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S 000	Initial Comments Facility Reported Incident to 12/3/20/IL129328 - F689 J cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3100d)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999		

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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. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

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.

Section 300.3100 General Building Requirements

d) Doors and Windows

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.

Section 300.3240 Abuse and Neglect

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide supervision and intervene when a cognitively impaired, high risk elopement resident, with previous exit attempts was in a non-resident care area displaying non purposeful wandering behavior, and failed to ensure that one exit door's alarm was enabled and this same exit door's other alarm was in working condition for one (R1) resident reviewed for elopement. These failures resulted in R1 leaving the building unsupervised for approximately three hours putting the resident at risk for serious injury or death.

Findings include:

The facility's Elopement Prevention Policy, revised 10/06, documents "It is the policy of (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." This policy continues with "Procedure: 3. A facility staff member will take a photograph of the resident upon or within 8 hours of admission. The photograph will be placed in the Medication Administration Record. Any resident assessed to be at high risk for elopement will have their

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photograph and basic identifying information placed in a special folder or binder to be maintained at the nurse's station. 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. 5. The Interdisciplinary Team will initiate a plan of care for any resident determined high risk for elopement. Facility specific measures as well as resident specific measures with 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. 6. Interventions of personal door alarm devices and monitoring will be initiated as deemed necessary by the IDT (Interdisciplinary Team) and documented in the individual resident's plan of care. 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 an exit door."

R1's facesheet documents R1 admitted to the facility on 11-19-2019 with a diagnosis of Dementia.

The facility's reported incident on R1 notes the following: Missing Resident Timeline: "12-3-2020 at 12:15pm (V4) Business Office Manager/BOM noted (R1) pacing back and forth outside (V4's) office. At 12:30pm (V4) noticed (R1) was missing and advised Administrator (V2 former Administrator). All staff were alerted and missing resident protocol was initiated." This same report documents the following interview by V4: "At 12:15pm I noticed (R1) pacing back and forth

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outside my office. I had to walk up to the front printer and was up there for about 15 minutes. At 12:30pm I walked back to my office and did not see (R1) so I checked all the rooms that I could down by my office. Once I noticed that he was not in any of the rooms, I notified (V2)."

R1's A.I.M. (Assess, Intercommunicate, Manage) for Wellness, dated 12-3-2020 and signed by V3 former Director of Nursing/DON, documents the following regarding an Exit Attempt which started on 12-3-2020; "(R1) has been known to wander in vicinity of doors, states he needs to take care of the farm"; "12:30pm this nurse (V3) and nursing home administrator (V2) made aware at approximately 12:30pm resident noted to exit facility."

R1's ED (Emergency Department) to Hospital Admission report, dated 12-4-2020, documents "Hospital Course: Patient has moderate dementia and lives at (named facility). Skip from the facility on 12/03. Was found wandering outside and brought to the ED."

On 12-17-2020, at 9:15am, V5 Social Service Director/SSD walked surveyors to the area where R1 was found on 12-3-2020 by local emergency crews. This area where R1 was found was a walking distance of approximately 1100 feet from the front of the facility. The facility and area where R1 was found is surrounded by large wooded areas with a known ravine to the west, has a four lane highway with a 45mph (mile per hour) speed limit to the east approximately 700 feet away, and a large river about 800 feet further east of the highway.

R1's Minimum Data Set/MDS assessment, dated 11-23-2020, documents R1 has a BIMS (Brief

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Interview Mental Status) of 11 (moderately impaired cognition) with disorganized thinking; R1 has diagnoses of Hypertension and non-Alzheimer's Disease.

R1's Elopement Evaluation, dated 11-16-2020 and signed by V3 former Director of Nursing/DON, documents that R1 is physically able to exit the building independently; has poor decision making skills; has inability to identify safety needs; has altered perception of awareness leading to seeking exit/escape;has a level of agitation requiring supervision; has dementia: history of wandering in vicinity of exit doors in the last 90 days; and wandering in vicinity of exit doors. Score = 7; 5-10 is high risk. Interventions: Ambulate indoors, redirect to common areas." This evaluation includes a hand written note by V3 stating R1 "frequently talks about having to take care of his cattle/horses."

R1's Elopement Evaluation, dated 11-23-2020 and signed by V8 Minimum Data Set/MDS Coordinator, documents R1's elopement risk score = 5; 5-10 is high risk. This evaluation includes Interventions: Ambulate indoors, redirect to common areas. V8's hand written note documents "(R1) talks about taking care of the farm."

