will not leave the facility unsupervised throughout the next review. Interventions: Staff to do frequent checks on (R2)." R2's Minimum Data Set signed 6/24/2022 document R2 was moderately impaired for cognition. R2 has no physical impairments and can walk independently. R2's Facility Assessment dated 7/27/2022 document R2 is a high risk for elopement. The Assessment form also documents, "Complete on admission" there was no date on the form or date of R2's admission (6/13/2022). The only date was 7/27/2022 of the date the form was completed. On 7/28/2022 at 1:10 PM, V1, Administrator stated, "(R2) did elope from the facility but he was checked off at 6:30 AM by the hall monitor and when staff did their rounds an hour later, they could not find him, so we called the police and did an elopement search and hour later the police found him and brought him back. (R2) had only been gone an hour at the most. We are not sure how he got out." R2's Police Report documents, "Wednesday, July 27, 2022, at approximately 11:12 AM hours, I,	S9999		

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S9999	Continued From page 3 Officer (V8) responded to the area of State Street and West van Buren Street to attempt to locate a white elderly male wearing a black shirt and pajama pants and no shoes. Furthermore, dispatch advised the caller and stated the subject appeared confused. Officer (V9) responded to assist. I located the above-described individual sitting on a sidewalk behind The Edge near the intersection of State St. and W. van Buren St. Upon contacting the subject, he identified himself as (R2), and while speaking with him he was able to provide his birth date, Social Security number, and Illinois Driver's License number. (R2) was talkative, he spoke with me about his military background. His clothing appeared to be wet but not dripping wet, there was what appeared to be mud on the lower portion of his pant legs and had no explanation of where his shoes were. I photographed (R2). (R2) made the following statements written in essence not verbatim: I've been at (Facility) for five months; I don't like how I'm taken care of. I walked away from there last night (7/26/22) right before dark; I'm trying to get back home to Paris IL. I'm prescribed multiple medications but the only one they give me is my blood thinner and I have not taken it since I left. I could have a pulmonary embolism if I don't have it. I contacted dispatch providing (R2's) information and requested an ambulance to respond to my location; dispatch advised he was clear with no alerts and (ambulance company) EMS was dispatched. Additionally, I requested dispatch to contact (Facility) to find out if (R2) was a patient and if they were aware he had walked away. Dispatch advised when they attempted phone contact, no one answered. (V14, Officer) and (V15, Officer) were dispatched to Integrity to make contact. (V14, Officer) made contact at (Facility) and advised me that (R2) is a resident there and that they were not aware he	S9999		

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had walked away. Additionally, he stated an employee would be responding to our location. Ambulance arrived on scene. A short time later, (V16) (Business Office Manager) and (V17) Social Services Director) arrived on the scene. (V16) signed a refusal with ambulance for transport of R2 and stated they had one of their vans in route to transport (R2) back to (Facility). Shortly thereafter, an (Facility) transport van arrived and (R2) walked into the van."

On 7/29/2022 at 4:01 PM, V8, Officer of Local Police Department stated, "I was with Officer (V9) when we were contacted because we got a call that there was a confused resident, wandering around. (R2) was able to tell us that he was from (Facility). He was dirty, no shoes, clothes were wet, mud on his feet and ankles. (R2) told us he had left the night before and been wandering around. We took him to the facility and staff were not even aware that he had left. Nobody from the facility alerted us or notified us at any time on 7/26/2022 or 7/27/2022 that any resident was missing from the facility."

