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S 000	Initial Comments Complaint Investigation 2424848/IL174601	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

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

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.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced

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by:

Based on interview and record review, the facility failed to provide supervision to a resident identified as an elopement risk, who had been exhibiting an increase in verbalizations of exit seeking behavior. On the morning of 05/18/24, R1 removed his (elopement alert bracelet) and exited the facility unnoticed. R1 was later found propelling his wheelchair approaching a road containing a high volume of traffic. R1 was one of three residents reviewed for wandering/elopement in the sample of three.

Findings include:

The facility's 'Code Pink- Missing Resident/Elopement' policy (revised 04/2023) documents, "The facility maintains a process to assess all residents for risk for elopement, implement risk reduction strategies for those identified as an elopement risk, and institute measure for resident identification at the time of admission. Elopement is the ability of a cognitively impaired resident who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way." This same policy documents, "Risk Reductions Measures: Interventions that may be used for residents identified as high risk for elopement include: Frequent monitoring of the resident's whereabouts to assure he or she remains in the facility; room placement close to common areas such as the nurse's station and away from exits; promoting activities that are in full view of staff members; Alternative activities to maintain the interest level of the wanderer; Implementation of wander bracelet or other electronic alert systems, transfer to a more suitable or more secured

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unit/facility, if needed." This policy also documents, "Verification of control systems: If an electronic surveillance system is in place, door alarms are tested weekly for proper functioning and the testing is documented; Door alarm codes are changed routinely; Resident electronic monitoring sensors are checked every shift for placement and daily for proper functioning and documented in the Resident Record, Treatment Administration Record, Medication Administration Record, or a specifically designed log."

R1's Medical Record documents R1 was admitted to the facility on 04/02/24 with the following diagnoses: Urinary Tract Infection, Major Depressive Disorder, Vascular Dementia, and Delusional Disorder.

R1's Elopement Risk Assessment (dated 05/13/24) documents a score of 8, indicating R1 is, "at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated."

R1's Elopement Risk/Wanderer care plan (dated 05/13/24) documents R1 is at risk for elopement and documents the following interventions: "1:1 monitoring. IDT (interdisciplinary team) to discuss and re-evaluate; Assess for fall risk; Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; Identify pattern of wandering- Is wandering purposeful? Does it indicate the need for more exercise? Intervene as appropriate; Provide 1:1 supervision with staff; Provide structured activities- toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes."

R1's Physician Order (dated 05/21/24)

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documents the following order: "Ensure (elopement alert bracelet) is attached to right ankle every shift and night shift to test function."

R1's Treatment Administration Record (dated May 2024) documents R1's elopement alert bracelet was not checked on the day shift of 05/18/24 and was last checked at some point during night shift on 05/17/24.

R1's Progress Note (dated 05/13/24) documents: "(R1) was assessed for elopement/unauthorized leave. The resident does not have a history of wandering/elopement and does not verbalize a strong desire to leave. The resident has a diagnosis of dementia and/or severe mental illness. Resident has reported or documented episodes of elopement and/or attempts to elope. The resident's representative (i.e., Health Care Power of Attorney, close family member, guardian) has requested that the resident be monitored on the Elopement Protocol. Behavioral Observations include: Verbalizes a serious/strong intent to leave the facility in the absence of an appropriate discharge plan. Responds poorly to staff re-direction when roaming into areas that are "off limits" or unauthorized. Has the physical ability to leave the building. Becomes agitated, confused and/or disoriented or displays consistently poor judgement (would not be able to safely care for him/herself outside of the facility). Resident is at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for Elopement is indicated."

On 07/03/24 at 10:30 AM, V11 (Social Service Director) stated R1's cognition would fluctuate from day to day, "He could always answer the questions from the BIMS (brief interview for mental status) assessment correctly and would

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score 15 (indicating cognitively intact), but there were several instances when he could not recall a conversation I had with him the previous day. I had multiple conversations with him about why he had a court-appointed guardian. He would then ask me the same thing the following day and could not recall the same conversation we'd had about it from the day before."

R1's Progress Note (dated 05/18/24), written by V1 (Administrator), documents, "Resident (R1) noted to have exited facility, no alarm sounded. Staff approached resident and attempted to redirect back to the facility; these attempts were unsuccessful. 911 called and (R1) resisted and was aggressive towards emergency personnel before being sent to (local hospital) for evaluation. No injury noted. Guardian and physician notified."

