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S 000	Initial Comments Complaint Investigation: 2483412/ IL172618 2483815/ IL173188	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999		

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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:

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.

These requirments are not met as evidenced by:

Based on observation, interview and record review, the facility failed to supervise and monitor two residents (R1 and R3) of 6 residents reviewed for supervision. These failures resulted in R3 eloping from the facility without staff knowing that R3 eloped and R1 having a fall after being left in the shower room unattended and sustaining a forehead laceration which required sutures and sustaining a non-displaced linear fracture of the right distal radius.

Findings include:

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According to face sheet, R1 is a 64-year-old resident admitted to the facility on 01/07/20222. R1's face sheet documents the following diagnoses including but not limited to: Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, gastritis, unspecified, with bleeding, aphasia following cerebral infarction, essential (primary) hypertension, heart failure, unspecified, encounter for palliative care, dysphagia, oropharyngeal phase, acute respiratory failure with hypoxia.

MDS section GG (dated 03/12/2024) documents that R1 requires substantial/maximal assistance for showers and transfers. (Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.). MDS section C (dated 03/12/2024) documents that R1 has a BIMS score of 10, indicating that R1 has moderate cognitive impairment.

Care plan (dated 11/20/2023) documents that R1 has a self-care deficit (ADLs/Mobility) r/t hemiparesis/hemiplegia. The care plan documents that R1 is at risk for falls r/t weakness and impaired mobility and cognition.

R1's Fall Risk Assessment (dated 01/23/2024) documents that R1 is a high fall risk with the score of 12.

R1's Progress Note (dated 05/03/2024) documents, "Upon arrival to 3 south, this writer was informed that the resident was on the floor by the housekeeper. This writer promptly responded. Resident observed on floor in 3-South, assisted bath-shower room. Head to toe assessment

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performed. Resident observed with laceration to right side of scalp, right shoulder bruise and right knee bruise. Resident transferred safely to wheelchair per 3 staff members due to space issue. Resident's vital signs- BP 150/98 P 101 R 20 O2 98% on room air, T 97.9. NP notified and orders to transfer resident to [community] Hospital ER obtained. Resident's daughter contacted and was notified. Director of Nursing made aware of incident & pending transfer. Resident exited via gurney per 911 paramedics."

R1's Progress Note (dated 05/03/2024) documents, "The writer called [community] hospital to follow-up on resident. The resident will be discharged back to Facility. ER nurse will call back with ETA."

R1's Progress Note (dated 05/04/2024) documents, "Resident returned from [community] hospital ER after been evaluated post fall yesterday morning. Brought back by two ambulance personnel and head to toe assessment was performed in which she has splint on her right-hand order of lidocaine patch was also brought back from the hospital. Quietly in bed sleeping."

R1's Hospital Diagnostic Imagining Report (dated 05/03/2024) states: There appears to be a non-displaced linear fracture through the right distal radius laterally which is best seen on the oblique view. There are no fractures or dislocations of the right hand. Discharge instructions for Laceration Repair of the scalp: Your scalp wound was cleansed and closed with stitches, staples, rubber bands, or adhesive strips.

Facility Final Incident Investigation Report (dated

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05/10/2024) states: On 05/03/2024 at 9:10am, R1's assigned CNA. was assisting her with a shower. The CNA was assisting R1 with getting dressed after the shower was complete when R1 fell to the floor. The CNA immediately called for assistance. The nurse responded and assessed R1 injury noting a small cut to the right side of her head, bruising to her right shoulder, and bruising to her right knee. R1's NP was notified of the fall and post-fall assessment findings and the new orders were received to transfer R1 to the hospital for further evaluation and treatment. R1's daughter, was notified of R1's fall and transfer to the hospital. While in the hospital, R1 was diagnosed with a non-displaced linear fracture of the right distal radius. She returned from the hospital on 05/04/2024 with a splint and a Lidoderm patch for pain.

On 05/21/2024 at 11:42am V12 (Licensed Practical Nurse) stated, "R1 requires extensive care at times. For showers, R1 needs assistance. She can't do it by herself. R1 needs to be transferred into the shower chair and then transferred from the shower chair to her wheelchair. R1 needs to be dressed by staff and she needs help with everything. During the shower, you cannot leave R1 alone. We don't leave any resident alone during showers. For showers, R1 requires the assistance of 1 staff member."

