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INTEGRITY HC OF CARBONDALE	120 NORTH TOWER ROAD CARBONDALE, IL 62901

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation 2550499/IL184860	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.690a) 300.1210b) 300.1210d)6) 300.1220b)2)3) 300.3100d)2) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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	S9999		

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S9999	Continued From page 1 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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.	S9999		

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S9999	Continued From page 2 Section 300.3100 General Building Requirements 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. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident with dementia and a diffuse traumatic brain injury was adequately supervised to prevent elopements and failed to develop and implement new interventions to prevent elopements for 1 (R22) of 2 residents reviewed for supervision in a sample of 42. This failure resulted in R22 exiting the facility multiple times without staff knowledge, including on an unknown date in October or November of 2024 in which R22 walked approximately 0.8 miles from the facility down a busy street and across a busy highway in town, and was later located by facility staff walking around a business parking lot. The facility also failed to implement effective fall prevention interventions to prevent falls for 2 of 6 residents (R26, R55) reviewed for accidents/incidents in the sample of 42. Findings Include:	S9999		

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1. R22's Admission Record with a print date of 1/30/25 documents R22 was admitted to the facility on 12/04/2018 with diagnoses that include unspecified dementia, diffuse traumatic brain injury, major depressive disorder, anxiety disorder, and insomnia.

R22's MDS (Minimum Data Set) dated 11/7/24 documents R22 has a moderate cognitive impairment. This same MDS documents under Section E-Behavior, R22 has a behavior of wandering and the wandering placed R22 at significant risk of getting to a potentially dangerous place.

R22's Elopement/Wandering risk assessments dated 2/9/24, 5/7/24, 8/8/24, and 11/6/24 document R22 is at risk for elopement.

R22's Progress Notes document the following: 2/10/24 8:43 AM, "At approximately 0843 (8:43 AM) this writer was informed that resident was outside. Resident was escorted back inside facility. Resident came inside willingly. Full facility count was initiated, and it was confirmed that only this resident was outside. A head to toe assessment completed with no new skin issues noted or reported at this time, vital signs assessed, stable and recorded in EHR (Electronic Health Record). Resident was wearing Tie Dye shirt with grey sweat pants, non-skid footwear and a reflective vest, Administrator, DON (Director of Nursing), and MD (Physician) notified with NNO (no new orders) at this time Outside temp (temperature) 42 degrees, clear and sunny, Resident is currently in his room resting." Signed by V44 (Former DON/Director of Nurses)

6/15/24 9:31 AM, "(R22) found in the parking lot by staff on arrival to facility. (R22) brought in by

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said staff and informed this nurse. Resident is well appearing. No scratches, no bruises, no injuries observed. Resident seen by this nurse approximately 30 minutes prior. Residents nurse and administrator notified." Signed by V45 (RN/Registered Nurse)

6/24/24 3:46 PM, "Resident elopes through north hall emergency exit door. 2 staff ran to door upon alarms. The resident had already gotten to church parking lot by the time staff reached the resident." Signed by V45 (RN)

7/13/24 11:58 AM, "Resident exited facility and was returned safely by staff. Head to toe assessment performed. All body systems are at baseline. No trauma to skin. All vitals WNL (within normal limits). Resident given ice water and re-educated that he needs staff to accompany him when going outside. Resident currently in his room being assisted with breakfast meal. Call light within reach." Signed by V45 (RN)

10/27/24 9:04 AM, "Resident exits the building today. His 101 (sic) sitter was right behind him when he exited. Resident was redirected into the building safely. Skin assessment performed. No skin integrity issues present." Signed by V45 (RN)

11/21/24 8:52 AM, "Resident exited the building and was returned safely by staff. Skin assessed. No injuries and skin intact. Provider notified. Vitals WNL." Signed by V45 (RN)

This surveyor attempted to contact V45 (RN) who no longer works at the facility on 1/29/25 at 1:20 PM and again on 2/3/25 at 9:31 AM, with no answer. This surveyor requested a return call with each attempt and no return call was received.

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S9999	Continued From page 5 On 1/28/25 at 8:23 AM, R22 walked into the beauty shop where the surveyors were working. There was no staff present with R22 at this time. R22 then left the beauty shop by himself and walked to the south hall where an unknown staff member saw R22 wandering around and took R22 to the front of the building by the reception desk. The unknown receptionist gave R22 a donut and then an unknown staff member walking in the door put on a mask and took R22 with her to his hall. R22's Progress Notes document on 1/29/25 at 7:14 AM, "At approximately 0707 (7:07 AM) this writer was informed that resident was outside. Resident was escorted back inside facility by staff. Resident came inside willingly. Full facility count was initiated, and it was confirmed that only this resident was outside. A head to toe assessment completed with no new skin issues noted or reported at this time, vital signs assessed, stable and recorded in EHR. Resident wearing blue shirt with blue sweat pants, non-skid footwear and a reflective vest, Administrator, DON, and MD notified with NNO at this time. Outside temp 40 degrees, clear and sunny. Resident is currently in his room resting in his bed." Signed by V23 (RN/Registered Nurse) On 1/29/25 at 12:19 PM, when asked if she did investigations on elopements, V1 stated she did not think she had any official documentation. V1 stated the tracking and trending they do for R22's elopements include reviewing the care plan and discussing them in the daily QA (quality assurance) meetings. The facility Daily QA (Quality Assurance) Meeting Notes included multiple pages and handwritten dates with no year documented on some of them.	S9999		

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The QA Meeting notes document the following under Resident Behaviors.
"6/17/24 (R22) out of facility door alarm sounding, seen by staff member, returned without incident ...."
"6/25 (initials of R22): North R (right) staff to alarm."
"7/15 (initials of R22) South left, staff responded to alarm running, staff caught."
"10/28 (initials of R22) North R (right) with 1:1 ..."
"11/22 Admin Add on Notes: (initials of R22): South, turned around with no difficulty."

