| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6013437 | A. BUILDING: _____ B. WING _____ | C 06/07/2022 |

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| S 000 | Initial Comments<br><br>Complaint Investigation 2264266/ IL147502 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>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. | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br><br>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:<br><br>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.<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review the facility failed to provide supervision for a severely cognitively impaired resident, who was assessed as being at risk for elopement (leaving the facility unnoticed), wandered from the facility unnoticed and undetected by staff. This failure affects one of three residents (R1) reviewed for elopement risk in a sample list of three. This failure resulted in R1 leaving the building unattended and without staff knowledge, R1 was found when a community member called the facility to notify them that R1 was outside, standing in slipper socks on the busy road in front of the facility.<br><br>Findings Include:<br><br>R1's Minimum Data Set (MDS) dated 3/1/22 documents R1 is diagnosed with Non-traumatic Brain Dysfunction, Non-Alzheimer's Dementia, Anxiety, and Unspecified Dementia with Behavioral Disturbance. The same MDS documents R1 is Severely Cognitively Impaired | S9999 | | |

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| S9999 | Continued From page 2 | S9999 | | |

and Hard of Hearing. R1 uses a walker for transfers and ambulation and does so independently.

R1's Care Plan dated March of 2022 documents R1 is high risk for falls related to confusion, gait/balance problems, unaware of safety needs, and impulsive behaviors. The same Care Plan documents R1 has impaired cognitive function and impaired thought processes related to Dementia and requires supervision/assistance with all decision making. The same Care Plan documents R1 is considered at risk for abuse/neglect related to her dependence on others, Dementia diagnosis, Anxiety disorder and Behaviors such as refusal of care, hitting, and kicking staff.

On 6/2/22 between 1:00 PM and 2:40 PM, R1 was observed wandering around the facility, going up and down the halls, sitting on the couch, going in and out of the dining areas, walking down by her room and up and down the main hallway.

On 6/1/22 at 2:47 PM, V13 (Social Services Director) stated around the beginning of the year (January 2022), the facility placed a departure alert bracelet on R1's walker because she has severe Dementia, can ambulate on her own, and would often sit at the check in table by the back door. V13 stated she placed the bracelet on R1 as a precaution and wanted to make sure if R1 did go out of the back door, the staff would be alerted.

The Facility Incident Report dated 5/29/22 documents R1 eloped from the building.

On 6/1/22 at 1:55 PM, V7 (Certified Nurse

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| S9999 | Continued From page 3<br><br>Assistant/CNA) stated R1 was standing right inside the back door of the facility by the check in table on 5/29/22 a little before 6:00 PM when V7 and V14 (Certified Nurse Assistants/CNAs) came inside the building after a break. V7 (CNA) stated as the door opened, the departure alert system sounded and V7 entered the code to shut it off. V7 stated she then walked away from the door with her back to R1. V7 stated as she walked away R1 was still standing by the back door. V7 stated she did not make sure the back sliding door had closed all the way and did not watch R1 until the door was completely closed or until the departure alert system alarm had time to reset. V7 stated she was not aware at the time that the departure alert system required approximately 25 seconds to reset before it would be active again.<br><br>On 6/2/22 at 1:54 PM, V14 (CNA) stated R1 was standing right inside the back door of the facility by the check in table on 5/29/22 shortly before 6:00 PM when she (V14) and V7 (CNA) re-entered the building after a break. V14 stated the departure alert system sounded as the door opened and V7 entered in the code to shut it off. V14 stated she started walking towards the XXX Hall with R1 but then R1 stated she forgot something and turned around. V14 stated she kept walking to the XXX Hall and did not monitor R1 any further. V14 stated she was not aware at the time that the departure alert system required approximately 25 seconds to reset before it would be active again.<br><br>On 6/1/22 at 3:17 PM, V5 (Licensed Practical Nurse/LPN) stated on 5/29/22, R1 was noted to be wandering around the facility and asking for her grandson multiple times. V5 stated R1 was fixated that evening on finding and talking to her grandson. Every time someone was on the phone | S9999 | | |