On 05/21/2024 at 11:46am, surveyor observed R1 on the 3rd floor, secured memory care unit. R1 was being monitored by staff while R1 was sitting in the day room participating in resident activities. R1 was observed to be working on a puzzle. R1 nodded her head in response to surveyor, indicating that R1 is doing fine. R1 was observed to be comfortable and safe within her

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environment. Surveyor inspected R1's room and noted that R1's bed was in a low position, and a landing mat was present at the resident's bedside. R1 was observed to be wearing a helmet for safety.

On 05/22/2024 at 11:15am V20 (Housekeeper) stated, "On 05/03/2024, I was cleaning a room and I heard a sound that sounded like boom. I went to the shower room to see where the sound came from. I opened up the door to the shower room and I saw R1 laying on the ground. I went to inform the nurse. R1 was in the shower room by herself. There was a shower chair in the shower room, and R1 fell from the shower chair. No staff where present in the shower room when I saw R1 on the floor. I went to inform the nurse and the nurse came to assess R1 immediately."

On 05/22/2024 at 11:44am V19 (Nurse) stated, "On 05/03/2024, I arrived on the unit and V20 (Housekeeper) said to me that he heard a fall. V20 alerted me and another nurse. I immediately went to the shower room, and I saw R1 laying on the floor. I assessed R1 from head to toe. R1 had a laceration to the right scalp, a bruise to her right shoulder and a bruise to her right knee. R1 was crying and R1 was in pain. R1 is not able to verbalize readily. R1 can nod her head in response to a question, and make her needs known for the most part. R1 is on the memory care unit. I was told by the other nurse that the certified nursing assistant (V23) who was assigned to R1, left R1 in the shower room unattended. This incident took place somewhere between 7am and 8am. I called R1's Nurse Practitioner, the ambulance and I called R1's daughter. R1's daughter said that she was on her way to the facility. The ambulance arrived right away. R1's daughter arrived almost at the same

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time as the ambulance. R1 was transported to the hospital. I believe R1 returned back to the facility that same evening. R1 is a resident that requires a lot of supervision. It is not appropriate and not safe at all to leave R1 alone in the shower room."

Surveyor inquired about interviewing V23 (Certified Nursing Assistant assigned to R1 on 05/03/2024, at time the fall incident took place). On 05/22/2024 at 12:21pm V1 (Administrator) stated, "V23 was terminated on 05/03/2024, the day of R1's fall incident.

On 05/22/2024 at 12:48pm, V24 (R1's Physician) stated, "R1 is a high fall risk. R1 requires assistance from nurses and certified nursing assistants. R1 is not safe to be in the shower room by herself. R1's fall on 05/03/2024 could have been prevented, this was a preventable fall."

On 05/23/2024 at 11:37am V15 (Restorative Nurse) stated, "R1 is a high fall risk due to having weakness and her health diagnosis. The fall prevention measures in place for R1 are floor mats at bed side for when R1 is in bed, a helmet, non-slip pad for R1's wheelchair, low bed and close monitoring. R1 needs to be up in a chair and R1 needs to be closely monitored when R1 is not in bed to prevent falls. R1 is not safe to be left alone in the shower room."

According to face sheet, R3 is a 74-year-old resident admitted to the facility on 04/19/2024. R3's face sheet documents the following diagnoses including but not limited to: Syncope and collapse, essential (primary) hypertension, type 2 diabetes mellitus without complications, cardiac arrest, cause unspecified, cerebrovascular disease, unspecified. According

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to a nursing progress note (dated 04/19/2024), R1 is ambulatory and alert and oriented x3. According to progress notes, R3 eloped from the facility on 04/26/2024.

R3's Care plan (dated 04/22/2024) documents that R3 is at risk for falls related to general weakness. The care plan documents that R3 has a self-care deficit (ADLs/Mobility) de-conditioning from recent hospitalization.

R3's Progress Note (dated 04/26/2024) documents, "Resident not present upon doing rounds at facility. CNA staff stated that resident was possibly at appointment and had not returned on shift. Resident was reportedly not seen prior to lunch and did not eat lunch. No f/u information was given or received from 1st shift nurse during report. Unable to f/u due to lack of information about appt that resident may have been at. Oncoming nurse aware that client has not returned to facility from whereabouts."

R3's Progress Note (dated 04/27/2024) documents, "Resident not received in report."

R3's Progress Note (dated 04/27/2024) documents, "Resident not observed on unit during routine rounds. Manager on duty made aware. All staff on unit initiated a thorough search of the unit. DON made aware and code yellow paged overhead. All staff completed a thorough search of the facility grounds. Staff unable to locate the resident. Police department notified. Resident physician notified. Resident's listed cell phone contacted, and family member answered the phone. Family notified of resident not in facility. Calls placed to area hospitals, shelters, and senior centers with no success locating resident. Writer spoke with resident's roommate

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who indicated that resident called his family to pick him up in the side parking lot. Resident packed his personal belongings and left the facility AMA."

