STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. BUILDING _____ B. WING _____	**09/08/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to determine identified discharge needs; ensure adequate supports were in place; and determine if care givers were capable of caring for one of three residents (R4) reviewed for discharge in a sample of 15. The findings include: R4's electronic medical record documents he is [AGE] years old and was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Discharge MDS (Minimum Data Sets) assessment dated [DATE] lists R4 as having a BIMS (Brief Interview for Mental Status) score of 6, indicating severe cognitive impairment with physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurring 1 to 3 days, wandering occurring daily, and listing R4 as independent with transfers, ambulation in his room, and frequently incontinent of both bowel and bladder. R4 weighs 171 pounds, and the answer to the question, has a referral been made to the Local Contact Agency, says No-Referral is or may be needed. The quarterly MDS dated [DATE] Section S Discharge Planning Review lists R4 as having barriers to discharge, as having extensive care needs secondary to physical disabilities, has had problems complying with his/her psychiatric treatment regimen. This same document lists R4's discharge potential as cannot determine and discharge status as personal residence with support services and the staff is to initiate discharge planning. R4's screening documents from the referring out of state hospital sent to V1 (Administrator) prior to admission into the facility, says on 2/27/2020, [AGE] year-old male with [MEDICAL CONDITION] with behavioral disturbance, admitted since 1/19/20 due to ongoing impulsivity/agitation. This same document lists hospital day 40 as R4 being labile, confused, delusional, frequent redirections and continues to wander into other rooms, and received PRN (taken as necessary) [MEDICATION NAME] 10mg (milligrams) orally at 8:04 this AM. The exam completed that day states agitation noted, walking around trying to open cupboards. Thought content was unable to be assessed with [REDACTED]. In this same document an assessment note on the same day states Patient has been moved to the back hall and since then he continues to exhibit intrusive behavior, irritability and restlessness. He continues to have poor executive/overall cognitive function along with confusion and with mood symptoms. His [MEDICAL CONDITION] also increased his sensitivity to medication, making adjustment to medication difficult. He needs reminding and assistance with most tasks and his short-term memory is severely impaired making him unable to fully care for himself .Remains on Precautions: Assault/Violence, Elopement, Fall Risk. On 8/27/20 at 11:08 AM, V6 (Family Member) verified that she had been wanting R4 to be moved closer and felt if she could visit with him more often, his behaviors would not be as violent. She said she had been talking with the staff at the facility about getting him moved closer to her residence (which is in another state) into a long-term care facility, but they were not having much success due to R4 testing positive for COVID, and his insurance being state specific. V6 went on to state that V9 (Director of Nursing/DON) called her on 8/6/20 and said they could no longer take care of R4 and they were going to bring him to V6's state of residence. V6 stated they met in the hospital parking lot on 8/7/20 and when they arrived and R4 got out of the car and he looked thin and unstable on his feet. V6 said the only papers she received was a paper with a list of medications on it. V6 took R4 inside the hospital and a physician there said what the facility did by bringing R4 the way they did was called Dumping. V6 said she kept R4 at her home for 6 days trying to care for him, then V6 called another family member as she could no longer do it. V30 (Family Member) told V6 to bring R4 to his home and V30 would try to care for R4. V6 also said R4's insurance was specific to the state he was residing in prior to the exchange, and would not be accepted in V6's state of residence for medical care. V6 added that since R4's move to V30's residence, R4 did have to go to the hospital for care. On 8/28/20 at 1:35 PM, V9 (DON) said that he looked at the screening information for R4 prior to his discharge from the out of state hospital but did not see R4 prior to admission to the facility for screening. V9 said that V6 wanted R4 closer to her, so they tried to find facilities closer to her to refer R4. V9 also said there were several reasons facilities in V6's state of residence would not accept R4, some of them related to COVID (Coronavirus), as R4 was positive for COVID at one point, behavioral, an elopement risk, has a [MEDICAL CONDITION] diagnosis, as well as issues with his funding source. V9 said R4 was difficult to care for, and attempts to find facilities closer to V6's home that would be better equipped to handle him were unsuccessful. V9 said R4's discharge plan was to be discharged home with V6, and if she was unable to handle R4, she would seek placement in her state of residence. V9 further stated the staff at this facility felt if R4 was in V6's state of residence, there would be a better chance of getting R4 into a facility closer to V6's home. V9 said V6 knew R4 was aggressive, and an elopement risk, but she wanted to try to handle him. When asked who educated V6 about R4's aftercare needs and resources in her area for R4, V9 stated I did not educate her specifically, and verified V9 could have done a better job at researching the resources in V6's area for R4, prior to his discharge. When asked about how R4's behavioral health needs were supposed to be met after discharge, V9 said I can't answer that. V9 also verified the only document provided to V6 was a medication list for R4. On 8/28/20 at 12:12 PM, V11 (Licensed Practical Nurse) stated that on the morning of 8/6/20, she asked V6 if she wanted the facility to bring R4 to her state of residence and V6 called back later that same evening and said yes. V6 expressed her only concern was fearing R4 would get out of her house and go to the neighbor's house. When asked what R4's discharge needs were, V11 said she did not specifically know, but felt V6 knew R4 needed a mental health facility and was very aware of R4's behaviors. On 8/28/20 at 12:55 PM, V12 ([MEDICAL CONDITION] Coordinator) said he did not talk to V6 about the specific behavioral health needs of R4, and verified he did not consult or contact any local contact agencies regarding R4's discharge. A progress note dated 8/7/20 at 4:45 PM in R4's record states Resident handed off to care of (V6) On 9/1/20 at 12:02 PM, V30 (Family Member) said R4 was at his house currently, because V6 could not keep him at her house. V30 said he had a visit scheduled for 8/9/20 at the facility, and was not told R4 had been discharged out of state with V6. V30 also said he had to take R4 to the hospital due to his inability to walk right after V6 brought him to his house. V30 said he still does not know why R4 could not walk, but he is walking now. V30 stated that R4 was currently doing well emotionally and is enjoying being at V30's home at this time. R4's Care Plan with a close date of 8/12/20 does not list any focus areas, goals or interventions related to his discharge. A statement under R4's care plan focus area of 'Activity of Daily Living' states There are no plans for discharge at this time. A document entitled Interdisciplinary Discharge Summary states R4 has no sensory impairments, and no special treatments or procedures planned for discharge. A facility policy entitled Transfer or Discharge, Preparing a Resident for states under the heading of policy interpretation and implementation, number 2 A post-discharge plan is developed for each resident prior to his or her transfer or discharge.

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