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	IL6006076	A. BUILDING: _____ B. WING _____	C 06/06/2024

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S 000	Initial Comments Complaint Investigation: 2424139/IL173628	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)6) 300.3100d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing	S9999		

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3100 General Building Requirements
d)Doors and Windows

2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the memory care unit exit doors and bracelet alarms were loud and widespread enough to alert staff when activated. The facility failed to identify and investigate incidents of elopement, revise a care plan, and implement interventions for a resident who eloped from the facility. The facility failed to follow facility elopement policies and failed to

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provide adequate supervision for one of three residents (R1) reviewed for elopement in the sample of three. These failures resulted in a cognitively impaired resident (R1) who resides in the facility's locked memory care unit, exiting the facility without staff knowledge and being found soaking wet, laying on the parking lot pavement with facial and head trauma accompanied with excessive bleeding, approximately 50 to 70 feet from the exit doors. R1 was found at approximately 5:45pm and the weather was pouring down rain and cool. R1 was transferred to the local emergency room and later transferred to a tertiary (higher level) hospital where he was admitted to an intensive care unit for treatment of facial and cervical spine fractures.

Findings include:

The facility's Wandering and Elopement policy, dated 8/24/20, documents "All residents in this facility shall be assessed for risk of elopement/unsafe wandering, utilizing the Elopement Risk Assessment tool. Procedure: Elopement is defined as a wandering resident who is assessed as being cognitively impaired, who is not capable of protecting him/herself from harm who has left the building unsupervised. If the resident is considered to have eloped, the incident must be reported to (the State Agency). This facility will complete assessment upon admission, readmission, quarterly, significant change and upon an attempt of elopement, each resident will be assessed for their risk assessment utilizing the Elopement Risk Assessment tool." This policy also documents "An accident/incident report must be done by the charge nurse. All incidents of elopement must be investigated by nursing administration and reported to the facility administrator. The

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administrator of his designee must report every incident of elopement to the (State Agency). All incidents of elopement must result in comprehensive care plan review/revision."

The facility's Fall Reduction policy, dated 11/5/19, documents "Purpose: To provide an environment that remains as free of accident hazards as possible. To identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries. To promotes a systematic approach and monitoring process for the care of residents who have fallen and/or those who are determined to be at risk."

R1's current electronic Care Plan, printed on 5/29/24, documents R1 has diagnoses of Unspecified Dementia, Psychotic Disturbance, Mood Disorder, Anxiety, Epilepsy and recurrent Seizures, Repeated Falls, Muscle Weakness, Abnormalities of Gait and Mobility, Lack of Coordination, Muscle Wasting and Atrophy. This care plan documents "My current risk for Wandering /Elopement is high risk and my safety will be monitored every shift by all staff." This care plan was implemented on 5/25/23 and has no updated intervention since 2023. This same Care Plan documents "I currently have an alteration in my behavior status related to exit seeking, insomnia, aggression towards staff, yelling/screaming, rejection of care." This care plan was last updated/revised on 4/30/24. This same Care Plan documents "I am currently a High Risk for falls. Cognitive Deficit, Vision Impairment, Poor balance." This care plan was last updated on 1/25/24.

R1's Minimum Data Set assessment, dated 4/12/24, documents R1's mental cognition is

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severely impaired.

R1's Behavior Note, dated 5/10/24 at 1:55 PM, documents "Resident reached door to 400 hall, alarm (ankle bracelet) sounded. Staff followed behind and was able to redirect (R1) back inside. (V2 Director of Nursing) aware."

R1's Behavior Note, dated 5/14/24 at 8:57 PM, documents "(R1 is) antsy, wandering this shift. Becoming slightly aggressive when staff tries to redirect him. Aide was able to get him to the restroom and changed and ready for bed. Currently resting in bed with eyes closed and breathing even and unlabored."

R1's Nursing Progress Note, dated 5/24/24 at 6:00 PM, and completed by V2 (Director of Nursing) documents "Late Entry: Note Text: Nurse observed resident (R1) on the ground around 5:45 PM, resident noted to have injuries to face, knees, and arms. 911 (Emergency Services) called. Nurse then requested supplies to help stop bleeding. Ambulance arrived and transported resident (R1) to hospital."

R1's Wandering/Elopement Risk Assessment, dated 4/4/24, documents R1 was assessed to be at a high risk of elopement.

R1's Wandering/Elopement Risk Assessment, dated 5/27/24, documents R1 has "No history of escape or elopement."

