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
	IL6013023	A. BUILDING: ______ B. WING ______	C 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI RESTORATIVE CARE	1455 HOSPITAL ROAD SILVIS, IL 61282

(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
S 000	Initial Comments Facility Reported Incident investigation to incident of 5/19/22/IL00147191	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210 b) 300.1210 c) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident to meet the total nursing and personal care needs of the resident.

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.

These requirements are not met as evidenced by:

Based on observation, interview and record review the Facility failed to ensure placement and functionality of an electronic monitoring system bracelet and failed to provide adequate supervision for one (R1) of three residents reviewed for elopement in a sample of three. These failures resulted in R1 exiting the building and falling in the parking lot grass, requiring medical attention at the local Emergency Department.

Findings include:

Facility Elopement Risk/Elopement (Missing Resident) Process, revised 3/2022, documents: to provide a safe environment for all residents; to properly assess resident and plan their care plan to prevent accidents related to wandering behavior and elopement; defines elopement as

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S9999	Continued From page 2 slipping away secretly, running away and leaving without accompaniment or knowledge of the staff; an alarm bracelet may be placed on the resident to audibly alert staff of attempts by the resident to exit the community; if for any reason the door alarms are turned off, the staff will continually visually monitor the doors and must document and assign a staff member that is not providing direct care; and if an alarm is discovered de-activated, staff will perform an immediate head count to ensure all residents are accounted for. Facility Elopement Precautions Policy, revised 4/2022, documents: elopement precautions establishes guidelines for identifying residents at risk for elopement and the process for initiating elopement prevention; elopement is a resident leaving without permission; any resident, regardless of location, if consistently exit seeking should have an electronic monitoring device; resident's on electronic monitoring will be fitted with an arm or ankle band, or will have clothing fitted with tracking devices; the tracking device, worn by the resident, will be tested daily and documented on the resident's Medication Administration Record/MAR. On 5/21/22, during the hours of 9:00 am and 12:00 pm, a sign was visible to all residents, hanging above the Medicare exit door electronic code keypad, that had the pass code numbers (148796) that allowed exit from the door. R1's Physician Order Sheet/POS, printed 5/21/22 at 11:40 am, documents an order (dated 5/20/21) to check R1's electronic monitoring system bracelet placement to right wrist every shift. The POS also documents an order (dated 5/21/22) to check electronic monitoring system bracelet	S9999		

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function daily and as needed every night shift.

R1's Minimum Data Set/MDS, dated 5/4/22, documents that R1 has a Brief Interview for Mental Status/BIMS score of seven (7/15), indicating moderate/severe cognitive deficits.

R1's Nursing Notes, dated 5/19/22 at 10:01 am, documents that V7 (Activity Director) spoke to R1's daughter (V8) about R1 having a electronic monitoring system bracelet on. "On Sunday (5/15/21) when I was coming to work, resident tried to exit the front door when I was coming in. (R1) stated (R1) could not remember where he parked his car. I was able to redirect the resident when I came in. I did let the Administrator (V1) know my concern when I saw her. Family was 'ok' with the resident having electronic monitoring system bracelet on."

R1's Nursing Note, dated 5/19/22 at 11:10 pm, documents that R1 returned to the facility, back from the Emergency Department at 8:48 pm, alert and oriented accompanied by (V8) and one facility staff. (R1) stated that "his left knee was hurting him a little bit" and scheduled pain medication was administered (Tramadol). The Nursing Notes do not document R1's Elopement incident, monitoring or interventions upon return to the facility.

Facility Elopement/Missing Resident Investigation dated 5/19/22 at 7:05 pm, documents that R1 was found by V4 (R4's family member) in the facility parking lot on the grass. (V4) alerted staff that R1 had fallen out of (R1's) wheelchair and was on the ground. Emergency (911) was called and R1 was noted lying in the grass, with no injuries noted, but (R1) did complain of left side pain. R1 was transported to the Emergency

