

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ILL6005623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/05/2016
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NAME OF PROVIDER OR SUPPLIER LYDIA HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 13901 SOUTH LYDIA ROBBINS, IL 60472
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p>Initial Comments</p> <p>Incident Report Investigation to Incident of 8/1/16/IL87464.</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violation:</p> <p>300.1210d)6)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on interview and record review, the facility failed to ensure the safety and prevent an elopement for one resident (R1) of three reviewed for safety and elopement in a sample of three.</p> <p>Findings include:</p>	S9999	<p>Attachment A</p> <p>Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>The facility's Activity Dept. Policy, undated, documents "Consumers should be monitored at all times for attendance and appropriate behaviors...In the event a consumer is not accounted for, one Activity Aide should remain with the rest of the group and the other should begin a search. If the search is uneventful, the police may be called...Upon leaving the venue to return to the facility, another count should be performed to ensure all consumers that went on the outing are accounted for."</p> <p>R1's Pass Level Safety Assessment, dated 6/13/16, documents that R1 does not meet the requirements for a level A pass. R1 is to be supervised while outside of the building.</p> <p>R1's Nurses Notes, dated 8/1/16 at 11:00pm, documents that R1 was not present for the 10:00pm census. This same form documents that the facility's elopement policy was implemented, and R1 was not located after a building search. The local Police Department was notified and a missing person report was filed.</p> <p>R1's Nurses Notes, dated 8/2/16 at 4:45am, documents that a call was received from R1's family, stating that R1 had shown up at their home and requested Facility to pick R1 up.</p> <p>R1's Nurses Notes, dated 8/2/16 at 7:00am, documents that R1 returned to the facility. R1 stated that R1 was playing basketball last night and ran from staff. This same form documents that R1 was delusional and sent to the local emergency room for an evaluation and treatment. The facility's Critical Incident Report, dated 8/1/16, documents that R1 was not located at the 10:00pm census, and the elopement policy was initiated.</p> <p>The facility's Activity Attendance Sheet, dated 8/1/16, documents that R1 was signed out to play basketball in the park.</p> <p>On 8/5/16 at 2:30pm, E6, Activity Aide, stated</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>"(R1) was playing basketball in the park. Consumers were taken back into the building at 7:45pm. I assumed that (R1) was back in the building, because when I went back to check the park, no one was there. I did not do a head count when we returned to the building." R1 also stated that the facility policy documents to do a head count when returning to the facility.</p> <p>On 8/5/16 at 12:30pm, E5, Operations Director, stated that on the evening shift a census check is done at 4:00pm and at 10:00pm. E5 stated that if a consumer is missing, a building search is performed, then the elopement policy is initiated. E5 stated that the activity started at 6:00pm and ended at 7:34pm. E5 verified that E6 did not check off E6's consumers when returning to the building, so R1 was not noticed to be missing until the 10:00pm census check. E5 confirmed that E6 did not follow the facility's policy and do a head count when returning to the building from an activity.</p> <p>On 8/5/16 at 4:15pm, E7, Activity Director, verified that it is the facility policy to do a head count when returning consumers to the building, after a outing. E7 stated that it is the staff's responsibility to make sure the consumers have returned.</p> <p style="text-align: center;">(B)</p>	S9999		