

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006555</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/15/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NOKOMIS REHAB &amp; HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 STEVENS STREET NOKOMIS, IL 62075</b>
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S 000	Initial Comments  Complaint Investigation #2042042/IL121093	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610 a) 300.1210 b) 300.1210 d)6) 300.2900 d)2) 300.3100 d)2) 300.3240 a)  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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X8) DATE  10/05/20
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S9999	<p>Continued From page 1</p> <p>care needs of the resident.</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>Section 300.2900/ 300.3100 General Building Requirements</p> <p>d) Doors and Windows</p> <p>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</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide adequate supervision to prevent elopement for 2 of 2 residents (R1, R2) reviewed for supervision in the sample of 15. This failure resulted in R1 leaving the building, falling, and obtaining a fractured nose and hematoma to the forehead.</p> <p>Findings include:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>1. R1's Minimum Data Set, (MDS), dated 1/27/20, documents diagnosis as Chronic Lymphocytic Leukemia, Diabetes, Hyperlipidemia, Hypertension, Coronary Artery Disease, (CAD), Supraventricular Tachycardia, (SVT), Urinary Catheter, Colostomy, Dementia. R1's Brief Interview for Mental Status, (BIMS) is 3, severely cognitively impaired. Functional Status: Transfers-Limited assist of one person. Walk in room/corridor Supervision. Locomotion off unit, Limited assist of one person.</p> <p>R1's Care Plan dated, 12/18/19, documents R1 as risk factors for falls: "Balance unsteady at times. Needs assist for transfer with supervision. Medical Conditions, Diabetic. Poor safety awareness, due to cognitive status. Assist with transfers using assist as needed to accomplish task safely. Ensure assistive device is used for transfers if appropriate. Observe for and educate on proper transfer technique and use of devices. Assist with ambulation using assist as necessary to complete task safely. Ensure use of assistive device used for ambulation if necessary. Keep call light within reach: Keep floors clean, dry and free of clutter; keep assistive device within reach; keep personal articles used frequently within reach while in bed; Ensure appropriate clean eyewear; assess and provide adequate lighting; encourage wearing of non-skid shoes or slippers for all transfers/ambulation. Assess cognitive deficits and accommodate forgetfulness regarding safety and environmental hazards. Observe for behaviors that place resident at risk for injury. Observe and assist as needed to avoid hazards. Assess behavioral issues that place resident at risk for fall/injury. Redirect as needed to maintain safety. Accommodate routine or approaches to minimize safety risks. New to facility, behavioral concerns or cognitive level</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>may cause resident to seek to leave facility. Resident has severe cognitive impairment. Resident has desire to return to her own home. Resident has been known to wander in facility since admission. Monitor for exit seeking behavior. Attempt to identify precursor or pattern to exit seeking behaviors. Redirect from exits and distract. Seek alternate/diversional activity for exit seeking-share effective approaches with others. Apply location monitoring device if needed. Add identifying information to Elopement Notebook if need indicates. Observe for level of risk and identify need for monitoring. Continue monitoring as necessary to maintain safety. Wander guard remains in place due to high elopement risk. Resident is alert and oriented times 1 and is up ad lib with supervision. Resident is high fall risk and does not always follow commands."</p> <p>R1's Care Plan, dated 3/10/20, documents "Elopement risk/Fall risk; Staff to monitor resident with ambulation and redirect as appropriate. Monitor hematoma, neuros for changes and fracture from elopement with fall on 3/10/20. Notify medical doctor, family of any changes. Monitor for signs and symptoms of pain or distress."</p> <p>R1's Elopement Evaluation Form, dated 12/22/19, documents PHYSICAL FUNCTION; Is Resident physically able to exit the building independently YES. Do physical impairments require assistance once outside the building? YES COGNITIVE MOOD STATUS: Poor decision-making skills? YES. Inability to identify safety needs? YES. Altered perception of awareness leading to seeking exit/escape? YES. MEDICAL DISORDERS-Diagnosis which may lead to leaving unattended: Severe Mental</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>Illness/CVA/Brain Injury TBI/Alzheimer's/Dementia YES. High Risk for elopement. INTERVENTIONS: Door alarm/Bracelet/Ankle, Redirect to Common Areas. The IDT has reviewed the resident's capabilities, needs and preferences and has determined Resident is: At risk for leaving home unattended.