On 1/29/25 at 9:15 AM, V6 (Certified Nursing Assistant/CNA) stated she came to work at 7:00 AM on 1/29/25 and was told R22 had left the facility. V6 stated she didn't know details about what happened. V6 stated she had been told V21 (CNA) was outside and happened to notice R22 in the parking lot. V6 stated it is hard to keep up with R22 while providing care to the other residents. V6 stated R22 has a 1:1 staff member because he likes to get out and she thinks someone is always with R22. V6 stated R22 also wears a safety vest like construction workers wear (reflective) to make R22 more visible.

On 1/29/25 at 10:19 AM, V21 (CNA) stated she got to the facility around 7:05 AM on 1/29/25 and saw R22 running around the parking lot. V21 stated R22 was wearing pants, shirts, socks, and had a blanket. V21 stated the doors were not alarming and they were trying to find out which door R22 went out. V21 stated R22 got out of the facility a month or two ago and was walking down the road toward the stop sign by a (2 lane highway). V21 stated she didn't have any other information about that time.

According to the website Google.com/maps,

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(road referenced) is approximately 0.3 miles from the facility.

On 1/29/25 at 11:08 AM, V22 (CNA) stated she was responsible for R22 on night shift beginning on 1/28/25 and clocked out at 7:20 AM on 1/29/25. V22 stated she was giving report to the oncoming shift at 7:00 AM and R22 was doing laps around the facility. V22 stated R22 went into a room where they were covid testing staff around 7:10 AM. V22 stated R22 wasn't in his room when she did the walk through with the day shift staff relieving her, but she had just seen him walking around. V22 stated she wasn't aware he was found outside the facility, in the parking lot, until after she clocked out. V22 stated there were no door alarms sounding when she left. V22 stated if R22 had exited through any other hall exit door she wouldn't have heard the alarm. V22 stated she was not aware of R22 exiting the facility without staff supervision any other time. V22 stated R22 doesn't have a 1:1 staff on night shift because they don't have enough staff to provide it. V22 stated most of the time they have enough staff to keep R22 safe and meet the needs of the other residents. V22 stated R22 wears the safety vest at night in case he does elope.

On 1/29/25 at 11:24 AM, V23 (RN) stated she works 12-hour night shift (7 PM to 7 AM). V23 stated on the morning of 1/29/25, she was giving report to day shift (V4 LPN/Licensed Practical Nurse) a little after 7:10 AM, when she was notified R22 had exited the facility and was in the driveway/parking lot. V23 stated she didn't hear a door alarm sound. V23 stated she "looked at" R22 to make sure he didn't have any injuries. V23 stated R22 had eloped before but it had been a while since he had. V23 stated R22 wears a

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reflective vest they take off when they put his pajamas on at night. V23 stated she had been told they couldn't use the wander guard system since it was considered a restraint.

On 1/29/25 at 2:07 PM, V4 (LPN) stated she arrived at the facility around 6:30 AM on 1/29/25. V4 stated she was told R22 had eloped, and administration was checking to see which door he exited and checking the panels to see what alarms were going off. V4 did not have any other information related to this elopement.

On 1/29/25 at 10:03 AM, V27 (CNA) stated he wasn't aware R22 eloped on the morning of 1/29/25. V27 stated R22 has a sitter with him, the doors are alarmed, and R22 won't leave the facility. V27 stated R22 has a tracker on his ankle, and they can track him if he would leave. V27 stated anyone who sees R22 should redirect him back to his area. V27 stated if R22 starts walking the sitter follows him but once he takes his medications, "he is chill."

On 1/29/25 at 11:36 AM, V12 (Maintenance Director) stated he was aware R22 had eloped on 1/29/25 and had already checked all the doors to make sure they were working correctly, and they were. V12 stated he makes daily rounds and hadn't had any door locks/alarms not working. At 11:41 AM on this same date, this surveyor walked with V12 to the exit door located near the beauty shop. V12 opened the door, and it alarmed as it should. This surveyor walked with V12 to see if the alarm could be heard on the halls the residents reside on and/or near the nurse's station. The alarm was no longer able to be heard after turning the corner and prior to reaching the nurse's station and/or resident room areas on the south hall. This surveyor and V12 walked toward

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the north hall and the alarm sound was no longer able to be heard near the entrance door of the dining room which is prior to the north hall nurse's station and resident room areas. V12 also confirmed he could not hear the alarms. When asked if they couldn't hear the alarms how would staff know someone had exited the facility, V12 stated, he knows they have a 1:1 staff sitting with R22, he wears a reflective vest, and V1 (Administrator) has something on her phone with R22's GPS (Global Positioning System) location.

On 1/29/25 at 1:56 PM, V16 (CNA) stated she was not aware R22 had eloped on the morning of 1/29/25. V16 stated she wasn't sure what R22's interventions were to prevent elopement. V16 stated R22 has a consistent one to one staff from 8:00 AM to 3:00 PM but after 3:00 PM he pretty much does his own thing, especially if they are short staffed.

On 1/29/25 at 9:28 PM, V24 (CNA) stated R22 doesn't have a 1:1 staff with him on night shift. V24 stated they watch him the best they can. V24 stated it is easy to watch him through the night it's in the morning when they are trying to get people up that is it harder. V24 stated R22 is very smart and has the concept of holding the door until it opens. V24 stated he wears the safety vest so people can see him if he gets out. V24 stated she was working when R22 eloped on 1/29/25 but he wasn't one of her assignments. V24 stated none of the alarms sounded. When asked if she could hear the alarms V24 stated, "Not very well." V24 stated R22 is supposed to always have the safety vest on.

On 1/29/25 at 9:38 PM, V18 (CNA) stated R22 has a staff member sitting with him throughout the day but not on nights.

