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
	IL6002869	A. BUILDING: ______ B. WING ______	C 12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH & REHAB CTR	ONE PERRYMAN STREET LEBANON, IL 62254

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation: 22410015/IL154411	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental 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.

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.

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:

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

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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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This REQUIREMENT is not met as evidenced by:

There are two deficient practice statements.

A. Based on observation, interview and record review the Facility failed to assess, monitor, implement interventions and provide supervision to prevent elopement for one of 22 residents (R65) reviewed for wandering/elopement risks in the sample of 55. This resulted in R65 eloping from the facility, being found by the local police department, and sent to hospital and diagnosed with acute hypothermia.

Findings include:

R65's Face Sheet documents he was admitted to the facility on 9/23/2022.

R65's December 2022 Physician's Order Sheet (POS) document R65 has diagnoses of encephalopathy, type 2 diabetes, altered mental status, and a history of alcohol abuse.

R65's Minimum Data Set (MDS) dated 12/12/2022 documents R65 had severely impaired cognition. The MDS documents, "Has

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S9999	Continued From page 3 the resident wandered?" And the response was "Behavior not exhibited." R65's MDS documents he requires extensive assist of two plus staff members for transfers. R65's MDS documents his balance is not steady and he is only able to stabilize with staff assistance. R65's Care Plan, dated 10/3/2022 document R65 is at risk for falls due poor balance, unsteady gait and cognitively impaired. The Care Plan documented that R65 had diagnoses of encephalopathy and alcohol abuse. R65's Care Plan also documents R65 has a self-care deficit as evidenced by R65 requires assistance with activities of daily living (ADLS). R65's Care Plan does not document R65 had any wandering and or elopement behaviors before 12/17/2022. R65's Offense/Incident Report Police Report dated 12/17/2022, documents, "On 12/17/2022 at approximately 7:40 PM, (V8 Police Officer) received a call from dispatch pertaining to an elderly man lying on the ground behind (Facility). Upon arrival I met with (ambulance) individual who were on scene and behind the residence was talking with an individual on the ground. (R65) was talking to the paramedics and explained to them that he escaped the nearby nursing home (Facility). While standing there with the paramedics I could hear an audio sounding alarm coming from the nursing home which was 75 feet away. As I traveled towards the nursing home on foot, I located the wheelchair with an alarm sounding about 25 from the southern exit doors of the nursing home. I brought the wheelchair back where (R65) was located, assisted in getting him up in the wheelchair, and was able to safely get (R65) in the ambulance. Once (R65) was loaded and transported to (Hospital) I loaded the wheelchair	S9999		

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S9999	Continued From page 4 into my squad car and transported it to the nursing home. (Central Command) advised me that they made several attempts to contact the nursing home but did not reach anyone. (V12 Officer) and I arrived at the front door with the wheelchair (Central Command) advised that they did reach the staff members and they would meet us at the door. (V13 Licensed Practical Nurse/LPN) was able to provide me with (R65's) information. I informed her of the situation and that (R65) was transported to the hospital. I provided the wheelchair with alarm to the staff member and cleared the area around 8:07 PM." On 12/21/22 at 9:00 AM, V8 stated that R65 was coherent when he arrived on the scene on 12/17/22. V8 stated that he (V8) was cold so R65 had to be cold. V8 stated it was about 35 degrees outside. V8 stated he did not notice any scratches or bruises on R65 but stated that it was dark. V8 stated R65 had soiled himself. V8 stated R65 was wearing sweatpants, socks, and a hoodie. V8 stated R65 was not wearing any shoes or slippers. R65's Emergency Medical Service (EMS) Report dated 12/17/2022 at 7:58 PM, document "EMS arrived on scene with Police Departments. EMS crew arrived at patient side to find the patient laying in the backyard of a residence. Patient is alert and orientated to person. Patient stated he is a resident at a medical facility. Police found the patient's wheelchair about 10 yards from the patient. Patient is found approximately 200 feet from the nursing home. Patient is unable to tell EMS how long he has been outside. Patient has urinated his pants and is cold to the touch. Patient was unable to tell EMS if he had any injuries."	S9999		

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On 12/21/22 at 8:43 AM, an observation was made of the location R65 was found on 12/17/22. There is a concrete sidewalk that runs south of the facility that follows along a sloped hill. The sloped hill is south of the sidewalk. There is a large ditch to the southwest of the facility. The ditch is approximately 30 feet from the facility. The ditch is sloped on both sides. The ditch is approximately 10 feet deep. There is row of residential houses that run south of the facility. The house that R65 was found nearby, according to the police report is approximately 60 feet from the facility and 30 feet from the ditch.

