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
	IL6005706	A. BUILDING: ______ B. WING ______	C 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY MAPLE CREST	4452 SQUAW PRAIRIE ROAD BELVIDERE, IL 61008

(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 Complaint Investigation Survey #2317053/ IL163602	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 applicable, must develop and implement a 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. (Section 3-202.2a of the Act) 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: 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	S9999		

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that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were not met evidenced by:

Based on observation, interview and record review the facility failed to ensure that a resident with a history of wandering and elopement attempts and a diagnosis of Frontotemporal Neurocognitive Disorder did not leave the facility unsupervised. The facility failed to have a policy and procedure in place to account for all residents after the emergency exit door alarm sounded and no residents could be observed outside. This failure resulted in R1 eloping from the facility at 7:15 PM on 8/27/23 and was found at approximately 8:55 PM on 8/27/23 by V13 (CNA) in the rear parking lot of a local business over 800 feet from the facility. On 8/27/23, R1 was last seen by facility staff between 6:00 PM-6:30 PM. The door alarm sounded at approximately 7:15 PM. The facility began a search for R1 when they discovered R1 missing from her room between 8:00 PM and 8:30 PM. This applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 5.

The findings include:

R1's Incident Report dated 8/27/23 states, "The nurse noted the resident was not in her room. A search was initiated inside the building. The resident was unable to be located. Elopement procedure was initiated. Staff began searching building and perimeter. 911 was called. On-call nurse (manager) made aware. Officers and medic arrived at approximately 8:55 PM.

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Resident located prior to police and ambulance arrival. Resident was returned to her room and EMT assessed resident. After EMT left, this nurse did full body assessment of the resident. No bruising, skin tears or scratches observed. VS (vital signs) stable. BS (blood sugar) checked and neuro-check done and were within normal limits. Resident was asked if she had any pain and she denied pain or discomfort. When resident asked what she had been doing, she stated, "I was just out for a walk. I may have tripped but I am okay." Resident stated that she was a little bit cold. Resident was given a blanket and made comfortable in bed. Fifteen minute checks initiated. POA and Providers were called and notified."

R1's Physician's Order Sheet dated 8/29/23 shows that R1 has diagnoses including Frontotemporal Neurocognitive Disorder, Atrial Fibrillation and Polyosteoarthritis.

R1's Minimum Data Set of 6/23/23 shows that R1 has moderate cognitive deficit. (8 on a scale of 0-15)
This same document shows that R1 requires supervision for walking in her room and in the corridor.

R1's Elopement Screen date 6/29/23 shows that R1 is High Risk for elopement.

On 8/30/23 at 10:20 AM V10 (RN) stated, "My shift ended at 6:00PM, I had already given report and I was finishing my charting so I could leave. I heard the alarm, I got up and checked the doors by the nurse's station in the 200 wing. There is a panel by the nurse's station and it says front door, side door etc. There were no lights on the panel but the alarm was going off. (V4-LPN) said she

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was going to check the back door of the 200 wing and she was going to walk the perimeter of the building. The alarm was going off about 6:30 PM and I left the building about 7:00PM. The alarm was not going off anymore when I left. The CNAs both said they checked their rooms and everyone was there. I saw (V4) as I was leaving and I think I said to her- Everything good? and she said yes."

On 8/29/23 at 2:30 PM V9 (CNA) stated, " I came in at 6:00 PM. I spent time in Dining Room and I took care of (R1's) roommate about 6:15 PM-6:20 PM and (R1) was in her room. When the alarm went off I was on the floor, I was on the end of the hallway so I checked the door. I don't remember if (V4) was down there. The CNAs are usually the ones to check the doors. I looked out the door, this alarm was going off a very long time. Longer than usual. I checked both doors (on the 200 wing). I don't know which door is making the alarm. The alarm to the porch door has a code-I put the code in and the the alarm didn't stop. That is the most popular door that people use. The door at the end is the Fire exit- I checked that one too. I can look out the door but can not get out that door. The alarm kept going. I don't know how the alarm turned off. I went to nurse's station. V10 was checking the alarms. I continued working and I didn't see anyone else around. (V4) was sitting by the computer and the alarm was going off. (V10) just said we don't know what happened. I didn't get any orders from anyone- it was chaotic, 20-30 minutes all this was going on. When I realized there was no one on the floor, I just stayed on the floor. I did not go outside and look for anyone."