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S9999	Continued From page 10 On 1/29/25 at 4:30 PM, V1 (Administrator) provided this surveyor with the facility undated "Self-Identified Quality Assurance Plan of Correction" documents, "Problem Identified: Exit from facility. Resident did not leave grounds, resident not harmed or emotional upset. Returned to facility without difficulty. 1. Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? (R22 initials) was immediately returned to the facility without complication and placed on 1:1 supervision ...3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Facility immediately checked all exit doors for alarm function. All alarms functioning and require a key to shut them off. Facility immediately did a resident head count to assure all residents accounted for. All residents were accounted for. Facility interviewed all staff, and no one answered an alarm and shut it off. Facility has educated all staff on duty and will educate all staff who haven't previously been educated for the next three days about monitoring door closure behind them when they come in the facility or when they leave the facility to make sure door closes securely and properly. Facility placed (R22's initials) on 1:1 supervision and will continue until re-evaluate by the IDT (Interdisciplinary Team) to decide if is safe to remove the supervision. Facility contacted the sister and will send referrals to all TBI (Traumatic Brain Injury) facilities that can be located in the state of Illinois. Facility has ordered additional door exit alarms for the three doors that are the furthest from the nurse's station as added precaution. Facility has ordered Stop Sign door guards to be applied at each exit door with the exception of the front lobby door where visitors	S9999		

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and staff enter and exit many times a day. Staff will be educated to not remove the door guards.
4. How will you monitor the corrective action (s) to ensure the deficient practice will not recur
...Admin (administrator), DON, and/or designees will do random observations of at least one staff member entering and exiting the facility a minimum of 5 times per week for 4 weeks. Admin, DON, and/or designees will do random observations of Stop Sign door guards properly applied to each exit door a minimum of 5 times per week for 4 weeks. Results of the observations will be discussed in the Quarterly QA (Quality Assurance) Meeting times 2 with educational needs discussed as need by the Facility Administrator, DON, and or designee. Completion Date: 1/29/25. The untitled document dated 1/29/25 attached to this plan of correction documents "1/29/25 After investigation, IDT concluded that resident (R22) followed an employee out of a door. During investigation all door alarms were checked and functioning properly on 1/29/25. In addition, door alarms are checked daily by maintenance or designee. IDT identified QAPI (Quality Assurance and Performance Improvement) and implemented staff in-servicing immediately."

On 1/30/25 at 12:02 PM, V28 (Family Member) stated the facility hadn't communicated with her at all recently. When asked how long it had been since the facility had called her with an update, V28 stated it had been a couple of months since she heard anything from them. V28 stated she was R22's surrogate mom and she was the only one they would contact regarding R22's condition and care. V28 stated she was told awhile back (date unknown) R22 had attempted to "escape" the facility. V28 stated that is the only elopement she was made aware of. V28 stated she hadn't

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been contacted by the facility at all the past few days. V28 stated she is concerned with the care R22 is getting because she is the one who always looks after him and she hadn't been getting any communication from the facility.

On 1/30/25 at 1:15 PM, V1 (Administrator) stated they have a tracking tag on R22 so if he exits the facility, they call her or the Director of Nursing and they track where R22 is located. V1 stated they don't have a wander guard system because it would be expensive to implement in the building. V1 stated V31 (Social Services Director) was the staff member who contacted V28 (Family Member) after R22's elopement on 1/29/25.

On 1/30/25 at 2:00 PM, V31 (Social Services Director) stated R22 eloped once while she was at the facility. V31 stated he made it to the facility parking lot. V31 stated he just gets out and the facility staff get him and bring him back in. V31 stated he doesn't make it very far. When asked if she called V28 (Family Member) to discuss possible placement in a TBI (Traumatic Brain Injury) facility after he eloped on 1/29/25, V31 stated she had not spoken with her and hadn't sent out any referrals. V31 stated she tries to call everyone's power of attorneys who are on her advocate list and V28 had never returned her calls. V31 stated, "she (V28) is MIA (missing in action)." V31 stated she had worked at the facility since 12/2023 and had never had contact with V28. V31 stated she had left a number for V28 to return calls and she had never called her back. When asked if she had attempted to contact V28 after R22 eloped on 1/29/25, V31 stated, "No, I haven't tried to call her yet."

On 1/30/25 at 10:04 AM, V7 (CNA) stated she had provided care for R22, and he elopes at

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times. V7 stated they can't hear the door alarms when they go off and R22 moves fast. V7 stated R22 got close to the next town one time and that is when they implemented the reflective vest. V7 stated they also put an air tag on his ankle. V7 stated R22 usually walks to the church located next to the facility.

On 1/30/25 at 10:41 AM, R46, who is alert to person, place, and time, stated sometimes R22 will run out of the door. R46 stated R22 looks for food all the time, will take whatever he finds, and eat it. R46 stated R22 has made it out the door, run across the street, and made it into people's houses. R46 stated this occurred about a month and a half ago. R46 stated he also went towards the stop sign located at the corner of Old Murphysboro Road and Tower Road.

On 1/30/25 at 1:32 PM, V29 (Medical Records/CNA) stated she had been working when R22 had eloped in the past. V29 stated R22 wanders and has a staff member who sits with him. V29 stated they try to have one 24 hours a day, but it doesn't always work that way. V29 stated R22 isn't afraid to just walk out the door. V29 stated she wasn't working when R22 made it to the next town or into neighboring houses but had heard about it and believes it was more than a year ago that it occurred.

On 1/30/25 at 3:07 PM, V32 (CNA) stated R22 usually had a staff member sitting with him from 8 AM to 1 PM or 3 PM. V32 stated when R22 doesn't have a sitter the other aids can't always keep an eye on him. V32 stated most of the time R22 stays in his room. V32 stated the farthest R22 got was down Tower Road toward Old Murphysboro Road. V32 stated one time (date unknown) he did make it to the gym located close

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to the intersection of Old Murphysboro Road and New Route 13 (4 lane highway). V32 stated she was busy providing care to another resident that day and she thought V33 (CNA Supervisor) was the one who picked R22 up. V32 stated R22 didn't have a staff member sitting with him that day. V32 stated the front door was alarming and they were able to hear it. V32 stated R22 wasn't injured or upset when he returned to the facility. V32 stated she had heard R22 had gotten into the houses across the street from the facility but that was before she started working at the facility in 2023.

