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	IL6006878	A. BUILDING: _____ B. WING _____	C 05/15/2024

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S 000	Initial Comments Complaint Investigation: 2452958/IL171941 2453374/IL172565 2453369/IL172558	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3) 300.3210t) 300.3240a) 300.610a) Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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	S9999		

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the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

These regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure residents were free from sexual abuse for 3 of 3 (R2, R9, R11) residents reviewed for abuse in the sample of 34. This failure occurred on 4/23/24 when V4 (Physician/Co-Medical Director) asked to see and touch R9's genitalia (inappropriate word for female genitalia), while R9 was sitting in the lobby of the facility near the front doors. R9 stated this had been going on for a few months, she would get upset by V4's behavior, her anxiety would rise before he was scheduled to visit, and she began wondering if she had said something to initiate this behavior and began blaming herself. R9 stated she was afraid to tell anyone because it would be her word against his and no one would believe her.

Findings Include:

1. On 4/23/24 at 12:50 PM, this surveyor was sitting in the beauty shop waiting on a staff member to interview. This surveyor heard a male voice and a female voice start a conversation. They were not in the line of sight of this surveyor but were close enough to the beauty shop to hear their conversation. He asked if she was leaving. She told the man no she was just sitting. The conversation continued between the male and female voice and then the male voice asked her if he could see her pu**y and then asked if he could touch her pu**y. This surveyor stepped to the door and both the woman (later identified by staff as R9), and the man identified by this surveyor as

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V4 (Physician/Co-Medical Director) were there. R9 was sitting on a seat located just outside the beauty shop door and near the front doors of the facility. V4 was standing in front of R9. V4 exited the facility and this surveyor sat down next to R9, after asking V37 (RN/ Registered Nurse) who was coming for an interview to wait just a minute. This surveyor asked R9 if she knew who the man was and she said he was the doctor who comes to the facility. This surveyor asked R9 if V4 said something unusual to her and she said, "Oh, that is just how he is," and shrugged her shoulders.

On 4/23/24 at 12:51 PM, V37 (RN) identified the resident sitting in the lobby speaking with V4 as R9.

On 4/23/24 at 1:15 PM, R9 agreed to speak with this surveyor and wanted to talk in the beauty shop. This surveyor asked R9 if V4 had said something inappropriate to her. R9 stated he had and that he had done it before. This surveyor asked R9 if we could get a staff member to speak with us and she agreed. V2 (DON/Director of Nurses) was the first staff member this surveyor located in the conference room. V2 went with this surveyor to the beauty shop where R9 was waiting. This surveyor informed V2 this surveyor heard V4 say something inappropriate to R9. R9 told V2 that V4 had asked to touch her breasts and vagina and had been asking it for several months. R9 told V2 she thought V4 was joking at first but that it had gotten worse. V2 left with R9 to report the allegation to V1 (Administrator).

The facility Verification of Incident Investigation/Administrative Summary date of incident 4/23/24, documents under Brief description of the incident/event: "An allegation was made by the (state survey agency) surveyor

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that she overheard V4 (Physician/Co-Medical Director) make an inappropriate sexual comment to resident (R9). Administrator notified and investigation immediately initiated. (V4) exited the facility immediately after alleged incident and then was informed by staff that he could not return to facility pending outcome of investigation ...Resident has been observed, assessed and/or interviewed, showing potential effects related to allegation. Such affects have been addressed and care plan has been updated .... A comprehensive investigation was initiated on 4/23/24. (State survey agency) surveyor alleged that (V4) asked resident (R9) "if he could see her pu**y." Upon interviewing (name of state surveyor) she stated that she heard (V4) state that but did not hear if R9 said anything prior to that. (State Surveyor) was unsure of general conversation or what was said in between or what had been said prior to that. (State Surveyor) stated she observed (V4) in front of (R9) but there was no contact observed by (State Surveyor). (R9) stated in her interview that (V4) asked to see "her breasts and vagina." (R9) said that it had been going on a couple of months and she had never told anyone. (R9) denies saying anything sexual to (V4) on 4/23/24. (V4) was interviewed and stated as he was leaving the facility (R9) was near the front door and asked him if he wanted to touch her tits and pu**y. (V4) stated he repeated to her what she said for clarification and then he advised (R9) that he absolutely did not want to touch her and never would do so. Interview with V48 (MDS Coordinator, RN/Registered Nurse) in which she stated that there have been several times where (V4) stated to (V48) that he would not go to (R9's) room without someone with him as she often comes off as inappropriate in a sexual manner, speaks of multiple boyfriends while attempting to

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display herself flirtatiously. Review of records note on visit on 8/14/23 that (V4) notes in his medical visit with (R9) that "she tends to flirt with all the males and that is not a secret. She tells you that. She says she has many boyfriends." Also noted, "She flirts with all the men and does show them dirty pictures on telephone and that is the first I knew about it today." Residents interviewed denied (V4) had said anything inappropriate and had no concerns with his care. Staff interviewed had not witnessed (V4) say anything inappropriate to residents but had been witness to (V4) stating he did not want to go into (R9's) room by himself due to her inappropriate behavior. The facility does not substantiate the allegation as (V4) stated he was repeating what she said and that (R9) propositioned him. There are notes of (R9's) behavior noted in previous MD (physician) progress note on 8/23 and staff have also heard (V4) express concern of going by himself due to her flirtatious behavior prior to this allegation. The residents and staff have not had any concerns with (V4's) care. (R9) denies he stated the word "pu**y", and her account is not the same as what was reported. (R9) remains at baseline and has had no negative psychosocial outcome ...Follow-Up Actions Taken: Trauma Assessment completed. Abuse assessment completed. Discussed the choice of changing attending Physician with resident and decision was made by resident to change. Psychosocial assessment and follow up in progress. Care plan was reviewed and updated by IDT (Interdisciplinary Team). (V4) is assisted on rounds for all residents and will continue to be assisted by a licensed nurse while in the building." There is an x next to Responsible Party, Attending Physician, (name of survey agency)/Licensing and Certification, Ombudsman, Local Police Department; indicating

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they were notified of the allegation with no dates or times of notifications documented.

On 4/30/24 at 10: 20 AM, R9 was interviewed and was found to be alert and oriented times three. R9 denied hallucinations, delusions, and paranoia. When asked if she had anxiety R9 stated, "depends. When under stress, it goes up a lot." R9 stated V4 had been her primary care physician since she was admitted to the facility. R9 stated at no time during her interactions with V4 did he appear confused or disoriented. R9 stated V4 sees her "a lot, he is here about every week or every other week." R9 stated she felt like she was getting good care from V4 and there was nothing unusual in his interactions with her until a few months ago. R9 stated that is when V4 started telling her, "You are pretty," and asking, "Do you have a boyfriend." R9 stated, "I felt at first like he was trying to make me feel good and raise my spirits." But then he started saying, "I have never seen you naked, maybe I need to." R9 stated, "He (V4) did not say that (he needed to see me naked), and then give me a physical exam and I did not believe he was talking about giving me an exam. I felt like he was suggesting something sexual. I felt like his behavior was inappropriate for a doctor. I told him there was no reason to see me naked and I told him if I did need a physical exam, I would have another doctor do it, not him." R9 stated, V4 began to get worse with his comments, saying "he wanted to play with my pu**y and breasts." R9 stated she previously stated V4 used the word "vagina" but the actual word he used was "pu**y" but she was ashamed to say that word. R9 stated, "I told him he was going too far in saying things like that and he would laugh and act like it was a joke." R9 stated she would get upset by V4's behavior and her anxiety would rise before he was scheduled

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to visit wondering, "what will he say or do today?" R9 stated she began wondering if she had said something to initiate this behavior and blamed herself. R9 stated he had never actually touched her except to take her pulse. R9 stated V4 did not threaten her not to tell, but he told her, "This conversation is between us, its personal, not professional." R9 stated she was afraid if she told staff, it would be her word against his and nobody would believe her. R9 stated, "I just wanted to try to handle it by myself." R9 stated V4 never said anything inappropriate in front of staff, and usually staff were with him. R9 stated after V4 was done seeing everyone he would, "sneak back into my room when they weren't looking." R9 said she was glad the surveyor heard what V4 said so that now he will stop. R9 stated staff called her in the office after the surveyor reported what she heard and questioned her about it and had a bunch of papers she had to sign. R9 stated she "felt like staff felt as though I had led him on in some way, although nobody actually said that." R9 stated staff did not tell her they reported it to the police and the police had not contacted her. R9 stated she would not be comfortable with V4 as her physician and the facility had told her they would get her another physician. R9 stated R11 is a younger resident and she had asked R11 if she had ever experienced V4 saying or doing anything inappropriate to her and R11 stated V4 had been telling R11 she was pretty.

On 5/1/24 at 1:45pm, V52 (Family Member) stated, on 4/23/24 or 4/24/24, "She (R9) told me that her physician (V4) made inappropriate comments to her. She (R9) said she was sitting out in the front lobby area by the entrance, and he (V4) was leaving, and he (V4) said something to the effect of 'I want to see your boobs and vagina and touch your body.'" V52 stated mom is friendly

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and told V52 that she was worried that by being friendly she somehow brought his behavior on. V52 stated she told R9 his (V4) conduct was inappropriate and she had not done anything to cause it and it was not her fault. V52 stated this was the first time R9 said anything about him acting that way. V52 stated she didn't think R9 had any residual effects from the incident aside from being somewhat stressed out about it. V52 stated she didn't think R9 understood the severity of what he did until the surveyor heard it and came out and asked her about it. V52 stated R9 had no history of sexually inappropriate behaviors. V52 stated R9 has no history of making up allegations against staff. V52 stated she believed her mom as there is no reason not to.

On 5/2/24 at 3:13 PM, when asked if he could describe what happened with R9 on 4/23/24, V4 ((Physician/Co-Medical Director)) stated, R9 always propositions him. V4 stated it was not the first time. V4 stated he said, "absolutely no" and walked out the door that day. When asked if he recalled the conversation, he had with her that day in the lobby he said she was asking him to touch her. V4 stated he could not really remember what was said but something like that. V4 stated that R9 was always flirting. V4 stated R9 was always asking him to touch her. V4 stated he would tell her to go away, and she would come up and flirt. V4 stated most of the time it happened in the cafeteria. V4 stated when he would see residents someone (staff) was with him but that didn't matter to R9, she would find him. V4 stated he didn't think R9 was cognitively with it. V4 stated the facility reported she had alcoholic dementia. When asked how many times R9's behaviors occurred, V4 stated in excess of 10 times. V4 stated it was documented in R9's

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progress notes. When asked if he could recall the dates of those notes, V4 stated no that is what the facility told him. V4 stated he wasn't sure how long he had been R9's doctor but it had been maybe a few years. V4 stated he was not her doctor prior to R9 coming to the facility. V4 stated he only sees residents in nursing homes. V4 stated the last word he said to R9 was "absolutely no," and has not seen her since. V4 stated he wasn't sure if he was still R9's doctor.

On 5/1/24 at 2:05 PM, R22 stated none of the female residents have made inappropriate sexual comments to him, nor shown him inappropriate material. R22 stated R9 told him, "a couple of weeks ago," that she was upset because she was having problems with her doctor saying things to her he shouldn't say, saying he wanted to see her naked or to see her "t**ties" or something like that. R22 stated he told R9 she needed to tell somebody, but she didn't want to. R22 stated, "from what I've heard he's (V4) a big flirt."

On 5/7/24 at 10:00 AM, V3 (CNA/Certified Nursing Assistant) stated the last abuse in-service they had was maybe a couple of weeks ago, she's not sure. V3 stated she had never witnessed R9 being provocative or sexually inappropriate with any male staff or residents. V3 stated she had never seen R9 dress inappropriately.

On 5/7/24 at 10:05 AM, V56 (CNA) stated the last abuse training they had was this past Friday. V56 stated she had never witnessed R9 being inappropriate or sexually inappropriate with male staff or residents, nor dressing suggestively.

On 5/7/24 at 10:10am, V57 (CNA) stated they went around with a training for the staff to read

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and a sign in sheet about abuse within the past week. V57 stated she had seen R9 showing male residents' stuff on her phone, but hadn't seen what they were looking at, so she can't say whether it was sexual in nature. V57 stated she had not seen any inappropriate sexual behavior on her part toward staff or residents. V57 stated she had not witnessed R9 dress inappropriately.

