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
	IL6005722	A. BUILDING: ____ B. WING ____	C 01/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

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S 000	Initial Comments Original Complaint Investigation #2120002/IL129871	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210d)3) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	**Attachment A** **Statement of Licensure Violations**	

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

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.

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.

These requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure all facility doors were properly alarmed and ensure an electronic wander management transmitter bracelet was in working order for one resident (R1). In addition, the facility failed to provide adequate supervision and revise/develop an elopement plan of care for two severely cognitively impaired residents at risk of elopement for two (R1, R2) of three residents reviewed for elopement risk in the sample of four.

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These failures resulted in R1, a severely cognitively impaired resident with the diagnosis of Dementia, eloping from the facility in the dark in 25 to 28 degrees Fahrenheit weather and falling onto an ice packed ground approximately 500 feet from the building. The facility was unaware of R1 missing until the police located R1 and contacted the facility.

Findings include:

The facility's Elopements and Wandering Residents policy dated 1-1-20 documents, "Policy: The facility ensures that resident who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering and elopement risk. Definition: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. Policy explanation and compliance guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risk, and monitoring of effectiveness and modifying interventions when necessary. 4. Monitoring and managing residents at risk for elopement or unsafe wandering. a. Residents will be assessed for

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risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary team. b. The interdisciplinary team will evaluate the unique factors to contributing the risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. The effectiveness of interventions will be evaluated and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff."

The wander management transmitter bracelet manufacturer's instructions (undated) document, "A 90-day device is stamped with the activate by date which indicates the last date the device can be activated to permit approximately 90 days of use. Record the date in the resident's records. The one-year device is stamped with a replacement date which indicates the last date the device will work. Do not keep the device on a resident past this date."

On 1-4-21 at 11:20 AM, R1 was sitting in her room. R1 was pleasantly confused and was unaware of date, time, and place. R1 stated that she is currently living in (a neighboring town).

R1's Medical Record from 1-1-20 through 1-4-21 does not include documentation of the wander management transmitter bracelet's date of expiration or date that it was applied.

R1's Physician's Order Sheets dated January 4,

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S9999	Continued From page 4 2021 document R1 is an 81-year-old that has diagnoses of Dementia with Behavioral Disturbance, Anxiety Disorder, Repeated Falls, and Alzheimer's Disease. R1's MDS (Minimum Data Set) Assessment dated 10-6-20 documents R1 is severely cognitively impaired and experiences occasional wandering. This same MDS Assessment documents R1 requires oversight/supervision with walking in her room, walking in the corridor, locomotion on the unit, and locomotion off of the unit. R1's Physician Progress notes dated 10-21-20 and signed by V17 (Physician) document, "(R1) roams around quite a bit." R1's Wander Care Plan dated 4-30-20 documents, "Focus: (R1) wanders with no rational purpose, seemingly oblivious to needs or safety throughout the healthcare center. Goal: (R1) will wander safely within the facility by next review (target dated 1-31-21). Interventions: Administer medications. Avoid over-stimulation. Convey an attitude of acceptance towards (R1). (R1) wears a wander management transmitter bracelet. Please check the wander management transmitter bracelet routinely to ensure (R1's) safety. Maintain a calm environment and approach (R1) from the front. When (R1) begins to wander, attempt to engage (R1) in an activity or something that will hold (R1's) interest. When (R1) begins to wander, provide comfort measures for basic needs. Date initiated 1-4-21 (R1) is on 30-minute safety checks until further notice." R1's Elopement Care Plan dated 8-29-19 documents, "Focus: (R1) is at risk for elopement due to impaired cognition and dementia. Goal:	S9999		

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(R1's) safety will be maintained through the review date and (R1) will not leave the facility unattended through the next review date (1-31-21). Interventions: Assess for fall risk. Distract (R1) from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book. Monitor (R1) for fatigue and weight loss. Provide structured activities such as toileting, walking inside and outside, and re-orientation strategies including signs, pictures, and memory boxes. Wander guard to be checked for placement every shift and function daily."

R1's Wandering Risk Assessment dated 11-27-20 documents R1 is forgetful, has a short attention span, does not understand surroundings, experiences feelings of anger and fear of abandonment, is independent with mobility, is a known wanderer with a history of wandering, and has a diagnosis of Alzheimer's disease.

