| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6014658 | A. BUILDING: _____ B. WING _____ | R-C 07/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIVER CROSSING OF ROCKFORD | 1660 SOUTH MULFORD ROCKFORD, IL 61108 |

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| S 000 | Initial Comments<br><br>Follow-up to Complaint Survey 2213716/IL146835 of 5/18/22 | S 000 | | |
| S9999 | Final Observations<br><br>Statment of Licensure Violations:<br><br>300.610a)<br>300.1210 b)<br>300.1210 c)<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>Section 300.1210 General Requirements for Nursing and Personal Care<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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>These requirments are not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to supervise a resident and failed to ensure the alarm on the front door was on. This failure resulted in a resident with dementia, leaving the facility through the unalarmed front door on July 5, 2022, without staff knowledge. R256 was located by the city police and taken to a local emergency room without facility knowledge. This applies to 1 of 4 residents (R256) reviewed for safety and supervision in the sample of 19.<br><br>The findings include:<br><br>The facility Incident Report dated 7/5/22 states, "Resident is a 58 year old male resident admitted on 4/21/22 with diagnoses including of Diabetes, Depression, Dementia, Hypertension, TIA, Hypercholesteremia, Anxiety. Resident was last seen by night nurse at approximately between 5:00 AM- 5:30 AM during the medication pass. Resident was noted missing, facility search began, and room sweeps were done. POA notified. Police were notified of missing resident. Police called and confirmed they had located resident. Resident was taken to local hospital for evaluation and returned safely to the facility. Investigation ongoing. "<br><br>On 7/5/22 at 7:41 AM as Surveyors entered the facility parking lot, multiple facility staff were observed wandering throughout the parking lot | S9999 | | |

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| S9999 | Continued From page 2<br>and appeared to be looking for something.<br><br>On 7/5/22 at 1:40 PM V1 (Administrator) stated, "We had a resident get out this morning. He said he was looking for his house in Mount Prospect. He was gone for about an hour and he was found on Cybele Lane about 1 block away. He needs to be in a locked unit, and we are looking for one for him. "<br><br>On 7/5/22 at 2:00 PM V4 (Agency RN) stated, "Most of the night (R256) was sleeping in the TV room. He woke up about 5:00 AM so I checked his blood sugar and gave him his medicine. Then I went down to check on another resident and he was standing at the nurse's station. This is the first time I have cared for him. The CNAs for day shift start at 6:00 AM and around 7:00 AM they told me he was not in his room. We did a room sweep and went outside and checked the area- when we didn't find him, we notified the unit manager, (V5). Then (V5) called the DON, the ADON and the Nurse Practitioner. The unit manager called 911 and the dispatcher told her that they had already found him sitting on the block. The police had already called EMS and they were taking him to (Local Hospital). He returned here about 11:00 AM. I guess he has tried to go outside before but I don't know anything about that. I suspect that he went out the front door because no alarms went off when he left."<br><br>On 7/5/22 V5(Unit Manager) stated, "The floor staff notified me about 6:45 AM that they were unable to locate him. I came in at 6:00 AM. I called a code green, and we did a building sweep and a headcount. I had some staff go and walk around outside the building and 1 staff who had just gotten here went out in the car to drive | S9999 | | |

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around and try to find him. I called his sister and let her know that we didn't physically have eyes on him. Then I touched base with the nurses, and no one had found him, so I called 911- that was a little after 8:00 AM. I called 911 and the dispatcher said, "I think they may have already picked him up. Let me have the officer call you. The officer called me and said they found him on Cybele Lane- 1 block West of facility and he was sitting on the sidewalk. He said (R256) told him that he came here with his mother from Chicago, and he was trying to get back home to Mount Prospect. They knew he was confused so they called the ambulance, and they came and took him to the hospital. He is usually only alert and oriented to person. I called his sister back and she went over to the hospital to be with him. He went out the front door one other time and was walking around the parking lot but when the CNA went out there and told him he needed to come back in- he was very compliant and came right back inside. His story changed several times when he came back. I am assuming he went out the front door because none of the other doors were alarming. The front door is locked from the outside so no one can get in, but you can just push it to get out. There is no alarm on that door. "

On 7/5/22 at 3:00 PM V7 (Receptionist) stated, "There is someone at the front desk from 8:00 AM- 8:00 PM 7 days a week. The front door should be alarmed after 8:00 PM. I let the nurses know that I am leaving, and they should come and set the alarm. It is very loud; you can hear it throughout the building. (V8- Maintenance) usually gets here about 5:30 AM, sometimes earlier and he removes the alarm or sometimes the Manager on duty will do it. Most of the staff come through the front door and do the COVID