The facility's incident report to the State Agency, dated 5/25/24, documents "5/24/24: (R1) is 81 years old with diagnoses of Unspecified Dementia, Severe without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Muscle wasting and

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Atrophy, was observed on the ground by nurse. Resident ambulating self without walker. EMS (Emergency Medical Services) called and transferred to the Emergency Room."

On 5/29/24 at 10:24 AM, V6 (Local Emergency Room Registered Nurse) stated "I was (R1's) nurse in the emergency room. From my understanding staff saw the resident outside (the facility) and called 911. Emergency Medical Services reported they got the call that (R1) was found outside on the ground with facial trauma. (R1) had an ankle bracelet on and there was a facility staff member (V15 Certified Nursing Assistant/CNA) who came with the resident. (V15) told me who he was and that he was a resident in the facility's memory care unit. (R1) had facial injuries but also had further testing and his injuries were pretty significant. (R1) arrived in the Emergency Room at 6:06 PM and was discharged to (tertiary hospital) at 8:48 PM, due to his injuries."

On 5/29/24 at 12:00 PM, V11 (Certified Nursing Assistant/CNA) stated "(R1) typically is an exit seeker. Especially lately, he didn't want to take his Ativan (anti-anxiety medication) and he would become more anxious. (R1) was aggressive that morning (5/24). We (staff) would sit with him and that would help him stay calm. (R1) required a lot of one-on-one attention. When (R1) would exit seek, he would always go to the end of the hall exit door. That is the exit I believe he used that day (5/24). I am not sure if it alarmed or not. You may not hear it if you were further up the hall because it's not a loud alarm noise. (R1) has gotten outside before this incident. Maybe about a month ago (R1) got out into the facility parking lot."

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On 5/29/24 at 2:20 PM, V8 (CNA) stated "I was working that day (5/24) in (R1's) unit. I had taken him to the bathroom probably 10-15 minutes prior to when he was found. I went to the linen closet and took (R3) into their room. Once I got done in (R3's) room I was going out and the other CNA (V14) was coming back from break, and she notified me of (R1) being outside. I went down to see if they (staff) needed help. Sometimes (R1) does just tend to get up and walk. He uses a walker to get around. When I was in (R3's) room I didn't hear any alarms with the door closed but once I opened the door, I could hear an alarm sounding down the hall. The (ankle bracelet) and the door alarm were all going off. (V7 Licensed Practical Nurse/LPN) was the nurse for the memory care unit that day, she was also in another room with a resident."

On 5/29/24 at 2:40 PM, V13 (CNA) stated "I was taking my linen out just before 6:00 PM (on 5/24). I noticed there was an oncoming nurse (V9 LPN) banging on the door outside of the 300 hall exit door. She was hollering for help. (V15 CNA) and I both went to (R1) and then I called (V2 Director of Nursing), (V15) called 911, we both saw (V9) at the same time. Employees enter that way which is how (V9) saw him. (R1) was laying partially on his butt also trying to push himself up. Once he saw help, we had control of him. The weather was pouring down rain that day, not super cold, maybe high 60's (degree Fahrenheit) temperature. To me it looked like (R1) fell face first in the parking lot. That's where he was when we got to him. It would have taken him a good ten minutes at least to get from where he exited the locked unit door to where we found him. There is some grass out there and also pavement. I entered back into the locked unit. I could hear the locked unit alarm going off from

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outside the doors. I couldn't hear any alarms inside the building from the 300 hall. I do know that (R1) has gotten out before. I am actually the one who found him that time. (R1) was holding onto one of the signs out there. A male was outside mowing and banged on the door (of the 300 hall) from the outside. He was alerting us that we had a resident outside. I can't remember if the alarm was going off that day. I just remember the adrenaline of it all and getting him back inside the building. That time he was maybe 10 feet away from the building, closer than he was this last time (5/24)."

On 5/30/24 at 11:05 AM, V15 (CNA) walked down the 300 hall and outside to the employee parking lot. V15 pointed to a lined area of parking lot pavement and stated "(R1) was lying here in a rain puddle, and you could see his blood mixed in the water. Who knows how long he was laying there or how long before he had fallen once he got out. (V9) was coming into work this way, and she is the one who found him."

V9's (LPN) written statement, dated 5/24/24, documents "I arrived at (the facility) on May 24th for my 12 hour shift (around 5:45 PM). Upon entering the facility's back parking lot, I saw an individual lying on the ground, in a puddle, unable to get up. I ran to the 300 hall door and knocked for assistance. I requested gauze to apply to the resident's face to stop the bleeding. (R1) was taken by ambulance for injuries."