R9's Admission Record with a print date of 4/29/24, documents R9 was admitted to the facility on 7/31/22 with diagnoses that include unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anemia, alcoholic hepatitis.

R9's MDS (Minimum Data Set) dated 1/31/24 documents R9 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R9 is cognitively intact. This same MDS documents under Mood that R9 is assessed as having little interest or pleasure in doing things, feeling down and depressed, trouble falling and staying asleep, and feeling bad about yourself- or that you are a failure or have let yourself or your family down. This same MDS documents R9 has no behaviors, and no potential indicators of psychosis.

R9's current Care Plan documents a Focus Area of "(R9) displays attention seeking behaviors which can be disruptive, insensitive and/or disrespectful to staff and peers. Ned (sic) for immediate gratification. Date Initiated: 07/14/2023 ..." Interventions for this care area initiation date of 7/14/23 include, "Assure the resident that staff are more than willing to address legitimate concerns ...Educate resident on appropriate means of requesting help for self or others ...If the residents use "We" statements intervene by

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saying "Please speak for yourself. Please use 'I.' Tell me what YOU want. Let other residents speak for themselves." .... Inform the resident that he/she may share his thoughts, needs and feelings with on (sic) identified staff member ...Psych eval and tx (treatment) as necessary .... Remind resident that if emergent situation exists, staff will call 911 as appropriate ...Set Limits ..." R9's Care Plan documents a Focus Area of "Anxiety: As manifested by Situational anxiety. Date Initiated: 08/01/2023, Created on: 08/01/2023." This Focus Area documents interventions dated 08/01/2023 that include, "Anti-anxiety medication as ordered ...Encourage resident to identify and express causes of anxiety ...Encourage to participate and discuss personal care ..." There is no Focus Area for sexually inappropriate behaviors documented in R9's Care Plan.

R9's Abuse Risk Assessment dated 4/25/24 documents the following risk factors were identified; history of chemical or substance abuse, persistent anger, fear, or anxiety, diagnosis of dementia, history of unsanitary living conditions, and attention seeking behaviors.

R9's Behavior Monitoring and Interventions Report dated 4/30/24 documents, "No results found for selected parameters."

R9's Physician/Order Progress notes signed by V4 (Physician/Co-Medical Director) document the following:
12/5/22- "Purpose of Visit: This lady is back to normal, totally cognitively intact. Takes care of all activities of daily living. I forget why she is here, but the examination is totally, totally normal. I am asking (V48) MDS/Care Plan Coordinator, who knows her well, how much of this is related to

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alcohol? Probably a lot but we are unsure. She is getting ready to go back home and that I hope is not a problem." There is no documentation of inappropriate sexual behavior on this physician progress note.
1/2/23- "Purpose of Visit: She takes care of all activities of daily living. She is getting ready to go home is what I have said before, but she is not home. She appears to have some cognitive impairment but what can she do for herself? Everything. Physical exam, review of systems, laboratory, medication. Now we are not sure about her going home. I looked at medications."
2/7/23- "Purpose of Visit: toxic encephalopathy, malnutrition, alcoholic hepatitis without ascites, difficulty walking, altered mental status. She is back to normal. 15 out of 15 MMSE (Mini Mental State Examination) I watched her walk .... So, she has all of the above problems, now solved so to speak ... She specifically is on no psychotropic ..." This physician progress note does not document any sexually inappropriate behaviors.
4/24/23- "Purpose of Visit: she was admitted actually with toxic encephalopathy, alcoholic hepatitis without ascites, malnutrition, difficulty walking, altered mental status. Her cognition returned to pretty well normal. This toxic encephalopathy was apparently related to alcohol. She is up and about, taking care of all activities of daily living, telling me she can fry chicken real well because she ran a golf course restaurant which specialized in barbeque, and I am sure this is true. Actually, the heart, lungs, and abdomen negative. She will be going according to the daughter to an assisted living, so most of these have been resolved .... I want to make sure I have her on vitamin D. I looked at all the medicine she is on, and she is on appropriate vitamin D. I do not really see anything that we need to discontinue. Now, the question is when

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she goes home, will she start drinking again, an unanswerable question. Of course, when she goes to assisted living, it might a (sic) little more difficult to get." There is no documentation of inappropriate sexual behavior on this physician progress note.
6/12/2023- "Purpose of Visit: She was admitted with inability to care for self. I am seeing her for routine care plus a "itchy" dry place anterior aspect of the right lower leg just above the ankle. She has obviously been scratching it because of scratch marks. She says she is not. I think this is dry skin. I asked (V48), care plan coordinator, has she cleared cognitively since admission. Yes, dramatically. She does everything by herself. She is ready for discharge but there is no home for her. I say that because she was admitted with toxic encephalopathy, alcoholic hepatitis, ascites, malnutrition, altered mental status, difficulty walking. This appears, as I have said before, quite normal. I watched her walk. She had normal gait and balance. Used a wheeled walker. Is not falling. Review of systems totally negative. I looked at many blood pressures, pulses- they are all normal. She is doing not well, very well. She is on vitamin D, Artificial Tears, Dulcolax, Iron, folic acid, loratadine, Milk of Mag, omeprazole, Tylenol, B1, zonisamide." There is no documentation of inappropriate sexual behavior on this physician progress note.
8/14/2023- "Purpose of Visit: She is homeless. She has a daughter who just had a baby, and she tends to flirt with all the males and that is not a secret. She tells you that. She says she has many boyfriends, but I am seeing her for routine required evaluation. She has a history of toxic encephalopathy apparently due to excessive alcohol. I have talked about that before. But actually, she does everything herself; feeds, clothes, bathes herself. Does she have any

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problems: I do not think so. She flirts with all the mean (sic) and does show them dirty pictures on her telephone, and that is the first I knew about it was today. She has actually recovered it appeared form alcoholic encephalopathy but the heart, the lungs, the abdomen negative. She wants nothing. And she will probably be a permanent resident here. Her vital signs look good. Heart, lungs, abdomen as stated negative. She has been to behavioral health at (name of regional hospital). They said she had dementia with aggressive behavior. I do not see that, and she certainly does not have aggressive behavior. Inappropriate behavior. She is on very minimal medication. She is on iron with no recent laboratory."
10/16/23- handwritten note that documents, "stable, history of alcohol, cares for self, homeless."
12/19/23- handwritten note that documents, "Needs to go home, oriented x (times) 4, exam all ok, Ok to go home."
2/13/24- handwritten note that documents, "Does everything, Dx alcoholic encephalopathy ..."
4/23/24-handwritten note that documents, "Can care for self- can live alone Past diagnosis alcoholic dementia now BIMS 15 Ok to DC (discharge). I told her return if she wish."
There is no documentation of inappropriate sexual behavior on the physician progress notes dated 10/16/23, 12/19/23, 2/13/24, and/or 4/23/24.

R9's Progress notes from 8/03/23 to 4/4/24 contain no documentation of inappropriate sexual behavior, boyfriends, or sharing inappropriate material with anyone. R9's progress notes document a late entry dated 4/23/24 that documents, "Alleged allegation of inappropriate statements made to resident from physician.

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Resident was taken to a safe area, surveyor reported to DON (V2), DON (V2) reported to ADMIN (administrator/V1), confirmed resident was safe, and physician was immediately suspended from facility until further notice of investigation and findings." R9's Progress Notes document continue to document the following 4/30/24, "Spoke to resident in regards to her MD (physician). Resident stated she would like to have a different MD that is in the (name of town) area for when she discharges to home. Physicians in (name of town) reviewed. Resident did decide she would like to use (name of physician) as her facility physician. MD contacted and did accept." 4/30/24 7:37 PM, "Spoke to V4 and advised that facility had completed investigation and allegations are unfounded at facility level. Furthermore, advised V4 facility continues to await response from (State Survey Agency)."

R9's electronic medical record including care plan, progress notes, behavior tracking, and tasks do not document any behaviors including sexually inappropriate behaviors were being tracked and/or occurred.

2. On 4/30/24 at 3:15 PM, R11 stated V4 is her primary care physician, and he sees her about once per month. R11 stated R9 told her a few days ago that she was sitting in the front lobby area when V4, "Talked to her bad, he said he wanted to play with her breasts and finger her vagina." R11 stated "A bunch of us residents have talked about V4 being a big flirt." R11 identified R2 a resident who passed away and R31 a resident who moved as being some of the residents who discussed V4 being a flirt. R11 stated V4 would say to them, "You're a pretty woman, what are you doing in here?" R11 stated,

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R2 and R31 interpreted that as him trying to lift their spirits. R11 stated V4 had also told her she was pretty. R11 stated, "a few months ago he told me his wife had died and in the same conversation he told me he was going to write me a prescription for a boyfriend, and I felt like he was hinting for a date." R11 stated, "The last visit I had with him, not sure what the date was. I was uncomfortable, he started talking about his car, how fast it goes, what a good deal he got on it, how nice it is, and I thought, is this dude trying to ask me for a date?" R11 stated V4 had never touched her inappropriately and staff were always with him in her room. R11 stated she believed R9 when she told her about her encounter with V4. R11 stated she had known R9 pretty well for a while now and from what she had seen R9 is not the type of person to make stuff up or be dramatic to get attention. When asked how she felt about continuing to have V4 as her physician, R11 stated, "I never wanted him in the first place, everybody knows he's a quack. I asked him why my legs swell up and he said, "it's because your fat."

On 5/2/24 at 9:40 AM, R31 denied concerns with V4.

R11's Resident Information sheet with a print date of 5/3/24 documents R11 was admitted to the facility on 12/09/23 with diagnoses that include malignant neoplasm of long bones, diabetes, asthma, morbid obesity, hypertension, mass and lump right lower limb, sleep apnea, major depressive disorder, adjustment disorder with anxiety, post-traumatic stress disorder, anxiety disorder, panic disorder, malingering, chronic cluster headache, leiomyoma of uterus, and bone transplant.

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R11's current Care Plan documents a Focus Area of "This resident has the potential for abuse/neglect r/t (related to) Depression diagnosis, psychiatric diagnosis or manifestation, including delusions, paranoia, and hallucinations, Underlying factors that increase vulnerability; including such as dementia, confusion, poor judgement, wandering and giving away personal property." The interventions for this Focus Area include assess coping skills and support system, consult psychiatry as indicated, encourage to discuss feelings, give choices regarding personal care, monitor/documents any signs/symptoms of potential self-harm or harm directed at others, notify physician of any at risk behavior, perform risk assessments as needed, set limits to ensure safety. R11's diagnoses listed in her record do not include a diagnosis of dementia.

R11's behavior tracking sheet for April and May 2024 documents no behaviors were observed.

R11's progress notes document the following
5/2/24 5:18 PM, "Resident involved in allegation of abuse."
5/2/24 5:20 PM, "Call placed to V4 to advise him that he would not be able to come to building as resident has made an allegation that V4 made her uncomfortable during a visit and she feels that he wants a date with her. V4 expressed understanding that he cannot come to facility at this time."
5/2/24 5:47 PM, (name of officer) Badge number 45 was at the facility and did interview resident. (Name of officer) did come to my office and notify me that resident did refuse to write a statement. (Name of officer) did question resident in regard to accusation and resident denied any sexual verbal comments from V4. (Name of officer) notified me that he would make a statement if

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needed and I could stop by the (name of local police) for a copy this week. Will follow up this week to obtain a copy."

The Dispatched Event Details (police report) documents on 5/2/24 at 5:50 PM, V2 (DON) called and reported an allegation of verbal sexual abuse. Under Supplemental Event Notes the report documents, " ...On 5/2/24 at approx. (approximately) 6PM, I was dispatched to (name of facility). Upon arrival, I met with the Director (V2/DON). She explained that 2 of the residents had made allegations that a Dr (doctor) had made sexual advances to them. I went and talked to the first one, (R11). I asked what had happened, she said the Dr. had joked around with her but had never said any thing sexual in nature to her. She said he had said some things that made her uncomfortable but nothing sexual. I asked her to write a statement and she declined to make a statement. I then talked to (R9) she said the Dr. had asked to see her breasts and vagina. I asked what she said, and she said she didn't say anything and that there was a state inspector that overheard him say it. I then had her write a statement."

3. R2's Admission Record with a print date of 4/23/24 documents R2 was admitted to the facility on 8/16/23 with diagnoses that include osteomyelitis, diabetes, malignant neoplasm of colon, morbid obesity, and peripheral vascular disease. R2's MDS dated 4/9/24 documents R2 is independent with decision making.

