

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009740	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/06/2023
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NAME OF PROVIDER OR SUPPLIER WASHINGTON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 NEWCASTLE WASHINGTON, IL 61571
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S 000	Initial Comments Facility Reported Incident of 5/26/23/IL160458	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3100d)2) 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. 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		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.</p> <p>Section 300.3100 General Building Requirements</p>	S9999		

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S9999	Continued From page 2 d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide adequate supervision, failed to ensure exit door alarms were answered immediately by staff, failed to develop and implement a monitoring schedule as directed by the facility's policy for a known wandering resident, failed to ensure staff were aware of residents they were responsible for monitoring and providing care for one of three residents (R1) reviewed for elopement risk in the sample of three. These failures resulted in cognitively impaired resident (R1) with a known history of wandering, who required assistance of staff for locomotion and walking, exiting the facility without staff knowledge and for an undetermined amount of time, being found wandering aimlessly and confused, across the street from the facility approximately 400 feet from the facility. The street R1 had crossed was a street with a high activity of traffic. Findings include: The facility's Door Alarm Policy (undated)	S9999		

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S9999	<p>Continued From page 3</p> <p>documents, "When a door alarm sounds, staff shall: 1. Check the alarm panel to determine which door has been opened. Do not assume someone else has already done this. 2. Check the exit door for any exiting resident by means of a visual check. Also perform search of the building parameter for exited resident."</p> <p>The facility Wandering Residents policy dated 08/2006 documents, "Every effort will be made to prevent wandering episodes while maintaining the least restrictive environment for residents who are at risk for elopement. All residents who are at risk for harm because of wandering will be assessed. If a resident repeatedly wanders off the unit, a monitoring schedule will be implemented to ensure resident safety. The resident's care plan will be documented as to the implementation of the monitoring schedule."</p> <p>The facility's Elopement and Search (Code Pink) policy dated 02/2014 documents, "Policy: To establish methods for protecting residents who are at risk for elopement and for conducting an organized search for a resident who cannot be located. Policy Specifications: 1. All nursing personnel are responsible for: a. Knowing the whereabouts of residents for which they are assigned. c. Staff are responsible for keeping the nurse informed of a resident's whereabouts 3. Residents are not allowed to leave the building unless a physician order is present. 7. All personnel are responsible for promptly going to the location and determining the cause of the activated audible door alarm. 8. When a resident makes repeated/continuous attempts to leave the building, the resident will be visibly observed every fifteen (minutes) until the behavior has resolved."</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R1's Admission Note dated 6-1-23 and signed by V12 (R1's Physician) documents, "(R1) admitted to (facility) from (assisted living facility) on 2-21-23 with Alzheimer's Disease due to the inability to provide self-cares and wandering. (R1) is conversational but confused making history unreliable or unknown."</p> <p>R1's MDS (Minimum Data Set) Assessment dated 2-27-23 documents R1 is a 69-year-old that was admitted to the facility on 2-21-23. This same MDS Assessment documents R1 is moderately cognitively impaired, requires one assist of physical assistance of staff for locomotion on and off of the unit and for walking in R1's room and in the corridor, and has a behavior of wandering.