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	IL6006399	A. BUILDING: _____ B. WING _____	C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE MORTON VILLA	190 EAST QUEENWOOD ROAD MORTON, IL 61550

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S 000	Initial Comments Complaint Survey: 2421263/IL169825	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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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 were NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to provide adequate supervision during a facility fire as directed by the facility's policy for a known wandering resident with Dementia, failed to ensure staff were aware of the exit doors being unlocked when the fire alarm sounded and their responsibility to monitor wandering, confused residents during an emergency, and failed to keep the Wandering Resident binders updated, completed, and accessible for two (R2 and R9) of three residents reviewed for Elopement risk in a sample of 10. These failures resulted in a cognitively impaired resident (R2) with a known history of wandering, who required supervision or touch assistance by staff for locomotion and walking, exiting the facility without staff knowledge for approximately twenty minutes, being found after ambulating approximately 400 feet, crossing a one lane, low traffic, side street after midnight in the dark, going door to door at an apartment complex. The street in front of the facility approximately 400 feet from the apartment complex where R2 was located is a two lane street with moderate activity of traffic

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and a 35 mph (mile per hour) speed limit.

Findings include:

A. The facility's Emergency Operations Plan-Fire Alarm/Detection System policy, dated 11/1/17, documents "Purpose: Code Reference: Facilities shall have and maintain a plan for the protection of all persons in the event of fire, or other emergency, which would require either relocation or evacuation." This policy also states: "Code Reference: For nursing homes/hospice facilities, the proper protection of residents requires the prompt and effective response of health care staff. The basic response required of staff includes removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of residents." This policy goes on to state "3. Emergency Incident Command. 6. Assign supervision of those residents requiring special attention or services, such as wandering, confused, non-alert, or intellectually disabled residents."

On 2/14/24, at 1:00pm, R2 is lying in bed awake, talking insensibly. V6 Agency Certified Nursing Assistant/CNA is seated in the room with R2.

On 2/14/24, at 1:05pm, V6 CNA stated the following: "I am her one on one. I am an agency CNA. I heard that during the fire (R2) got out and was over at the apartments inside someone's apartment for about 45 minutes. I think she heard the alarm, and it was her natural instinct to get out. I did not work that day but worked the day after. She is not really a wanderer. She walks

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back and forth out in the hallways but had never tried to leave before that I know of. She would stop at the exit doors and look out. She will push on the bar, but when it alarms, she'll step back."

On 2/14/24, at 2:15pm, V4 Environmental Services Director stated that the exit doors automatically unlock when the fire alarms go off.

R2's Elopement Risk Assessment, dated 1/25/24, documents R2 has a diagnosis of Dementia, has the physical ability to leave the building, spends time on the first floor or wanders between floors and units, is a risk to elope at this time and placement on the Elopement Risk Protocol is indicated.

R2's Minimum Data Set/MDS assessment, dated 1/22/24, documents R2 is severely cognitively impaired, wanders, and requires supervision or touching assistance for ambulation.

R2's Fall Risk Assessment, dated 2/8/24, documents R2 is disoriented x (times) three at all times, has balance problems while standing and walking, jerking or unstable when making turns, requires use of assistive device, and is at risk for falling.

R2's current Care plan includes: R2 is an elopement risk/wanderer related to Dementia, ambulatory, and recent history of attempt to elope on 2/9/24 and additional comorbidities. R2 is an elopement risk/wanderer related to history of wandering off property at home prior to admission to facility, Dementia, ambulatory, and additional comorbidities.

R2's Progress Note, dated 2/9/24 at 3:54am by V7 Licensed Practical Nurse/ LPN, documents:

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"Resident was wandering and exit seeking during fire incident. Alarms and locks on doors were checked and intact during initial attempt to exit. Resident redirected away from door. When staff went to assist other resident's, staff eventually noticed resident was not in area. Staff began to look for resident. Management informed staff that resident was noted by police in residential apartment across the street. Resident assisted back to facility for cares, assessments, and monitoring. Full body assessment completed, and 15 minute checks initiated. All notifications were notified."

On 2/15/24, at 1:55pm, this writer viewed the path out the exit door that R2 eloped from. The sidewalk has a slight downward slope and there is a high curb to step down into the side street.