R2's Progress Notes dated 4/9/24 document, " ...Resident (R2) was taken to an appointment with (name of physician), her O2 sats were down and they were unable to get them up therefore resident was sent to the ER (emergency room) at

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(name of regional hospital)."

On 4/18/24 at 12:37 PM, V3 (Family Member) stated R2 passed away at the hospital on 4/10/24.

On 4/23/24 at 9:20 AM, V32 (Family Member) stated R2's physician (V4) made a comment to R2 one time when she had something wrong with her bladder. V32 stated V4 told R2 that she needed more sex.

The facility Abuse Policy dated 01/109/24 documents, "Purpose: To provide guidance and Procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Responsibility: the administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staff responsibility (sic) report any allegation or witnessed abuse immediately to the Administrator (Abuse Coordinator). Abuse Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and

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mistreatment of residents. Procedure: conducting pre-employment screening of employees and pre-admission screening of residents, orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property. Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. Identifying occurrences and patterns of potential mistreatment, identifying concerns of residents allegations of deprivation of goods and services by staff, immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property, implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences, assuring that physical restraints are used sparingly and properly, and that chemical restraints are not used and filing accurate and timely investigative reports ..."
Under Definitions the policy documents, "
...Sexual Abuse is non-consensual sexual contact of any type with a resident ...Non-consensual is defined as one of the following: 1) the resident may welcome the act, but the (sic) lacks the ability to consent 2) the resident does not want the contact 3) resident is unconscious/comatose 4) resident is sedated. This abuse includes, but is not limited to, unwanted intimate touching of any kind (especially of breast or perineal area), sexual harassment, sexual coercion, sexual assault such as rape, sodomy, or coerced nudity. Further examples include forced observation of masturbation or pornography, taking sexually explicit photographs, audio/video recording of a resident(s) and maintaining/distributing them.

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S9999	Continued From page 20 (This would include but is not limited to nudity, fondling or intercourse involving a resident). (B) Statement of Licensure Violations (2 of 3) 300.610a) 300.1210a) 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 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 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	S9999		

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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.

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 regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure residents assessed as being a high risk for elopement were adequately supervised and then failed to identify this same resident as an elopement risk after an elopement for 1 of 3 (R1) residents reviewed for accidents and supervision in the sample of 34. This failure resulted in R1, who had a history of confusion and was assessed as being a high risk

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for elopement, exiting the facility without staff knowledge, at an unknown time, walking 4.4 miles to a neighboring town along a busy highway where he was located by facility staff at 7:00 AM on 4/13/24.

Findings Include:

1. R1's Admission Record with a print date of 4/16/24 documents R1 was admitted to the facility on 1/30/24 with diagnoses that included disorders of circulatory system, diabetes with hyperglycemia, hypertension, hypercholesterolemia, atrial fibrillation, and tobacco use. R1's MDS (Minimum Data Set) dated 2/6/24 documents a BIMS (Brief Interview for Mental Status) score of 14, which indicates R1 is cognitively intact.

R1's hospital records dated 1/29/24 documents R1 was taken to the local emergency room by a friend and stated R1 was more confused than normal. "Pt (patient) alert to person and place only. Disoriented to time. Pt is currently homeless and has been staying with friends. They are trying to get patient into (name of homeless shelter) .... Patient has been approved but they cannot accept him until tomorrow at 1:30 for intake ...Pt states he has a home, but no running water or electricity. Suggested that pt return to his home for tonight as temperatures are not below freezing and go to (homeless shelter) tomorrow for intake ...." R1's hospital records document under neurological assessments R1 is alert and oriented to person, place, and time.

R1's hospital records dated 1/30/24 documents on 1/30/24 at 2:57 PM, (R1) ...with a past medical history that includes- DMII (diabetes mellitus), HLD (hyperlipidemia), HTN (hypertension), MRSA

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(methicillin resistant staphylococcus aureus) abscess, a-fib (atrial fibrillation) RVR (Rapid Ventricular Response), DKA (diabetic ketoacidosis) ---presents to the ER (emergency room) c/o (complaints of) being found walking through town and had soiled himself. Was going to be intake to (name of homeless shelter) today, but they canot (sic) take a dementia resident. He is asking to go to a SNF (Skilled Nursing Facility)." The hospital record documents under Medical Decision Making ...Details: Adult protective services caseworker (V46)."

On 4/30/24 at 11:18 AM, V46 (Adult Protective Services) stated that on 1/29/24 R1 was evaluated at the emergency room (ER) and was discharged. V46 stated R1 was supposed to go to a homeless shelter but either had forgotten or didn't call them. V46 stated R1 was found by friends wandering outside in the cold. V46 stated R1 was covered in feces and urine and had gotten frost bite. V46 stated R1 didn't recognize his friends so they contacted the police who contacted V46 on 1/30/24. V46 stated R1 was taken back to the hospital, and she felt like R1 needed placement in a long-term care facility. V46 stated she spoke with the ER physician, and he agreed. V46 stated after R1 was admitted to the facility on 1/30/24, she followed up with him at the facility. V46 stated she could recall the specific day but at that time R1 looked good, he was clean, and had friends at the facility. V46 stated she closed out R1's case since he was in the facility. V46 stated when she would see R1 he would not remember her, and she would have to remind him who she was. When asked if she would consider R1 safe to come and go independently from the facility, V46 stated, she would say so, but her concern would be R1 getting linked up with someone who would take

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advantage of him. V46 stated that is what happened with his home and stuff.

R1's regional hospital Progress Notes dated 1/30/24 documents, "SW (Social Work) informed that patient is in ED (Emergency Department) and requesting nursing home placement. Per chart, patient was accepted to homeless shelter yesterday, but they could not accept until today. Patient was found today by friend confused and wondering the streets. SW met with patient who confirms would like nursing home placement .... Patient states would prefer to stay in (name of town) but is agreeable to whatever facility can accept him at this time .... (Name of facility currently residing in) has accepted. Nurse updated patient. Facility to transport ...."

On 5/1/24 at 4:06 PM, V55 (Director of Social Service Regional Hospital) stated R1 was evaluated at the emergency room on 1/29/24 and was accepted by a local homeless shelter, but they didn't have an opening until the next day. V55 stated R1 had a home but it had no running water. V55 stated R1 was going to stay at his home that night and then go to the homeless shelter the next day. V55 stated R1 came back to the hospital the next day. V55 stated a different social worker saw R1 and his mentation had gotten worse so they decided it would be better for R1 to be placed in a nursing home. V55 stated R1 got really confused. V55 stated the physician didn't say he was confused it was the social workers assessment.

R1's current Care Plan documents a Focus area of "Potential Risk of Elopement-Exit seeking behavior Date Initiated 3/22/24." This Focus area documents the following interventions dated 3/22/24, "Place Electronic Sensor device to alert

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staff of exit attempt (or if unavailable, place on 1:1 observation) Routinely check device placement, check battery function, eval (evaluate) effectiveness ...Identify any patterns or exacerbating factors ...Maintain adequate I.D. (identification) ...Monitor residents interactions with peers to identify escalating tension, frustration or aggression; Intervene ...Monitor whereabouts regularly; Recognize any unsafe condition or escalating patterns ...Provide redirection and diversion as needed ...Respond to any alarm activation promptly ...try to identify reasons when possible. Address physical needs such as hunger, thirst, pain, toileting, hot/cold, emotional needs, fear/distress, loneliness, worry ..."

R1's Elopement Risk Assessments dated 3/8/24 documents a score of 02, indicating R1 is not at risk for elopement.

R1's Progress Notes document on 3/22/24 at 8:02 PM, "alarm sounding to side area yard that is fenced in. Nurse immediately went to alarm outside and found resident confused holding the fence on the inside of the yard, not leaving the premises. Head to toe assessment completed with no injuries noted to resident. Resident was immediately redirected to inside the building without any aggression or hesitation. Wander-guard was immediately placed on resident left ankle with 2 finger breadths noted. Resident placed on 15 minutes checks related to safety. MD (physician) and emergency contact notified with no concerns voiced at this time. Nursing management notified, and MDS notified for care-plan placement."

R1's Order Recap Report dated 3/24/24 to 5/31/24 includes the following orders, "Place

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wanderguard on resident for safety r/t (related to) exit seeking behaviors,". "Wanderguard check function Q (every) weekday shift every Fri (Friday) for Wandering," "Wanderguard - Check placement every shift for monitoring," all have a start date of 3/22/24.

R1's Community Safety Awareness Summary dated 3/22/24 documents a handwritten assessment that documents R1's prior living arrangements as homeless, that he lived alone and came to the facility for medical condition of frostbite. R1 is documented as having secondary comorbidities that include diabetes with no history of substance or alcohol abuse. The assessment documents R1 is alert and oriented to person, place, and time and makes decisions independently. This assessment documents R1 doesn't have difficulty focusing attention, is not easily distracted, doesn't have difficulty keeping track of what is said and is not on any antidepressants, antianxiety, sedative hypnotics, narcotic pain medications, or psychotropics. This assessment documents R1 is safe to ambulate independently and can cross a street independently with or without a light. It documents no potential risks and that R1 is safe to leave the facility on pass. This assessment is signed by V1 (Administrator), V2 (DON), V48 (MDS Coordinator) and V28 (Social Services Director).

On 4/30/24 at 3:56 PM, V1 (Administrator) stated the Community Risk Assessment dated 3/22/24 was signed by V2 (DON/Director of Nursing), V48 (MDS Coordinator), and V28 (Social Services Director/SSD). V1 stated they were all at the facility doing the assessment. When asked if she remembered what time it was done, V1 stated it was done early, sometime in the morning.

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R1's Documentation Survey Report VT2 dated March 2024 documents a behavior of wandering on 3/22/24 evening shift.

The next Elopement Risk Assessment for R1 found in the record was dated 4/3/24 and documents a score of 18, which indicates R1 is at high risk of elopement.

On 4/19/24 at 10:52 PM, V22 (Anonymous) stated on 3/22/24 R1 was outside and attempting to leave the grounds, and she convinced him to stay because it was cold outside. V22 stated R1 thought he was in a different town and didn't know he was in the town the facility is located in. V22 stated R1 did not have any health issues that would have caused the confusion.

On 4/24/24 at 1:49 PM, this surveyor reviewed R1's 3/22/24 progress note and asked V2 (DON/Director of Nursing) if there were alarms on the outside gate. V2 stated there were not. V2 stated she didn't know if she was contacted related to the incident on 3/22/24 that she would have to check into what this surveyor was talking about. This surveyor reviewed the progress note again with V2 and asked if that helped her remember. V2 stated R1 is not a high risk for elopement. When asked if she was aware R1 had been assessed as being at high risk for elopement V2 stated if it was at night, then no.

On 4/24/24 at 3:24 PM, this surveyor reviewed with V1 (Administrator) R1's 3/22/4 progress note where R1 was outside leaning on the fence, confused, and was assessed as being at risk for elopement. V1 stated she didn't know what else was going on that night and V4 (Physician/Co-Medical Director) said he was doing it as a safety measure. V1 stated V4

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(Physician) saw R1 prior to him being at the facility. When asked if she knew what happened on 3/22/24, V1 stated she read the note and she remembered the nurse saying R1 was outside holding on to the fence, but the note didn't say if R1 was trying to get out. V1 stated R1 was assessed as being a high risk for elopement at that point due to safety until he could be assessed. V1 stated V4 always wants to come in and look at the residents and talk to them. When asked if V4 came to the facility and assessed R1 after the 3/22/24 incident, V1 stated she wasn't sure.

On 4/19/24 at 9:40 AM, V24 (Dietary Aid/Cook) stated she was driving to work the morning R1 eloped and thought maybe she saw a resident walking by a restaurant in the next town over from the facility. V24 stated she called the kitchen around 6:00 AM and talked to V8 (Cook) and asked her to check on R1. V24 stated they checked to see if R1 was at the facility. When asked if anyone from administration had spoken with her after the incident, V24 stated, "No."

On 4/18/24 at 10:55 AM, V8 (Cook) stated she was working on the morning of 4/13/24 and she came to work around 5:00 AM. V8 stated she got a call from V24 (Dietary Aid/Cook) around 5:30 AM, who said they may have seen R1 walking in the next town near a restaurant. V8 stated they searched the facility and couldn't find R1. V8 stated she believed someone drove to the next town and found R1 after that.