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S9999	Continued From page 4 Department via ambulance and returned with no new orders. The Investigation documents that R1 stated, "I do not know" why I exited the facility, the outside temperature was 82 degrees and that R1 exited the Medicare NS door. The Investigation documents that the door alarm did not sound when R1 exited the building. R1's Medication Administration Report/MAR, dated 5/1/22 through 5/21/22, documents that electronic monitoring system bracelet placement checks to R1's right wrist were initiated on 5/20/22 at 2:00 pm and electronic monitoring system bracelet function checks were initiated on 5/20/22 at 10:00 pm. The MAR does not document monitoring, function or placement checks from the date of placement of the electronic monitoring system bracelet (5/15/22 through 5/19/22). On 5/21/22 at 9:34 am, V1 (Administrator) stated, "The last time that (R1) was seen before eloping was at 7:00 pm, on the back hall (B Hall) by V5 (Certified Nursing Assistant). We think that V4 (R4's spouse) exited the building and let (R1) out the door, then a few minutes later, (V4) came back in and told V6 (Licensed Practical Nurse) that a visitor was outside laying in the grass. V6 then called Emergency (911) and proceeded out to the grass, and that is when (V6) discovered that it was (R1) and not a visitor. I am not sure why the electronic monitoring system bracelet did not sound, but it works now. The alarm should have sounded when (R1) went through the door. Last Sunday (5/15/21), I was here and (V7/Activity Director) told me that (R1) was sitting at the front door asking about a car and (V7) got concerned and told me about it. At that time, we put a electronic monitoring system bracelet on. I am not sure if the electronic monitoring system	S9999		

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S9999	Continued From page 5 bracelet was functioning prior to putting it on (R1)." On 5/21/22 at 11:18 am, V6 (Licensed Practical Nurse/LPN) stated, "I am actually the MDS Nurse and was working the floor. I was right at the nurse's station by the exit door, because I was helping another family member. (V4) came in and told me that a visitor had fallen outside on the ground, so I immediately called Emergency (911). Then I went straight out to the parking lot and that is when I realized that it was not a visitor, but it was (R1). (R1) was lying on (R1's) left side and stated that (R1's) left side hurt. (R1) was sent by ambulance to the Emergency Department for assessment. I am not sure how (R1) got out; I think that (V4) let him out. The alarms were not sounding, and I did not know that (R1) was out of the building until (V4) came to tell me." On 5/21/22 at 11:25 am, V4 (R4's spouse) stated, "I came to visit my husband and when I was leaving the facility, there are two exit doors with an area in between and a gentleman in a wheelchair was already through the first exit door. I proceeded to go through the next exit door to the outside parking area and helped the gentleman out the second door, because he was in a wheelchair, I thought he probably needed help. I had a family member at another facility that was an escape artist and was constantly trying to get out of the facility and had to wear an alarm bracelet, but every time he went by a door, there were bells and whistles going off to alert that he was close to an exit door. When I exited the first door and saw (R1) at the second door, I figured he was a resident with privileges or a visitor, because no alarms were sounding, plus they have the code posted at the door, so everyone can see it. I was concerned because	S9999		

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(R1) was in a wheelchair, so I watched (R1) wheel himself towards a car that was parked in the handicap spot, so I figured that it all made sense. Once (R1) got to the car in the handicap spot, (R1's) wheelchair bumped the car tire and (R1) popped out of the wheelchair and landed onto the grass. That is when I immediately ran back into the nurse's station and told them that (R1) had fallen."

On 5/23/22 at 10:40 am, V1 (Administrator) stated, "(R1's) electronic monitoring system bracelet was put on (R1's) right wrist on 5/15/22 and the Medication Administration Report/MAR and Nursing Notes do not document that it was checked until 5/20/22, after the hospital incident, then it was done."

On 5/23/22 at 11:04 am, V7 (Activity Director) stated, "On Sunday 5/15/22, I noticed (R1) hanging out at the facility's primary entrance and exit door, also known as the Medicare door by the nurse's station, when I came into work. (R1) had been recently wandering around the facility a little more than usual, so I notified (V1/Administrator) and (V1) and nursing initiated the placement of the electronic monitoring system bracelet on that day, 5/15/22. I did see (R1) on Tuesday, 5/17/22, and (R1) had a electronic monitoring system bracelet on (R1's) right wrist at that time. I am not sure if it was working because (R1) was not around an exit door at that time."

On 5/23/22 at 2:08 pm, V11 (Certified Nursing Assistant/CNA) stated, "I worked on 5/17/22 and 5/18/22, I never heard an alarm sound when R1 was by a door. I actually never saw a electronic monitoring system bracelet on R1 either, but I was not specifically looking for one either, I did not know he had one put on."

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S9999	Continued From page 7 On 5/23/22, at 3:29 pm, V9 (Agency Nurse) stated, "On Sunday, 5/15/22, I was working the back hall, on the opposite side of the building as the Medicare Exit door, and I was (R1's) nurse. On 5/15/22 around 4:00-5:00 pm, V10 (Registered Nurse/RN) told me that (V1/Administrator) told us that we needed to put a electronic monitoring system bracelet on (R1) because (R1) was wandering a lot more than usual. I could not find one, but V10 found one and gave it to me, and I put it on (R1). I was working the back hall, on the opposite side of the building from the Medicare exit door and put the electronic monitoring system bracelet on (R1) at that time." (B)	S9999		