</p> <p>R1's nurses notes, dated 3/10/20, document, "As I pulled up to facility at this time, I noted this resident sitting in the grass by southeast dining room door. I immediately called facility as I approached resident. I noted hematoma to left side of forehead, blood on resident's face, and abrasion to residents left shoulder. I called 911 for an ambulance. Staff showed up to assist with resident while waiting for ambulance to arrive. Residents body temp noted to be warm. While waiting for ambulance to arrive, I continued to assess resident. Resident stated, NO, when asked if she was hurt or had pain anywhere. Blankets were retrieved by a Certified Nurse Aide, (CNA) to ensure resident stayed warm. Ambulance arrived on site and loaded resident."</p> <p>R1's Hospital records, dated 3/10/20, documents Computerized Tomography Scan, (CT) report IMPRESSION: 1. Left nasal bone fracture. 2. Frontal Scalp Hematoma.</p> <p>The facility's final report sent to IDPH, dated 3/19/20, documents, "Please accept this letter as the final report to the initial notification submitted on 3/13/20 regarding a fall involving (R1), resident. (R1) is an 81-year-old female with a diagnosis of Chronic Lymphocytic Leukemia, Diabetes Mellitus, Hyperlipidemia, Hypertension, CAD, SVT, urinary catheter, colostomy and Dementia. On 3/10/20 at approximately 12:30</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>PM, staff reported that (R1) had a fall in the back driveway. Staff found (R1) sitting in the drive with a hematoma to the left side of her forehead. (R1) did complain of pain on the left side of the body. (R1) denied any complaints of pain at this time but was sent to ER for further evaluation. This facility-initiated investigation per protocol including physician and family. During this investigation it is noted that (R1), who is alert and oriented X 1, up ad lib with supervision by staff, reports that "I got up and went for a walk and went out the door because, it looked nice outside." When resident walked onto the loose gravel, she fell and on the left side of her body. Resident was sent immediately to the Emergency Room (ER) for evaluation. That ER sent (R1) to another hospital for further evaluation and it was determined that she had a left nasal fracture, that was reported to the facility on 3/13/20."</p> <p>On 9/3/20 at 9:00 AM, V1, Administrator, stated, "On 3/10/20, (R1) went out the back door. She pushed the door open and went out. She fell, had a hematoma on the left side of her forehead. She went to the closest emergency room for evaluation and from there was sent to a larger hospital. She had a nasal fracture and hematoma."</p> <p>On 9/03/20 at 11:00 AM, V1 stated, "(R1) and (R2) both have wander guards on, but there is a total of 7 doors that exit to the outside but, only 2 doors in the facility that have wander guard alarms on them the front (west) and back (east) doors."</p> <p>On 9/08/20 at 3:37 PM, V12, Registered Nurse (RN), stated, "I went home during lunch, I live only a couple blocks away. As I was coming back, the road I was on was near the cemetery,</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>you can see the facility from there. I could see someone out there on the ground, I hadn't turned in the drive yet, but I could see someone, I knew it was (R1) because, I remembered she had all grey on that day, grey shirt and pants. I called the facility to let them know she was outside on the ground. Then I called 911, she had blood on her face. I stayed with her until the ambulance came and took her to the hospital. I don't know if the alarms were sounding."</p> <p>On 9/09/20 at 9:15 AM, when asked if R1 and R2 should have had better supervision, V1 stated, "Obviously, they never should have made it outside."</p> <p>On 9/09/20 at 12:33 PM, V15, Medical Doctor, stated, "Obviously, elopement is a concern with dementia residents. I would think they would have some kind of system in place to keep the residents safe."</p> <p>The facility Policy and Procedure, revised 10/06, documents, ELOPEMENT PREVENTION POLICY</p> <p>Policy: It is the policy of this facility to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and interventions for prevention be established in the plan of care to minimize the risk for elopement.</p> <p>PROCEDURE:</p> <p>#4. Department supervisors will be provided with a listing of residents at high risk for elopement. Each department supervisor will confidentially disclose this information to their employees as necessary.</p> <p>#5. The Interdisciplinary Team will imitate a plan</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>of care for any resident determined high risk for elopement. Facility specific measures as well as resident specific measures will be included in each high-risk resident's plan of care to minimize risk factors. Communication of these interventions will be made to direct care staff through exposure to the resident's plan of care and periodic review and disclosure of the contents of Elopement File/Binder</p> <p>#6. Interventions of personal door alarm devices and monitoring will be initiated as deemed necessary by the IDT and documented in the individual resident's plan of care.