On 2/16/24, at 2:38pm and on 2/21/23 at 10:19am, V11 CNA stated the following about the night of the fire: I saw (R2) in another resident room, R2 got out of there and was redirected, but I didn't see (R2) try to get out. When the fire alarms sound the exit doors get disabled, I guess. (R2) moves very quickly. V11 continued to state that no one was assigned to monitor the wanderers. Our main thing to do when the fire happened was to get everybody out of their rooms. (R2) was in my group. (R2) is a wanderer so have to keep a close eye on her and pay attention. (R2) has pushed on exit doors before; she pushes on everything.

The facility's Daily Assignment Sheet dated 2/8/24 documents the third shift nurse assigned to R2's (B) Hall was V7 Agency Licensed Practical Nurse/LPN; R2 was assigned to V10 and V11 CNA's group of residents.

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On 2/16/24, at 5:26pm, V7 Agency LPN, confirmed V7 was working on B Hall the night of the fire. V7 stated the following: V12 LPN was giving lots of orders and seemed to be taking charge. No one was assigned to watch the wanderers. (R2) wanders around the building. I noticed (R2) went to one of the exit doors. I didn't see her push it. I checked the door, and it was locked, and the fire alarms were sounding. Afterwards they said that eventually when it switches to the generator the doors unlock. V7 stated "If it is a known thing that these (exit) doors unlocked then most definitely wanderers should be supervised. I don't think staff knew that. Not sure they have the staff for that though because they have a lot of elopement risk residents so doors should be watched."

On 2/20/24, at 1:50pm, V1 Administrator confirmed the fire alarm sounded on 2/09/24 at 12:01am. This writer viewed the camera footage of R2 exiting the facility during the fire emergency with V1 Administrator. R2 was pacing the hall, going in/out of resident rooms, and standing by and looking out the exit door several times. At 12:32am R2 slipped out the exit door at the end of B hall. At 12:45am V11 CNA noticed R2 was missing. At 12:48am V1 announced to staff a resident was over at the apartment (per police notification). Staff took off running out the door including V1 Administrator and V11 CNA. At this time, V1 stated that a policeman came up to V1 in the front lobby area and informed V1 a resident was over at Apartment 10; the owners had called police. Police didn't know who the resident was. At 12:50am V1 came back in from outside the exit door then at 12:52am R2 was seen escorted back into facility at the B Hall exit door then placed in a wheelchair upon entrance.

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On 2/20/24, at 2:22pm, V12 LPN confirmed V12 worked on A Hall the night of the fire and stated the following: The nurse who was the Registered Nurse/RN was who was to be in charge. So (V21 RN) was in charge and they were reporting to (V21) what we were to do and (V21) was relaying it back to us. Not aware if anyone was put in charge of wanderers. They said afterwards that when the fire alarms go off the exit doors become unlocked. I did not know that before the fire, but it was only my second day. There could have been someone to monitor wanderers, but there is not a lot of staff at night to assign someone. There is an emergency plan at the nurses' station. I think it said that B wing nurse should be in charge, but not that someone should be in charge of the wanderers.

On 2/20/24, at 2:47pm, V21 RN confirmed V21 was working on A Hall the night of the fire and is an Agency nurse. V21 stated the following: I was not specifically in charge for the emergency. From my understanding the fact that they had the Director of Nursing/DON (V2) there (V2) would have been in charge of everything.

On 2/21/24, at 9:30am, V10 CNA stated the following regarding the night of the fire: I originally had (R2) in my group, but due to a call off I took a different group of residents. The exit doors unlock once the fire alarms go off, 15 seconds later. I suspected it beforehand but didn't know for sure until afterwards. No one was designated to watch the wanderers specifically. V10 stated that (R2) is confused and that it is unsafe for (R2) to be outside without supervision.

On 2/21/24, at 11:13am, V2 Director of Nursing/DON stated the following: After I got here, I would have been considered the person

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S9999	Continued From page 7 taking charge. V2 confirmed (R2) is a wanderer. (R2) was in her room when I got here. (V7 LPN) and I got (R2) out of (R2's) room and (V7) took (R2) to the nurse's station. After that I don't think I saw (R2) again. No one was assigned to specific wandering residents. No one was assigned to watch exit doors, but they were in sight from nurse's station. (R2) did not have 1:1 during the fire. V2 is unaware that the facility's Emergency Operations Plan-Fire Alarm/Detection System policy documents that supervision is to be assigned to the wanderers during a facility fire emergency. (A)	S9999		