On 8/2/2022 at 11:41 AM, V9, Officer of Local Police Department stated, "I was at State Street and West van Buren in Belleville Illinois. This is a very busy area and is close to interstate 15 and North Belt streets which are both very busy and unsafe for people walking. When I saw (R2) he was confused, wearing pajamas, and no shoes and was wandering the streets. We had had a big storm the night before and (R2's) clothes appeared wet. He was not wearing any shoes, was bare foot and had dried mud around his ankles. He told me had had walked out of the facility the night before and wanted to go to his home (Paris, Illinois). We also have a creek in that area, and it floods. (R2) was able to tell me

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his name, and social security number. Initially he did not want to give the name of the facility because he did not want to go back. He told me he had been at the facility for five months and was not getting the correct medication. He went on to say that he was on blood thinners and had not taken any since the night before and was worried that he could have a pulmonary embolism. He said the facility was not giving him his correct medications. We tried to call the facility but at first, we could not get anybody to answer. Then when they finally responded they were able to confirm that he was a resident there and when we asked to speak to him, they said just in minute, they left then they came back and then they told us they could not find him and that was when we told the facility he was in our custody. The facility was not even aware that he was gone. I did an internet search of past weather conditions and for Belleville IL indicated an overnight low air temperature of 72 degrees Fahrenheit with 10mph winds and thunderstorms. Additionally, the most direct path by road from the facility to our location was two miles as indicated by an internet search. I was also told they door alarms were not working at that time. The facility had no clue when he left the facility and or how long he had even been gone. We found (R2) on 7/27/2022 at around 11:12 AM."

There were no entries in R2's Progress Notes documented on 7/25/2022 or 7/26/2022.

R2's Progress Notes dated 7/27/2022 at 9:13 AM, document "Staff unable to locate resident, breakfast served in resident room, not there, staff believed resident was out for smoke break as he does like to go out with the smokers for fresh air or visiting with peers as he likes to do this. Immediately staff-initiated search for resident in

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S9999	Continued From page 6 facility and surroundings. Resident was located walking down a road. (local) Police with resident and staff picked up and transported to (hospital)." R2's Incident Report dated 7/27/2022 at 9:13 AM, 'Staff unable to locate resident was not in his room, facility and immediate surrounding searched initiated following elopement, protocol. Resident taken to Hospital. No injuries observed at time of incident." (Filed out by V2, Director of Nursing). R2's July 2022 Medication Administrator Record (MAR) documents R2 received and/or refused medications on 7/28/22 and 7/30/22 although he was in the hospital during this time, in addition, staff were documenting R2's pain level on 7/28, 7/30 and 7/31, although R2 was in the hospital during this time. R2's Emergency Record document he was admitted to the hospital on 7/27/2022 at 1:00 PM. R2's Emergency Room Report documents R2's Mental Status: "Cognitively he has some deficits of his intelligence, fund of knowledge, insight, and judgement." R2's Hospital Records dated 7/27/2022 document, "Patient is 70-year-old gentlemen admitted through the Emergency Department (ER) for psychotic agitation after eloping out a window of his psychiatric nursing home. History of Present Illness: Emergency Department Documentation, Residential staff members' states patient has been increasingly agitated, trying to escape. States he even jumped out of a window today. Patient stated he is unhappy there and wants to return home." On 7/28/2022 at 3:03 PM, V5, Nurse Manager	S9999		

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S9999	Continued From page 7 stated, "Staff are constantly checking on residents during medication pass, and we have hall monitors continuously checking. I am not aware of any issues with staffing or not having enough hall monitors. The hall monitors check off a list every hour for every resident. We found out (R2) was not here because I was going to do a room change and he wasn't in his room. I went and saw nurse (V6, Licensed Practical Nurse, LPN) and she had not seen him either, so we all spread out or started looking for him. We were looking for him for about 15-20 minutes on property and then we called the police and the police found him about 15-20 minutes later and brought him back and then we sent him out to the hospital, and he is still there. I never, personally talked with the police." On 7/28/2022 at 3:23 PM, V6, Licensed Practical Nurse (LPN), stated, stated, "I was working the day (V5) approached me and told me (R2) was missing. I think it was about 2 days ago. I am not sure I have heard 2 different stories, so I am not sure what really happened. I heard (R2) wandered out the night before and then I heard he only wandered out this morning I don't know which one is right. (R2) can ambulate by himself and he is independent and alert and orientated x 3. He can answer questions and tell you what happened. The nurse manager came to me and asked me if I had seen (R2) because he was going to do a room check and he wanted to know the last time I had seen (R2), which I could not remember. We started a search because I could not remember when I had last seen him. He has two roommates, and they were not able to provide any information. That is all I really remember. I did not contact the police but cannot say if anyone else did. The police were the ones that brought (R2) back into the facility and then	S9999		

