Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003685	A. BUILDING: ______ B. WING ______	08/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOME	2130 HARRISON STREET QUINCY, IL 62301

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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)3) 300.1220 b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general	S9999	Attachment A Statement of Licensure Violations	

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nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to respond immediately to a sounding exit door alarm, failed to adequately supervise a known wandering resident (R8), failed to re-assess R8 as high risk for elopement once R8 started to exit seek, failed to develop and implement interventions and plan of care to

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address R8's exit-seeking behaviors after R8 attempted to exit seek, and failed investigate and report R8's elopement thoroughly for one of three residents (R8) reviewed for elopement in the sample of 41. These failures resulted in R8, a severely cognitively impaired resident with the diagnosis of Dementia, eloping from the facility approximately 70 feet from the facility, falling, and being found on the curb next to the road, after attempting to exit the building earlier that evening on 6-7-23.

Findings include:

The facility's Resident Elopement Policy, dated 6-12-18, documents, "Policy: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans. All staff are responsible. Missing resident shall be defined as a resident who has left the main building without signing him/herself out of the facility. Residents who are at risk for elopement shall be provided at least one of the following safety precautions by the facility: Door alarms on facility exits, code alert bracelet, staff supervision of facility exits, and pictures of residents at risk for elopement will be kept at the front desk for quick identification. Elopement assessment will be done on admission, quarterly, and change in condition which puts them at risk for elopement. Residents at risk for impaired safety awareness and wandering as well as elopement shall be identified by the elopement assessment and interventions documented in the individual plan of care. Residents at risk for elopement shall be

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identified on the "Resident Watch List" with accompanying photograph as well as in the clinical record. The list shall be updated whenever new resident safety issues are identified. Photographs of each resident are located in the Medication Administration Record, face sheet, and front receptionist desk. When responding to an exterior door alarm: If a resident is found leaving the building, attempt to prevent departure. After assessing resident's behavior, nursing administration will determine the need for ever 15 minute/ever one hour documented checks. Care plan session will be held to review/modify care plan approach. Procedures for missing resident and/or elopements: Notify the Administrator."

R8's Physician's Order Sheets, dated 8-1-23 through 8-31-23, document R8 has the diagnoses of Dementia without behavioral disturbance, Psychotic Disturbances, Mood Disturbance, and Anxiety.

R8's MDS (Minimum Data Set) Assessment, dated 6-26-23, documents R8 is severely cognitively impaired and requires supervision of one staff physical assistance for locomotion of and on the unit and walking in his room and in the corridor, and requires extensive assistance of one person physical assistance for transfers.

R8's PASRR (Preadmission Screening and Resident Review), dated 4-2-22, documents, "You know who you are but you do not know where you are, why the time, or date. You are not able to focus and our mood changes a lot. You need supervision."

R8's Event Report, dated 6-7-23 at 5:30 PM, and signed by V3 (RN/Registered Nurse) documents,

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"Resident was found between double doors of the east exit of Eastbrook Lane (floor within facility). Combativeness and resisting redirection from staff prior to elopement. New onset of agitation and confusion. Immediate measures taken-returned resident to room. Interventions ineffective."

R8's Progress Notes, dated 6-7-23 at 5:30 PM and signed by V3 (RN/Registered Nurse), document, "(R8) attempted to leave through the east door on Eastbrook Lane (floor within facility). (R8) stopped and escorted back to his room. (R8) was not using his walker at the time. (R8) stated that he wanted to get his keys out (of) his car. Nurse and CNA (Certified Nursing Assistant/V8) re-directed him. Nurse grabbed walker and nurse and CNA (V8) escorted him back to his room."

R8's Event Reports, dated 6-7-23 at 7:00 PM and signed by V3, documents, "(R8) exited through the south side door on Eastbrook. (R8) was found by road next to cottage at about 7:00 PM. Combativeness, elopement attempts, and resisting redirection from staff behaviors exhibited prior to elopement. New onset of agitation, resistiveness, and restlessness. Resident was laying on ground next to road by cottages on his side. He was picking flowers in the grass."