On 1/30/25 at 3:16 PM, V33 (CNA Supervisor) stated she was working when R22 had eloped in the past. V33 stated R22 usually elopes at shift change when they are getting the residents up in the morning. V33 stated R22 made it to the gym located at the corner of Old Murphysboro Road and New Route 13. V33 stated it occurred around 7:00 AM. V33 was unable to recall the exact date but stated it was in October or November of 2024. V33 stated on that day, she saw R22 make a lap around the unit and when R22 starts wandering, they redirect him back to his room. V33 stated she happened to hear the alarm go off and she knew she needed to look for him. V33 stated she got in her car, and she went one way and other staff went another way. V33 stated she found him wandering around the gym parking lot (located at the intersection of Old Murphysboro Road and New Route 13), with a cup in his hand. V33 stated she got R22 in the car and took him back to the facility. V33 stated another time R22 left, he made it onto Old Murphysboro Road and was found near the funeral home (located 2 miles from the facility). V33 stated R22 had the reflective vest on and that happened a long time ago (unable to provide a date). V33 stated if it's

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quiet enough they can hear the alarms on the doors.

According to the website Google.com/maps, the gym is located 0.8 miles from the facility and would take the average person 16 minutes to walk from the facility to the gym.

On 2/3/25 at 10:02 AM, V43 (CNA) stated he remembered R22 exiting the facility without staff. V43 stated R22 likes to go through his bathroom into the adjoining room and out that room's door. V43 stated they immediately mobilized a search party and found him about 15 minutes later. V43 stated he believed it was V33 (CNA Supervisor) who located him that time. V43 was not able to remember the date it occurred but believed it was 2-3 months ago. V43 stated he knew R22 had eloped two other times and was trying to get into someone's residence and someone's car but that was probably two years ago. V43 wasn't sure if R22 had a 1:1 present with those elopements. V43 stated it is very hard to do 1:1 with him if no one is assigned to him. V43 stated it is very hard to keep track of him.

On 2/6/25 at 10:22 AM, V51 (CNA) stated she was working when R22 eloped once. V51 stated she believed it was in December of 2024 but couldn't remember the exact date. V51 stated staff heard the alarm on the laundry room door, and all went to see why it was alarming. V51 stated R22 was found in a neighbor's yard by V45 (RN). V51 stated R22 didn't have staff with him and when they located him, he was trying to wrap himself in a blanket. V51 stated she didn't think he was gone long because the neighbors called the facility and believed it happened around 8:00 AM.

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On 2/6/25 at 9:40 AM, V50 (CNA) stated she was working when R22 eloped in the past. V50 stated she couldn't remember the exact date, but she knows the elopements occurred in 2024. V50 stated it happened twice. V50 stated one of the times (date unknown) she was in or near the dining room when a resident told her the door alarm was sounding on R22's unit. V50 stated as she went around the corner onto the unit, she could hear the alarm and see the door was cracked. V50 stated she spotted R22 across the main busy street, walking on the sidewalk, towards the stop sign located at the intersection of Tower Road and Old Murphysboro Road. V50 stated R22 was alone with no staff with him. V50 stated she yelled his name, and he kept walking. V50 stated she caught up to him close to the intersection, turned him around, brought him back to the facility, and notified nursing. V50 stated the other time she walked to the nurse's station on the north hall and heard the door alarm sounding. V50 stated she quickly walked to the door and when she looked out, she saw R22 outside without staff, walking toward the stop sign. V50 stated she caught up to him close to the intersection. V50 stated she didn't remember the date of these occurrences, but they were both in 2024.

On 1/30/25 at 3:51 PM, V44 (Former Director of Nurses) stated she worked at the facility from 2/24/23 to 1/10/25. V44 stated R22 did leave the facility when she was working and he either went out the front door or out the door at the end of his hall and staff were with him. V44 stated when R22 doesn't have a sitter everyone keeps an eye on him. V44 stated they try to keep him away from the beauty shop hall since that door is the farthest away and hardest to hear. V44 stated she doesn't recall R22 ever making it to the gym

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located on Murphysboro Road and New Route 13.

R22's current Care Plan documents a Focus area of "(R22) is an elopement risk/wanderer AEB (as evidenced by) Disoriented to place, History of attempts to leave facility unattended, Impaired safety awareness, Resident wanders aimlessly, significantly intrudes on the privacy or activities of others. Date Initiated: 05/24/2022." The interventions documented for this Focus Area are, "1:1 sitter x (times) 72 hours. Medication review and adjustments made as ordered. Date Initiated: 06/01/2022 ...Hydroxyzine as ordered for anxiety and restless behaviors. Date Initiated: 08/18/2023 ...Allow him to sleep longer in the morning and offer snack upon waking up. Date Initiated: 08/21/2022 ... Medications times changed, no meds to be given before 9 a.m. Date Initiated: 8/21/2022 ...offer a more substantial snack such as peanut butter and jelly or appropriate substitute at bedtime. Date Initiated: 08/21/2022 .... Offer snack upon waking, Date Initiated: 08/21/2022 ...Safety device monitor to right ankle-check for placement every shift and notify management (DON/Director of Nurses, ADON/Assistant Director of Nurses, Administrator) if it is not in place. Date Initiated: 8/11/2023 ...Assess for fall risk. Date Initiated: 5/24/2022 Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Likes to listen to music. Date Initiated: 05/24/2022. Documents wandering behavior and attempted diversional interventions in behavior log. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist: Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Date Initiated: 05/24/2022. Monitor for fatigue and

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weight loss. Date Initiated: 05/24/2022. Safety vest on at night. Date Initiated: 12/11/2024.