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S9999	Continued From page 8 he was sent out to the hospital." On 7/31/2022 at 8:00 PM, V11, Hall Monitor stated, "I am not aware of anybody eloping the facility in the last 3 months. Nobody told me about anything. I have a clipboard and I must go and check off residents every hour. There is supposed to be three of us, but I am the only one working tonight. I have the whole building to do." Staffing schedules document V11 and V16, Business Office Manager, were both working as hall monitors on 7/26/2022. On 8/4/2022 at 10:03 AM, V13, Certified Nursing Assistant stated, "I worked on 7/27/2022 but (R2) was already missing. Everybody was talking about (R2) and they told me he had left on 7/26/2022 at night. We did not do any room search or anything because he was already gone. I worked the 300 halls but (R2) was already gone. I heard staff talking about it when I started my shift at 6:30 AM on 7/27/2022 but again he was already gone, and they said he had left the night before. Nobody was doing any searches because he had gone the night before." Staffing schedules were reviewed for 7/27/2022 for the day shift for the 300 hall and V6 was documented as the nurse working the 300 halls for the day shift, and V12 was documented as the certified nursing assistant working on the 300 halls. On 8/4/2022 at 1:43 PM, V17, Social Service Director stated, "The police contacted the facility and they told us they had (R2). I am not sure who took the call. This was on 7/27/2022. I am not sure about the time. We didn't know how long (R2) had been gone and or when he had left.	S9999		

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I cannot really say as I don't know. (V16, Business Office Manager) and I got in my car, and we drove out to the (Family entertainment business) where the police said (R2) was at. (V5) the nurse told us to send (R2) to (hospital). We waited for the facility bus and had (R2) sent out to the hospital per (V5). (R2) was in his Pajamas and he had mud on PJ's and was not wearing any shoes and was barefoot. He is still in the hospital and has not returned."

On 8/4/2022 at 1:55 PM, V4, LPN, Nurse Manager stated, "Once we knew (R2) was not at the facility then I had staff send him directly to the hospital to get an evaluation on him. No, I do not know how long he had been missing and/or when he had left the facility. (V16) and (V17) both went out to where the police had found him and had the van send him to the hospital."

On 8/4/2022 at 1:05 PM, V18, Hall Monitor stated, "I was working the day (R2) got out of the facility. Nobody knows when he got out and or how long he had been out. When I was doing my hour checks. We have a clip board with names of residents who are at risk, and we are supposed to go around every hour and lay eyes on the residents at risk and check them off on the clip board. When I went into (R2's) room he has two other roommates and when I opened the door, I saw 3 people laying in each bed, so I checked it off. Later, the police came and brought (R2) back. I am not sure what time. But when I went and checked (R6) was laying in (R2's) bed. (R6) had apparently been sleeping in his bed all night so I did not realize it was not (R2) and checked him off as being in the facility."

On 8/4/2022 at 3:35 PM, R2 was in his room, clothes clean sitting on his bed. R2 was missing

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some teeth on his lower jaw. At 3:37 PM, R2 stated, "Yes, it is true I tried to run away from here. I jumped out of the window here a week ago because I was trying to go home. I hate it here! I have no life here. People here do not really care about you. I told them I was not happy here, but nothing changed. Day after day everything the same. I guess I don't matter to anybody here. I left at night when everyone was sleeping. It was raining when I left. I fell and hurt my back. I used to work at an automotive shop and had a herniated disk. I think I hurt it again my herniated disk because it hurts now. It still hurts. I used to live by myself, and I want to do that again. I could not sleep that night, so I left through the window in my bedroom. I don't like it here and they brought me right back here."

On 8/4/2022 at 5:13 PM, V16, Business Office Manager stated, "I received a phone call from the police telling me that they had (R2). I do not recall any of the details. At the time of the call, we did not know he was missing and or when he had gotten out or when he had left."