R1's Progress Notes dated 1/2/2021 at 7:15 PM and signed by V6 (Licensed Practical Nurse/LPN) document, "(R1) was found trying to exit hall two. Wander management transmitter bracelet system went off and the button was shut off. This writer re-directed (R1) to common area."

R1's Progress Notes dated 1/3/2021 at 1:24 AM and signed by V5 (Registered Nurse/RN) document, "(R1) eloped from hall one around 8:56 PM (On 1-2-21) after being re-directed in hall two from an elopement attempt. (R1) was found approximately 150 yards from the facility and the sheriff's department was notified. The Sheriff and EMS (Emergency Medical System) responded and returned (R1) to facility after elopement. EMS and nursing staff assessed resident and found no abnormalities, vital signs

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were stable, and (R1) could not recall where she went or the details of the incident."

R1's Police Report #21I-01-001 dated 1-2-21 at 9:17 PM and signed by V4 and V16 (Police Officers) documents, "On 1-2-21 around 9:17 PM (V4 and V16) were dispatched to 112 Clinton Drive on a female yelling for help. On arrival (V4 and V16) found a frail 81-year-old female, later identified as (R1), sitting on the curb in front of 112 Clinton Drive, Eureka. (R1) was shivering and stated she was very cold. (R1) had wet pants on from sitting in the snow and ice. The temperature outside was approximately 25 degrees Fahrenheit. (R1) was not wearing a winter hat, winter coat, or winter gloves. (R1) was wearing thin shoes and socks, a pair of thin slacks, and a thin shirt. (R1) stated that she had fell and could not get up off the ground on her own. Paramedics called to check (R1) for injuries and hypothermia. While speaking to (R1), (R1) could not remember her date of birth and thought she was in Creve Coeur, Illinois. (R1) stated she was just going for a walk and had just left her house when she slipped and fell on the snow and ice. (R1) did not know how long she had been outside. I asked dispatch to call (the nursing home) to see if (R1) was a patient there. Dispatch made the call and confirmed that (R1) was missing from the facility. (V5) stated that he was responsible for resident health care for wings four, five, and six but had primarily been on wing six, which is located downstairs and is not the wing that (R1) resides on. (V5) also confirmed that (R1) has Dementia and Alzheimer's (disease). The facility staff also informed (V4) that they are grossly understaffed and have four managers sitting at home doing nothing that could help take some of the work load off. The staff also stated that the facility's upper

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management has been made aware of the staffing issues numerous times but have failed to resolve the issue. Once we (V4 and V16) exited the main entrance, (V4) could hear a loud beeping alarm noise going off at the northern most entrance of the facility. (V6/LPN) met us at the door from within the facility and was able to disarm the alarm and open the door. Alarm could not be heard at the main entrance within the facility. It is possible that (R1) exited the facility through that door. It is unknown how (R1) was able to walk past staff members, other residents, video surveillance, and a locked door that requires a code."

R1's Elopement Care Plan dated 8-29-19 through 1-3-21 and R1's Wander Care Plan dated 4-30-20 to 1-31-21 do not include any documentation of R1's elopement from the facility on 1-2-21, or a revision of R1's goals/interventions to prevent R1 from future elopements.

V13's (Assistant Director of Nursing) investigation notes regarding R1's 1-2-21 elopement document R1's wander management transmitter bracelet was not working, and door alarms were shut off at the panel. These same notes document R1 left the building at 8:56 PM.

On 1-5-21 at 9:30 AM V17 (Community Witness) stated, "On 1-2-21 at 9:00 PM, I was in my living room and had just turned the television off. I heard someone outside yelling 'Help me. Help me.' I looked out the window and saw an elderly women sitting on the curb facing route 117. The woman did not have on a hat, gloves, or coat and there was snow and ice on the ground. I immediately called 911 and two police officers and an ambulance came and helped the woman.

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I looked at my phone that night and my phone said it was 28 degrees Fahrenheit outside."