On 4/16/24 at 3:39 PM, V9 (Certified Nursing Assistant/CNA) stated she came to work on 4/13/24 at approximately 5:45 AM and started working at 6:00 AM. V9 stated everyone was doing their normal routines and there was no

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indication a resident had eloped. V9 stated she was checking resident's vital signs and V26 (LPN/Licensed Practical Nurse) was passing medications like nothing was wrong. V9 stated a kitchen staff member (maybe V8/Cook) walked down the hall and after that V26 stated they needed to start looking for R1. V9 stated V26 looked a little frantic at that point. V9 stated she was told V24 (Dietary Aid/Cook) thought she saw R1 walking on the road toward the next town over. V9 stated after hearing that she realized she may have also seen R1 on her way to work but didn't see the person close enough to know if it was R1. V9 stated she told V26 she may have also seen him on her drive to work and V26 told her to go get R1. V9 stated she left the facility and drove to the next town. V9 stated she stopped at a gas station/store to see if they had seen R1. V9 stated they had seen a man walking but he had continued to walk. V9 stated she left that area and continued to drive and when she got to the interstate, she saw R1 walking under the overpass. V9 stated she parked her car and asked R1 what he was doing. V9 stated R1 said he had some in laws that lived by one of the local restaurants and he was going to see them. V9 stated she told R1 he scared them, and he got in her car, put the seat belt on, and she started to drive back to the facility. V9 stated she asked R1 what time he left the facility, and he told her about 10:00 PM the night before. V9 stated R1 said he had gone to the woods looking for a walking stick then to the railroad tracks where he found a piece of board and used that for his walking stick. V9 stated R1 told her a factory worker gave him a bag of chips and he sat and ate them. V9 stated R1's wander guard wasn't on him anymore, but she didn't know what happened to it. V9 stated R1 was in good spirits when she found him, but he said his feet and legs were very sore. V9

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stated she picked R1 up at 7:00 AM and got him back to the facility at 7:08 AM. V9 stated they looked for his wander guard and couldn't find it and while she was giving her statement to administration, they put another one on him. V9 stated V26 (LPN) gave her statement to administration first and V26 told them she noticed R1 was missing between 4:30 and 5:00 AM, but she (V26) had no reason to think R1 had left the building. V9 stated V26 didn't tell anyone she couldn't find him. V9 stated the first person to realize R1 was gone was V24 (Dietary Aid/Cook) who saw him walking on the highway. V9 stated V7 (LPN/Licensed Practical Nurse) who was also working said she saw R1 around 4:00 AM coloring. V9 stated there is no way he walked that far in 30 minutes. V9 stated V7 (LPN) didn't know R1 was missing until she got the phone call from V24 around 6:44 AM. V9 stated V7 then started notifying administration. When asked if she had any concerns with how the incident was handled. V9 stated, "Yes, it seems strange to me we had a resident missing and no one knew he was gone." V9 stated if they were doing bed checks every two hours, they should have known R1 was gone. V9 stated when V26 realized R1 was missing at 4:30 or 5:00 AM and didn't do anything about it, "to me that is neglect."

According to Google maps https://www.google.com/search?q=google+maps&rlz=1C1GCEB_enUS1019US1019&oq=google+maps&gs_lcrp=EgZjaHJvbWUqEggAEEUYOxiDARixAxjJAxiABDISCAAQRRg7GIMBGLEDGMkDGIAEMg0IARAAGIMBGLEDGIAEMhAIAhAAGIMBGJIDGLEDGIAEMhAIAxAAGIMBGJIDGLEDGIAEMgYIBBBFGDwyBggFEEUYPDIGCAYQRRg8MgYIBxAFGEDSAQgyNzg4ajBqN6gCALACAA&sourceid=chrome&ie=UTF-8 it would take the average person one hour and thirty-three minutes

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to walk from the facility to the location R1 was found which was 4.4 miles away. The path R1 walked was on US highway 50 which is a busy two-lane highway that is not well lit and merges into a four-lane highway once it nears the next town.

This surveyor attempted to contact V26 via telephone on at least three occasions with no answer and no return phone call. V26 is an agency nurse so is unable to be contacted at the facility.

On 4/18/24 at 10:26 PM, V7 (LPN/Licensed Practical Nurse) stated she worked from 7 PM to 7 AM on 4/12/24 and 4/13/24. V7 stated on the morning of 4/13/24, before 6:40 AM, she answered the facility phone and someone who she believed was V24 (Dietary Aid) told her they thought they saw R1 walking. V7 stated she checked with R1's nurse, started doing a head count, and had the CNA's looking for R1. V7 stated she called V49 (Wound Nurse), who didn't answer so she called V48 (MDS/Care Plan Coordinator), who answered, and then she called V1 (Administrator). V7 stated she started walking around outside the facility and when she came back in R1 was there. V7 stated she couldn't recall if she had seen R1 throughout her shift. V7 stated she does not work on R1's hall she always tries to stay on her hall close to the residents she is assigned to.

On 4/18/24 at 11:11 PM, V17 (CNA) stated she was working night shift on 4/12/24 when R1 left the facility. V17 stated she really didn't know what happened. V17 stated R1 was coloring around 12:30 or 1:00 AM but she couldn't recall if she saw R1 after that. V17 stated R1 is very independent and does everything himself. V17

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stated the nurse working on R1's hall was an agency nurse and she asked about R1 before 6:00 AM. V17 stated they went outside and R1's nurse went back in before she did. V17 stated then day shift arrived, and she left at 6:00 AM. V17 stated no management staff had talked to her about what occurred.

On 4/19/24 at 10:10 PM, V18 (Anonymous) stated she was working night shift on 4/12/24. V18 stated she didn't think R1 had a wanderguard on. V18 stated R1 likes to roam around, and she thought he was aware of the door codes. V18 stated she did have eyes on R1, and she thought R1 could have left when they started getting residents up on the morning of 4/13/24. V18 stated she didn't hear any alarms sound which is why she said she didn't think R1 was wearing a wanderguard. V18 stated she was in R1's room tending to his roommate quite a few times through the night. V18 stated on the morning of 4/13/24 she was in R1's room around 1:00 AM and then around 3:30 AM. V18 stated R1 was in his bed at those times. V18 stated she saw R1 go to the couch around 4:45 or 5:00 AM. When asked how she became aware R1 was gone from the facility, V18 stated she got a call from management and when they asked if she was working, she told them no thinking they were talking about when R1 attempted to leave a few weeks prior. When asked if anyone from management followed back up with her, V18 stated they had not. V18 stated when she came back to work on 4/13/24 there was a manager there due to a call in and they told her to do 15-minute checks on R1 and to check the door alarms.

On 4/19/24 at 10:31 PM, V20 (CNA) stated she was working on 4/12/24 when R1 left the facility.

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V20 stated it was a normal night and she didn't realize R1 was missing until she left around 6:30 AM. V20 stated she saw what she thought was R1 walking down the main street in the next town over. V20 stated R1 was near the interstate walking with a stick. V20 stated she called the facility and spoke with an unknown nurse and asked them to see if R1 was at the facility. V20 stated the nurse said she would and never called back. V20 stated she didn't work on R1's hall that night but she did see R1 in passing around 1:00 or 2:00 AM. V20 stated V48 (MDS/Care Plan Coordinator) called her around 8:00 AM and asked if she had heard any alarms and if she had seen R1. When asked if there was any training after the incident, V20 stated she wouldn't say training. V20 stated they had them sign a paper, but administration didn't talk with night shift. V20 stated she knows staff were talking about a nurse knowing R1 was missing about an hour before she (V20) called the facility. V20 stated she thinks they aren't noticing things like they should. V20 stated she didn't really talk with R1 much, just some small talk. V20 stated they don't get information on residents' cognitive status. V20 stated they just tell them if they are alert and oriented. V20 stated R1 seemed aware of what was going on and could carry on small conversations, but she wouldn't say he would be able to take care of himself. V20 stated she could tell R1's cognitive levels weren't at "full function."

On 4/19/24 at 10:21 PM, V19 (CNA) stated he was working on the night of 4/12/24 and finished his bed checks around 5:30 AM. V19 stated he got mandated to stay and worked until about 8:30 AM. V19 stated he found out around 6:30 AM that R1 wasn't in the facility. V19 stated they locked the facility down and looked for R1. V19 stated he did remember seeing R1 around 2:30 or 3:00 AM

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in the dining room coloring and watching tv. V19 stated administration had asked him to give a statement. V19 stated a few months back R1 said he was going to leave so they placed a wanderguard at that time and R1 was on 15 minutes checks.

On 4/23/24 at 10:01 AM, V33 (Agency LPN) stated she was working on the night of 4/12/24 when R1 eloped. V33 stated R1 wasn't her resident, and she wasn't aware R1 was gone until she had left the facility. V33 stated an unknown nurse came to her around 5:45 or 5:50 AM and asked if she had seen R1. V33 stated she wasn't sure who the nurse was talking about. V33 stated the nurse described him to her and she realized she knew who R1 was. V33 stated she had seen him around 10:00 PM in the dining room coloring pages. V33 stated he was at the table closest to the doors on the right. V33 stated she saw him again in the dining room when she went to the snack machine around 12:00 or 12:30 AM. V33 stated after that she was at the nurse's station. V33 stated she shared this with the nurse and the nurse didn't look worried, so she thought she was just looking for him for morning medications. V33 stated she didn't know the nurse, but she didn't look concerned and didn't come back to say R1 was missing. V33 stated she left the facility and was getting ready to pull her car out when an unknown lady pulled in and said through her car window that she (V33) needed to write a statement. V33 stated she asked her what she needed a statement for, and the lady responded for the elopement. V33 stated she asked her what elopement and the lady responded that R1 was found by the overpass. V33 stated she thought they were talking about the one right outside the building and told the lady she would give the statement that night when she returned

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to the facility. V33 stated no one left a note for her or said anymore about a statement. V33 stated she was "ear hustling" when she returned to work, and they were saying R1 got out and was all the way in the next town. V33 stated the aids were saying they didn't even know R1 was missing. V33 stated she told the CNA's that was why it was so important for them to count the residents and even if they didn't need bed checks to make sure they were laying eyes on their residents. When asked if she was aware of any policy related to checking residents, V33 stated she thought it was a state regulation that they should be doing that. V33 stated she figured they would all know that it doesn't matter if they are independent, they still need help.

On 4/16/24 at 2:34 PM, R1 was in the dining room participating in activities. After he was finished with the activity this surveyor asked if I could speak with him. R1 stated we could talk in the common area. R1 appeared clean and well-groomed with no obvious signs of distress. When asked if he had left the facility, R1 stated he did yesterday around 8 or 9 pm. R1 stated he didn't tell anyone he just started walking to (name of next town). R1 stated it took him all night. R1 stated he was trying to figure out where to go when a lady from the facility found him. R1 stated he had a bracelet (Wanderguard) on his ankle, but it got cut off. R1 stated he was almost to (name of next town) when he ran into a "fella" and this fella asked if he wanted him to cut it off. R1 stated the guy cut it off with his (the guys) knife. R1 stated he didn't remember if the door alarm sounded when he left the facility. R1 stated it worked today when they had me test it out. R1 stated the facility staff had him walk in front of the door to see if it worked. When asked if he had a wanderguard on at that time, R1 stated yeah and

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pulled his pant legs up. There was no electronic monitoring bracelet on either leg. R1 stated, "Oh no, they didn't put it back on." R1 stated when he left the facility, he went out the dining room door and left when a bunch of people went out. R1 stated he figured that was the best time to leave. R1 was asked the following questions and gave the following responses. What day is it? "I don't know." Season? "It is supposed to be winter, but we didn't have much of a winter." Who is the president of the United States? "Trump. I know it is the middle of an election year." What year is it? "I don't know." What meals have you had today? "I know I had breakfast. The kitchen treats me good, and they come check on me." R1 stated he didn't know why he left the facility, and he didn't really have a plan when he left. R1 stated he knew he was in the next town over and he knows people who live there but he couldn't remember where they lived. R1 stated, "Memory loss is what I have problems with lately." R1 stated when he left the facility it was warm and not raining. R1 stated he wasn't injured while he was gone. R1 stated he met some guy who was going to work while he was out, and they sat down and shared a cigarette. R1 stated he (the unknown guy) was the one who cut his bracelet (electronic monitoring device) off. R1 stated when he got back to the facility the staff talked to him about how he was doing. When asked if the facility staff talked to him about what to do if he wanted to leave again, R1 stated, "They didn't go into detail." R1 stated if he wants to go for a walk he just goes into the courtyard. When asked if the facility staff talked to him about signing out if he leaves again, R1 stated, "No, they didn't they just mentioned to talk to someone if I wanted to leave."