On 8/5/2022 at 9:48 AM, V2, Director of Nursing stated, "(V5) was making rounds on 7/27/2022 as he wanted to do a move change. He went to check with (R2) and (R2) was not there and was missing. I do not believe our cameras work in the front so we really cannot say when or we are not exactly sure when (R2) left the facility."

On 8/5/2022 at 9:51 AM, V1, Administrator stated, "I do not have anything on camera showing when (R2) left the facility. The cameras do not even work on the halls. I have no way of showing or knowing exactly when (R2) left the facility."

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S9999	Continued From page 11 On 8/5/2022 at 8:41 AM, V19, Hospital Physician stated, "(R2) when he was admitted to us, he had neurocognitive disorder, dementia, possibility of the mixed type with Alzheimer and vascular contributions with psychosis and behavioral features. He was having delusions and was confused, and he was not able to fully understand reality. He was more than likely not able to understand safety awareness including traffic, and inclement weather and reduced awareness of his environment. He was admitted to our facility and was here for a week." On 8/5/2022 at 9:02 AM, V20, Medical Director stated, "I cannot recall who (R2) is as a patient. If (R2) was admitted in June, then I have not personally seen him as I have been out of the country. I cannot say or testify as I do not know him. We need to know how (R2) got into the facility in the first place. Was he living alone before? We never want to see any resident get out of the facility without staff knowing." On 8/5/2022 at 9:32 AM, V12, Certified Nursing Assistant (CNA), stated, "I know I was working on 7/27/2022 and I usually pass out meal trays. (R2) does not eat in the dining room he takes his meals in his rooms. (R2) is also a smoker and so when I passed out his breakfast tray, he was not in his room but that was normal for him because he is a smoker. There is a smoke break around breakfast time and that is usually where you will find him. Nobody came to me and asked me if I had seen him or told me that he was missing. I did not learn about it until a few days later when I returned to work. I did not help with any search or was even aware that anybody was looking for (R2) that day." On 8/5/2022 at 10:23 AM, V24, CNA stated, "I	S9999		

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(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 heard about (R2) eloping because all of the staff was talking about how he got out of the building. Nobody knows when or what time he got out." On 7/22/2022 at 1:32 PM, the facility provided an elopement risk dated 7/27/2022 and document the following residents at risk, R1, R2, R3, R7-R42. The surveyor requested the Elopement policy on 8/4/22 and was provided "Elopement/Missing Resident Procedure Policy" with a revision date of December 2020. The policy documents, "Staff shall investigate and report all cases of missing residents. Staff shall promptly report a resident who tries to leave the premises or is suspected of being missing to the Charge Nurse of Director of Nursing. Staff shall promptly report any resident who tried to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. If an employee observes a resident leaving the premises, he/she should a. attempt to prevent the departure in a courteous manner, b. get help from other staff members in the immediate vicinity, if necessary, and instruct other staff member to inform the Charge Nurse or Director of Nursing that a resident has left the premises. When a departing individual returns to the facility, the DON or charge nurse shall a, examine the resident for injuries, b, notify the attending physician, c, notify the residents legal representative (sponsor) of the incident, d. document the event. If an employee discovers that a resident is missing from the facility, he/she shall: a. determine if the resident is missing from the facility, he/she shall b. if the resident was not authorized to leave, initiate a search of the building (s) and premises; c. if the resident is not located, notify the Administrator and the DON, the resident's legal representative, the Attending	S9999		

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 08/10/2022

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S9999	Continued From page 13 Physician, law enforcement officials and (as necessary) volunteer agencies. Provide search teams with resident identification information and initiate an extensive search of the surrounding area. When the Resident returns to the facility, the DON shall A, examine the resident for injuries, B, Contact the Attending Physician, and report finding and conditions of the resident. C, Notify the legal representative A (sponsor). D, notifies search teams that the resident has been located. E. document relevant information and update plan of care." (B)	S9999		