On 8/29/23 at 9:10 AM V4 (LPN) stated, " I went to give (R1) her meds at 8:30-8:40 PM and she wasn't there (in her room). We searched the

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building and she wasn't there. We didn't find her. We called V3 (Assistant Director of Nursing) and then we called 911 and started looking outside. CNAs went out all over and one of the CNAs drove up towards the animal control building and (R1) was up there. She was just standing around and V13 (CNA- Certified Nursing Assistant) said she thought she was a volunteer. Then she got (R1) to get into the car. That all took about 20 minutes. The last time I saw (R1) was at dinner. Dinner is about 6:00 PM.
I think (R1) went out one of the doors in the back of the 200 wing. We heard the alarm go off and I did a search and I didn't see anyone. I went to the side door and walked around the whole building and I didn't see anyone. That was about 7:15 PM. I was at the nurse's station (when the alarm went off). I had two CNAs- (V5 and V9- CNAs) (V13) is the CNA that found her. (R1) got into (V13's) car and came willingly back to the facility. (R1) had no injuries. She said that she tripped but she is not a good historian. She was found about 8:55 PM. 911 arrived the same time she was found. They assessed her and then they left. (V2 -Director of Nursing) and (V3) also came to the facility. (R1) has a (Electronic monitoring device). We try to notice what she is doing. She wanders around the building after dinner most of the time. It was just me that looked when the alarm went off about 7:15 PM. I just assumed that since people push on that door all the time it alarms and then they walk away, I assumed that is what had happened."

The Sheriff's Department Call for Service Report dated 8/27/23 shows that the call came in to them regarding a missing person at 8:51 PM.

On 8/29/23 at 10:00 AM V2 and V3 (interviewed together) stated, "We have discovered through

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our investigation that it was the alarm at the end of the 200 wing. It went off about 7:10-7:15 PM. (V4) said she was there at the nurse's station. She looked out the door then went out the door across from the nurse's station, looked around by the screen porch. Then she turned left (going towards the door that was alarming) and walked around the building and then came back in and assumed someone had pushed the bar and not gone out. Around 8:30 PM (V4) went to administer(R1's) medication and (R1) was not in her room and she looked around the 200 wing and talked to the 100 wing nurse and asked if she had seen (R1). (V4) instructed everyone to look for (R1). They did not find her so (V4) sent staff outside to look for (R1). At 8:45 PM (V4) called (V3) and (V4) was instructed to look in every room at the facility. They had already initiated the search outside so (V3) instructed (V4) to call 911. V3 said she then notified (V1-Administrator) and (V2 -Director of Nursing).

V2 stated, "I live about 5 minutes away. Staff were all out looking for (R1) when I pulled in. (V13) found her at the animal control building and put her in the car and brought her back- (R1) was in the front seat, giggling. (R1) said "I went out for a walk". The EMT went to the room and assessed her when he left he said she seems fine. No reason to transport (R1) to the ER. (R1) will usually walk out there with the CNAs. Her family takes her out for ice cream. R1's private caregiver takes her out for walks. We have never seen her attempt to open the door and go out."

V3 stated, "(R1) needs to be with people that are similar to her. Now we are doing 15 minute checks, we have had the (Electronic Monitoring Device) on her. We try to redirect her to activities and she is usually easily redirected."

V2 stated, "That night she was wearing pants, a jacket and a hat. She had her (Electronic

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Monitoring Device) on her shoe- white rubber shoes. We put it on the shoes because she keeps taking it off. We are still investigating. (V4) said she walked the whole perimeter of the building and she did not see anybody. (R1) walks well but I don't know how she walks on uneven ground."
V3 stated, "When the alarm triggers- (V4) said she walked around the perimeter. Two people should go and then do a head count if no residents are found outside. We should at least look for those residents that are at risk or elopement."

On 8/29/23 at 9:30 AM V8 (Maintenance) stated, " I check the alarms every Friday. I remember what happened next door and I don't want that to happen here. A lady died."
On 8/30/23 at 10:45 AM V8 stated, "The door panel is not part of the system and has not worked for at least 15 years, since I have been here. There is no way to tell which door is alarming, If a door alarms you have to go to THAT door and push the button or enter the code in order to turn the alarm off. Someone has to physically push the button to stop the alarm from sounding. "

At 9:35 AM, Surveyor and V8 walked the suspected route that R1 took from the exit door at the end of the 200 wing to the Animal Control Building, across the grassy field. V8 used a wheeled measuring device and measured 798 feet from the facility door to front door of the business. (It was later discovered that R1 was found in the back of the building). The grassy field was bumpy and uneven with many divots.

On 8/30/23 at 2:27 PM V5 (CNA) stated, " I was working on the 200 wing when (V13-CNA) came

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down and asked if I had seen (R1). That was about 8:00 PM. About 7:15 PM the alarm had gone off. I was toileting a resident in the hall bathroom and when I came out the alarm was going off. Everyone was running around looking for the alarm so I took the resident back to their room. (V10-RN, V4-LPN and V9- CNA) were all looking for the alarm. Then the alarm shut off. Then about 7:30 PM the alarm went off again. (V10) was up at the front door with a resident from the 100 wing (R2) and her (Electronic Monitoring Device) had set off the alarm. (V10) took (R2) back to her room and I went back to working on my hall. Then about 8:00 PM, me and (V9) were in a room putting a resident to bed with a (mechanical lift). (V13) came and asked me if I had seen (R1) and I told her I had not seen her since after dinner. I told (V9) I was going to go outside and I told her to stay on the floor. (V13) went outside with me. Then (V13) said she was going to go get her keys and go out in her car. We continued to look around the building. Other staff came out too. Then I called (V13) and I was on the phone with her when she found (R1). (When (R1) came back to the facility) (R1) was in the car and smiling as usual. She didn't have an injuries and (R1) just said, "I went for a walk." I have heard that (R1) has tried to get out a couple of times but she has never actually gotten out."