R3's Progress Note (dated 04/29/2024) documents, "Resident remains absent from facility as of this time."

Facility Final Incident Investigation Report (dated 04/29/2024) states: On 04/26/2024, around noon, R3 was observed by his roommate, R9, talking to his family on the phone about wanting to leave the facility. According to R9, R3 had been talking to his family on the phone throughout the afternoon. R3 appeared upset with his family because he wanted to leave immediately, however, they couldn't pick him up until they got off of work later in the evening. Nurse V25 (Licensed Practical Nurse) was R3's assigned nurse for 3-11 and 11-7 shifts. She was late for work, arriving at 4pm. She did not receive nurse-to-nurse handoff because the prior shift nurse had already left for the day. She did not complete routine rounds. Between 4pm and 5pm, R3 packed up his belongings and left the facility with his family. R3 left through the front door. His family picked him up in the side parking lot. Staff contacted the VA (Veteran Affairs) regarding R3 leaving the facility. The VA caseworker indicated that this is a common behavior for R3, he frequently admits to skilled nursing facilities and leaves AMA abruptly. The VA caseworker indicates they have had contact with R3, and he is safe in the community.

On 05/21/2024 at 10:03am via telephone V4 (R3's friend) stated, "R3 is fine. R3 did not like the facility and he left. R3 is fine and safe. I just talked to R3 a little while ago. R3 told them that

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he was going to get his mail and then he left the facility. R3 took all of his belongings when he left, and I picked him up from the side parking lot. R3 did not like the facility so he just left right out."

On 05/21/2024 at 10:14am V3 (Nurse Consultant) stated, "We did have one elopement. The elopement was R3. R3 left on 04/26/2024. R3 was an alert and oriented resident. R3 was admitted to the facility on 04/19/2024. R3 was alert and oriented and R3 left. We were able to determine that R3 left somewhere between 4 and 5pm on 04/26/2024. R3 left and did not tell any staff that he was leaving. R3's roommate told us that R3 was on the phone with his family, or someone that sounded like his family. The roommate told us that the person picking R3 up was going to pick him up after work, which is after 4pm. R3 packed up all his personal items and was picked up in the side parking lot of the facility. We talked to the Veteran Affairs (VA), and they were able to locate him after R3 left. R3 was not answering his phone after he left from the facility. We did a whole house education on supervision and elopements. We hired a second front door monitor because we had a bad survey related to substance abuse, so we placed a second person there for monitoring and supervision. It is believed that R3 walked right out the front door without being stopped. R3 is safe after he eloped from the facility. On 04/26/2024 at 7:30, there is a progress note that says that the nurse did rounds and R3 was not there. This nurse put the note in after the fact. It was during her shift that we determined that the resident eloped. The timeline of the progress notes does not reflect the timeline of the actual occurrence of R3's elopement. The date and time are not properly reflected in the progress notes. V5 was the nurse who initiated the code "Yellow," That's a

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code for a missing resident. A search was done on all units and R3 was not found."

On 05/21/2024 at 11:20am V5 (Licensed Practical Nurse) stated, " I left here on 04/26/2024 at 3pm and R3 was still in the facility. R3 was still here when I left. On 04/27/2024 when I returned to work the next day, R3 was not here. R3 was not able to be located when I showed up to work the next day. R3 did not sign the Against Medical Advice (AMA) form with me. When I started my shift on 04/27/24, I noticed R3 was not here and I called a code "Yellow," which means there is a missing resident. During the code, we were not able to find R3. R3's roommate stated that R3 packed his belongings and left with a family member. R3's roommate also left AMA, so the roommate is not at the facility anymore. I tried to reach out to the resident via cell phone and R3 did not answer. The police were called the same day when R3 was noted to be gone from the facility and a report was filed."

Elopement Policy (undated) states: The facility has a plan in case of an elopement of a resident from the facility. This enables the missing resident to be found as quickly as possible and to maintain the resident's safety, dignity, and privacy; If the resident is not located the facility supervisor will designate an employee to notify the resident representative, attending physician, policy department, surrounding area hospitals, surrounding shelters, surrounding area senior shelters.

Supervision and Safety Policy (undated) states: Our policy strives to make the environment as free from hazards as possible. Resident safety and supervision are facility-wide priorities. Resident supervision is a core component to

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