</p> <p>R1's current Elopement Risk/Wanderer Care Plan last updated 5-30-23 does not include a monitoring schedule.</p> <p>R1's Elopement Evaluation dated 2-21-23 documents R1 is at risk for elopement and has a history of elopement or an attempted elopement while at home, a history of elopement or attempted leaving the facility without informing staff, has verbally expressed the desire to go home or stayed near an exit door, wanders, and wanders aimlessly or non-goal directed (confused, moved without purpose, may enter others' rooms, or explore others' belongings).</p> <p>R1's Fall Risk Evaluation dated 5-22-23 documents R1 has intermittent confusion, had balance problems while walking, and is at risk for falling.</p> <p>R1's Nursing Admission Note dated 2/21/2023 at 7:16 PM documents, "(R1) admitted to facility</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>from home. Residents' family at facility upon residents' arrival. Resident was a resident at (Assisted Living Facility) prior to going home. Resident has Alzheimer's diagnosis. (R1) known to wander at last facility. (R1) alert with confusion."</p> <p>R1's Social Service Note dated 2/24/2023 at 4:49 PM documents R1 does wander the facility and expressed wishes to leave and has a Wander guard on to help keep him safe.</p> <p>R1's Nursing Note dated 5/26/2023 at 4:30 PM and signed by V5 (Agency RN/Registered Nurse) documents, "Writer received a call at the southwest nurses station regarding (R1). The young woman stated, 'I'm walking with (R1). I used to work at a facility he was at, so that is how I recognized (R1).' Writer alerted (R1's) nurse that patient was outside. Writer went to assist (R1) back into building. (R1) was talkative, no physical or verbal aggression noted. (R1) refused to state how he was let out of the building. (R1) denied pain or discomfort. Nurse notified that (R1) was back in facility."</p> <p>The facility's Daily Assignment Sheet dated 5-26-23 documents V8 (Agency CNA) was directly responsible for R1's care and monitoring on 5/26/23 between 2:30 PM and 10:30 PM. This same Daily Assignment Sheet documents V9 (Agency CNA) was working a different section on the hallway R1 resided on and V11 (RN) was the nurse responsible for R1's care and monitoring on 5-26-23 from 1:45 PM through 10:30 PM.</p> <p>R1's Facility Incident Report Form dated 5-26-23 and signed by V3 (Assistant Director of Nursing) documents, "Diagnosis and Mental Status: Alzheimer's Disease, Asthma, Epilepsy,</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>Hypothyroidism, Dementia, History of Falling, Unsteadiness on Feet, Muscle Weakness, Unspecified Lack of Coordination, and Non-Compliance with other medical treatment and regimen due to unspecified reason. (R1) was observed outside by the assisted living facility across the street. They (assisted living) called this campus to inform us. (R1) was brought back inside and assessed by the nurse. No unusual findings. POA (Power of Attorney), MD (Medical Doctor), DON (Director of Nursing), and Administrator made aware. (R1) is being observed for any change in mood, status, or behavior. Wander guard (electronic monitoring device) in place and alarm sounded. (R1) stated (he) followed someone outside and was just looking around. Investigation initiated."</p> <p>On 6-1-23 at 8:50 AM V4 (CNA/Certified Nursing Assistant) stated, "I heard (R1) left the building unattended by staff the other day. (R1) is always wandering throughout all halls of the facility. (R1) gets confused and is not always aware of his surroundings. I am not sure if (R1) would know where he was going if he went outside without staff. (R1) is not on a monitoring schedule that I am aware of. I just try to watch (R1) more if I can."</p> <p>On 6-1-23 at 9:15 AM V5 (Agency RN/Registered Nurse) stated, "I was doing a medication pass around 4:30 PM and got a call from a staff member at the assisted living facility across the street from the facility that (R1) was walking on the sidewalk of the east side of the assisted living in front of a church and ballfield. I am not sure the name of the assisted living staff. The assisted living staff member recognized (R1) from taking care of him in the past and called the facility to report he was outside. I left and went</p>	S9999			