R22's Care Plan/Behavior Tracking Record was reviewed from 1/2024 to 2/3/2025 and documents under Problem Statement, "(R22) will wander putting his health and safety at risk." The "Goal" is documented as, "(R22) will be easily redirected in the next review." With Interventions documented as, "1. Point in the direction you would like (R22) to go. 2. Get (R22) snacks/drink. 3. Redirect. 4. Refer to nursing as needed." These same records document R22 wandered 9 days in 1/2024, 6 days in 2/2024, 28 days in 3/2024, 16 days in 4/2024, 22 days in 5/2024, 28 days in 6/2024, 23 days in 7/2024, 30 days in 8/2024, 22 days in 9/2024, 17 days in 10/2024, 30 days in 11/2024, 26 days in 12/2024, 10 days in 1/2025, 2/1, 2/2, and 2/3. Each day R22 wandered has multiple episodes of wandering documented. The facility was unable to provide any behavior tracking specific to elopements.

On 01/29/25 at 12:32 PM, V8 (MDS Coordinator) stated she was responsible for updating and implementing interventions on resident care plans. V8 stated R22 didn't have any new interventions implemented to prevent elopements in the year 2024. V8 stated she didn't implement any new interventions because R22 was never out of eyesight of staff. V8 stated she just implemented new interventions when she was directed to by the Administrator and Director of Nursing. When asked what their usual routine was if someone had a new event occur, V8 stated they discuss it in meetings and implement an intervention to try to decrease risk. When asked why they didn't do that each time R22 eloped, V8 stated, "I couldn't tell you." V8 stated she didn't remember any details about R22's elopements

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and she didn't believe any notes were taken when they met. This surveyor reviewed the care plan interventions documented on R22's current care plan and asked V8 if R22 had eloped in December 2024 and if not why was there a new intervention of the safety vest documented on 12/11/2024. V8 stated she would have to check on it.

On 1/29/25 at 1:48 PM, V8 (MDS Coordinator) stated the intervention of the vest was implemented before 12/11/24 it just wasn't documented on R22's care plan. V8 stated it was found when the previous regional nurse was doing a review of R22's record and she added it to the care plan. V8 stated she wasn't sure when they implemented the safety vest intervention.

On 2/3/25 at 2:07 PM, V1 (Administrator) stated she was not able to locate any other documentation on R22's elopements for the year 2024. V1 stated the IDT (Interdisciplinary Team) had not met yet to determine if R22 was safe to not have a 1:1, 24 hours a day. V1 stated R22 was currently on 1:1, 24 hours a day. When asked why he wasn't on it on the night when I called and spoke with staff V1 stated, "Ok. When did you call." This surveyor responded with 1/29/25 and asked again if he had 1:1, 24 hours a day. V1 stated, "We are working on it." When asked what that meant, V1 stated, "We are working to schedule 1:1, 24 hours a day. When asked does he currently have 1:1 supervision 24 hours a day, V1 stated, "I will have to checkwith the person who does scheduling." This surveyor reviewed with V1 that V31 (Social Services Director) had stated she did not talk with V28 (Family Member) after the elopement on 1/29/25 and had not spoken with her since she started working at the facility. V1 stated they reached out

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to V28 and V28 didn't answer so they kept calling until they got a hold of her. V1 stated they spoke with V28 on 2/3/25. When asked if she could remember what happened each time R22's progress notes document an elopement, V1 stated possibly after reviewing everything. This surveyor reviewed with V1, the interviews documenting R22 was found at the gym located 0.8 miles from the facility and V1 stated she was not aware of that. This surveyor asked V1 if they should notify the family and physician with each elopement and V1 stated, "I would have to check." When asked if she could say why there were no new interventions implemented after each elopement for the year 2024, V1 stated, "I cannot." When asked if there should have been new interventions implemented, V1 stated, "I am not sure. I will need to check."

On 2/4/25 at 8:46 AM, V1 (Administrator) stated she couldn't remember the exact date the 1:1 staff supervision on day shift started for R22, but she believed it was in July or August of 2023. V1 stated they didn't implement that intervention to prevent elopements but had implemented it to keep R22 from taking other residents' food out of their rooms and they didn't set it up to have to be consistent with the time frames that R22 had 1:1 staff but they tried to have them during meal hours.

On 01/30/25 at 2:19 PM, V34 (Physician) stated he was not notified that R22 had eloped and did not feel that he was safe in the community alone. V34 stated he was aware R22 had a history of wandering and stealing food but does not recall any communication regarding him leaving the facility.

The facility "Elopement/Missing Resident

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Procedure" dated 2020 documents, "Staff shall investigate and report all cases of missing resident ...1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. 2. 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 c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises. 3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Notify the Attending Physician; c. Notify the resident's legal representative (sponsor) of the incident; d. Document the event. 4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on an authorized leave or pass; 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 Director of Nursing Services, the resident's legal representative (sponsor), the Attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e. Emergency Management, Rescue Squads, etc.); d. Provide search teams with resident identification information; and e. Initiate an extensive search of the surrounding area. 5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Contact the Attending Physician and report findings and conditions of the resident; c. Notify the resident's legal representative (sponsor); d. Notify search teams that the resident has been

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located; e. Document relevant information and update plan of care."

2. R26's admission record documents an admission date of 11/29/24 and includes the following diagnoses in part; syncope and collapse, depression, anxiety, muscle weakness, difficulty walking, history of falling.

R26's Minimum Data Set (MDS) dated 12/06/24 documents a Brief Interview for Mental Status (BIMS) of 13 indicating R26 is cognitively intact. Section GG documents that R26 uses a walker and does not use a wheelchair. Section GG also documents that R26 transfers independently, including toilet transfers and can walk independently up to 150 feet.