</p> <p>#7. Any high-risk resident will be promptly and courteously escorted back to the appropriate nursing unit, activity room, dining area or resident room when noted to be near and exit door.</p> <p>2. Incident Report Form, dated 8/17/2020, for R2 documents: "Date of Incident: 8/17/2020. Time of Incident: 5:40 P.M. Location of Incident: South Side of building. Resident (R2) exiting facility without supervision. The facility initiated investigation per protocol and follow up report will be sent. Type of Incident: Missing Resident."</p> <p>Facility Nursing Notes, dated 8/17/2020 at 5:40PM, documents in part, "South door alarm sounding. This writer (V6/Licensed Practical Nurse/LPN) went out SW (southwest) door &amp; (and) CNA (certified nursing assistant) went out SE (southeast) door. Unable to locate res (resident). Searched grounds c (with) no success. CNA then saw res on road walking toward cemetery. Assisted res into building."</p> <p>R2's Elopement Assessments, dated 7/9/19, 9/23/19, and 12/31/19, documents R2 having poor decision making skills, inability to identify safety needs, and Dementia. The assessment</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>fails to document R2 having a "Door Alarm/Bracelet/Anklet."</p> <p>R2's Elopement Evaluation, dated 8/17/2020, documents in part, "HISTORY - LAST 90 days Attempts to leave undetected or without properly signing out" with a response of yes. The Evaluation further documents R2 "Wandering in vicinity of exit doors," with a response of yes. The Evaluation documents R2 having a "Door Alarm/Bracelet/Anklet."</p> <p>On 9/9/2020 at 8:36AM, V1, Administrator, could not explain how R2 could be a low risk for elopement when informed staff state R2 has had the wanderguard (alarm anklet) on his person for at least a year. V1 stated she can't explain the reason R2 is not listed as having a wanderguard, but admits R2 having the wanderguard on before 8/17/2020.</p> <p>Minimum Data Set (MDS), dated 7/1/2020, documents R2 having a Memory problem and being moderately cognitively impaired.</p> <p>On 9/3/2020 at 1:20PM, distance measured from South door (door R2 eloped from on 8/17/2020) to road in front of facility was 145 feet.</p> <p>On 9/9/2020 at 9:28AM, distance measured from the back gate of the courtyard to the road was 8 feet. Distance from facility's back gate to the bean field was 30 feet.</p> <p>On 9/3/2020 at 9:57AM, V5, CNA, stated R2 "got out of the South Hall (quarantine) and he was room 74 and got out by room 82, I believe." V5 further stated the nurses' station is "down on North hall and he was clear down on South Hall."</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>On 9/3/2020 at 11:26AM V5, CNA, stated she, V10, CNA, and V6, LPN, were on duty on 8/17/2020 when R2 eloped from the building. When asked if R2 was exit seeking towards the doors, V5, CNA, stated "it was his (R2) normal behavior and he (R2) tried to get out the doors and he was the only person down that unit. He had already tried that twice prior earlier that same day, and oh yea, he was always walking towards the doors." V5, CNA, stated on 8/17/2020 the first time R2 tried to get through the doors on the south hall was around after lunch, and then he tried again and she was able to bring him back through the door. V5 also stated R2 had the wanderguard on his arm initially, but because she thought he tried taking it off, a new one was placed on his left ankle. V5 also stated R2 "had had a wanderguard (ankle alarm) on for as long as I have been an aide here, and that's been at least a year." She said around 5:00 PM she and V10, CNA, were in R6's performing a full mechanical transfer on R6 when V6, LPN, walked into the room to give R6 her medications and that is when she heard the alarm sound. V5 further stated, "you can't hear the alarms unless you are right there at the nurse's station to hear them." She stated that is when V10, CNA and V6, LPN, went running outside while she stayed on the hall and did a resident head count.</p> <p>Facility Schedule, dated 8/1/2020 through 8/31/2020, documents V10, CNA, V6, LPN, and V5, CNA were the only 3 nursing staff at the time of R2's elopement.</p> <p>On 9/9/2020 at 9:17AM, V6, LPN, stated the "alarms weren't always this loud, like today." She said back on 8/17/2020 she was on duty when she was coming into a room when she heard what she "thought was an alarm and that's when I</p>	S9999		