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| S9999 | Continued From page 4<br>screening before they start their shift. "<br><br>On 7/5/22 at 2:15 PM, R256 was sitting in a chair in the TV room by the 100/200 wing nurse's station. When R256 was asked what happened this morning he stated, " I just went outside to walk around the campus. I was not aware of where I was or where I was going. The police found me walking on the street and took me to the hospital." Resident then stood up and ambulated with slow methodic gait to his room at the end of the 100 hall.<br><br>On 7/5/22 at 3:25 PM V8 stated, "This morning I came in at 6:30 AM. I always unlock and open up the front door and the back door. I check the alarms routinely. The alarm is always on if there is no receptionist. This morning I took the alarm off at 6:30 AM. I don't know how the day shift staff got in this morning or who turned off the alarm. "<br><br>R256's Progress Notes dated 6/26/22 at 9:06 PM, state, "Resident went for a walk outside in front parking lot, when asked to return to building resident/patient easily directed patient and staff returned to building. Patient informed to ask nursing staff to accompany him outside when he feels restless and in need of fresh air and res/pt. verbally agreed, okay. Resident ambulation is good and slow occasionally holds on to rails for support, while returning to his assigned room. Director of Nursing services informed of resident/ patient activities."<br><br>On 7/7/22 at 8:20 AM V13 (LPN) stated, "That was my first time working with (R256) (6/26/22). I was responding to a door alarm on the front door. It was after 8:00 PM and the door was locked so when the alarm went off, I went to make sure there was no one out there and I saw him in the | S9999 | | |

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parking lot. I just asked him to come back in the building and I told him it was kind of dark out there and I didn't want him to fall. He turned around and came back in with no problem at all."

On 7/6/22 at 10:45 AM, V11 (CNA) stated, "(R256) does wander around."

On 7/6/22 at 10:50 AM V12 (CNA) stated, "(R256) wanders the halls. I worked a double on Sunday, July 3 he was on his way to the dining room and stopped in front of the double doors (leading to the front lobby and front door) and I told him to keep going. I told the other staff to keep a look out for him since he was eyeing the doors."

R256's (NRS) Elopement Risk Screen dated 6/29/22 shows that he scored a 3. This same form states, "Score of 5 or greater = High risk wandering/ elopement potential."

The Physician's Order Sheet dated 7/5/22 shows that R256 has diagnoses including Dementia without Behavioral Disturbance, Depression, Mood Disorder due to known Psychological Condition with Manic Features and Generalized Anxiety.

R256's Minimum Data Set of 4/27/22 shows that he has mild- moderate cognitive impairment.

R256's Current Care Plan does not address his risk for elopement from the facility.

On 7/6/22 at 9:00 AM, V1 provided a copy of a piece of paper handwritten by (V10- Police Officer) showing: Incident # 22-138653, 7/5/22 at 7:46 AM, Located at **** Cybele Lane. around 8:43 AM. Taken to (Local Hospital). (This location

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| S9999 | Continued From page 6<br>is 0.8 miles (per Google Maps) from the facility and required R256 to cross a busy 4 lane street).<br><br>On 7/6/22 at 7:30 AM, V9 (Regional Director of Operations) stated that the facility had reviewed the video from 7/5/22 and observed that R256 exited the building through the front door at 4:54 AM. At 11:00 AM V9 stated that R256 was dressed in normal clothes, has (wound) wraps on his feet and wears slides (flip flops).<br><br>R256's Hospital Emergency Room Report dated 7/5/22 at 8:30 AM stated, "Patient arrives via EMS due to patient being found by police wondering around outside. AMS (Altered Mental Status) to is a patient at River Crossing- facility was unaware that patient was not at the facility and unknown last time seen, Patient is covered in urine and stool. EMS reports blood sugar of 104.<br>Patient oriented to self only.<br>RN from River Crossing, patient normally confused- oriented to self only.<br>RN reports patient was at 4:00 AM during vitals check.<br>Patient was found wandering. He has a history of disorientation; it is usually oriented x1 and wandered off from nursing facility. He denies any complaints. He is not sure where he is, He thinks he is at River Crossing now. He states he is 64 years old. Not a reliable historian., He denies any pain- no headache, no chest pain, back or neck pain,. No abdominal pain. "<br><br>(A) | S9999 | | |