On 8/30/23 at 2:40 PM V13 stated, " I saw (R1) at supper about 6:15 PM when we were taking everyone back to their rooms. Me and the other CNA on the 100 wing were putting someone to bed when (V4) and the other nurse asked us if we had seen (R1). The other CNA went outside right away and I started looking all over the building, every room I could get to. I saw (V5) and (V9) and asked them if they had seen (R1). (V5) went outside and (V9) stayed on the floor. Then I went

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outside and we were looking through the fields with our cell phone flash lights. I said to (V4), "Should we call the police?" and she told me to calm down, we are going to find her and to just keep looking. I decided to go in and get my keys and take my car and start driving around. I told everyone I was going to drive over to the cemetery (across the street from the facility) and then they all came over and started looking through the cemetery too. We were driving around and then the other CNA got in my car and we drove over to (Assisted Living Facility) (Located on the opposite side of the facility from the cemetery) because (R1) used to live there so I thought maybe she went over there. We went to the front door and it was locked so we pushed the buzzer and asked if they had seen a lady walking around outside. They said No so the other CNA walked back to the facility and I decided to turn right (came from the left) out of the parking lot and go up by the animal control building. It was dark so I really don't know where I pulled in but I saw a white van so I kind of pulled in at an angle. I turned on the road just past the building (back of the building) and I thought I saw someone. At first I thought is was her and then I thought it was a man so I started to back up and leave. Then I thought I could ask the man if he had seen a lady walking around. I pulled forward again and realized it was (R1). I told (V5) on the phone that I think I found her. I got out of the car and called her name. She was between the building and a white van that was parked there. I could hear a lot of dogs barking. (R1) saw me and she smiled. She said, "I was looking for everyone." I told her we have been looking for her and I was going to take her back home. I helped her get in my car and I told her I was going to honk the horn and not to be scared. Then I honked the horn several times to let everyone else know that I had found

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S9999	Continued From page 10 (R1). When I pulled into the parking lot there were 2-3 cop cars and about 6 staff members. (V2 and V3) were there and a couple of family members that were visiting another resident were out there too. (R1) seemed happy and content. The police went up to her and talked to her. She didn't have any dirt on her or anything. She looked fine." On 8/29/23 at 2:00 PM, V7 (R1's Physician) stated, "As I understand it, she wandered outside away from the facility The problem is she wants to leave and she can't. The family does not want her in a locked unit which would be the second floor at (Sister Facility). The facility is between a rock and a hard place. We need (The State Health Department) to help us out. (R1) is in danger if she goes out, I can agree with that but what are we supposed to do? The family doesn't want her at (Sister Facility). Aside from monitoring the doors as much as they can, with the weather being so nice people want to be outside and even if things are controlled, things are going to happen." On 8/29/23 at 11:35 AM, R1 was in her room, walking in just socks, talking to staff. R1 sat down on the bed with Surveyor to talk. R1 stated, "There are wonderful people here, I love it here." Surveyor asked about her walk she took the other night. R1 stated, "I never thought it was such a big deal. I don't remember what door I went out but I'm sure I went out a door. I didn't climb through the window. I was going out for some air- some cooler air. That sounds weird because I am always freezing. I went to the green trees. Like the ladies bathroom has but theirs are gold. Like little leaves, very simple. I think I came back in the wheelchair, it wasn't cold outside or raining. I wouldn't go out in the rain. I didn't fall or hurt	S9999		