On 1-4-21 at 2:10 PM V4 (Police Officer) stated, "On 1-2-21 at 9:17 PM we received a 911 call from V17 (Community Witness) stating that a women was outside of (V17's) apartment screaming for help. (V16/Police Officer) and I immediately went to the scene. (R1) was sitting on a curb and stated she had fallen. (R1) was sitting on a curb facing route 117. Route 117 is a very busy roadway. (R1) was around 500 feet away from the nursing home and was out of sight of the nursing home. (R1) had no hat, gloves, or coat on and was shivering. (R1's) pants were soaked with water. (R1) only had on a light shirt and pants. (R1) stated she had fallen and could not get up. It was 25 degrees Fahrenheit outside and it had just started to snow. The ground was covered in ice and snow. (R1) knew her name but was not sure where she lived. I called EMS (Emergency Medical Services) and they came to the sight and assessed her. (R1) did not have hypothermia. Dispatch called the nursing home (the facility) and staff were unaware that (R1) had left the facility. The staff did confirm that the name (R1) gave me was a resident of theirs. Me and (V16) returned (R1) to the nursing facility. When we got to the facility an alarm was sounding outside at the 100-hallway door. When we took (R1) inside there was no alarm sounding at the main entrance or at the nurse's station. The staff told me that they are inadequately staffed. (R1) would have died outside had (V17) not heard (R1) yelling for help."

On 1-4-21 at 11:05 AM V1 (Administrator) stated, "It was reported to me that (R1) exited the facility at the end of 100 hallway. (R1) is ambulatory and has very severe Dementia.

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On 1-4-21 at 11:50 AM V13 (Assistant Director of Nursing) stated, "The staff called me about (R1) leaving the facility and I went to the facility immediately. The facility's surveillance cameras showed (R1) walking back and forth on 100 hallway. On the third trip down 100 hallway at 8:56 PM, (R1) left the building out of the 100-hallway door. (R1) pushed the door for 15 seconds and then the door opened. (R1) tried to open the door back up to go back inside the building but was unable to get the door open. (R1) then turned around and left. Earlier that night (R1) had tried to go out of the 200-hallway door and was re-directed by staff. (R1)'s wander management transmitter bracelet was checked and did not work. (V14/Director of Operations) came in around 10:00 PM and went to the alarm panel behind the nurse's desk. (V14) noticed that two or three alarms shut off at the panel, so the door alarm would not have alarmed at the desk. No residents reside on 100 hall, and the hall has doors that close in the middle of the hall. Staff would not be able to hear an alarm at the door. (R1) is confused to time, place, and family. (R1) has poor safety awareness and would not know where to go if she were to get outside of the building. There are times (R1) does not know how to get back to her room."

On 1-4-21 at 12:05 PM V14 (Director of Operations) stated, "I came into the facility on 1-2-21 around 10:00 PM. The alarm to 100 hallway had been shut off at the nurse's station. The staff informed me that the alarm had not went off at the nurse's station panel. The alarm at the door on 100 hall was alarming. The alarm at the 100 hallway is very faint."

On 1-4-21 at 6:15 PM V5 (Registered Nurse/RN)

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S9999	Continued From page 10 stated, "On Saturday 1-2-21 I was (R1's) nurse and I was working downstairs on a different floor from where (R1) resides. I had not been told that (R1) tried to open the 200-hallway door earlier that night. When the police returned (R1) to the facility we checked (R1's) wander management transmitter bracelet and it was not working. I was not aware that a wander management transmitter bracelet had an expiration date. I never have checked to see if (R1's) wander management transmitter bracelet was expired. No alarms were sounding at the nurse's station when (R1) had left the facility. Two CNAs (Certified Nursing Assistant) is not enough staff to take care of all the residents on the 200, 300, 400, and 500 hallways. We did not have enough staff and that is why (R1) was able to elope unnoticed." On 1-4-21 at 1:00 PM, V8 (CNA) stated, "On 1-2-21 Me and (V7/CNA) were the only two CNAs working after 8:00 PM on the 200, 300, 400, and 500 hallways. Sometime before 8:00 PM that night, (R1) tried to leave out of the 200-hall door. I re-directed (R1) to turn around and walk back up towards the nurse's station. The alarm to the 200-hall door had alarmed at the door and the nurse's station. I turned the alarm off at the door and (V7) turned the alarm off at the nurse's station. (R1) continued to wander on all hallways that night. I did not see (R1) go down 100 hall and did not know (R1) exited the building. There were not alarms going off at the 100-hall door or the nurse's station. When the police brought (R1) back to the facility I checked (R1's) wander management transmitter bracelet. (R1's) bracelet was expired and did not work with the transmitter tester. I am not aware of what residents are elopement risks. Two CNAs is not enough to take care of and supervise all of the residents upstairs (200, 300, 400, and 500 hallway)."	S9999		