R1's current Care plan includes impaired cognition with need for supervision with ADLs (Activities of Daily Living); R1 known to wander, may seek to leave the home; related diagnosis includes dementia with behavior disturbance. R1's Care Plan also includes that R1 wandered in vicinity of doors; start date of 11-16-2020.

On 12-10-2020 at 12:55pm, V4 BOM stated the following: "(On 12-3-2020) R1 was pacing outside

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my office. I could hear and see (R1) going back and forth. It was between 12 and 12:30pm when I last saw (R1) looking through the windows of the East side door (leading to a resident hallway). I headed up front to the copy machine for 5-10 minutes then walked back. I didn't see or hear (R1) anymore. It was not normal for (R1) to be back here. The alarm wasn't going off when I got back to my office. I never heard an alarm (sounding on 12-3-2020); it is very loud." V4 stated V4 quickly checked the rooms and offices in the hallway where R1 was last seen. When V4 did not see R1 anywhere V4 immediately ran to V5 SSD's office which is where V2 (former Administrator) also was and informed V2 and V5 that V4 believed R1 left the building. V4 stated "V2 took off running. I did another sweep here (near the East exit door)." V4 stated "After the facility sweep I checked the (East) door alarm box and noticed that it was unlocked." V4 stated a key is needed to turn the red box door alarm on and off and V4 has a key to this alarm. V4 stated "I then locked the alarm box and told (V2). The door alarm is supposed to be locked at all times. Not sure why it wasn't." At this time, V4 verified that for the alarm to sound from the red alarm box on the door, the alarm needs to be in a locked position and that each exit door has a second alarm which sounds at the nurse's station.

On 12-16-2020 at 1:10pm, V4 BOM stated "I was not aware (R1) was an elopement risk. I would have had (R1) come to the printer with me (instead of leaving R1 alone, unsupervised)."

On 12-16-2020, at 10:50am, an Elopement binder was on a shelf at the nurse's station. This binder included R1 as a high risk for elopement and contained R1's photo and demographic information.

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On 12-10-2020 at 1:11pm, V5 Social Service Director/SSD stated "(On 12-3-2020) I was in my office with (V2) when (V4 BOM) came in and said (V4) thought (R1) got out (of the facility). (V2) and I swept the facility; we divided up. I last saw (R1) walk back towards (V4's) office." V5 continued to state "(R1) was not redirected. I would assume someone should have been alerted to redirect (R1) before (V4) left (R1). (R1) is confused at times." V5 also stated "The elopement book is for residents who wander and are high risk for elopement. Anyone in this elopement book found wandering out of their area should be redirected immediately." At this time, V5 confirmed that R1 is in the elopement binder as a high risk for elopement and should never be left unsupervised near an exit door.

On 12-16-2020 at 1:25pm, V5 stated that there were no alarms going off (on 12-3-2020 when R1 walked out of the facility). If (an alarm) at the door was going off I would hear it in my office which is where I was when it happened (R1 walked out of the facility)."

R1's Psychosocial History, dated 11-26-19 and signed by V5 SSD, documents a Social Service Interim Treatment Plan which includes Safety/Mood/Behaviors of "wanders" and "elopement watch."

On 12-18-2020 at 10:01am, V5 SSD stated that V5 completed and signed the Psychosocial History form, dated 11-26-2019. V5 stated that V5 marked that (R1) wanders on the form because V5 could tell (R1) was confused, (R1) kept asking why (R1) was here while wandering all around the building.

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R1's Community Survival Skills Assessment, dated 11-26-2020 and signed by V5 SSD, documents R1 is not sufficiently oriented and coherent affording (R1) the potential for independent pass privileges, and R1 is not capable of unsupervised outside pass privileges at this time.

R1's Nursing Summaries, dated 12-3-19 and 3-3-2020, each document under Mood/Behavior that R1 "wanders."

On 12-10-2020 at 1:31pm, V23 Certified Nursing Assistant/CNA stated "(R1) was in (R1's) room (on 12-3-2020) until I went to bring juice to (R1). (R1) was walking out of (R1's) room so I said 'hi' and left the juice in (R1's room). (R1) walked straight down Northwest hall - (R1's) hall." V23 verified that no alarms were sounding on 12-3-2020 when R1 eloped from the facility. V23 continued to state "I am not sure if (R1) was in the elopement binder. (R1) did get out before. (R1) kind of wandered; walks around the building all the time. (R1) went outside once saying he went to check the cows." V23 verified that no call was received from (V4 BOM) reporting that (R1) had wandered near V4's office.