R26's care plan documents a focus are with an initiation date of 12/15/24 of at risk for falls r/t (related to) confusion, unsteady gait, dx (diagnosis) seizure disorder, syncope, use of antidepressant medications. Ambulates ad lib with use of walker. (utilized rollator when first admitted). R26's care plan documents the following interventions, "12/4/24 Encourage and assist with toileting needs prior to breakfast," with an initiation and creation date of 12/15/2024. "12/9/24 Non-skid strips next to bed," with an initiation and creation date of 12/15/24.

On 01/27/25 at 12:48pm, R26 stated they took her walker away a while ago. R26 stated, "Staff say that I can't fall in a wheelchair, but I still did." R26 stated she is pleased with her care otherwise and denies any issues.

On 01/27/25 at 12:48pm, R26 was observed sitting on the other bed in her room that was not hers, there was a wheelchair in front of her. There

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were no fall prevention interventions in place around this bed, bed was sitting at the highest position. The floor in front of R26's bed had non-skid strips in place. A "call don't fall" sign was posted on R26's bathroom door. R26's bathroom had a new toilet and handrail in place. No walker was observed anywhere in R26's room.

On 01/27/25 at 12:55pm, R26 was observed ambulating in her room with no walker visually present. The only assistive device in R26's room was a wheelchair.

On 01/27/25 at 2:05pm, R26 was observed unsteadily walking around her room without an assistive device. No walker was observed in R26's room and the wheelchair was still sitting next to unoccupied bed.

On 01/27/25 at 2:10pm, R26 was observed attempting to come out into the hallway, still without an assistive device. Staff saw R26 and attempted to redirect her. Staff moved chair with arms out of R26's room into the hallway and assisted her into it.

On 01/28/25 at 02:05pm, R26 was seen ambulating in her room unassisted, her walker was present, but she was not using it.

On 01/28/25 at 11:31am, V40 (Physical Therapist Assistant/PTA) stated that they had discharged R26 from physical therapy, mostly due to her behaviors. V40 stated R26 started around the first week of December and was discharged the first week of January. V40 stated R26 gave 6 refusals in a row, which by their standards is grounds for discharge. V40 stated R26 came in with a rollator walker but was downgraded to a front wheeled walker. V40 stated that R26's goals were all

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about balance and they used a wheelchair to help her in therapy. V40 stated R26 has not been evaluated or instructed to use a wheelchair otherwise.

On 01/29/25 at 12:32 PM, V8 (Minimum Data Set coordinator/LPN) stated she is responsible for updating and implementing interventions on care plans. V8 stated she implements interventions when told to by the administrator/DON during the IDT meetings. V8 stated the normal routine if someone has a new event occur is to discuss it in meeting and implement an intervention to try to decrease risk. V8 stated she did not think any notes were taken during these meetings.

A review of R26's incident reports related to falls documents R26 fell on the following dates, 12/4/25, 12/9/25, 12/10/25 at 7:12am and 10:23am, 12/11/25, 12/12/25, 12/16/25, 01/04/25, 01/15/25, 01/18/25, and 01/20/25.

An incident report dated 12/04/25 at 06:15am documents in part " ...resident was found sitting on the floor in front of the south nurse's station. She was seated on her bottom with her legs folded in towards her body ... This nurse had just seen her walking by the nurse's station. This nurse did not hear her fall and was only a few feet away. I feel she sat herself on the floor. When asked how she fell how she fell resident responded, this is just what I do. I fell." The conclusion of this investigation stated, " ...it is believed that the root cause of this occurrence is related to resident ambulating independently without staff involvement resulting in a fall ...Fall also could potentially have been influenced by impaired cognitive status, unsteady gait, impatience, poor safety awareness."

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b)2.) R55's admission record documents an admission date of 01/17/25 and list the following diagnoses in part; vascular dementia, mild with psychotic disturbances, history of falling, depression, muscle weakness and difficulty walking, not elsewhere classified, cerebral vascular accident, and multiple sclerosis.

R55's MDS (Minimum Data Set) dated 01/24/25, documents a BIMS (Brief Interview for Mental Status) of 11, indicating that R55 is moderately cognitively impaired. Section GG-functional abilities documents that R55 is partial/moderate assistance with toileting hygiene and lower body dressing. It also indicates in the section "indoor mobility", that R55 needs some help-Resident needed assistance from another person to complete any activities. R55's section H-bowel and bladder documents R55 is occasionally incontinent of bladder and frequently incontinent of bowel.

R55's care plan documents she is at risk for falls r/t (related to) decreased cognition, poor safety awareness, weakness, dx(diagnoses) CVA (Cerebral vascular accident), MS (multiple sclerosis). R55's care plan documents a fall intervention initiated on 01/29/25 as bed alarm placed to alert staff of need for assistance. Fall intervention with initiation date of 01/30/25 documents R55 needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light.

R55's medical record documents she had an unwitnessed fall on 01/29/25 at 03:44am white attempting to toilet self.

R55's medical record does not document a fall risk assessment was not completed until

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01/29/25.

On 01/29/25 at 12:01PM, V37 (Family member) stated every time they come in to visit R55 she is sitting on the edge of the bed, in the dark and her TV is off. V37 stated that R55 has a history of falling and she is content sitting in front of the tv. V37 stated if they did not want her to fall, leaving her sitting in the dark alone with no tv on would not be a good idea. V37 stated he has brought this to multiple staff members attention. V37, she had lost her remote for the first three days she was here, and they continued to ask staff about it. V37 stated they had requested she have some kind of alarm, to hopefully alert them if she was trying to get up unassisted, but nothing had been done yet.