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S9999	<p>Continued From page 7</p> <p>across the street to bring (R1) back into the facility. (R1) stated he was just taking a walk and would not tell me how he got out of the facility. I did not know the front door alarms were sounding until the assisted living staff member called to report (R1) was at their facility. Both the Wander guard (electronic monitoring device) door alarm and the regular door alarm were sounding when I had left the building to go get (R1). If residents with Wander guard are sitting in the room next to the alarm, the Wander guard door alarm is always sounding so sometimes we are not even sure if a resident has left the facility. We get used to hearing the alarm. We (facility staff) did not know that (R1) left the facility. When I returned him to the building, he was fine and had no injuries. The weather was nice and was not raining."</p> <p>On 6-1-23 at 9:25 AM V6 (Agency CNA/Certified Nursing Assistant) stated, "I was working the front south hallway and was told (R1) had gotten out of the building unattended on (5-26-23). I did not hear any of the front alarms working when (R1) had gotten out the front door. I was not the staff member responsible for (R1) that night. (R1) is frequently trying to get out the front door and is sneaky. I have heard (R1) tries to leave behind visitors when the visitors leave the facility. An employee of the assisted living building had found (R1) walking on the sidewalk across the street from this facility. I let the nurse (V5) and (R1) back in the front door when (V5) had gone to get (R1). (R1) was not in any distress. (R1) is always trying to get out of the facility. (R1) gets confused. If we had enough staff (R1) should have a one-on-one staff member to watch him more closely."</p> <p>On 6-1-23 at 10:30 AM V3 (Assistant Director of</p>	S9999		

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S9999	Continued From page 8 Nursing) stated, "(R1) always wanders on all hallways. I am not aware of a specific monitoring schedule to increase (R1's) supervision. (R1's) care plan does not have a monitoring schedule. (R1) was not put on 15-minute visual checks until after he left the facility unattended (5-26-23). (V8/CNA), V9 (CNA), and V11 (RN) were the staff responsible for (R1) on 5-26-23 when (R1) left the building without staff. (V8) would have been his direct staff that was responsible for (R1) as (V8) was assigned to the Northwest hallway for the half of the residents that included (R1). I do not know how long (R1) was outside unattended by staff. I was told (R1) was found by the church across the street." On 6-1-23 at 10:45 AM V8 (Agency CNA) stated, "I do not know who (R1) is or what (R1) looks like. I worked the Northwest hallway on (5-26-23) from 2:30 PM through 10:45 PM. I was never told on (5-26-23) that (R1) got out of the building unattended. I was not (R1's) responsible staff member on (5-26-23)." On 6-1-23 at 10:50 AM V10 (RN) stated, "I know (R1) lived up on the front hallways before and was always trying to leave out the front doors. (R1) has wandered since admission and always tries to leave. (R1) is hard to re-direct. (R1) was not on any type of frequent checks before. I am not aware of (R1) ever actually getting out of the facility without staff or being found at the assisted living facility. I know within the last few days (R1) has been on 15-minute visual checks. I do not know why (R1) has been put on 15-minute checks. (R1) is definitely not safe outside by himself. (R1) would not know where he was." On 6-1-23 at 11:30 AM V6 (RN Shift Supervisor) stated, "I was working the evening that (R1)	S9999		

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S9999	Continued From page 9 eloped (5-26-23). (R1) had a history of attempting to leave the building at the facility he lived at prior to admission to this facility. (R1) is always wandering all hallways and attempts to leave the building frequently, especially out of the front doors. I cannot remember who told me that (R1) had gotten out of the facility without staff. I went up to the front hallway as soon as I was told (R1) was found and both the Wander guard alarm and door alarm was sounding. I cannot answer why staff had not responded to the alarms. I did not ask the staff when they had last saw (R1) that night before he had left the facility unattended. (R1) did not have a monitoring schedule prior to 5-26-23. I started 15-minute checks the night of 5-26-23. (R1) is unsafe to leave the building unattended. (R1) had poor safety awareness and has Dementia." On 6-1-23 at 8:45 AM R1 was walking the North-West hallway independently. R1 was confused to time and place when asked and stated, "I did not do it" when asked if he had gone outside without staff. On 6-1-23 at 12:00 PM this surveyor viewed the streets and church where R1 was found on 5-26-23. The facility's front parking lot exits onto a high traffic road. The sidewalk across from the facility is located parallel to the high traffic road and wraps around to the east to an additional high traffic road. The church (R1) was found in front of is located approximately 400 feet from the facility. These two roads have a high level of traffic due to having a central school located on these roads and multiple businesses. (A)	S9999		