On 12-10-2020 at 1:40pm, V6 Maintenance Director stated "I was not at the facility the day (R1) left the building. I did hear that the red alarm box was disarmed. I don't know why that would have been. I did not do an investigation into why the box was unlocked."

On 12-16-2020 at 9:54am, V6 stated "There is a button that pops out in the door jam that makes it alarm. I don't believe anyone told me the button jammed. I would expect to be told if so. I would have replaced it (the button) even if the door

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alarm continued to work afterwards." At this time, V6 verified V6 was informed the alarms didn't sound that day. V6 denied being aware of which residents in the facility are high risk for elopement.

On 12-11-2020 at 1:45pm, V10 Maintenance Assistant stated "(On 12-3-2020) I started hearing people running around while I was in my office which is on the West side by the nurse's station. I heard commotion so I asked (what was happening) and they said a resident was missing. V10 stated "I didn't hear any alarm going off or see it lit up on the panel."

On 12-16-2020 at 10:50am, when V10 was asked what elopement means, V10 responded with a long pause and then said, "I don't know, does it mean to cause problems? I haven't been told much about the residents. I see residents walking around but I just assume people are allowed to. I went through a lot of paperwork with orientation and I signed a lot, but I don't remember anything about elopement or an elopement binder."

On 12-10-2020 at 2:15pm, V7 Licensed Practical Nurse/LPN stated "I worked 6am-6pm on Dec 3rd. I am agency. I know (R1). I was passing meds (medications), but not on (R1's) side of the hall yet. Staff were passing lunch trays. (V2 former Administrator) came and said we think (R1) got out. I gathered staff up, did a head count and searched rooms. (On 12-3-2020) I saw (R1) in the hall right before lunch. (R1) was trying to get into the Covid unit so (V11 Certified Nursing Assistant/CNA) redirected him. (R1) redirects easily. I heard (R1) talks about (R1's) cattle. (R1) was an elopement risk. (R1) needs to be watched closely."

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On 12-11-2020 at 3:55pm, V11 CNA stated "(On 12-3-2020) I saw (R1) by the Covid hall and I deterred (R1) away. I told (R1) it was lunch time and to go to (R1's) room. (R1) was trying to get into the Covid hall on northeast but turned around. There was no alarm sounding (on 12-3-2020) or I would have went to the panel to see what door it was then gone to that door. I don't remember any alarm going off."

On 12-11-2020 at 2:21pm, V16 CNA stated "That day (12-3-2020) I was on East hall in the Covid unit. There was no alarm sounding." V16 stated that R1 would wander and that V16 is not familiar with an elopement binder. V16 also stated "The door that (R1) escaped from we would have heard the alarm at the East exit door. That door is right there where we are so it's so loud I can hear it."

On 12-11-2020 at 2:57pm, V24 LPN stated "I was called in that day (12-3-2020) for four hours to help look for (R1). (R1) wandered throughout the building. I would imagine (R1) was in the Elopement book. I'm agency and not there consistently. Communication there is not very good."

On 12-17-2020 at 1:50pm, V15 CNA denied knowing which residents are at high risk for elopement and denied receiving training on elopement prior to 12-3-2020. V15 stated they did not go over which residents were elopement risk or have training on elopement." V15 continued to state "No, I did not know (R1) was a risk for elopement before 12-3-20."

On 12-11-2020 at 1:31pm, V17 CNA stated "(On 12-3-2020) I last saw (R1) picking up trash and I told (R1) to go back to (R1's) room for lunch. (R1)

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was (near to and) kind of across from V5's office where there is a chair. (R1) said ok and then I went out the front door. When I came back in (V7 LPN) asked me if I saw (R1). I told (V7) where (I last saw R1) and (V7) said (R1) wasn't there. I went to check in the front area and (R1) was no longer there. No alarm was going off." V17 continued to state "I know about the Elopement binder now, but didn't then. I never saw the elopement binder before (R1) got out. But I know my residents and have been there almost 10 years. I know (R1) was high risk for elopement. (R1) wanders around the facility all the time."