R65's Emergency Room visit dated 12/17/2022 to 12/18/2022 document, "Patient presents emergency room having been found at the bottom of the hill next to (Facility) nursing home. Patient was out of his wheelchair on the ground. Someone noticed him at the base of the hill and the Emergency Medical Service (EMS) was called. (R65) was diagnosed with mild hypothermia." The Report documented "Hypothermia due to cold environment." The Report documented R65's blood pressure was 89/58.

The weather conditions website documents on 12/17/2022 at 7:34 PM, the temperature was 30 degrees Fahrenheit (F).

R65's Nurse's Notes dated 12/18/2022 documented "Resident return to facility from (Hospital) emergency department, transferred by EMS, (Emergency Medical Services.) Resident diagnosis for Acute Hypothermia, Resident is lying in bed with no complaints of pain, resident was singing and talking with me, he responds to verbal command, no complaints of pain or discomfort at this time."

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On 12/20/2022 at 9:15 AM, V3 (Certified Nursing Assistant/CNA), stated, "I was off the day (R65) got away. (R65) he is in a wheelchair and wanders around all over the place. He can't sit still. I believe he had a (name of alarm system) before the incident."

On 12/20/2022 at 9:23 AM, V4 (CNA) stated, "I was working that night (R65) got away. We got a call from the police that they had found (R65) in a ditch. They said he did not have any shoes on, or coat and he almost froze to death. I never heard any alarm going off letting us know anybody had gone out a door. The police said (R65) was pretty cold and they were not sure if he was going to make it. I heard he went out the C hall door. They said that night that (V1 Administrator) watched the cameras and saw him go out the C hall door. Maintenance came in later and checked it and the alarm was not going off. (R65) was always all over the facility. He did not like to stay in one place and was antsy. He likes to move around a lot. I am not sure if he had a wander guard before or after he got out."

On 12/20/2022 at 9:32 AM, V5 (LPN) stated, "I heard (R65) got out of the facility because the alarm was not working. I was not working that day. (R65) liked to wander and was going around the facility in his wheelchair all of the times. He was a wanderer."

On 12/20/2022 at 4:16 PM, V7 (Registered Nurse/RN), stated, "I worked the B hall the night (R65) got out. I do not know how he got out and I did not hear any alarms alerting me that any resident had left the building. I was doing medication pass and one of my coworkers told me the police had notified them that (R65) was

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missing. (R65) liked to go around in circles with his wheelchair. He was always moving, constantly moving he could not stay still. I am not aware of how he got out of the building."

On 12/20/2022 at 4:23 PM, V11 (RN) stated, "I was not working the night (R65) got out of the building, but I heard the doors were not working and no alarm sounded, and nobody saw (R65) leave and he got out of the building unnoticed. (R65) was constantly propelling himself around the facility and was wandering around the facility."

On 12/20/2022 at 4:28 PM, V31 (CNA) stated, "(R65) likes to wander around the facility and is very confused. He is constantly propelling himself with his feet in his wheelchair and is all over the place. I was not working the night (R65) got out of the building, but I heard he got out on the C hall because the door was not locked. Nobody knew he was missing until the police showed up. We are not sure why the door was not locked. I could not tell you."

On 12/21/22 at 8:43 AM V9 (Maintenance Director) states all exit door alarms are checked every morning and evening. V9 stated they just started documenting the daily checks, prior to that they were only documenting the weekly checks but were checking them daily. V9 stated maintenance is who does the daily and weekly checks of the door alarms and wander guards at the exits. V9 stated the activity department checks the (name of alarm system) on the residents. V9 stated all exit doors have a (name of alarm system). V9 stated he takes a (name of alarm system) and checks in and then the Activity Department has a "wand" that they use to check the individual resident's (name of alarm system). V9 stated if the (name of alarm system) is yellow,