On 02/03/25 at 10:42AM, V36 (Family member) V36 stated he came in this past Friday morning, and R55 was sitting on the edge of the bed in the dark with no tv on. V36 stated R55 wanted to put pants on, and he could not find her house shoes. V36 stated he felt like the room was just in complete disarray. V36 stated he finally found R55's house shoes under the other bed. V36 stated he stood R55 up and realized the pressure alarm was not under her or on and was tossed over on the edge of the bed by the window. V36 stated he went to the nurse's station and asked for the administrator, he spoke with her about his concerns and felt like she brushed him off. V36 stated he, along with family made the decision to get things to bring R55 home the next day, so she did not have to go through all the crap she's had to at this facility.

On 01/29/25 at 12:45pm, R55 was laying on the edge of her bed, she was awake and staring at the window. R55's lights and TV were off. R55 did

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S9999	Continued From page 27 not have a pressure alarm in place at this time. On 01/30/25 at 09:14am, R55 was observed sitting on the side of her bed, no pressure alarm was observed in place, her lights and TV were off. Facility policy titled "Fall management", with a review date of 2019 documents "It is the policy of the facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Program will monitor the program to assure ongoing effectiveness. This policy documents under standards that a Fall Risk Assessment will be performed by a licensed nursing (SIC) at the time of admission. The assessment tool will incorporate current clinical practice guidelines. Documented under standard fall/safety precautions: all residents ... The resident's personal possessions will be maintained within reach when possible. These items include tissues, water, drinking glass and phone. Assistive devices such as walker and canes will be places within reach of those residents who have physician's orders to ambulate independently and as clinically indicated. The resident's environment will be kept clear of clutter which would affect ambulation and remove hazards. Lighting will be appropriate for the time of day and in accordance to the resident's desire and the plan of care. (A)	S9999		

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S9999	Continued From page 28 Statement of Licensure Violations 2 of 2 300.690a) 300.1010h) 300.1210b) 300.1210d)1)6) 300.1220b)2) 300.1620a) 300.1630d) 300.1630e) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	S9999		

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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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

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:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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S9999	Continued From page 30 Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure physician's orders were followed,	S9999		

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for 1 of 5 residents (R55) reviewed for significant medication errors in the sample of 30. This failure resulted in R55 missing three doses of long-acting insulin from 1/17/25 to 1/19/25, causing R55's blood sugars to be extremely elevated. This has the potential to lead to ketoacidosis which could result in coma and possible death.

Findings include:

R55's admission record documents an admission date of 01/17/25 and list the following diagnoses in part; vascular dementia, mild with psychotic disturbances and type 2 diabetes mellitus.

R55's MDS (Minimum Data Set) dated 01/24/25, documents a BIMS (Brief Interview for Mental Status) of 11, indicating that R55 is moderately cognitively impaired. Section I-active diagnoses documents an active diagnosis of diabetes mellitus.

R55's care plan documents an initiation date of 01/28/25 for a focus area that states R55 is at risk for complications r/t (related to) dm (diabetes mellitus).

R55's Physician's Order Sheet (POS) documents an order with an order date and a start date of 01/17/25 for Toujeo Solostar Subcutaneous Solution pen-injector 300 Units/ML, (Insulin Glargine) (long-acting insulin), Inject 70 units at bedtime for diabetes mellitus.

R55's Physician's Order Sheet (POS) documents an order with a start date of 01/18/25 for Blood glucose per fingerstick as needed for signs/symptoms of hyperglycemia/hypoglycemia.

On 01/27/25 at 10:03am, V36 (Family member)

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stated that they continued to ask the nurse about R55's meds the first couple of days of being in the facility because she wasn't getting all of them or her insulin, they continued to be told they were still working on it. V36 stated staff reported they were still working on her admission through Sunday. V36 stated R55 was not getting her blood sugar checked at meals either. V36 stated that R55 had her blood sugar checked four times a day at the hospital and she had continuous monitoring at home.

On 01/29/25 at 12:01pm, V37 (Family member) stated R55 was admitted on Friday 01/17/25 in the evening, and it was a struggle all weekend getting her medications. V37 said that they asked the nurses several times from Friday to approximately Sunday or Monday for R55's medications and insulin's and they kept saying that they were working on getting her admitted still. V37 stated they asked staff several times to check R55's blood sugar around mealtime, which is what she did at home and at the hospital, but no one did.

R55's progress notes document that on 01/17/25 and 01/19/25 Toujeo Solostar Subcutaneous Solution pen-injector (Insulin Glargine) (long-acting insulin) was not administered due to awaiting pharmacy delivery.

R55's January 2025 Medication Administration Record (MAR) documents a blood glucose finger stick was started and administered by V42 (Registered Nurse/RN) on 01/18/25 and documents a blood sugar of 308.

R55's January 2025 MAR documents no signatures on 01/17/25 or 01/19/25 for Toujeo Solostar Subcutaneous Solution pen-injector

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(Insulin Glargine) (long-acting insulin), indicating it was not administered.

R55's January 2025 MAR documents a signature on 01/18/25 for Toujeo Solostar Subcutaneous Solution pen-injector (Insulin Glargine) (long-acting insulin) indicating that it was administered by V46 (Registered Nurse/RN), and a blood sugar of 411. V46 was unavailable for interview to explain how she was able to administer a medication that was not available in the facility or why she documented in the MAR a blood sugar of 411 and did not contact the physician.

On 01/30/25 at 09:58am, V41 (Pharmacy medical records) reviewed medication orders for R55. V41 stated a new order was received from the facility for long-acting insulin on 1/17/25. V41 stated an emergency order was called to the backup pharmacy (a local pharmacy) on 1/17/25. V41 stated the order was never picked up by facility. V41 stated on 1/19/25, a nurse from the facility called to ask about it and the pharmacy informed them it was to be delivered later that evening or there was an emergency order called in to the backup pharmacy and they stated they will wait for the delivery. V41 confirmed the long-acting insulin was delivered on 01/19/25. V41 stated the facility would not be able to access their supply without contacting the pharmacy for a code to open the bin the medication was in.