On 4/18/24 at 9:52 AM, R1 was sitting in the

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dining room/common area at the facility. R1 appeared clean and well-groomed with no signs of obvious distress. R1 was not able to tell this surveyor what the date, month, or year it was. R1 stated he was 66 years old. R1 is 67 years old. When asked what season it was, R1 stated he would need to know what month it was, and he usually just looks outside. When asked if he had breakfast R1 stated he had. When asked what he had for breakfast, R1 stated, "just breakfast is all I can say." Then R1 stated he had hash browns, eggs, toast, coffee, and a donut or cookie. When asked if the facility spoke with him after he left the facility, R1 stated he couldn't remember if they did or not. R1 stated, "My memory isn't that good. I am struggling with memory." When asked how long he was gone from the facility R1 stated, "Most of the night." R1 stated he left around 7 or 8 PM but did stop and talk to a couple of people on the way.

On 4/18/24 at 10:55 AM, V8 (Cook) stated she worked on 4/18/24 and served breakfast. V8 stated she remembered what she served to R1, and it was two biscuits, two sausages, double scrambled eggs, two bowls of cereal, milk, and juice. V8 stated there were no cookies or donuts served to R1 that she was aware of.

R1's progress notes do not document any note dated 4/13/24.

R1's Progress Note dated 4/14/24 documents, "Continues on 15-minute visuals r/t (related to) elopement attempt. Wander guard in place and functioning. No attempts made during this shift. ROM (range of motion) WNL (within normal limits) per residents' normal functions. Denies any c/o (complaints of) pain or discomfort. No injuries noted. Respirations even and non-labored on

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room air. No s/s (signs or symptoms) of acute distress noted at this time. Currently resting quietly in bed with call light and frequently used items within easy reach." This note is struck out and documents, "Strike Out Reason: Incorrect Documentation. Strike Out Date: 4/16/2024."

R1's Elopement Risk Assessments dated 4/13/24 document a score of 18 which indicates R1 is at high risk of elopement.

R1's QAPI (Quality Assurance Performance Improvement) Ad Hoc (As needed) Form dated 4/13/24 documents, Meeting Attendees: V2 (DON/Director of Nursing), V48 (MDS/Care Plan Coordinator), V47 (ADON/Assistant Director of Nurses), and V51 (Physical Therapy Assistant). Identified Opportunity for Improvement/Deficient Practice: Elopement 1. Immediate Corrective Action for those affected by the deficient practice: 4/13/24 Resident located and returned to facility. Head to toe assessment, no injuries noted, nursing assessment complete. 4/13/24 MD (physician) notification- Completed. 4/13/24 Wanderguard on and functioning- Completed. 4/13/24 Investigation initiated. - Completed. 4/13/24 Staff educated on wandering/elopement policy and responding to door alarm immediately-door alarms, supervision, wanderguard verifications- ongoing. 4/13/24 Trauma, pain, skin, elopement risk, abuse risk assessments completed, resident put on 15 min visuals for 72 hours. 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents Elopement assessment- Residents at risk- care plan reviewed with appropriate interventions in place or initiated. Elopement books updated with current assessments. Elopement assessments will be completed upon admission with additions

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to care plan and elopement books as indicated, i.e., high/moderate risk. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur. 100% Staff in-servicing on Elopement Policy, door alarms, supervision of residents, wanderguard verifications. 100 % Residents completed Elopement Assessment with Care Plan Reviews and Interventions Implemented as indicated. Nursing staff will visualize resident q (every) 2 hours. 4. Plan to monitor performance to ensure solutions are sustained. Nursing staff or designees will audit door alarms for functionality and sound every shift until reviewed by QA Committee. Administrator or DON will audit 2 hour rounding daily for compliance until review by QA Committee.

R1's Order Recap Report dated 3/24/24 to 5/31/24 includes the following orders: ""Wanderguard check function Q (every) week every day shift every Fri (Friday) for Wandering ..." with a start date of 3/22/24
"Wanderguard-Check placement every shift for Monitoring ..." with a start date of 3/22/24,
"15-minute visual checks r/t (related to) exit seeking behaviors every shift ..." With an order date of 4/15/24. "Accu checks and contact MD (physician) orders Notify MD if BS (blood sugar) less than 60 or greater than 400 before meals and at bedtime."

R1's MAR (Medication Administration Record) dated 4/1/24 to 4/30/24 documents the wanderguard and 15-minute check, physician orders are signed as administered as ordered by the physician. R1's physician order to check R1's accu check before meals and at bedtime is signed administered as ordered each day and shift except 4/13/24 at 6:00 AM, indicating all accu checks were done as ordered except the

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one ordered for 6:00 AM on 4/13/24.

On 4/24/24 at 1:49 PM, V2 (DON) stated she was out of town on 4/13/24 and wasn't involved in the incident.

On 4/24/24 at 4:11 PM, V1 (Administrator) stated on 4/13/24 at 6:35 AM, V9 (CNA) stated she was notified R1 was missing by staff member (gave initials of staff member). When asked who that staff member was, V1 stated she would have to look. (Initials were never verified and didn't match staff currently working in the facility). V1 stated at 6:44 am, V7 (LPN) was notified R1 was possibly seen near a restaurant by V24 (Dietary Aid/Cook). V1 stated at this time, V9 left the facility and drove towards the restaurant. V1 stated V48 (MDS Coordinator) and V1 were notified, R1 was not at the facility, at 6:45 AM. V1 stated at 7:09 AM herself, V48, and V49 (Wound Nurse) notified R1's physician, R1 had left the facility. V1 stated R1 doesn't have a power of attorney to notify. V1 stated they completed assessments, increased monitoring until R1's physician could review, and noted any changes to monitoring would be made as needed. When asked if she spoke with all staff who worked midnight shift, V1 stated they talked to most of them. V1 stated some of them were shift key and they weren't able to get in touch with them. When asked if they were able to determine what time R1 left the facility, V1 stated they didn't have a time R1 was last seen. V1 stated R1 was seen at the plastic table coloring, but they couldn't tell them what time. V1 stated R1 couldn't tell them what time he left the facility. V1 stated staff were unaware R1 had left the facility. V1 stated R1 is hard to get to talk. When asked if she was able to speak to R1's nurse that was providing care the night of 4/12/24, V1 stated that was V7 (LPN). V1 stated yes, they had talked to V7. V1

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then stated no it was a shift key nurse because V7 was the one who called administration. V1 stated she couldn't speak to R1's nurse and no one got a statement from the nurse before she left the facility. When asked if she considered R1 to be at risk of elopement on the morning of 4/13/24, V1 stated she didn't know every resident by heart so her first response was to jump out of bed, throw clothes on, and head to the facility. V1 stated R1 was back at the facility before she got there. V1 stated they are not a lock down unit, and they are not a mental health unit. V1 stated it is a resident's right to leave the premises. V1 stated R1's BIMS score is a 14. V1 stated if a resident who has a BIMS of 14 wants to walk to the next town what gives her the right to stop him.

On 4/17/24 at 12:04 PM, during an interview with V4 (Physician/Co-Medical Director) this surveyor reviewed the incident that happened with R1 on 3/22/24 when R1 was confused and was found outside of the facility. This surveyor reviewed with V4 that after the 3/22/24 incident the facility assessed R1 to be at risk of elopement and then at an unknown time on the night of 4/12/24, or the morning of 4/13/24, R1 left the facility again, without staff being aware, and walked to the next town. This surveyor shared with V4, R1's BIMS score was a 14. V4 stated he wasn't familiar with BIMS scores. This surveyor explained a BIMS of 14 indicated R1 was cognitively intact. This surveyor shared with V4 the facility reported V4 deemed R1 to not be an elopement risk and R1 leaving the facility without staff being aware to not be an elopement. V4 stated, "He obviously eloped." V4 stated R1 got out of the building without them being aware and it is a risk whether he is cognitively intact or not. V4 stated, "He left cognitively intact or not, he left. He got out with a wanderguard on which is even worse."

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On 4/18/24 at 1:14 PM, V5 (CNA) stated she is agency staffing and has only worked at the facility three days. V5 stated if there is any specific information they need to know when they first work at a facility, it is given to them in report. V5 stated she worked on the night of 4/12/24 and 4/13/24. V5 stated she wasn't aware of a resident leaving the facility on 4/12/24 until she returned to work on the night of 4/13/24. V5 stated she found out about it when she was assisting residents to eat in the dining room and other staff were talking about it. V5 stated she left at 6:00 AM on the morning of 4/13/24 and returned at 2:00 PM on that same day. V5 stated they had two CNA's working each hall and she felt that was enough staff to meet the needs of the residents on night shift. V5 stated two CNA's per hall on any other shift would not be enough staff.

On 4/19/24 at 11:33 PM, V23 (LPN) stated she wasn't working on the night of 4/12/24 but did work on 4/13/24. V23 stated they did have a meeting after R1's elopement. When asked if they covered elopements, V23 stated she didn't think so. V23 stated she saw on messages they had someone elope. When asked if there was any specific training done with the facility staff related to R1's elopement, V23 stated, "No."

On 4/23/24 at 11:59 AM, V35 (CNA) stated she was not working when R1 left the facility. V35 stated she hadn't had any training related to R1's elopement.

2. R1's Ad Hoc (as needed) QAPI (Quality Assurance Performance Improvement) meeting dated 4/16/24 documents meeting attendees as; V1 (Administrator), V2 (Director of Nurses), V48 (MDS Coordinator), V47 (ADON), V49 (Wound

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Nurse), V44 (Resident Services Coordinator), V28 (Social Services Director). This same report documents under "Identified Opportunity for Improvement/Deficient Practice: Elopement Assessments (R1). Review of Elopement definition based off (State Survey Agency) and (Federal Survey Agency)/Revision of Elopement Assessments of residents. Review 4/13/24 (R1). 1. Immediate Corrective Action for those affected by the deficient practice: Review of resident (R1) Elopement assessments completed for accuracy from 1/30/24 to current. Elopement Assessments revised as needed. Care plan updated as needed. MD (Physician) reviewed res (resident) and signed orders in person one on one on 4/16/24. Community Safety Assessment Completed, Wander guard D/C (discontinued) per MD. Resident educated on sign out book in front lobby. Resident verified placement of sign out book. 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: Elopement Assessment audit for accuracy based off (State Survey Agency) and (Federal Survey Agency) definition. Care Plan audit with updates as needed based off assessment findings. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur. On 4/16/24 Educate management on (State Survey Agency) and (Federal Survey Agency) definition of Elopement. On 4/16/24 Staff will be educated on (State Survey Agency) and (Federal Survey Agency) definition of Elopement. On 4/16/24 Staff will be educated on resident rights and LOA (leave of absence). 4. Plan to monitor performance to ensure solutions are sustained. Admin (Administrator) or DON/ADON (Director of Nurses/Assistant Director of Nurses) or designee will audit elopement assessments weekly in IDT (Interdisciplinary Team) meeting x 4 weeks and

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review in QA (Quality Assurance) with IDT and Medical Director. Any descepencies (sic) will be immediately corrected and education (sic) provided as needed. Issue will be given to QA x (times) 3 meetings to be reviewed and discussed with QA team and education to be provided as needed." Attached to this meeting is an In-Service Sign in Sheet dated 4/16/24 that documents the Inservice Topic as "(State Survey Agency)/ (Federal Survey Agency) Elopement Definition. Attached to this In Service Sign in Sheet is an untitled undated sheet that documents, "Wandering and Elopement- ...A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring, and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without the facility's awareness and/or appropriate supervision. In addition, the resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident."

R1's Order Recap Report dated 3/24/24 to 5/31/24 includes the following orders:
""Wanderguard check function Q (every) week every day shift every Fri (Friday) for Wandering ..." with a start date of 3/22/24
"Wanderguard-Check placement every shift for

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Monitoring ..." with a start date of 3/22/24, "15-minute visual checks r/t (related to) exit seeking behaviors every shift ..." With an order date of 4/15/24. "Accu checks and contact MD (physician) orders Notify MD if BS (blood sugar) less than 60 or greater than 400 before meals and at bedtime." This same report documents these orders have a discontinue date of 4/16/24.

R1's Elopement Risk Assessment dated 4/16/24 documents a score of 02, which indicates R1 is not at risk of elopement.