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S9999	Continued From page 8 it is working properly, when it goes off, it will go back and flash red and yellow and make a chirping noise, the alarm itself will not go off until the (name of alarm system) crosses the threshold, usually when the door is opened and then the door alarm sounds, and the intercom comes on and states where that the alarm is going off and the location. V9 stated the exit doors have 2 alarms on them, one must be reset by a key and maintenance and the nurses have a key and then the reset button must be held down for 10 seconds before the alarm will stop sounding and it will then be reset. V9 stated the only door that does not have a key access is the employee door and that one just has a keypad that a code must be entered in. V9 stated on 12/17/22 at around 8:30PM, and was told that R65 had escaped, slipped out of the building and he was being told that he had to come in and check all the door alarms. V9 stated all the door alarms and (name of alarm system) were functioning except the C-Hall exit door and it had been turned off. V9 stated he was unable to confirm with staff when the alarm was turned off if it was before or after R65 eloped. V9 state the door alarms had been checked about 12 hours prior on 12/17/22 and the alarm was on and functioning. On 12/21/22 at 09:10 AM, V10 (Activity Director) states they (Activity Department) check the resident's (name of alarm system) on the actual residents every Sunday and document it. V10 stated social services does the elopement assessment and they let activities know who needs a (name of alarm system). V10 stated if a nurse or social services lets them know, they will get one for the resident. V10 stated activities are here 7 days a week but if they are not, the nurses have access to a (name of alarm system) in the	S9999		

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S9999	Continued From page 9 e-hall nurses' cart. V10 stated there are elopement binders at the front desk and each nurse's station of all residents at risk for elopement. On 12/21/22 at 10:10 AM V19 (Social Services) states once a resident is determined to be at risk for elopement, they discuss it in the clinical meeting, and it is sent out via "communication line" which goes out to all managers to let them know there is a new resident at risk for elopement. V19 stated they (social services) verbally let the staff know that a new resident is at risk for elopement and the nurses check the elopement book. V19 stated they do not have staff sign an in-service sheet or communication sheet verifying that they were notified of a new resident at risk for elopement. V19 stated R65 had an elopement assessment completed upon admission and was not at risk for elopement on 12/17/22. V19 stated R65 did not have a (name of alarm system) prior to his elopement on 12/17/22. V19 stated they completed a new elopement assessment after his elopement on 12/17/22 and now he is at risk. On 12/22/2022 at 2:24 PM, V13 (LPN stated) "When the police came, I went to the door and talked with them. They told me they thought (R65) had gotten out of the back doors because they had found him in a large ditch at the back of the building. It was very cold that night and they said, (R65) was really cold, and they had found him because his chair alarm was going off and someone in the neighborhood had heard the alarm and called the police. Thank God, we found him in time. The police then took him to the hospital. I called (V2 the Director of Nursing). I am not sure what exactly happened but his nurse on the B hall was passing out medications	S9999		

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S9999	Continued From page 10 when they brought him back. No alarms went off and those are loud alarms. I think somebody must have shut off the alarm and forgot to turn it back on. We don't usually even use those doors. Those alarms are so loud, and no alarm was going off. (V1 Administrator) came up later on and the maintenance man and tested the door and the C hall door and the alarm was not working so we think that is how he got out. (R65) wanders a lot and is very confused. We know he was out there for about an hour, because (V1) looked at the cameras and said he went out the door at 7:03 PM so they thought he had been outside without the proper clothing for over an hour in the cold weather." On 12/21/2022 at 10:05 AM, V18 (Medical Director) stated, "I would expect residents who have wandering tendencies and confusion to be monitored and supervised. For hypothermia I would expect the body to slow down, their physical ability slows down to the point of death if they were not treated and removed from the cold. Again, hypothermia, and blood pressure of 89/58 would be linked with hypothermia and that would make sense that his body was starting to shut down with his blood pressure dropping. If (R65) would not be found and removed from the cold, it would have been bad, and he could have died." On 12/21/2022 at 10:32 AM, V1 (Administrator) stated, "The facility (V17 LPN), contacted me that (R65) had left the building. I do not know how he got out. I have not reviewed any cameras. Staff were contacted by the police that is how we knew (R65) was missing. We are still in the process of investigating." The Missing Policy with and revision dated of 10/15/2022 document, "To provide the facility staff	S9999		

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with guidelines for ensuring the health, safety and welfare of all residents, and protocol to be followed when a resident is noted to be missing."