On 12-15-2020 at 8:59am, V2 former Administrator stated "(On 12-3-2020) (V4 BOM) let me know that (V4) believed that (R1) had left the building. I called a code for a missing resident. (R1) was found on the other side of the apartment buildings by the water pumps." V2 continued to state "(R1) was a wanderer, mobile. Redirects easily. It was unusual behavior and out of character for (R1) to be over there (hallway by V4's office). Alarms did not sound (from the East exit door R1 eloped from on 12-3-2020) and that was unusual. We had the alarms checked and found there was a button that was stuck in the door frame (of the East exit door). (V10 Maintenance Assistant) fixed that and checked all the other doors. A more experienced maintenance man, (V22 Maintenance) came to look at alarms and said he had never seen anything like that happen before. Normally, when the door is open, the button pops out and that triggers the alarm (to sound). (On 12-3-2020) the button did not pop out for some reason. The red box alarm (on the East exit door) did not go off either." V2 verified at this time that the red box alarm should not have been turned off for any reason.

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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
S9999	Continued From page 12	S9999		

On 12-15-2020 at 11:00am, V3 former Director or Nursing/DON stated "I was working the floor that day (on 12-3-2020) and a nurse ran down and told me that they (facility staff) couldn't find (R1). We went room to room and did a head count. I went to (V2) and asked where (R1) was last seen. (V2) had said (R1 was last seen) around (V4's) office around 12:15pm. The search was initiated at 12:25pm because they (facility staff) thought he (R1) had gotten out." V3 stated "(R1) would stand at the front door and set the alarms off. (On 12-3-2020), it was found that the button on the door frame did not pop out which would trigger the alarm at the nurse's desk. The button got stuck and no alarms were sounding. The red box alarm didn't sound because it wasn't (turned) on. It should have been." V3 also stated that (R1) had attempted to exit seek before, and that staff should be knowledgeable as to who the elopement risk residents are.

On 12-17-2020 at 12:52pm, V19 LPN stated "(R1) was sometimes confused. I was not working when (R1) left (on 12-3-20). I had taken care of (R1) before when (R1) had tried to get out. At this time, V19 verified that R1 had attempted to exit seek two other times when V19 was working at the facility; once on 8-30-2020 and again on 11-13-2020; both times R1 redirected easily. I knew (R1) was a wanderer. (R1) was quiet. (R1) just goes around through the building. I would expect (R1) to be redirected if (R1) was found in a non-patient care area or away from (R1's) hall if not supervised. (R1) shouldn't be left unsupervised. I know a couple other elopement risks, but that's it. I don't know all of them. You see, I'm agency."

R1's Nursing Note, dated 8-30-2020 at 10:15am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003420	A. BUILDING: _____ B. WING _____	C 12/19/2020

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S9999	Continued From page 13	S9999		

and signed by V19 LPN, documents R1 exited the facility stating that R1 was going to get the cattle. (R1) was accompanied back into the facility and placed on 15 minute checks.

R1's Nursing Note, dated 11-13-2020 and signed by V19 LPN, documents R1 attempted to go out of the door on West Hall; alarm went off, this resident stated "I don't know what happened it just went off." (R1) accompanied back to (R1's) room and placed on 15 min checks. Administrator notified.

On 12-17-2020 at 3:06pm, V25 R1's family member/Power of Attorney/POA stated "(R1) has early onset dementia pretty bad. He lived on his own prior. He would go out at night walking. He would end up in other towns. It got so bad that one time in the winter, he walked a half mile up the road from his home and he was found outside laying on the ground of his neighbor's yard. The neighbor called 911 and he was taken to the hospital. The doctor at the hospital said there was no way he could return to living alone at home, so he went to (named facility)." V25 continues to state "It was well known when he admitted to the facility that he had a history of wandering. They had mentioned to me a couple times that he would try the doors and set the alarms off. He is a lot of times confused and he doesn't know where he's at. He was a farmer and I know he was having fears about his cattle being stolen. He keeps talking about his cattle and his farm." V25 also stated "(V5 SSD) called me that day (12-3-2020) to notify me that (R1) had gotten out of the facility and they (facility staff) were trying to locate (R1). I asked (V5) if the alarms had gone off and (V5) said the alarms didn't go off and that (R1) slipped out."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 On 12-10-2020 at 2:26pm, V1 Regional Director of Clinical verified R1 eloped from the facility on 12-3-2020. V1 stated "All staff should know who is an elopement risk. It is part of their orientation. Everyone's responsible to know who's in the elopement binder. A resident in the elopement binder should be redirected or call staff to alert them or speak to the resident to see how/what they are doing." V1 verified that a high risk elopement resident shouldn't be left pacing. (B)	S9999		