R1's Progress notes document the following. 4/16/24 10:15 AM, "Spoke to V4 (Physician/Co-Medical Director) with IDT (Interdisciplinary Team) following orders received: MD agrees that order from 1/30/24 continues to be true that resident is safe to go on LOA (leaves of absence) with meds, resident is safe to go into community without supervision, D/C (discontinue) wanderguard, and may work on D/C (discharge) planning per resident preference."

4/16/24 10:43 AM, "Educated resident on how to sign himself out of the facility, understood he needed to tell his nurse and sign out in the black book upfront."

4/16/24 12:21 PM, "V4 came to facility to evaluate resident states resident is not an elopement risk. SS (Social Services) reviewed and revised all elopement risk assessment from 1/30/24 -4/16/24."

R1's SLUMS (Saint Louis University Mental Status) Examination dated 4/16/24 documents a score of 15 out of 30. This indicates R1 scored in the dementia level.

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R1's Speech Therapy notes dated 4/17/24 documents, " ...Patient answered temporal orientation questions with 20% acc (accuracy) and spatial orientation questions with 80% acc. He named 5 items per category with 100% acc. Demonstrated paragraph retention given direct question and answer format with 83% acc. Provided 2 possible causes to each problem situation with 60% acc independently..."

R1's Physician Order/Progress Note(s) dated 4/16/24 documents in handwritten notes, "I was @ (at) the NH (nursing home) and saw this resident, orders given. I saw D/C (discontinue) Wander Guard I agree with the order from 1/3/2024 that he may go on leave of absence with ...and may d/c home his preference, Is safe in the community without supervision."

R1's Community Safety Awareness Summary dated 4/16/24 is a typed report that documents R1's prior living arrangements as homeless, that he lived alone and came to the facility for medical condition of frostbite. R1 is documented as having secondary comorbidities that include diabetes with no history of substance or alcohol abuse. The assessment documents R1 is alert and oriented to person, place, and time and makes decisions independently. This assessment documents R1 doesn't have difficulty focusing attention, is not easily distracted, doesn't have difficulty keeping track of what is said and is not on any antidepressants, antianxiety, sedative hypnotics, narcotic pain medications, or psychotropics. This assessment documents R1 is safe to ambulate independently and can cross a street independently with or without a light. It documents no potential risks and that R1 is safe to leave the facility on pass. This assessment documents V1 (Administrator), V2 (DON), and

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V28 (SSD) as present with V1's signature.

R1's BIMS assessment dated 4/18/24 documents a score of 14, which indicates R1 is cognitively intact.

On 4/18/24 at 4:00 PM, this surveyor called V1 (Administrator) to inform her we had serious concerns with R1's elopement and specifically with R1 not having any interventions in place to prevent future elopements. V1 stated R1 had been assessed by V4 and found to be alert and oriented times four and R1 was assessed to be safe alone in the community. V1 confirmed R1 didn't have any extra monitoring and/or wanderguard in place at this time. V1 stated R1 was alert and oriented and his last BIMS in 2/2024 was a 14. This surveyor shared with V1 that R1 couldn't answer basic orientation questions such as date, month, year, season, or what he had for breakfast just a few hours later and V1 stated, that is not right. R1 is alert and oriented and was probably just telling you that stuff. V1 stated this surveyor should take a staff member with her to ask R1 those same questions. V1 stated R1 was getting ready to move to an assisted living facility and was carrying cards around with the address and phone number on them and knew the phone number of the facility he was planning to move to. V1 stated R1 was alert and oriented and safe to be in the community alone but she would have someone speak with him again.
R1's Progress notes document the following.

4/18/24 4:53 PM, " ...Per meeting held with (V27) Medical Director, (V2) DON (Director of Nursing), (V28) SSD (Social Services Director), (V1) CEO (Chief Executive Officer). V27 reviewed resident chart, dx (diagnosis) show no cognitive

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impairment dx, only HTN (hypertension), Tobacco use, disorder of circulatory system, DM (diabetes mellitus), High Cholesterol, and Afib (atrial fibrillation). Resident interview shows no cognitive impairments. BIMS score reviewed and was 13 on 4/18/24. Medical Director does agree. DX reviewed for physical limitations and MD agrees no physical limitations at this time after review of adl's (activities of daily living) and assist needed. Residents Assessments reviewed with MD and Medical Director agrees with assessments and (V4) that resident is able and capable of leaving facility without supervision due to resident rights and capabilities of making his own decisions. Resident able to answer questions appropriately. Speech therapy reviewed treatment encounter notes showing his own decisions. Resident able to answer questions appropriately. Speech therapy reviewed treatment encounter notes showing 4/18/24 SLUMS examination along with TX (treatment) notes. Care plan reviewed and updates in meeting. Will continue to review on 4/19/24. Will continue to update as needed. Will continue with orders and recommendations per MD, Medical Director, and Speech Therapy."

On 4/24/24 at 1:49 PM, V2 stated R1 is not a high risk for elopement. When asked if she was aware R1 had been assessed as being at high risk for elopement V2 stated if it was at night, then no. When asked if both V4 (Physician) and V27 (Physician) assessed R1 at the time of the IDT meeting on 4/18/24, V2 stated, "Yes."

On 4/24/24 at 3:24 PM, V1 (Administrator) stated V4 (Physician/Co-Medical Director) saw R1 prior to him being at the facility and V4 and V27 (Physician) had assessed R1 to be discharged to any preference he had. When asked if R1 was assessed as being high risk for elopement from

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the 3/22/24 incident until the incident on 4/13/24 V1 stated she wasn't sure. V1 stated around 4/16/24, R1 was assessed as not being at risk for elopement. V1 stated on 4/13/24 R1 was assessed as being at risk for elopement and it was incorrect. When asked who made the determination the 4/13/24 assessment was incorrect, V1 stated V4 and V27. V1 stated they completed a community safety assessment also. When asked if V4 and V27 completed the community safety assessment, V1 stated she would have to look at the assessment. V1 stated they went back to 1/31/24 and reviewed R1's elopement assessments and revised them as needed up to 4/16/24, based off (State Survey Agency) and (Federal Survey Agency) definition. V1 stated Care Plan audits with updates were also completed.

On 4/24/24 at 4:11 PM, V1 stated R1 is hard to get to talk. V1 stated R1 will not talk to men. When asked how R1 talked with V4 and V27 since they are both men, V1 stated R1 will open up to them since he has talked to them over and over again. V1 stated R1's BIMS score is a 14. V1 stated if a resident who has a BIMS of 14 wants to walk to the next town what gives her the right to stop him. V1 stated the physicians assessed him as not being at risk for wandering. V1 stated R1 has signed out in the sign out book and left the facility and returned since the occurrence on 4/13/24.

On 4/30/24 at 3:28 PM, when asked if he was familiar with R1, V27 (Physician) stated he got a call from V1 (Administrator) last week and said R1 stays at the facility, goes out on the lawn, and said he goes independently. When asked if he had seen or assessed R1 in person, V27 stated he had not and if he had seen him one time, he

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would remember his name. V27 checked his records and stated he didn't have an assessment for R1. V27 stated he may have seen R1 while he was at the facility, but he has never seen R1 as his physician.

R1's SLUMS Examination dated 4/18/24 documents a score of 21 out of 30. This indicates R1 scored in the level of Mild Neurocognitive Disorder.

R1's Speech Therapy notes dated 4/18/24 documents, " ...Patient answered temporal orientation questions with 20% acc and spatial orientation questions with 60% acc. Followed 3-step verbal directives with 80% acc. Provided 2 possible solutions to each problem situation with 80% acc independently. He was re-assessed using the SLUMS Examination and demonstrated 20% improvement compared to scores on the Exam 2 days ago ..."

On 4/30/24 at 2:30 PM, V50 (Speech Therapist) stated the reason she redid R1's SLUM's assessment on 4/18/24 was because she was asked to.

On 4/30/24 at 3:56 PM, V1 (Administrator) stated the IDT meeting with V4 and V27 (Physicians) was done via telephone on 4/18/24. When asked if R1 was assessed by either V4 or V27, V1 stated V4 came to the facility on 4/16/24 and signed the orders. This surveyor with V1 reviewed the SLUMS assessments and that we had originally been given the assessment dated 4/18/24 and wasn't aware of the assessment done on 4/16/24 until we reviewed speech therapy notes. V1 stated she didn't know that because V50 (Speech Therapy) said R1 had a failure to participate on 4/16/24. This surveyor

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reviewed R1's score was a 15/30 on the 4/16/24 SLUMS assessment which indicates R1 is scored as having dementia. V1 stated she was told R1 wouldn't participate on 4/16/24 and would just say, "I don't know." V1 stated R1 wouldn't participate so they did the assessment again on 4/18/24. V1 said R1 did the same thing again today when he was assessed. V1 stated she would trust R1 to go to the local gas station independently and make it back to the facility by himself. When asked what they would do if R1 alerted the facility he wanted to walk to the next town over at 11:00 PM at night, V1 stated this is their home it is not a mental institution. When asked if she felt R1's cognition level was appropriate to walk independently to the next town at 11:00 PM at night, V1 stated it was not her duty to determine that. V1 stated she relies on the physician's and the assessments to determine that.

R1's Physician Order/Progress Note(s) dated 4/23/24 document in handwritten notes, "See for ? elopement? Alert x (times) 4. Totally cares for self. Had wanderguard does not need it. He left facility with wanderguard (did not need) and was allowed to come and go ... this was not and (sic) elopement. Severe anxiety x 2 + (plus) to ER (Secondary)? State Lady, inappropriate Dx, Normal male, Cognitive - normal. Was not an elopement."

R1's SLUMS Examination dated 4/30/24 documents a score of 11 out of 30 which indicates R1 scored in the dementia level.

R1's Speech Therapy notes dated 4/30/24 documents, " ...Patient reassessed this date using the SLUMS (St. Louis University Mental Status) Examination at the request of State

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Surveyor. Surveyor was present during the session. Patient was not feeling well and initially refused to sit up for the test. He was very sleepy and having difficulty remaining alert, though he answered a few questions regarding our requests to participate. He agreed to answer the questions if we would come back later. Surveyor and therapist planned to return in 30 minutes. Therapist was present with patient's roommate for that person's treatment when the nurse came and gave medication to (R1). (R1) then sat up to take his medications and began coughing again. Nurse asked him to lie down, but he refused at that time. As roommate's session was completed, therapist located Surveyor to attend the session with (R1). With Surveyor present the SLUMS was administered. Patient agreed to stay seated for the session. Results of the SLUMS indicated a score of 11 points out of a possible 30 (36%). However, patient stated he could not perform 2 of the subtests as he could not see the shapes shown to him, nor could he write to draw the clock as he was having pain in his hand. Patient refused these subtests. Therefore, results were somewhat skewed. Copies of the test were given to the Surveyor along with results of the same test given earlier on 4/16/24 and 04/18/24. Chest x-ray this date revealed patient has pneumonia. Patient's illness may have attributed to the drop in test scores and performance."

On 4/30/24 at 1:45 PM, V50 (ST) stated R1 has not been feeling well, coughing, and has had chest x-rays done. V50 stated she "recently did a couple of SLUMS assessments on him, the first one he scored low but the second one he had improved by 20%." When asked why she thought he had scored that way, V50 stated she thinks R1 is hard of hearing and had a hard time concentrating. V50 stated she didn't think he was

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concentrating very well the first time she did the assessment. V50 stated he "has pretty steady cognition most of the time."

On 4/30/24 at 2:15pm, V50 was observed administering a SLUMS assessment to R1. R1 stated he didn't feel well but didn't refuse to begin. R1 stated the date was Monday, Year 24, State Illinois. R1 got two of five words correct. R1 named 14 animals but refused to go the whole minute. R1 did the numbers forward and backward without difficulty. R1 stated he couldn't see the shapes to indicate which was largest. R1 could not give any details of the story and refused to draw the clock. V50 stated she would score what she could and make notes about the parts R1 refused to attempt.

On 4/24/24 at 3:24 PM, V1 (Administrator) stated around 4/16/24, R1 was assessed as not being at risk for elopement. V1 stated on 4/13/24 R1 was assessed as being at risk for elopement and it was incorrect. When asked who made the determination the 4/13/24 assessment was incorrect, V1 stated V4 and V27. V1 stated they completed a community safety assessment also. When asked if V4 and V27 completed the community safety assessment, V1 stated she would have to look at the assessment. V1 stated they went back to 1/31/24 and reviewed R1's elopement assessments and revised them as needed up to 4/16/24, based off (State Survey Agency) and (Federal Survey Agency) definition. V1 stated Care Plan audits with updates were also completed.

