STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002364	A. BUILDING: _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE DANVILLE	1701 NORTH BOWMAN DANVILLE, IL 61832

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S 000	Initial Comments Complaint Investigation 2460400/IL1468768	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 1 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. Section 300.3100 General Building Requirements 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 interview and record review the facility failed to properly monitor a door alarm and failed to ensure a resident did not exit the facility unnoticed (elopement). This failure resulted in R4 leaving the facility alone and unsupervised for over 1 hour and 16 minutes. This failure affects one (R4) of three residents reviewed for elopement in the sample of 5. R4 had potential for serious injury and/or death due to the inclement winter weather and residents' poor safety awareness of walking in the street. R4's hands and face were exposed to dangerously	S9999		

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S9999	Continued From page 2 cold temperatures increasing potential of frostbite. Findings include: R4's Facility Census documents R4 was admitted to the facility on 7/1/13 and has the following medical diagnoses; Schizophrenia, COPD, Malignant Neoplasm of Bladder, Epilepsy, Solitary Pulmonary Nodule, Hypertensive Urgency, Peripheral Vascular Disease, GERD, Dry Eye Syndrome, Hydronephrosis, Hyperlipidemia, Vitamin Deficiency, Constipation, Pain, and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. R4's Minimum Data Set (MDS) dated 12/25/23 documents R4's Brief Interview for Mental Status (BIMS) score 9, moderate cognitive impairment. TheWeatherChannel.com documented the temperature in (city) at 6:53 pm was 6 degrees Fahrenheit. Facilities Video Camera still photo's document R4 left the facility on 1/15/24 at 6:41.22 pm and returned at 9:03.39 pm. R4's Police Report#2024-00000349 documents on 1/15/24 at 7:06 pm V17 Police Officer was dispatched to (local address) avenue (local High School), (city) and arrived at 7:06 pm. Upon arrival, V17 located R4 just west of (local address) street walking westbound in the middle of the westbound lane. V17 had R4 get into V17's squad after R4 stated R4 was freezing. R4 stated R4 was looking for R4's residence (local address) Avenue but could not find it. R4 then explained that it was a glass house. V17 drove to (local address) Avenue and pointed it out to R4. R4	S9999		

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S9999	Continued From page 3	S9999		

stated that wasn't the house and the house is on the Northside of (local address) Avenue. R4 was explained at the even addresses were on the Southside of the roadway. R4 appeared confused asking V17 if they nuked the area because R4 didn't recognize it. R4 also notified V17 that R4 was told to 'walk off' and that was why R4 was outside walking. V17 drove R4 up and down (local address) Avenue for about 15 minutes it was decided to take R4 to the emergency department at (local address). Prior to going to the ER dispatch attempted to locate an address for R4 but was unsuccessful. While in the ER the staff at the front desk notified V17 that R4's last known address was (local address) Avenue. V17 recognized that to be nursing home. ER staff provided V17 with the nursing homes phone number. After about a 5-minute conversation the staff initially stated R4 did not reside there then they recanted and found R4 lived in the North building. Staff at the south building put V17 on hold while they transferred V17's call to the North building. The staff at the North building answered and hung up almost immediately. V17 called back and was hung up again then had dispatch make the phone call to confirm R4 was residing at a local residential address. V17 transported R4 back to the nursing home. Outside in the parking lot was V19 off duty supervisor, who was on scene to pick up son. V19 escorted R4 back inside to the staff on scene working.

R4's Nursing Note dated 1/15/23 at 8:30 pm documents at 8:08 pm, call received from V8 Licensed Practical Nurse (LPN) regarding a call from the local police department that R4 was picked up. Call placed to V1 Administrator and Regional nurse consultant, Medical Doctor (MD) and R4's Power of Attorney (POA) made aware. Upon review of the camera footage, determined

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S9999	Continued From page 4 R4 left the facility at 6:41pm and shut alarm off. R4 was wearing street clothes, shoes, and winter coat. Call placed to police department to verify. Officer notes first call placed at 7:06 pm, second 7:07pm. Police contacted R4 and at that point was placed in police car. R4 stated R4 lived at (local address) Avenue and officer drove R4 up and down the block a few times before going to a particular house where R4 believes R4's dad lives. R4 was brought back to the facility. Called placed to the hospital and noted R4 had not been taken to the emergency room. On arrival to facility, head to toe assessment unremarkable. R4 confused and slightly agitated. R4 denies pain. Placed on 15-minute checks upon arrival. On 1/16/24 at 11:15am R4 said, last night (1/15/23) after dinner R4 left the facility to go to R4's dad's house in (city). R4 said, R4 was wearing shoes, socks, blue jeans, a sweatshirt, and a winter jacket with a hood. R4 said, it was a little cold out. R4 said, it was dark out and R4 couldn't find the address on the building and kept looking. R4 said, a police officer picked R4 up and brought back to the facility. On 1/17/24 at 9:35 am V9 Certified Nursing Assistant (CNA) said, V9 worked on 1/15/24 from 7:00 pm to 7:00 am in the North Building Psychiatric Unit. V9 said, when V9 got to work there were no residents outside smoking. V9 said, when V9 reports to work, V9 goes to the nurses' station and gets report from the prior shift, on resident behaviors, residents out of the facility and any other pertinent information regarding residents. V9 said, V9 then walked the halls, checking V9's residents to make sure they were all accounted for. V9 said, V9 is not sure if V9 saw R4 in the building that evening. V9 said, at around 8:00 pm V8 Licensed Practical Nurse	S9999		