On 07/02/24 at 01:35 PM, V3 (Certified Nursing Assistant) stated the following regarding R1's 05/18/24 elopement, "I know it was on a weekend sometime in May. I was told he made it a couple of blocks. He was close to Route 24, which is a pretty busy road. He would say that he was going to leave daily. I heard he cut his (elopement alert bracelet) off and then left. I don't think the alarm sounded since he wasn't wearing his (elopement alert bracelet). He was pretty well in his right mind most of the time. The code to exit the building used to be posted next to the keypad in the breezeway near the front door, so he probably just entered the code to get out. I know they had to change codes to some of the other doors because he knew the code to unlock and open them. When (R1) got out of the building, he was in his wheelchair, and I believe someone in a car spotted him and notified the facility. I believe (V4, Certified Nursing Assistant) and (V5, Registered

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Nurse) left the building to find him."

On 07/02/24 at 02:00 PM, V6 (Certified Nursing Assistant) stated, "(R1) got out of the building on 05/18/24. He kept saying to that he was going to leave. I know he told (V7, Certified Nursing Assistant) that he was leaving on that same morning before he eloped. From what I have been told, (R1) got out alone and nearly made it to Route 24, and that is a very busy road. I am not sure how he was found."

On 07/02/24 at 02:10 PM, V4 (Certified Nursing Assistant) stated she was working on 05/18/24 when R1 eloped from the facility. V4 stated, "We were getting ready to serve breakfast, and I got a message from (V8, Certified Nursing Assistant) on our work communication messaging app. The message said, '(V5, Registered Nurse) and I (V8) are on (Route) 24 with (R1).' I tried calling (V5 and V8) and got no answer from either one of them. A few minutes later, I told the other staff in the building I was going to go find them. I got in my van and headed toward (Route) 24. I didn't see them, so I sent a text to (V8) for their location, and she responded that they were up by (Route) 24 on the side road towards (nearby town). When I found them, (R1) was very agitated, and shortly after I got there, the police showed up followed by an ambulance." V4 then stated, "(R1) must have gotten out the front door. He was in his wheelchair and made it down to the corner, turned left and headed toward Route 24. I believe some lady driving saw him and notified the facility."

On 07/02/24 at 02:30 PM, V8 (Certified Nursing Assistant) stated she was one of two staff members that were first to locate R1 on 05/18/24 after he had eloped from the facility. V8 stated, "It

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was about 08:00 AM and we were serving breakfast. I was up front in the lobby. (R1) likes to sit up front near the entrance to the building in the living room. I was talking to (V5, Registered Nurse), and a lady came in the front door. She told us she was driving and saw a man in a wheelchair on the road. She said that she had stopped to check on the man and he told her he was going home, so she decided to drive here and come inside to alert someone. (V5) and I got in her car and found (R1) propelling his wheelchair a couple blocks away. He had almost made it up to Route 24. He was actually very close, and that road is very busy with traffic. He was in his wheelchair, and he was very agitated because we had found him. We called (V1, Administrator) and (V2, Director of Nursing), and they talked to (R1) and basically explained his options. He remained agitated, so (V5) called 911. Two police officers showed up and then an ambulance. (R1) was sent to the emergency room and they (medics) had to sedate him to get him into the ambulance. (R1) somehow got his (Elopement alert bracelet) off. I heard he cut it off, and then he entered the code to exit the building since it used to be posted on the wall next to the keypad by the front door. It has since been changed. (R1) is alert enough to know how to enter the code to unlock the door. At some point, I had messaged (V4, Certified Nursing Assistant) to let her know where (V5) and I were because we had been out of the building for at least 30 minutes, and I knew people were going to start wondering where (V5) and I were at. (V4) came to where we were in the road in her van, and we loaded (R1's) wheelchair in her van when (R1) was taken to the hospital." V8 stated she was never asked to give a witness statement about the incident, "No one ever talked to me about it, and I thought that was a little weird."

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On 07/03/24 at 09:35 AM, V5 (Registered Nurse/Former Manager on Duty) stated she is one of the staff members that responded after R1 eloped from the facility on 05/18/24. V5 stated, "I remember I was on the phone with a resident's family member about lab results. A lady from the community came in the building and told (V8, Certified Nursing Assistant) that there was a man in a wheelchair going down the road. (V8) and I got in my car and located (R1). He was agitated that we had found him, and he was dead set that he was going home. I called (V1, Administrator) and (V2, Director of Nursing). Both tried talking to (R1) and he still refused to return, so 911 was called. The police arrived and then the medics. (R1) was combative with them and had to be sedated before they transported him to the hospital. While we were standing in the road, I noticed he did not have his (elopement alert bracelet) on his wheelchair. I asked him where it was, and he would not tell me. When he returned from the hospital a couple days later, he told me he had found a pair of scissors in the receptionist's desk drawer, cut the bracelet off, and threw it in a drawer with the scissors. I went and checked the drawers in the front living room, and there sat a pair of scissors and a cut (elopement alert) bracelet. (R1) had made it very close to Route 24. If that lady wouldn't have come when she did, it could have turned really ugly. I believe (R1) would have attempted to cross that road, and it's a road that is very, very busy with traffic." V5 stated she was never asked to give a witness statement or provide any details of the incident after it had occurred. V5 stated R1 was alert and oriented most of the time, but did exhibit some confusion about going home, "He did not understand why he had a court-appointed guardian, and this had been explained to him