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S9999	Continued From page 10  checked at the nurse's station where the alarm tells where it is going off and it was down at the other end of the building at the other door (South). I just remember going one way and (V5, CNA) went the other way and we met and we each thought maybe the other person had him (R2), but we didn't." V6 stated while she was on the phone with the Administrator, she noted V5, CNA, had R2 and brought him back into the building. V6 stated she was aware he got out the same door earlier after lunch as "He (R2) is always pacing back and forth to the doors."  On 9/3/2020 at 10:30AM, V10, CNA, stated she knows R2 was the only one on that hall at the time of his elopement from the facility on 8/17/2020. V10 said she had seen R2 about 3 to 4 minutes prior because he was walking up and down the north and south halls with his (beverage). She said she had to redirect him and "We kept bringing him back, bringing him back, and he was always trying to get out those doors, yes, right there (pointing towards the South doors)." She further stated, "That very day he was on the go, and he got out the same door and he was brought back in." V10 stated "He did get outside, and that's when we got him his (beverage). He was good for a while, and it was time then to get residents up for supper and I heard an alarm when I was in North Hall in (a residents room)." V10 stated when the door opened by V6, LPN, she heard the alarm, "You can't hear the alarm unless you're in the hallway." V10, CNA, further stated V6, LPN, was up at Nurses' station she thought getting medications because it was time for the residents' medications, and that was the complete opposite end of the south hall where R2's room was. V10 stated, "I was so upset that I can't remember exactly without sitting and thinking about it again.	S9999			

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S9999	<p>Continued From page 11</p> <p>I know a head count was done and (V5/CNA) was doing that and checking rooms and (V6/LPN) went outside and we couldn't see where he (R2) went and we went all around the building." V10, CNA, further stated, "It wasn't dark out and it was hot, but not too hot that day. (V6, LPN) went one way and I went another and we met and I thought for sure she (V6) had him and when I met her (V6) and found out she didn't have him and I didn't have him, I began to pray and I couldn't figure out where he was hiding." V10 also stated "He (R2) had the wanderguard (ankle alarm) on and that door he went out didn't alert like a wanderguard alarm, I did check to see which door was alarming at the time at the nurse's station before I went outside." V10 said she had to come back in the building and "thought maybe he sounded another alarm and came back in the building" and V10 stated she had to come into the front door because she got locked out by the South door and had to go to the front door in order to come back in the building. V10 stated she went back down the South hall and thought maybe he (R2) was in a room by now and she said she just kept thinking "where would he have gone, and then as I was looking in the rooms, I saw him through the window of the room, and I ran outside and he was in the road walking. We got him back in." V10 stated she can't recall for certain exactly when the alarm went off or for certain how long R2 was outside in the road.</p> <p>On 9/8/2020 at 9:10AM, V11, LPN, stated "He (R2) wanders up and down the halls all day and it's back and forth, all day long, and he goes to the first double doors."</p> <p>9/9/2020 at 9:10AM, V11, LPN, stated R2 was initially in Room 74 and the reason he was in room 74 was because he went to an</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>appointment. V11, stated, "I know there was only one nurse that day (V6/LPN) and she was stationed down by the main nurses' station (North Hall). V11 stated it wasn't until R2 was found outside that he was moved further down by the nurses' station. The first time he got out was earlier that day, and he wasn't moved, until he actually eloped the second time" in the same day.</p> <p>On 9/9/2020 at 845AM, surveyor asked if V1, Administrator, was aware that on 8/17/2020 prior to leaving the building and being found on the road, was she aware R2 had to be assisted back into the building by staff from the same door he eloped from? V1 stated, "He (R2) should've been moved the first time he exited the building and was going for the door. We should have moved him then."</p> <p>On 9/9/2020 at 9:14AM, when asked about R2 being in Room 74 and the only resident down the hall with no nurse at the nurse's station on 8/17/2020 at the time of R2's elopement from the building, V1 stated, "I would have expected those 2 residents (R1, R2) given they have a wanderguard (alarm/ankle/bracelet) on them to be supervised. They should have never made it outside."</p> <p>On 9/10/2020 at 1:58PM, V1, Administrator, stated, "He (R2) is only alert to person, he isn't to place, time or situation."</p> <p>On 9/10/2020 at 1:55PM, V11, LPN, stated she recalls back in about March 2019, R2 came back from the hospital and had a wanderguard on at that time.</p> <p>On 9/10/2020 at 2:34PM, when asked by surveyor about how R2 had a wanderguard for</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>over a year and yet his Elopement Assessment does not reflect in July 2020 he was a high risk for elopement, V11 stated, "I have yet to know why that is, and we should have done with an IDT (Interdisciplinary Team) meeting to discuss these residents that are confused and go about the facility, but we haven't been having them (IDT meetings)."