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On 1-4-21 at 1:30 PM, V6 (LPN) stated, "I worked on 1-2-21 from 6:00 PM to 10:00 PM. That night (R1) had went down 200 hallway door and pushed the door setting off the alarm on the panel at the nurse's desk and at the door. (V8 and V7) were the only CNAs working on the main floor that night. There was no actual CNA working on 500 hall (hallway R1 resides on) after 8:00 PM. At the time (R1) left the building, (V7) was working 200 hall and (V8) was working 400 hall. (R1) tried to leave the building all day. I was busy with medication pass that night and was unable to help the CNAs. The last time I saw (R1) was when she tried to exit out 200 hall door. I did not inform (V5/R1's Nurse) that (R1) tried to exit out of the 200-hallway door. The alarms were not sounding at the nurse's station when (R1) exited out the 100-hallway door.

On 1-4-21 at 1:40 PM V9 (CNA) stated, "I worked until 8:00 PM on 1-2-21. I was (R1's) CNA until 8:00 PM. No one told me that (R1) tried to leave out of the 200 hall door. If I would have known, then I would have monitored (R1) closer."

On 1-4-21 at 4:55 PM V7 (CNA) stated, "On 1-2-21 there were only two CNAs after 8:00 PM working the 200, 300, 400, and 500 halls. (R1) tried to elope out of the 200-hallway door earlier that night. (V6) re-directed (R1). I did not do anymore supervision of (R1) after (R1) tried to leave through the 200-hallway door. I pressed the button behind the nurse's station to turn off the alarm. I did not know that I had to re-press that same button to turn the alarm back on. I did not know that (R1) had left the building that night. There were no CNAs available to supervise residents on 500 hall that night from 8:00 PM to 10:00 PM. There was not enough staff to

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	IL6005722	A. BUILDING: ___ B. WING ___	C 01/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

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supervise (R1) and that is why (R1) left the facility without staff knowing. (V1/Administrator and V2/Director of Nursing) are fully aware of the staffing issues at the facility and when I report the staffing issues, they tell the staff to 'stay positive.' I have resigned from the facility due to not having enough staff to take care of the residents."

On 1-4-21 at 11:25 AM V15 (LPN) stated, "(R1) is confused to time and place. (R1) only knows her name. (R1) wanders throughout the facility daily and wanders into residents' rooms at times. (R1) always says she wants to go home. (R1) has no safety awareness and would not be safe to outside by herself. (R1) would have no idea where to go if she got outside unattended. I was never aware that wander management transmitter bracelets have an expiration date. I have never checked wander management transmitter bracelets for expiration."

On 1-5-21 at 2:45 PM V21 (LPN) stated, "I did not know that there was an expiration date to the wander management transmitter bracelets . (R1's) medical record does not include the expiration date to (R1's) wander management transmitter bracelet. (R1) has always wandered and is not safe to go outside by herself. (R1) has been wandering more often and has been more agitated since her husband has not been able to visit."

On 1-4-21 at 1:45 PM V12 (CNA) stated, "(R1) has very poor safety awareness. If (R1) left the building she would not know where she was going or what she was doing."

On 1-4-21 at 1:00 PM V3 (Care Plan Coordinator) stated, "(R1's) care plan has not been updated to include (R1's) elopement from the facility on

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1-2-21."

On 1-5-21 at 3:45 PM V10 (RN) stated, "I was not aware that wander management transmitter bracelets expire or have expiration dates stamped on them. I never check to see if wander management transmitter bracelets are expired. (R1) wanders around the facility and has tried to open the main entrance a couple of times."

On 1-4-21 at 12:55 PM V11 (Maintenance Director) stated, "I have never checked the wander management transmitter bracelets. Third shift nurses are responsible for checking the wander management transmitter bracelets."