On 4/19/24 at 10:52 AM, V22 (Anonymous) stated she spoke with R1 yesterday 4/18/24 and he was alert but thought he was in a different town than the facility is located in.

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On 4/18/24 at 11:07 PM, V25 stated she wasn't working on the night R1 eloped. V25 stated she isn't aware of R1 leaving the facility prior to that. V25 stated R1 is alert and oriented for the most part. V25 stated there is some confusion at times. V25 stated R1 walks around, watches tv, and watches people go out the door.

On 4/24/24 at 1:33 PM, V28 (Social Services Director) stated she wasn't at the facility when R1 left but she did do follow up assessments on R1. V28 stated R1 did not have a new BIMS score between February and April 2024 because R1's MDS wasn't due. V28 stated R1 scored a 14 on his BIMS assessment and stated R1 was able to answer all the questions as documented on the BIMS assessment.

The facility Wandering/Elopement Policy dated 3/13/24 documents, "Purpose: to provide guidance to facility on the assessment and monitoring of residents at risk for wandering/elopement. Policy: All residents are assessed for risk of unsafe wandering and/or elopement and those who are identified as at risk will be assessed for utilizing the safety intervention of a WanderGuard bracelet (where applicable) to prevent unsafe exit from the center. If not applicable, the interdisciplinary Team will meet to discuss other safety measures that will be put in place. Policy Interpretations and Implementation: All residents are assessed using the Elopement Risk Assessment V-2 in (name of electronic health records program) at the time of admission, quarterly and with changes in condition, especially those affecting cognition, or with changes in behavior. A resident who scores 7 or higher on the Elopement Risk Assessment V-2 is considered at moderate risk of elopement

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and will be assessed by the interdisciplinary team to determine what method of preventing unsafe wandering will be used. A resident who scores 10 or higher requires immediate Care Plan intervention by IDT. If no Wander Guard type system is available, the resident will be closely observed while an appropriate safety intervention is established. Non-WanderGuard interventions include separate locked units or alternate alarm system on exit doors. If resident exhibits exit seeking behaviors or expressed the desire/determination to leave and if that resident is not cognitively able to support independent decision making, a new elopement Risk Assessment and review by the interdisciplinary team will be conducted. Other safety interventions may be utilized pending the assessment. The facility shall not utilize using the WanderGuard or other similar interventions on a resident who is able to give consent based on cognitive level without further assessment to protect that resident's right to personal autonomy and decision making. This would include a BIMs assessment and a CRSHC Community Safety Awareness Summary, both in (name of electronic health records system), consultation with a physician or psychiatrist and IDT review. Unsafe wandering or elopement risk shall be care planned. The resident's photograph, description and other pertinent details are placed in the AT Risk of Wandering notebook which is kept at designated areas within the facility for rapid identification and intervention as needed. Notebook is updated regularly and as needed. "Missing Resident" drills are conducted at least quarterly and on rotating shifts to assure appropriate staff response in the event of an elopement or missing resident. A log of residents with WanderGuard bracelets, the placement location, the date of placement and the expiration

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date on the battery is maintained. A WanderGuard bracelet must be placed securely on the resident at risk of unsafe wandering. It may be placed in an area that will protect the bracelet from removal or destruction. Proper placement is verified daily and documented in the EMR (electronic medical record). WanderGuard bracelet relies on battery operation. Battery operation is verified weekly per manufacturer's recommendation per maintenance department ...The WanderGuard relies on alarm systems established on doors. Each door alarm will be checked for proper function at least weekly and recorded in maintenance record. Exiting a door with a keypad entry to bypass the alarm and prevent it from sounding require a code. Knowledge of alarm codes should be restricted to staff members to prevent unintentional discharge of the resident by a visitor or other person who does not recognize the resident to be at risk of elopement ...If a door alarm is sounding, it is every employee's responsibility to respond. If staff can identify the reason for the alarm ...the alarm by be cleared ...."

The facility Missing Resident Policy/Procedure dated 12/19/22 documents, "Purpose: To provide facility staff with guidelines for ensuring the health, safety and welfare of all residents, and protocol to be followed when a resident s noted to be missing. Policy: Nursing personnel must report and investigate all reports of missing residents. Responsibility: It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse as soon as practical ...Should an employee discover that a resident is missing from the facility, he/she should, A. Determine if the resident is out on an authorized leave or pass. If not: B. Make a

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thorough search of the building(s) and premises. If the resident is not located within 15 minutes, the unit Charge Nurse will report the incident to the Shift Supervisor/Director of Nursing who will direct additional staff to search the premises outside of the facility. C. If immediate search fails to locate resident, the Administrator will be notified. D. The Director of Nursing and the Administrator will determine need to report incident to the local Police department.
(A)
Statement of Licensure Violations (3 of 3)

300.610a)
300.1210a)
300.1210b)
300.1210d)1)2)
300.1610a)1)
300.1630d)
300.1630e)

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

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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 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.

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

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S9999	Continued From page 59 Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 3 (R23, R10, R27) of 13 residents reviewed for medication errors in the	S9999		

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sample of 34. This resulted in R23 experiencing a blood glucose level of 37, altered mental status and being transported by EMS (Emergency Medical Services) to the Emergency Department for evaluation and treatment. Additionally, this failure resulted in R27 experiencing anxiety and an increase in behavioral symptoms, requiring an inpatient psychiatric hospitalization.

Findings Include:

1. Review of R23's "Admission Record" documented an initial admission date to the facility as 12/19/21. R23 is documented as being 70 years old, with diagnoses including, but not limited to: Type 2 Diabetes Mellitus with Diabetic Polyneuropathy; Unspecified Asthma; Morbid (severe) Obesity due to excess calories; and Occlusion and Stenosis of Bilateral Carotid Arteries ...

R23's "Order Summary Report" documented an active physician order, with a start date of 11/4/23 for "Accu Checks (Blood Glucose Monitoring) BID (twice a day). Before breakfast and before bedtime. Notify MD (Doctor of Medicine) if BS (blood sugar) <(less than) 60 or > (greater than) 400 two times a day." R23's active orders on 4/9/24 include the administration orders of, "Humulin 70/30 Kwikpen (70-30) 100 UNIT/ML (milliliter) Suspension pen-injector. Inject 40 units subcutaneously in the morning for DM (diabetes mellitus) type 2 ....Victoza Solution Pen-Injector 18 MG (milligrams)/3 ML (Liraglutide). Inject 1.8 mg subcutaneously in the morning for DM."

R23's "Medication Administration Record" for 4/1/24 - 4/30/24 documented no "Accu Check" results on 4/9/24 at 0600, with the entry of "9." "9" is documented as representing, "Other / See

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Progress Notes." "Progress Notes" dated 4/9/24 at 5:25 AM document the notation regarding Accu Checks as "Not administered." Additional review of the "Medication Administration Record" for 4/1/24 - 4/30/24 documented despite R23 not having a blood glucose level completed on the AM of 4/9/24, R23 was administered subcutaneously 40 units of "Humulin 70/30" Insulin at 5:21 AM and 1.8 mg of "Victoza" at 5:17 AM.

On 5/7/24 at 2:52 PM, V43 (Agency Licensed Practical Nurse, LPN) stated that she was the nurse that was working at the facility on 4/9/24. V43 stated that she was unable to check R23's blood sugar on the morning of 4/9/24, as she couldn't find any glucose monitoring strips to check it with. V43 stated she isn't sure the oncoming nurses name, since she only works at the facility as agency staff but reported to her that morning that R23's blood sugar hadn't been checked yet due to having no strips. V43 stated the nurse told her they would find some or go buy some. V43 stated she documented the blood sugar in the Medication Administration Record (MAR) as not taken. V43 stated she left for the shift and never heard anything further regarding any concerns presenting after the insulin administration. In an additional interview with V43 on 5/7/24 at 3:36 PM, V43 confirmed that the shift she worked was 6PM-6AM beginning on 4/8/24, with the shift ending at 6AM on 4/9/24. V43 stated along with herself, two other nurses were also working at the facility that night. V43 confirmed she did not contact the physician to provide notification of being unable to check blood sugar levels due to a lack of strips or receive further orders. V43 confirms she administered insulin without knowing residents current blood sugar levels. V43 stated she did this as one of the other

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nurses working that night, who she didn't know their name, stated they had contacted V1 (Administrator) regarding not having blood sugar testing strips available. V43 stated V1 reportedly said they would get some strips and have them checked that morning.

On 5/8/24 at 10:13 AM V7 (LPN), stated that she recalled working the night of 4/8/24, into the morning of 4/9/24. V7 stated that she recalled there being a shortage of glucose testing strips that night. V7 stated that she was working C Hall and had just enough strips to check her resident's glucose levels on that hall. V7 stated that she did not know of any other strips available in the facility to share with other halls in the facility that were short of strips. V7 stated if she recalls correctly, V6 (Registered Nurse/RN) was working that night and had contacted V1 regarding the glucose testing supply shortage by phone. V7 stated to her knowledge, the facility was going to send someone to get more strips from the store and said they would just check the glucose levels of those still needing their levels checked later that morning after they obtained more strips.

On 5/8/24 at 2:00 PM, V6 (RN) stated that she recalled working on 4/8/24 into the morning of 4/9/24. V6 stated she had searched the entire facility looking for glucose strips as nursing staff had identified there would be enough strips for C hall to complete their AM blood glucose checks, but none for A or B halls. V6 stated V2 (Director of Nursing) was notified and instructed V6 to just document the blood glucose checks as not being done, and she would send someone from day shift first thing in the morning to get more strips. V2 communicated that day shift would take care of performing the accu checks and insulin administration. V6 stated nursing staff were never

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instructed to administer insulin without completing a blood glucose check.

On 5/7/24 at 12:25 PM, V56 (Certified Nurse Assistant/CNA) stated she was working the day that R23 was sent to the hospital after having a low blood sugar. V56 stated she believes she was entering R23's room to take her to breakfast and observed her with bubbles coming out of the side of her mouth, eyes closed, and not responding to physical or verbal stimuli. V56 stated she knows R23 is diabetic, so called for the nurse, V36 (LPN), who immediately responded. V56 stated she has no further knowledge of anything that occurred during R23's care at that time.

On 5/7/24 at 10:00 AM, V36 (LPN) stated that it was before lunch time on the day the CNA came and got her and said that R23 wasn't responding. V36 stated she immediately went to check on R23 and found that she was very lethargic with her eyes open, but not talking. V36 stated that she took R23's blood sugar, receiving a result of 37. V36 said V2 then came to assist. V36 stated R23 was attempted to be given oral glucose gel as ordered but couldn't swallow and the gel was running back out of her mouth. V36 stated she went to call the ambulance and V2 went to get IV (intravenous) supplies and start the IV. V36 stated at the time the 37 blood sugar was taken, the facility only had two blood glucose strips in the entire facility available for use. One of the strips was used to obtain the 37 reading. V36 stated R23's blood sugar was not taken again until the ambulance arrived, and she isn't sure if the ambulance took the blood sugar reading when they arrived, or the facility used their last strip. V36 stated that V2 had got the IV started and was able to infuse dextrose. V36 stated that V58 (CNA Supervisor) left the facility with the bottle of the

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blood glucose strips came in to go to (local store) and try and buy more strips. V36 stated that (local store) did not sell the strips that could be used with the facility's machines so he purchased a glucose monitor and the strips that could be used until their new strips came in. V36 stated V58 is responsible for ordering the strips and does not know why there was a shortage at that time. V36 stated there are other diabetic residents in the facility besides R23 who require glucose monitoring. V36 stated she isn't sure what she would have done if someone else needed blood glucose monitoring when strips weren't available. V36 stated luckily nobody needed their glucose checked during the time there was a shortage of strips and V58 was "hurrying as fast as he could."

R23's "Progress Notes" dated 4/9/24 at 10:52 AM documented a "Nursing Note" that stated, "Resident is in a very deep sleep, not responding when talking (sic) to her accu check is 37. Attempted to give glucose gel by mouth resident is spitting it out and won't swallow, attempted to give it with a syringe and she took in approximately half a tube. This nurse started getting her paperwork ready and called (name of local ambulance company) while V2 started an IV and dextrose. EMT (Emergency Medical Technician) arrived resident did open her eyes and spoke a few words BS (blood sugar) up to 83 at this time. Resident oof (out of facility) to ER (Emergency Room)."