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often. At times, (R1) would get into a state of mind where he was not making safe, rational decisions. Before he got out of the building, he kept talking about leaving. He knew the code to exit the dining room door that led to the courtyard, and since he was not allowed outside by himself after the incident, the code to exit the dining room door was changed. The code to the front door used to be posted right next to the keypad where you enter the code to unlock it. I am sure this is how (R1) got out, the code was posted so all he had to do was type it in on the keypad. That code had to be changed after all of this occurred."

On 07/03/24 at 10:55 AM, V7 (Certified Nursing Assistant) stated she was working on 05/18/24 when R1 eloped. V7 stated, "I talked to him early that morning when he was in his room. I asked him how he was doing, and he said 'OK.' He told me not to worry about his stuff because it's all packed up, and I saw that all of his personal items were packed in a black garbage bag. He then told me that he was going to leave that day. He said, 'right after breakfast I'm going to head out those doors.' I told (V12, local agency Licensed Practical Nurse), who was working in the East Hall that day. I never saw (V12) go and start checking on (R1) frequently after I had reported all of this to her. She really didn't do anything after I told her."

On 07/03/24 at 03:00 PM, V12 (local agency Licensed Practical Nurse) stated she recalls the day when R1 eloped from the facility, "I had never worked with that resident (R1) before. I was told he had been saying he was going to leave and go home. One of the CNAs (V7) told me that he told her he was leaving after breakfast and that he had all of his bags packed in a garbage bag. I saw him when he was heading to the dining

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room. I went ahead and gave him his medications, and that was the last time that I saw him. The manager on duty (V5, Registered Nurse) was aware of what he was saying and told me she had spoken with (R1), so I continued on with my medication pass." V12 stated, "I haven't worked at that facility much, but I do remember the code to unlock the door is posted right by the keypad in the entryway."

On 07/03/24 at 08:15 AM, V1 (Administrator) confirmed R1 eloped from the facility on 05/18/24 and stated, "It happened on the weekend. The alarm didn't give warning and (R1) went through the door. I believe he was about half a block away. When staff found him, he was very noncompliant and wasn't rationalizing with anyone. 911 was called and (R1) was sent to the hospital for a psychiatric evaluation. He was placed on 1:1 supervision when he returned to the facility. I believe someone from the community alerted staff in the building that a man was propelling his wheelchair down the road." V1 stated an incident investigation was not completed after R1's elopement, and therefore, he cannot provide an investigation for review.

On 07/03/24 at 12:55 PM, V2 (Director of Nursing) stated that R1 eloped on a day during the weekend, and she was not at the facility when it occurred. V2 stated, "I got a call from (V5, Registered Nurse) and she told me that she was outside of the building with (R1). I could hear (R1) in the background saying he wanted to go home. He lived in (nearby town), which is at least a 30-minute drive from the facility. I asked him to return to the facility with (V5) and told him that if he was not willing to return, EMS (emergency medical services) would be contacted to handle the situation. 911 was then called and R1 was

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taken to the hospital. I did find out later that he told (V5) that he cut his (elopement alert bracelet). V2 stated there was no type of investigation completed on R1's 05/18/24 elopement incident because, "he wasn't harmed from what I understand from the regulations." V2 stated, "(R1) has some periods of confusion. He couldn't understand why he couldn't just leave the building and wheel himself back to his hometown. There were multiple conversations that had to be repeated because he couldn't recall the same conversation that occurred the day before. He lacked safety awareness."

On 07/08/24 at 08:50 AM, V2 (Director of Nursing) stated an intervention should have been implemented on 05/18/24 when R1 was making statements of leaving the building. V2 stated, "If he had his bags packs and he was verbalizing a plan, I would expect staff to put him on 1:1 supervision."

On 07/08/24 at 09:00 AM, V5 (Registered Nurse/Former Manager on Duty) stated, "I was the Manager on Duty when (R1) eloped. I remember seeing (R1) in the dining room. I believe one of the CNAs (V7) reported to the nurse (V12) who then came to speak with me. I do recall speaking with (V12) about (R1). He was out in a common area, so he was never put on 1:1 supervision."

(A)