STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E257	A. BUILDING _____ B. WING _____	C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF SMITHTON	107 SOUTH LINCOLN SMITHTON, IL 62285

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1640743/IL83291	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Facility failed to supervise 1 of 1 resident who left the Facility without the knowledge of staff in the sample of 8. Findings include: R2's Nurses Note, dated 2/7/16 at 2:33 AM, documents "At 11:00 PM, shift change, resident noted not in bed. Facility and surrounding areas searched thoroughly. Local businesses searched. Resident not located. Administrator called at 12:15 AM and notified of resident missing from Facility. At 12:38 AM, resident returned to Facility. Resident fell on buttocks after taking a few steps into the building. Bleeding noted to right knuckle on pinky finger, also had abrasion to ring finger knuckle and middle finger knuckle. Three superficial scratches noted to right outer hand. Left knee bruising approximately 4 cm (centimeters) by 2 cm. Dr. notified of incident. Message left for Guardian."	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E1, Administrator, documented the following on notepaper: "2/7/16, 12:15 AM. (E1) called by the Facility in regards to (R2) not being in the building. Staff had looked at all of the resident rooms, bathrooms, etc. and had looked outside. Informed (E2, Director of Nursing, DON) that we may have to get police involved to assist. (E1) received a call about 12:35 AM stating that (R2) came back to the building. Staff noted right hand abrasion.
2/8/16, 12:06 PM, (E1) spoke with (R2) in regards to going outside. He (R2) stated that he went out to sit outside on the bench by the 300 Wing because he needed a breath of fresh air. (E1) instructed resident to inform a staff member of wanting to sit outside. Resident promised to tell someone that he wants to go out, stated 'I won't go out anywhere without someone else.' During the investigation, (E1) cannot determine how resident got out. His Brief Interview for Mental Status (BIMS) score is a 13 and he is alert and oriented. Will continue to monitor resident and encouraged him to continue with psychosocial groups. Administrator spoke to psychosocial in regards to his wanting to go outside and need for family to be aware of this issue. Checked alarms to ensure functioning. (R2) placed on 15 minute checks and family aware. Will continue to monitor."

R2 stated in an interview on 2/10/16 at 1:42 PM, "Yeah, I went out last Saturday night (2/6/16) - it was close to midnight. I went out the north door, the double doors. There was an alarm, but not loud. I was outside, maybe 1 - 1.5 hours. I didn't go anywhere. Why does everyone think I took off? I can barely walk as it is. I did not go to a bar - I just sat on the concrete bench. It wasn't

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that cold and I was dressed good. I came back in when I got cold."

E5, Certified Nurses Aide (CNA), stated in an interview at 3:05 PM on 2/10/16, that she was working the evening shift on 2/6/16 when R2 left the building without staff knowledge. E5 said that she did not hear any door alarms sounding. E5 said "I don't know, maybe (R2) went out of the window." E5 said that she and E6 were the only two CNAs working in the building that evening, and they worked the 3:00 PM - 11:00 PM shift. "We never knew he was outside. The last time I saw him was around 10:00 PM - 10:30 PM when he was taking a shower. He's never taken off before. (R2) is sneaky, he could have gotten outside when people were coming in to work. Sometimes the alarms go off during shift change. Sometimes staff set the 'quieter' alarm and you can't hear it. Some of the residents know how to move the alarm to a quieter setting or how to turn them all the way off. Some of the residents know how to work them."

On 2/11/16 at 12:30 PM, E6 said that she and E5 were the only two CNAs working during the evening shift on 2/6/16. E6 said that there was one nurse working, E9, Licensed Practical Nurse (LPN). E6 said that she saw R2 at 8:15 PM, when she took the residents outside to smoke. E6 said she then went to the 100/200 Hall to work until 9:45 PM. E6 said that she never heard a door alarm sound. E6 said that she had both front doors under visual observation from around 8:30 PM until 9:45 PM as they were concerned about another resident leaving. E6 said that she did not see (R2) again that evening. "I didn't know he had been gone until the next day when I came in to work." E6 said that the door alarms

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are fully alarmed at 7:00 PM. E6 said that R2 probably knows how to deactivate the door alarms, "maybe he watched someone put the code in, or you can totally deactivate it by pushing the slide all the way over. (R2) normally goes to bed after the last smoke break, which is 8:15 PM. This was out of character."

E2, DON, stated in an interview on 2/10/16 at 1:58 PM, that she came on duty at 11:00 PM on the night of 2/6/16 and immediately had staff conduct "face - checks." E2 said that E10, CNA, came to her and told her that they could not find R2. E2 said that the evening nurse, E11, LPN, said that R2 took a shower around 10:00 - 10:30 PM, and that was the last time that anyone had seen him. E2 said that they all began looking for R2 - they checked the entire building, inside and out. E2 said when they still could not locate R2, they began driving around looking for him - at the local quick stop, taverns, etc. "We still couldn't find him so I called (E1, Administrator) at 12:15 AM. I told her that we were going to call the police and (R2's) family. As I was calling the police, (R2) walked back into the building through the door by the office. I asked him where he had been and he said 'out for a breath of fresh air.' He didn't have any alcohol on his breath. His right hand was bruised. He said he fell outside and got an abrasion on his right hand and elbow. He wouldn't say how he got out. Staff should have seen him or heard the door alarm."

The R2's undated Cumulative Diagnoses Sheet documents diagnoses of History of Head Injury, Paranoid Schizophrenia, Hemiplegia and Diabetes Mellitus Type II.

R2's most recent Minimum Data Set (MDS),

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dated 11/23/16, documents that R2 has a BIMS score of 13, which means that he is cognitively intact. The MDS documents that R2 has no behaviors, and requires setup help and supervision with walking, eating and personal hygiene. The MDS also documents that R2 is not steady but able to stabilize without staff assistance for walking, turning around, moving from a seated to standing position and moving on and off of the toilet.

R2's plan of care, with an original date of 1/31/12, documents "hemiparesis on right side related to old head injury. At risk for falls related to gait disturbance. Taking psychotropic medication for schizophrenia and depression, he is at risk for changes in cognition and behavior, side effects and fall related to medication use."

There are two sets of double doors located on the front of the building, at either end of the building. These two doors are equipped with a battery powered box-type alarm. The bottom of the alarm has a bar which can be slid to "Chime/ Instant/ Delay/ or OFF." The alarm was set to "Chime" throughout all days of the survey. The "Chime" alarm was tested along with E4, Maintenance Director, on 2/10/16 at 2:10 PM. The "Chime" alarm could only be heard within approximately 20 feet of the door, and turns off when the door is closed.

E1 stated in a telephone interview on 2/16/16 at 1:58 PM that the Facility does not have a policy regarding entrance doors being alarmed or the supervision of residents.