On 6/3/24 at 10:00 AM, V7 (LPN) confirmed she was working in the memory care unit on 5/24/24 when R1 got outside of the building unattended. V7 stated "(V14 CNA) was on break. (V8 CNA) was in a resident's room (R3) by the nurse's station with the door closed. I was in another

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resident's room (R2), trying to get him calmed down. I came out the get (V8) to help me with (R2) and that is when I heard the alarm. At that time there was already several staff outside with the resident and so I started getting paperwork ready to be sent to the hospital. (V8) and I couldn't hear the alarms when in resident rooms. (R1) is a known wanderer and has gotten out from time to time. He is usually re-directable when he is walking. During the time that (R1) was outside it was pouring down rain."

On 5/29/24 at 2:19 PM, V1 confirmed the facility did not report R1's elopement on 5/24/24 to the State Agency. V1 stated "We reported the fall with injury to (the State Agency). We did not report the elopement because (R1) was still on the property. (R1) was outside but not "off property" and that is what I was told to do."

On 5/30/24 at 10:15 AM, V1 activated the locked memory care unit's ankle bracelet alarm and confirmed that when you are up the hall or if inside a resident's room it may not be audible. V1 then activated the exit door alarm that R1 exited on 5/24/24. The alarm was much louder but only alarmed at the exit doorway. V1 confirmed there is no speaker for this alarm up the hallway, at the nurse's station or anywhere else in the facility outside of the locked memory care unit. V1 confirmed that R1 has had another incident of getting out prior to this one and believes the date was 5/10/24.

On 5/30/24 at 11:24 AM, V18 (Social Services Director) stated "I do a wandering/elopement assessment in the computer quarterly, annually and with significant change. If there is an incident, we make sure alarms are working, care plan updated and see if assessment needs

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updated. On May 10th, (R1) breeched the door on 400 hall (in the memory care unit). What was reported to me is that he breeched the door and was brought back in by a CNA. After the 5/10/24 incident of getting out of the building, I reviewed the care plan, and we checked that alarms were sounding. I also checked to make sure they were doing 15-minute checks on (R1) and they were. So, I didn't have any new form or any care plan update to complete."

On 6/3/24 at 10:30 AM, V1 (Administrator) stated "Upon further investigating the incident where (R1) was found in the parking lot before the 5/24/24 incident was on 5/10/24. I think the reason it didn't get reported as an elopement is because our maintenance man (V20) was outside mowing, and he saw (R1) and they got him back into the building. So (R1) didn't go far. I didn't know he got outside at all during that incident until last week when you asked. It was never relayed to me."

On 6/3/24 at 12:55 PM, V2 (Director of Nursing) stated "I was not here that day (5/24), but I went in and made the notes in the resident's record once I read (employee) statements. On 5/10/24 I saw an CNA (V19) walking by quickly and so I followed her into the memory unit and then we went down by the (exit) doors. The alarm was going off, but the aids (V10 and V11 CNAs) were in the 500 hall (past the memory care nurse's station) and they thought it was the other door to go into the facility, due to it not being super loud. So, I went down to the end of the hall and when we went to open the door (V13 CNA) was coming in with (R1). I didn't do an investigation or an incident report. They (V13 and V20) had seen him right around the corner and so I didn't see it as an elopement. (V16 LPN) was the nurse that

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day and when I went back up the hall, she was behind the nurse's station. (V16) said she was in the medication room and didn't hear the alarm sounding."

R1's Emergency Physician Note, dated 5/24/24, documents "(R1) was found on the ground bleeding from the mouth. According to staff member at (facility) I spoke to, the Certified Nursing Assistant said she saw (R1) ten minutes prior to him being discovered down. Unknown loss of consciousness. Patient with history of Dementia, unable to contribute to history. Noted facial/mouth bleeding and deformity. Abrasions to bilateral knees." These Physician Notes also document "Impression and Plan: Fall, Fracture of Thoracic Spine, Cervical Spine Fracture, Bilateral Mandibular (lower jaw) Fracture, Closed Maxillary (upper jaw) fracture. Transfer to (tertiary hospital) on 5/24/24 at 8:40 PM."

R1's (tertiary hospital) Emergency room to Admission notes, dated 5/25/24, documents R1 was admitted to the Cardiac Intensive Care unit on 5/25/24. This note documents R1 underwent a T10-T11 (thoracic spine) Open Reduction Internal Fixation with Percutaneous screws on 5/26/24 and was transferred to the hospital's Neuroscience Critical Care unit on 5/27/24.

On 6/3/24 at 2:30 PM, V1 confirmed R1 remains hospitalized.

"A"