</p> <p>On 9/8/2020 at 9:16 AM, V13, Maintenance Director, stated when asked if he knew there were concerns the alarms cannot be heard, he said, "I have no idea they couldn't hear the alarms, and I can't make them louder." He said he hasn't been told that the alarms can't be heard and that the staff are generally at the nurse's station where the alarms are.</p> <p>On 9/9/2020 at 8:29AM, V1, Administrator, stated when informed that V13, Maintenance Director, had previously stated he was not aware that the alarms couldn't be heard, "Well, I don't know how that's possible, since we did a drill and I said then the alarm was not loud enough, and I told him you can hear it (alarm), just not effectively." V1 further stated she was unaware that the back gate was not alarmed as noted on Door Alarm log for August and September, 2020 when surveyor brought it to her attention, nor did she know anything about waiting for a part on order to fix the alarm.</p> <p>On 9/8/2020 at 9:22AM, V13, Maintenance Director, stated when asked as to why the alarm to the gate located in the courtyard was inoperable, he stated, "the part they say is in the mail." Upon immediate observation, the latch was able to be lifted up by V13 and noted to the back of the gate was not alarming. V13 stated that the road is used by the public and delivery</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>drivers.</p> <p>On 9/9/2020 at 8:35AM, when asked by surveyor why there were wanderguards alarms at the East and West (front/back) entrances to the building but not on the remaining doors in the building, including the South door in which R2 eloped, V1, Administrator, replied, "The wanderguard alarms are for those high risk residents and I expect all doors to be alarmed and the doors should be checked daily," to ensure they are operational. V1 said she was not aware of the door policy, but because of the recent elopements, she would expect them to be checked daily. V1 further stated the reason the gate in the courtyard has to be alarmed is because a resident could get out and that the lawn service uses that back gate all the time. V1 admits to a road and bean field just beyond the courtyard gate.</p> <p>Facility Policy entitled Missing Resident Policy, revised on 8/13/14, documents: Policy: It is the policy that reasonable precautions are taken to minimize the risks of resident elopement attempts. Reasonable precautions include, but are not limited to: door alarms, personal door alarm activation devices, staff intervention, staff education regarding response to door alarms, and individual resident intervention. It is the policy to demand immediate response to elopement attempts, door alarm activation and participation in search attempts in the event that a resident is deemed missing. The Policy further documents in part: "DON Responsibility:</p> <p>1. Conduct a thorough investigation using the "Investigative Report of Missing Resident" and report the findings of the investigation to the Quality Assurance Committee with a timeline of occurrences, interventions and responses. Prepare a summary of staff performance and</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>policy/procedure strengths and weaknesses.</p> <p>2. Report as required by State and Federal regulation to appropriate regulatory agencies.</p> <p>3. Conduct review of the occurrence in morning QA meeting to establish resident and facility specific strategies to prevent further occurrence."</p> <p>Facility Policy entitled Elopement Prevention Policy, dated 10/06, documents in part: "Policy: It is the policy to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and interventions for prevention be established in the plan of care to minimize the risk for elopement.</p> <p>Procedure:</p> <p>4. Department supervisors will be provided with a listing of residents at high risk for elopement. Each department supervisor will confidentially disclose this information to their employees as necessary.</p> <p>5. The Interdisciplinary Team will imitate a plan of care for any resident determined high risk for elopement. Facility specific measures as well as resident specific measures will be included in each high risk resident's plan of care to minimize risk factors. Communication of these interventions will be made to direct care staff through exposure to the resident's plan of care and periodic review and disclosure of the contents of Elopement File/Binder.</p> <p>6. Interventions of personal door alarm devices and monitoring will be initiated as deemed necessary by the IDT and documented in the individual resident's plan of care.</p> <p>7. Any high risk resident will be promptly and courteously escorted back to the appropriate nursing unit, activity room, dining area or resident room when noted to be near and exit door.</p>	S9999		
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S9999	Continued From page 16  10. All employees will be educated within a reasonable timeframe of hire and throughout the year with elopement education on the location of the elopement file/binder and Elopement Prevention Policy."  (B)	S9999		