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S9999	Continued From page 11 myself. I was at the green seats and we talked and then she left and I said ok I'll go in now. I just went out to get some cool air. It frustrates me sometimes. I just feel so light and just want to be outside... My daughter got me these good shoes (pointing to shoes on the floor in front of her) I try not to get too involved with the drama around here. I try to keep everyone happy." R1 picked up her shoes to put them on. R1 stated, "That is a little alarm" (R1 pointed to the electronic monitoring device on her right shoe) "so I don't go out!" R1 got up and walked to the hallway. R1 stated "Want to see the green room? It is at the end of the hall." Surveyor walked with R1 down the hall as R1 left her wheelchair outside of her room and walked unassisted with slow steady gait. As we approached the 2 chairs at the end of the hall, R1 stated, "Oh, those chairs are gold, I see them as green. We just sit here and talk or read." R1 motioned for Surveyor to sit in one of the chairs. (The chairs are located next to the Exit door R1 used on 8/27/23) R1 sat for a minute. Surveyor asked R1 if she ever went out the door. R1 got up from the chair and walked to the door. R1 stated, "This door, I opened it." R1 was pointing to the door on the right of the double doors. R1 tried to push on the door on the left but did not use much force. R1 stated, "Oh, this one must be locked for a reason." (Door was opened earlier by V8 and Surveyor- alarm sounded without difficulty) R1 sat back in the chair and talked about the books on the table between the chairs. "I look at all the books and find one I like to read." R1 looked at Surveyor and smiled, "I would really like to set off that alarm and let you hear it." Surveyor asked R1 if the alarm goes off often and R1 stated, "No only once about every 2 years." Surveyor then encouraged R1 to walk back to her wheelchair and get ready for lunch. R1 stated she was thirsty and hungry. R1	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005706	A. BUILDING: ______ B. WING ______	C 08/31/2023

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S9999	Continued From page 12	S9999		

ambulated back down the hall and found her wheelchair in the hallway where she left it. Staff then assisted R1 to sit in the chair and wheeled her to the dining room. While passing the restrooms in the hallway outside the dining room, R1 stated, "When did they change those cushions? (2 benches outside the restrooms with a similar pattern as the chairs at the end of the 200 hall) "They used to be green and now they are gold." R1 continued into the dining room, smiling and very pleasant.

On 8/29/23 at 3:45 PM, V1 (Administrator) stated that the facility did not have a policy regarding expected staff response to triggered alarms.

The Police Report dated 8/27/23 states, "On 8/27/23 at approximately 2055 hours (8:55 PM) I (V14) received a call from dispatch for a missing person from (Facility) which is a local nursing home in (Facility City)...
I then spoke with (V4)... I asked (V4) when the last time she did rounds to ensure patients were accounted for. (V4) replied that there was no scheduled checks for individuals but rather they monitor the citizens by walking down the hall periodically throughout their shift. I then asked (V4) when she last saw (R1) and she replied she last saw (R1) at dinner time which is around 1800 (6:00 PM). I then asked (V4) about the alarm that tripped on the door and at what time that was. (V4) stated it was between 1900-1911 hours (7:00 PM- 7:11 PM). I asked (V4) if she checked the door immediately once the alarm triggered and she states she checked it within 3-4 minutes of the door triggering. (V4) stated she checked the interior and the exterior and did not see any citizens so assumed it was a false trigger. I then asked (V4) at what time did she notice the (R1) was missing. (V4) stated at approximately 2045

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hours (8:45 PM) she was performing medication rounds and found that (R1) was not in her room. (V4) stated she then checked the interior of the building in an attempt to locate (R1) as she sometimes wanders into other citizen's rooms. (V4) stated that when she could not locate (R1) she called 911..."

R1's Progress Notes dated 7/4/23 state, "Patient presented with an altered mental status, increased confusion and aggression. She packed up her belongings into a wheelchair and she ran towards front entrance and attempted to elope. Staff redirected her, but she was combative, hitting and pinching staff. Four staff attempted to redirect her with ineffective results. NP (Nurse Practitioner) witnessed patient's manic episode, ordered Haldol (Antipsychotic) shot, one time dose. Notified POA, he asked to speak with her and get (her) to head back to her room. Patient was at door, on her phone for another hour before redirection was effective. Did not administer shot at this time."

R1's Care Plan dated 6/26/23 states, "(R1) has exhibited movement behavior that may be interpreted as wandering or roaming as she is able to propel self in wheelchair independently in the facility. Resident exhibits short term memory deficits and impaired decision making skills." The interventions related to safety include, "(Electronic Monitoring Device) for safety. (Electronic Monitoring Device) placed on R1's shoe." R1's Care Plan also states, "(R1) may be at risk for potential abuse related to cognitive deficits. elopement attempts. refusing care. verbal/physical aggression at times, being impulsive and not remember her physical limitations, fall risk due to her impulsiveness and cognitive deficits, need for physical care and

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supervision."

On 8/31/23 at 3:35 PM, V3 stated that the interventions that were put in place on 7/4/23 worked because R1 did not elope. So there was no need to put any other interventions in place.

The undated facility policy (Created on 8/30/23) states, "No alarm should ever be shut off without verifying the cause. If no identifiable cause for the triggering of the alarm can be found, you must leave the alarm on until the cause of the alarm is identified and follow the steps below. a) Ask staff, visitors, venders or residents in the vicinity if they saw anyone trigger the alarm. b) Search the perimeter outside the door that alarmed for the cause of the alarm. c) Account for all residents identified to be at risk for elopement. d)Account for all residents residing in the facility. "

(B)