On 02/03/25 at 03:43pm, V2 (DON) stated that discharge orders from residents admitted from the hospital are to be put into the computer system as soon as possible, copied and then faxed to the pharmacy. V2 stated if they are not faxed by 8pm, they will not be received that day. V2 stated some medications, including insulin's

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are kept in the emergency kit in the medication room. V2 stated if they are not in there, they should contact the pharmacy and see if they can bring them on an emergency run or from the backup pharmacy (local pharmacy). V2 stated if it comes from the backup pharmacy, she believes they deliver it. V2 stated she was not aware that R55 missed multiple doses of long-acting insulin before she reviewed her admission packet on 1/20/25 or 1/21/25. V2 stated at that time she contacted V34 (Physician) to see if he wanted R55 to have sliding scale insulin. V2 stated that her process for new admission orders is that two nurses independently review the orders and then she will review the admission packet also. V2 stated she would have expected V34 be contacted with any missed doses of insulin or blood sugars above 300.

On 02/03/25 at 12:03pm, V42 (RN) stated the process for admitting new residents with medications, is that the admitting nurse puts the orders in, and if they are not finished by the next shift, the oncoming nurse should finish them. V42 stated if she put an order in for an as needed (PRN) blood glucose fingerstick for R55, it was because it was either on her discharge sheet or ordered by the doctor. V42 stated that she did not notify the doctor of a blood sugar of 308 for R55 because they are not required to. V42 stated if they need medications, they call the pharmacy, if they cannot get them then they should notify the doctor. V42 stated on 01/19/25 when she was taking care of R55, her meds were still not available in the facility and she did not notify the physician.

On 02/03/25 at 12:19pm, V4 (License Practical Nurse/LPN) stated when a new admit comes, they get discharge orders and the nurse that

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receives the resident is to put them in. V4 stated they are then checked by a second nurse and then by V2 (DON). V4 stated this is a new process that was put in place by V2 since she started a few weeks ago. V4 stated the process for obtaining medications is to call the pharmacy and order the medication, see if it is in the emergency supply and then the backup pharmacy. V4 stated she was not sure who's responsibility it was to get meds from the backup pharmacy, but she has seen them come via door dash from a local pharmacy before. V4 stated residents should not miss a dose of insulin and if that were to happen, the doctor should be notified. V2 stated she did R55's admission but could not recall what the situation was with R55's medications when she was admitted.

On 01/30/25 at 02:19pm, V34 (Physician) stated on 01/17/25 he was notified late at night about R55 having a drug allergy and order clarification for a medication. V34 stated he was not contacted again until 1/21/25. V34 reviewed his communication with the facility and stated he had not been contacted at all about R55's insulin not being available or blood sugar until 1/21/25. V34 stated he was contacted on 01/21/25 by V2 (Director of Nursing/DON) about orders for sliding scale insulin for R55. V34 stated yes and he directed them to call his office if they were not familiar with his standard sliding scale. V34 stated he would expect to be contacted about any resident, not just a new resident, with a blood sugar of 308 and 411, especially the 411. V34 stated his expectation would also be that they recheck R55's blood sugar after numbers like that. V34 could not say for sure what would have happened or the level of harm that could have happened because everyone responds differently, but that he had not been notified of

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any of it. V34 stated his expectation would be for R55 to not miss any doses of insulin, especially if there was a script waiting at a pharmacy in town the same day. V34 stated his expectation would be to be notified in those instances.

On 02/03/25 at 02:45pm, V26 (LPN) stated she was working on 01/17/25. V26 stated she did not recall the situation with R55 and not receiving insulin. After a review of R55's medication administration record (MAR), V26 verified she did not administer R55's insulin and she recalled being told in report from the day shift nurse that the medication was on its way. V26 stated she could not recall if she notified the doctor or not but should have.

On 02/10/25 at 07:51am, V50 (Pharmacy medical records) stated it is the responsibility of the pharmacy couriers to pick up medications filled at the backup pharmacy. V50 stated she had no documentation as to why R55's insulin was not picked up from the backup pharmacy or that anyone from the facility contacted them about R55 until 01/19/25. V50 stated the facility did not attempt to obtain the medication from the Emergency kit for R55. V50 stated when the facility calls in the order to the pharmacy, if it is the emergency kit (E-kit), the pharmacy technician would advise them to pull from E-kit if it were available there. V50 stated the pharmacy technician would then walk them through the process and grant them access to the medication. V50 stated judging by the fact that an order was sent to the backup pharmacy immediately, the medication may not have been available in the E-kit. V50 confirmed there was not R55's type of insulin available in the facility emergency kit from 01/17/25-01/20/25. V50 confirmed there was no correspondence between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009203	A. BUILDING: _____ B. WING _____	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF CARBONDALE	120 NORTH TOWER ROAD CARBONDALE, IL 62901

(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 37 the facility and the pharmacy from 01/17/25 and 01/19/25 regarding R55's insulin. According to the Mayo Clinic website (https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551), Diabetic ketoacidosis is a serious complication of diabetes. Under "When to See a Doctor" it documents "Seek emergency care if: Your blood sugar level is higher than 300 milligrams per deciliter (mg/dL), or 16.7 millimoles per liter (mmol/L) for more than one test ...untreated diabetic ketoacidosis can lead to death." According to the Center for Disease Control (CDC) website (https://www.cdc.gov/diabetes/about/diabetic-ketoacidosis.html), Diabetic ketoacidosis (DKA) is serious and can be life-threatening. Under "Causes" it documents "Very high blood sugar and low insulin levels lead to DKA. The two most common causes are: ...2. Missing insulin shots, a clogged insulin pump, or the wrong insulin dose." Under "Testing" it documents "Go to the emergency room or call 911 right away if you can't get in touch with your doctor and if you're having any of these signs: Your blood sugar stays at 300 mg/dL or above ..." A facility document titled "Administering Medications" with a revision date of December 2012 documents under policy statement, "Medications shall be administered in a safe and timely manner, and as prescribed." (A)	S9999		