The Monitoring Wandering Resident Policy with a revision date of 10/15/2022 document, "Purpose to provide a system for monitoring wandering residents. Every effort will be made to prevent wandering episodes while maintaining the least restrictive environment for residents who are at risk for elopement. A Wandering or incident prone residents may be monitored frequently to confirm location. It is the responsibility of the Charge Nurse to determine what changes have occurred that would trigger elopement episodes. Interventions into the elopement episodes will be entered onto the residents' care plan and medical record. Should an elopement episode occur the contributing factors, as well as the interventions tried, will be documented on the nurse's notes. If a resident repeatedly attempts to exit seek, the charge nurse will start a monitoring schedule as appropriate and add to the communication or 24-hour nursing report. Staff will be aware of what residents are at risk for elopement and have a binder at each nursing station."

B. Based on observation, interview, and record review, the facility failed to develop and implement interventions to prevent falls for 4 of 4 residents (R1, R22, R31 and R51) reviewed for falls in the sample of 55.

Findings include:

1. R1's Face Sheet, undated, documents R1 has a diagnosis of a Left Femur Fracture.

R1's Progress Note, dated 11/23/22 at 3:21 PM,

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documents R1 was sitting on the floor in between his bed and the heater. The Progress Note documents R1 was not able to move his left leg properly and was complaining of left leg/hip pain and R1 was sent to the emergency room.

R1's Hospital History & Physical, dated 11/27/22, documents R1 was admitted with a left hip fracture.

R1's Minimum Data Set (MDS), dated 11/27/22, documents R1 has severe cognitive impairment, requires assistance with activities of daily living (ADLs) and R1's balance is unsteady during transitions and walking.

R1's Care Plan, dated 12/13/22, documents R1 is at risk for falls with interventions for a bed alarm and to move the bed against the wall to provide more room for resident. R1's Care Plan goes on to document R1 has a fracture of the left hip related to a fall with an intervention to have the bed in the lowest position.

On 12/21/22 at 2:03 PM, R1 was observed in bed. R1's bed was not in its lowest position. R1's bed alarm was not in place and the bed was not against the wall.

2. R31's Progress Note, dated 11/18/22 at 1:10 PM, documents R31 fell in the hallway while trying to walk out of his room. R31's Progress Note documented R31 sustained a skin tear to R1's left hand. The Progress Note documented R31 is confused and agitated.

R31's Progress Note, dated 11/19/22 at 5:08 AM, documents R31 fell in the hallway while trying to walk out of his room. The Progress Note documented no injuries were note and, R31 is

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	IL6002869	A. BUILDING: ________ B. WING ________	C 12/30/2022

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CEDAR RIDGE HEALTH & REHAB CTR	ONE PERRYMAN STREET LEBANON, IL 62254

(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 13 confused and agitated. R31's Progress Note, dated 11/27/22 at 7:07 PM, documents R31 was found sitting on the floor in his room. The Progress Note documented no injuries were noted. R31's Progress Note, dated 11/30/22 at 1:28 PM, documents R31 was found lying on the bathroom floor. The Progress Note documented R31 had no injuries and low bed in place. R31's Progress Note, dated 12/19/22 at 11:06 AM, documents R31 was on the floor in the bathroom. The Progress Note documented the nurse found R31 sitting on his buttocks in front of the wheelchair and toilet with feces smeared on the floor beside him. No injuries were noted. R31's Progress Note, dated 12/20/22 at 5:23 AM, documents R31 was lying on the floor. The Progress Note documented the Aide stated R31 "is on the floor again." R31's MDS, dated 11/21/22, documents R31 has severe cognitive impairment, requires assistance with ADL care and has an unsteady balance during transitions and walking. R31's Care Plan, dated 11/15/22, documents R31 it at risk for falls with interventions with interventions for non-skid strips next to the bed and in the bathroom and a pressure pad alarm while in bed. On 12/21/22 at 2:05 PM, R31 was observed in his room, the non-skid strips were not in place next to the bed or in the bathroom and there was no pressure pad alarm present.	S9999		