2. R2's Physician's Order Sheets dated 1-4-21 documents R2 has the following diagnoses: Parkinson's Disease, Dementia, Abnormalities of Gait and Mobility, Difficulty with Walking, Anxiety, Diabetes Mellitus Type II, and Convulsions.

R2's MDS Assessment dated 10-1-20 documents R2 is cognitively moderately impaired and requires extensive assistance of two-person physical assistance to transfer and walk in R2's room and the corridor. This same assessment documents R2 requires supervision of one staff physical assistance to move off and on the unit and is not steady with walking unless stabilized.

R2's Care Plan dated 10-16-20 documents R2 has a communication problem and does not always understand or is not always understood.

R2's Behavior Monitoring Logs dated 12-4-20 through 1-4-21 documents R2 has had four wandering attempts.

R2's Care Plan dated 10-16-20 does not include

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a plan of care or interventions to address R2's wandering and elopement attempts.

R2's Medical Record dated 7-20-20 (date of admission) to 1-4-21 does not include an assessment of R2's wandering/risk of elopement.

R2's Progress Notes dated 11-7-20 at 3:35 PM and signed by V10 (RN) document, "Call received from (V20/R2's Power of Attorney). (V20) states that she received two calls from (R2) so far today and was checking on him to see if he was agitated. (V20) stated the first time (R2) hung up on her during the conversation and then second time she hung up on him. (V20) stated after speaking with (R2), (R2) stopped speaking. Both times (R2) commented to (V20) that he wanted to come home and also said he wanted a friend. (V2) tried to reeducate (R2) about placement in the nursing home being long term, but (R2) is having hard time accepting this. (V20) also updated on elopements times four today. (R2) stated he was wanting to go home as the reason for leaving the building."

On 1-4-21 at 1:40 PM R4 stated, "About a month or two ago I was in my room and saw (R2) walking down the hill of the driveway unattended. I hollered at (V9/CNA) and then V9 went after (R2)."

On 1-4-21 at 1:40 PM V9 stated, "Sometime in the morning on November 7, 2020 (R4) yelled at me and told me (R2) was outside unattended. I found (R2) in the driveway of the facility. I could not get (R2) re-directed. I called the facility two times for help before I got an answer. (R2) was walking towards the road. The FedEx driver tried to help me. I finally got ahold of (V6/RN) and she helped me to get (R2) back into the facility. I was

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so upset that day and had notified (V1) of (R2) leaving the facility unattended and not wanting to go back inside."

On 1-4-21 at 1:30 PM V6 (RN) stated, "(V9) saw (R2) walking outside unattended on (November 7, 2020). (V9) called into the facility and asked me to help her with getting (R2) to go back inside. (R2) was in the middle of the facility's driveway. The front door alarm was alarming at the time. Me and (V9) were able to get (R2) back into the facility. I do not think I charted anything about the incident in (R2's) chart or notified (R2's) family or physician."

On 1-5-21 at 3:45 PM, V10 stated, "On 11-7-20 (R2) tried to elope four times that day. I was not at the facility for all of those attempts. I think (R2) might have gotten outside once unattended. I cannot remember all the specifics. (R2) wanders around in his wheelchair."

On 1-5-21 at 4:05 PM, V20 (R2's Family) stated, "I have never been notified about (R2) trying to leave the facility, or actually leaving the facility. I should have been informed if he is attempting to leave the facility. (R2) had to be admitted to the facility for supervision. (R2) had Parkinson's and Dementia and could not take care of himself at home."

On 1-4-21 at 1:45 PM V1 and V2 stated that (R2's) medical record does not include any documentation of R2 leaving the building unattended on 11-7-20. V1 also stated the facility has not investigated R2 leaving the building unattended on 11-7-20.

On 1-4-21 at 1:50 PM V2 (Director of Nursing) stated, "Wandering assessments are to be done

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S9999	Continued From page 16 quarterly when the MDS assessments are due." On 1-4-21 at 1:00 PM V3 stated, "(R2) has not had a wandering or elopement care plan. (R2) has never had a wandering/elopement risk assessment done." (A)	S9999		