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S9999	Continued From page 5	S9999		

(LPN) informed V9 that R4 was picked up by the police walking down (local address) Avenue and was bringing R4 back to the facility. V9 said, when R4 returned to the building R4 went back to R4's room and V8 assessed R4. V9 said, when the door alarm sounds, staff should go to the door and check to make sure no resident has left the facility. V9 said, there is a camera located at the nurses' station that captures the front door, and staff usually looks at it and check to make sure no one has left the building.

On 1/17/23 at 10:12 am V8 Licensed Practical Nurse (LPN) said, on 1/15/24 V8 was working the 7:00 am to 7:00 pm shift in the North Building Psychiatric Unit. V8 said, V8 got report from the previous shift and did not know that R4 was not in the building. V8 said, the Certified Nursing Assistant (CNA) should check to see if all their residents are accounted for, and report back to V8 is any were not accounted for. V8 said, around 8:00pm, V8 received a call from the local police department and was given R4's name and date of birth to check to see if R4 resided in the facility. V8 informed them R4 did reside in the facility. V8 said, the police informed V8 they had R4 at the hospital after several calls of R4 walking around the street. V8 said, they brought R4 to the hospital in an attempt to identify and find out where R4 lives. V8 said, the police brought R4 back to the facility a short time later. V8 said, when R4 came back to the facility, V8 asked if R4 was in any pain, and R4 said "no" R4 was fine. R4 just wanted to go to R4's room. V8 said, R4 would only let V8 assess R4's hands. R4 is always reluctant to get a body assessment. V8 said, R4's hands and face did not have frostbite. V8 said, V8 and V9 later went back to R4's room and were able to check R4's feet which were ok. V8 said, V8 notified V1 Administrator, V2 Director

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S9999	Continued From page 6 of Nursing and R4's Power of Attorney. On 1/18/23 at 9:50 am V2 Director of Nursing said, on 1/15/23 at around 8:10pm, V2 received a call from V8 Licensed Practical Nurse (LPN) that R4 has exited the facility and was pick up by the local police department. V2 said, V8 informed V2 the police were bringing R4 back to the facility. V2 said, upon review of the camera footage, R4 left the facility at 6:41 pm and shut the audible alarm off at the front door. V2 said, R4 was wearing street clothes, shoes, and winter coat. V2 said, the alarm panel at the nurses' station was still ringing and flashing. V2 said, staff should have gone to the front door to determine what set the alarm off. V2 said, at this time the 7:00 pm shift was arriving to work, and the dietary workers were leaving to the main building. V2 said, V2 called the police department to verify. V2 said, police dispatch informed V2 they received the first call at 7:06 pm and second at 7:07 pm. V2 said, police made contact with R4 and R4 was placed in police car. V2 said, R4 informed the police officer that R4 lived at (local address) Avenue and the officer drove R4 up and down the block a few times before going to a particular house where R4 believes R4's dad lives. V2 said, the police officer brought R4 to the emergency room to see if they could assist in identifying where R4 lived. V2 said, staff were able to identify a last known address and the officer recognized it as the nursing home. V2 said, contact was made with the facility, and it was verified that R4 was a resident at the facility. V2 said R4 was brought back to the facility at 9:03pm. On 1/19/24 at 11:40 am V1 Administrator said, on 1/15/23 V1 was notified by V2 Director of Nursing (DON) that R4 had left the North Psychiatric building and was brought back to the facility by	S9999		

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S9999	Continued From page 7 the police. V1 said, as soon as it was learned that V4 was located outside of the facility by the police a head count was conducted, and all residents were accounted for. V1 said, R4 has been a resident at the facility since 7/1/13 and has never attempted to elope. V1 said, R4 has never been an elopement risk. V1 said after the incident V15 Maintenance went to the facility and reviewed the video footage of the North Psychiatric building front door. The video showed on 1/15/23 at 6:41 pm R4 leaving the building wearing gym shoes, blue jeans, winter jacket and maybe gloves, and returning to the facility at 9:03 pm. V1 said, V1's expectations of staff when a door alarm goes off, staff should verify by going to the site of the alarm and verifying that no resident has left the building. V1 said, if staff is unable to verify who has left the building should have performed a head count, which was not done on 1/15/24. (A)	S9999		