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S9999	Continued From page 14 3. R22's Face Sheet documents that resident was admitted on 07/25/22. R22's Physician Order dated 11/23/22 documents diagnose of "repeated falls" and "syncope and collapse." R22's Minimum Data Set (MDS) dated 11/30/22 documents R22 is cognitively intact. R22's MDS documents R22 requires extensive assistance of two plus persons for bed mobility and transfer. R22's MDS documents R22 requires extensive assistance of one-person for corridor walk in room, walk in, dressing, toilet use, and personal hygiene. R22's MDS documents R22 is not steady, only able to stabilize with staff assistance and uses walker and wheelchair for mobility. R22's Nursing Note dated 12/07/22 at 6:56 AM documents "The nurse was called to the room and informed that the resident fell when trying to get off the toilet by herself. Staff assisted her to her wheelchair and brought her out of the restroom and the nurse assessed her and no open areas or new bruises were noted. The nurse asked her what happened, and she said she fell when she was trying to get up and hit her head. VS (Vital Signs) obtained 98.0 (temperature)-90 (pulse)-20 (respirations)-134/79 (blood pressure) -98% (oxygen saturation level) RA (room air). Nurse called (V18) and orders were received to send resident to (local hospital). The nurse called DON (Director of Nursing) and informed her of the incident. The nurse called residents husband and no answer received and nurse called (R22's daughter) and informed her about the incident, and she said she will call (R22's Husband) to inform him about incident. Resident is sitting up in her wheelchair in awaiting transport. (Local ambulance service) called and report called to	S9999		

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S9999	Continued From page 15	S9999		

(local hospital)."

R22's Fall Investigation dated 12/07/22 at 7:15 AM documents "Nurse called to resident room upon entering observed resident of floor in bathroom. When asked what happened resident reported she fell trying to get up and hit her head. Assessed for pain and injury, MD and family notified. Staff assisted resident up to w/c after nurse assessed her. VS 98.0-90-20-134/79-98%. IDT Meeting: Root Cause: Attempting self-transfer. Intervention: Resident educated on using call light and waiting for assistance."

R22's Care Plan, was reviewed on 12/21/22. There was no Care Plan related to R22's risk of falling and her falling on 12/7/22. The facility initiated a Care Plan related to falls on 12/21/22 and provided it to surveyor.

On 12/28/2022 at 8:25 AM, V2 (DON) stated that she would expect that if a resident had a history of falls and a diagnosis of repeated falls that the resident would have a care plan for falls.

4. R51's Face Sheet, undated, documents R51 has diagnoses of Cerebral Infarction and Alzheimer's Disease.

R51's Progress Note, dated 9/23/22 at 9:00 AM, documents staff notified the nurse that R51 had scooted herself out of her room for the second time and no injuries were noted.

R51's Progress Note, dated 10/21/22 at 5:55 AM, documents the fire alarms went off at approximately 3:30 AM and R51 attempted to get herself out of bed and fell onto the floor. The Note documented R51 sustained no injuries.

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S9999	Continued From page 16 R51's Progress Note, dated 11/18/22 at 11:11 PM, document at approximately 9:37 PM, R51's bed alarm was sounding and R51 was lying on the floor pad. A scratch was noted to the right big toe. R51's Progress Note, dated 11/25/22 at 12:21 AM, documents R51 was lying on her right side on the floor next to her bed. The Note documented R51 had redness and bruising was noted to the right upper forehead/temporal area and an ice pack was applied. R51's Progress Note, dated 12/2/22 at 5:52 AM, document R51 rolled out of bed. The Note documented an abrasion was noted to R51's left knee. R51's MDS, dated 10/20/22, documents R31 has modified independence with cognitive skills for daily decision making, requires assistance with ADL care and has an unsteady balance during transitions and walking. R51's Care Plan, dated 12/10/19, documents R1 is at risk for falls with interventions for non-skid strips to both sides of the bed, non-skid material to the chair and a pressure pad alarm in bed. On 12/21/22 at 2:00 PM, R51 was observed in bed. The non-skid strips to both sides of the bed were not in place, the non-skid material was not in place and the pressure pad alarm was not present. On 12/22/22 at 9:00 AM, V2 (DON) stated she would expect fall interventions to be in place. The "Accidents & Incidents" policy, with a revision date of 5/16/22, document "The Nursing team will	S9999		

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S9999	Continued From page 17 complete an investigation with the root cause and new interventions." "The Charge Nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate interventions to affected parties." "B"	S9999		