R8's Progress notes, dated 6-7-23 at 7:05 PM and signed by V3, documents, "(R8) has an unwitnessed fall following an elopement. (R8) exited the unit through the south door of (facility unit). (R8) was found laying on his side in the grass with his walker next to him. He has no complaints of pain. Assessment showed no injuries. (R8) was wearing shoes in good repair and was using his walker. (R8) was found by

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S9999	Continued From page 5 nurse and CNA (Certified Nursing Assistant) (V8) who used (mechanical lift) to get (R8) off the ground and into his wheelchair. Placed resident next to nurses station and placed on 15 minute checks." R8 did not have a comprehensive care plan developed regarding R8's wandering, exit-seeking, or elopement until 7-3-23 (26 days after R8's elopement). R8 did not have an elopement risk assessment completed once R8 started exhibiting exit-seeking behaviors, as directed by the facility's resident elopement policy, until 6-21-23 (14 days after R8's elopement). On 08/14/23 at 10:44 AM, R8 was in his bed. R8 was unable to answer where he was, what time of day it was, or what day it was. On 8-14-23 at 2:10 PM, V3 (RN) stated, "On 6-7-23, (R8) has having behaviors and trying to exit-seek. (R8) had exited around 5:30 PM and was found between the double doors of the east exit. (R8) was confused and combative and did not have his walker. I had to get his walker and take (R8) back to his room. I left for supper break and told the CNA's to keep a close eye on (R8) because he was trying to exit-seek. When I came back from the supper break, I heard the end of the south side door alarm going off. None of the staff were responding to the alarm. I went and answered the alarm and asked the staff where (R8) was. Nobody knew where (R8) was. I went outside and found (R8) outside by the road, laying on the curb, between the two cottage buildings. (R8) had fell (sic) to the ground with his walker beside him. I got him up and helped him back inside. I did not notify the Administrator	S9999		

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(V11) or Director of Nursing (V1) of (R8's) elopement."

On 8-15-23 at 11:45 AM, V7 (CNA) stated, "I was on break when (R8) went outside unattended on 6-7-23. I did not know (R8) had tried to exit earlier that night. I am not sure who found (R8) outside or if anything was done to monitor (R8) afterwards."

On 8-15-23 at 12:15 PM, V8 (Agency CNA) stated, "I was working contract at the facility and did not know (R8) very well. I did not know (R8) had tried to exit-seek earlier that night (on 6-7-23). (V3/RN) did not tell me that (R8) had tried to exit earlier, and did not tell me to monitor (R8) closely. Sometime around 7:00 PM, (V3) yelled at me and said she needed help because (R8) was outside and had fell (sic). I went outside with (V3) and (R8) had fell over the curb and was laying on the curb by the road. Me and (V3) had to use the mechanical lift to get (R8) back up off the ground and into a wheelchair. (R8) was not hurt. I wheeled (R8) back into the building. I am not aware of (R8) being put on 15 minute checks afterwards. I did not hear the exit-alarm sounding when (R8) went outside because I was in a room with another resident."

On 8-15-23 at 12:40 PM, V9 (CNA) stated, "On 6-7-23 I came to work at 6:30 PM. I did not know (R8) had try to exit earlier that night (on 6-7-23). I heard an alarm going off and thought it was the alarm where the residents who smoke go outside. I did not realize (R8) had eloped."

On 8-14-23 at 2:00 PM, V2 (Director of Nursing) stated, "I did not report to IDPH (Illinois Department of Public Health) when (R8) eloped. I was not told that (R8) had gotten outside

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S9999	Continued From page 7 unattended, so no investigation was done. I only was told (R8) had tried to exit. There were no exit-seeking or elopement interventions implemented or an elopement risk assessment completed once (R8) started to exit-seek on 6-7-23." (B)	S9999		