R23's local ambulance report dated 4/9/24 documented the ambulance company received the call for assistance needed at 10:32:01 AM. The call is documented as the facility reporting a female with low blood glucose. An ambulance is documented as being dispatched at 10:32:54 AM with lights and sirens. Upon their arrival to the

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facility at 10:40:56 AM, R23 is documented as being pale, warm, dry, PERRL (pupils equal reactive and responsive to light), airway patent, breathing adequate, but not responding to verbal stimuli. Upon EMS (Emergency Medical Service) arrival, the facility staff were observed administering D5 (5% dextrose) intravenously. Facility staff are documented as reporting R23 had been found cool and clammy, lethargic, with a blood sugar of 37 for an unknown amount of time that she had been that status. The facility is documented as reporting they initially tried to administer R23 oral glucose, but she wasn't able to swallow the solution. The facility reported starting a 22-gauge IV (intravenous) line to R23's right hand, administering approximately 50 mL (milliliters) of D5. The ambulance company is documented as taking R23's blood glucose level upon their arrival with her level now being 83. R23 departed the facility via EMS at 10:55:07 AM, arriving at the local hospital Emergency Department for evaluation and treatment at 11:09:26 AM.

R23's local hospital report dated 4/9/24 documented R23 presented with a chief complaint of low blood sugar. Per the ambulance company, R23 was unresponsive, cold and clammy with staff blood sugar noted to be 37. Once EMS were on the scene, R23's glucose level was checked, with a level then of 83. 10% dextrose was started and blood sugar rechecked, now at 76. R23 is documented as being confused, as her normal status, but reports she doesn't think she ate anything that morning. A fingerstick glucose level completed at the hospital prior to discharge back to the facility was 104, with a normal reference range listed as 70-108. R23 is documented as discharging back to the facility on 4/9/24, with the diagnoses of

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Hypoglycemia and History of Diabetes, with no new orders. R23's "Hospital Discharge Instructions" includes the notation of "Please make sure patient eats before she gets her insulin to help decrease the potential for low blood sugar episodes."

R23's "Eating & Amount Eaten" log at the facility reviewed for 4/9/24 documented no meal intake in the 6AM - 2PM entry slot.

R23's "Progress Notes" dated 4/9/24 at 3:27 PM documented, "Resident returned from (local hospital) dx (diagnosis) hypoglycemia BS is now up, received paperwork to educate resident."

On 5/8/24 at 9:02 AM, V62 (Emergency Room Physician) confirmed he was the physician who had seen R23 in the local Emergency Room on 4/9/24. V62 confirmed R23 was seen for hypoglycemia needs. V62 stated in reviewing his notes, upon EMS arrival to the facility, it looks like R23's glucose level was up to 83, after the administration of IV dextrose. The glucose level was initially documented as being 37. V62 confirmed that R23's hypoglycemia could have been a direct result of insulin being administered without first checking the blood glucose level. V62 acknowledged with severe cases in a resident with diabetes, if abnormal glucose levels are not monitored, medications inappropriately given, or levels left untreated, there is a potential for death.

On 5/7/24 at 12:58 PM V2 (Director of Nursing/DON) stated that she was notified by V36 (LPN) one morning after coming out of morning meeting that she needed help with R23. V2 stated that R23 was lethargic, and her BS was checked with a reading of 37. V2 stated R23 was not responsive enough to take the oral glucose

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gel, as they tried but it was just running out of her mouth. V2 stated V36 went to call the ambulance and she went to get IV supplies and start a Dextrose infusion. V2 stated by the time the ambulance arrived R23 was improving and more alert. V2 cannot say if the blood sugar was re-checked by the facility or the ambulance company. V2 stated other than that day she is not aware of any time when there has been a blood glucose monitoring strip shortage. V2 stated V1 was the staff member who sent V58 to (local store) to buy more glucose test strips.

On 5/7/24 at 4:10 PM, V1 (Administrator) stated that she doesn't recall the specific date or who she was notified by regarding the need for glucose testing strips. V1 stated it could have possibly been V2 because she was looking for the facility payment card to send for strips to be bought. V1 stated she is not aware of anytime the facility has not had test strips available for use. V1 stated she never instructed staff to administer insulin without knowing the blood sugar. V1 stated her expectation is for staff to notify the physician for abnormal blood sugar levels as outlined in that resident's plan of care and not administer insulin without knowing the resident's blood sugar level.

On 5/7/24 at 10:17 AM V58 (CNA Supervisor) stated he was aware of the time when there was a shortage of blood glucose testing strips at the facility. V58 stated he was sent to (local store) to buy more strips, but (local store) didn't carry the kind of strips needed. V58 stated he used the facility payment card to purchase an accu check machine and testing strips for the facility use. V58 stated the truck with supplies was due at the facility the next day, so the facility just needed supplies to hold them over a day. V58 confirmed

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he does the ordering of glucose strips for the facility and they just "went through them faster than expected."

R23's Plan of Care with a created date of 12/22/21 documented a focus area for "(R23) has Diabetes Mellitus." The goal of this focus area is that "(R23) will have no complications related to diabetes through the review date." "Interventions/Tasks" listed to help fulfill this goal include, "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness."

2. Review of R10's "Admission Record" documented an original admission date to the facility as 5/10/19. R10 is documented as being 69 years old, with diagnoses including, but not limited to: Type 2 Diabetes Mellitus with Hyperglycemia; Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified; Peripheral Vascular Disease, Unspecified; Chronic Obstructive Pulmonary Disease, Unspecified.

R10's "Order Summary Report" documented an active physician order, with a start date of 1/22/24 for "Accuchecks and contact MD orders if diabetic (BS <60 or >400) before meals and at bedtime." R10's active orders on 4/9/24 include, "Basaglar KwikPen Subcutaneous Solution Pen-injector 100 Unit/ML. Inject 60 unit subcutaneously every 12 hours for diabetes ... Admelog SoloStar Subcutaneous Solution Pen-injector 100 Unit/ML. Inject 9 unit subcutaneously one time a day for diabetes AND Inject 18 unit subcutaneously one time a day for diabetes AND Inject 9 unit subcutaneously one time a day for diabetes."

R10's "Medication Administration Record" for

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4/1/24 - 4/30/24 documented no "Accu Check" results on 4/9/24 at 6:30 AM, with the entry of "9." "9" is documented as representing, "Other / See Progress Notes." "Progress Notes" dated 4/9/24 at 5:37 AM document the notation regarding Accu Checks as "Not administered." Additional review of the "Medication Administration Record" for 4/1/24 - 4/30/24 documented despite R10 not having a blood glucose level completed on the AM of 4/9/24, R10 was administered subcutaneously 18 Units of "Admelog Solostar" Insulin at 5:10 AM and 60 Units of "Basaglar Kwikpen at 5:10 AM."

R10's Plan of Care with a "date initiated" as 3/13/23 documented a "Focus" area of, "The resident has Diabetes Mellitus." The "Goal" of this area is listed as, "The resident will have no complication related to diabetes through the review date." "Interventions/Tasks" documented include, "Accu Checks as ordered per M.D ...Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness."

The facility policy titled, "Insulin Administration via vial procedure" (undated) documented the purpose of the policy is, "To provide guidelines for the safe administration of insulin to residents with diabetes." "Steps in the Procedure (Insulin Injections via Syringe)" to include, "...2. Check blood glucose per physician order or facility protocol."

The policy titled "Blood Glucose Monitoring" with an issue date of 4/6/23 documented the purpose of the policy is, "To provide staff with guidelines for the proper procedures in monitoring blood glucose, while monitoring blood glucose levels..." The policy goes on to state, "Blood glucose

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monitoring will be done on all residents with a Physician's order."

Review of the current facility assessment dated for 2023/2024 documented "Conditions Diseases" the facility provides care for includes Diabetes (all types). Competencies included for this condition include but are not limited to insulin management.

3. R27's Face Sheet documented an Admission date of 9/6/23 and listed diagnoses including Alzheimer's Disease, Depression, Anxiety, and Personal History of Suicidal Behavior. A Minimum Data Set dated 3/19/24 documented a Brief Inventory for Mental Status Score of 2, indicating R27 has severe deficits in cognitive functioning.

A Telephone Order Sheet dated 1/16/24 documented an order for hydralazine 25mg (milligrams) one tablet three times daily.

R27's Current Order Review Report Dated 5/10/24 documents and order for Olanzapine (Zyprexa) Oral Tablet 2.5 MG (Milligrams) give one tablet by mouth in the morning related to dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance with a start date of 11/18/23. This same order report also documents and for for Olanzapine Oral Tablet 5 MG give one tablet by mouth at bedtime related to dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance with a start date of 11/17/23.

A 1/16/24 Nursing Progress Note documented, "Spoke with M.D. (Medical Doctor) re (regarding) resident is very anxious and agitated. N.O. (New Order) (given for) hydralazine 25mg 3 times daily." The next Nursing Progress Note in the

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(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 71	S9999		

record, dated 1/18/24 documented,"Resident's husband was here visiting and addressed wife's increased agitation," and further documented, "Notified (V27, Primary Care Physician), of the above situation and received orders to send to the ER (Emergency Room) at (a local hospital) for a Psychiatric Evaluation."

A Discharge Summary from a local hospital dated 1/26/24 stated, "Date of Admission: 1/18/24. (R27) arrived (from the facility) with a complaint of altered mental status, increased anger and irritation. Husband informed ER staff that he wasn't happy that she was sent to ER because now he will have another bill to pay, (and) is upset because the nursing home doesn't have her medications that she needs. Discharge instructions: Stop taking (this) medication: hydralazine 25mg.(milligrams). (Increase) Zyprexa to 5mg one tablet twice daily."

R27's January 2024 MAR (Medication Administration Record) documented that R27 received the hydralazine three times daily on both 1/17/24 and 1/18/24. This MAR also documented that R27 did not receive Zyprexa 2.5mg one tablet in the a.m. on 1/13/24 and 1/14/24.

On 5/3/24 at 12:40pm, R27 was observed in the facility's dining room self ambulating with the one to one supervision of V58 (Certified Nursing Assistant Supervisor). R27 was alert only to herself and was visibly upset and agitated.

On 5/8/24 at 8:55am, V71, R27's Power of Attorney, stated R27 was sent to a local hospital behavioral health unit on 1/18/24 due to an increase in anger and irritability and, "Not getting one of her medications, I'm not sure which one."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006878	A. BUILDING: _____ B. WING _____	C 05/15/2024

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S9999	Continued From page 72	S9999		

On 5/8/24 at 10:20am, V36 (LPN) stated when she called V27 on 1/16/24, V27 had ordered hydroxyzine 25mg one tablet three times daily for anxiety, not hydralazine, but she must have written the order as hydralazine. V36 stated she was not aware of this error til now. V36 stated she was not aware of R27 missing any doses of Zyprexa.

On 5/8/24 at 9:20am, V47 (Assistant Director of Nurses/ADON) stated she was not hired until March of 2024 and does not know anything about R27's medications.

On 5/8/24 at 1:40pm, V2 (DON) stated she was hired in January 2024 after the errors occurred and she does not know anything about it.

On 5/10/24 at 7:55am, V27 stated on 1/16/24 he had ordered Hydroxyzine 25mg one tablet three times daily for R27, not Hydralazine. V27 stated hydralazine is used for the treatment of hypertension, and hydroxyzine is used for the treatment of anxiety. V27 stated this was the first he was hearing about the medication error. V27 stated had he known, he would have discontinued the hydralazine and ordered R27's blood pressure to be monitored three times daily for 7 days, and if R27 had displayed any negative effects from the hydralazine he would have ordered her to be sent to the ER. V27 stated additionally, the facility had not notified him of the morning doses of Zyprexa not being available.

On 5/10/24 at 10:00 am, V1 stated she was not aware of the medication error with the hydralazine, nor of R27 not getting the morning dose of Zyprexa for two days.

According to information on The Physicians Desk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 73 Reference website, https://www.pdr.net/drug-summary/?drugLabelId=738, hydralazine is indicated for the treatment of hypertension. There is no documentation in this guidance to indicate hydralazine is used in the treatment of anxiety. A Medication Error Policy dated 7/16/23 documented," Medication/Treatment errors shall be documented as required. A medication error shall be defined as any variation in administration of medication from the physicians orders and/or facility policy." (A)	S9999		