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| S9999 | Continued From page 4<br><br>she would ask if it was her grandson they were talking to. V5 stated R1 would say, "My grandson works down the road about 25 miles and I could just walk there". V5 stated at approximately 5:57 PM V5 took a phone call at the nurse's station and R1 was standing there asking V5 if it was her grandson. V5 stated she (V5) ended the call and walked down a resident hallway away from R1. V5 confirmed R1 has poor safety awareness, is impulsive, has a history of falls, and is confused. V5 stated she is not sure how R1 left the building without staff noticing. V5 stated she was not aware at the time that the departure alert system required approximately 25 seconds to reset before it would be active again.<br><br>On 6/1/22 at 11:30 AM, V3 (Maintenance Supervisor) confirmed the departure alert system required approximately 25 seconds to reset before it would be active again. V3 confirmed R1 often sat at the table that was right next to the back door and V3 was afraid R1 might try to walk out the door. V3 stated he believes the staff should have been aware of the alarm reset delay and should have watched the door to make sure it closed all of the way. Staff should have watched R1 and redirected her away from the back door, giving the alarm enough time to reset itself.<br><br>On 6/1/22 at 4:00 PM, V12 (Medical Director) confirmed R1 does wander around the facility. R1 is confused and hard of hearing. R1 is impulsive, has impaired safety awareness, and does exhibit behaviors of aggression. V12 stated facility staff should supervise R1 and should have redirected her away from the back door when the departure alert alarm went off. V12 confirmed staff should have been aware of the 25 second reset delay and made sure the alarm was working before walking away from R1. | S9999 | | |

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| S9999 | Continued From page 5<br><br>On 6/1/22 at 10:35 AM, V1 (Administrator) confirmed R1 eloped from the back door of the building at approximately 6:00 PM on the evening of 5/29/22. V1 stated the facility was not aware R1 had left the building until they were alerted of R1's elopement by V11 (Community Member) who called the facility at 6:18 PM and told them V11 found R1 at the road in front of the facility. V1 confirmed R1 was brought back to the facility with no injuries.<br><br>On 6/3/22 at 10:00 AM, V1 (Administrator) stated the departure alert system does have a preset 15-25 second delay time before resetting itself. V1 confirmed on 5/29/22 when R1 triggered the departure alert alarm, staff should have supervised R1 until the departure alert alarm reset itself and was working again. V1 confirmed staff should always redirect R1 away from exit ways and supervise R1 when R1 is hovering by doorways or continually coming back to the exits.<br><br>On 6/3/22 at 10:50 AM, V11 (Community Member) stated at about 6:15 PM on 5/29/22 she was driving down the road in front of the facility and noticed R1 in the middle of the road. An oncoming truck swerved around R1 in order not to hit her. V11 stated as she got closer she noticed that R1 was using a wheeled walker and had on slipper socks. V11 stated she pulled over, ran out to direct R1 off the road, and called the facility. V11 stated she was very concerned for R1 as she was on a busy road where drivers often speed and there are a lot of semi-trucks.<br><br>On 6/1/22 at 1:25 PM, observations of the immediate area outside of the facility include the following: drainage ditches along two sides of the facility (one with very tall grass), manufacturing | S9999 | | |

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| S9999 | Continued From page 6<br>plant directly across the street, residential neighborhood to one side of the facility, fields on the back side of the facility, and construction equipment working across the street on large dirt mounds next to a retention pond. The road in front of the facility has a posted speed limit of 30 miles per hour and during observation multiple semi-trucks and cars passed by the facility in both directions.<br><br>The Elopement and Search (Code Pink) Policy dated February 2014 documents "all nursing staff are responsible for knowing the whereabouts of residents for which they are assigned. Residents are not permitted to leave the building alone unless ordered by physician."<br><br>(A) | S9999 | | |