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S 000	Initial Comments Complaint Investigation 2469803/IL181787	S 000		
S9999	Final Observations Statement of Licensure of Violations: 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	S9999		

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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. Restorative measures shall include, at a minimum, the following procedures.

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 are not met as evidenced by:

Based on observation, interview and record review the facility failed to provide adequate supervision for a severely cognitively impaired

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resident (R8) known to wander about the facility. The facility also failed to: complete a timely resident elopement assessment, implement fall interventions, assess a resident who had an unwitnessed fall prior to moving them, provide a safe environment, and have exit doors monitored. These failures affect one (R8) resident of six residents reviewed for elopement/accidents in the sample list of twelve residents. These failures resulted in R8 exiting the facility unnoticed and unsupervised in the dark exposing R8 to 21-degree Fahrenheit temperatures outside the building, and R8 falling in the facility mechanical room with an improperly stored chemical spilled on R8.

Findings include:

a.) R8's undated Face Sheet documents medical diagnoses of Dementia with Agitation, Alzheimer's Disease, Glaucoma, Anxiety, Muscle Weakness, Unsteady on Feet, Need for Assistance with Personal Care and Chronic Pain.

R8's Minimum Data Set (MDS) dated 9/15/24 documents R8 as severely cognitively impaired. This same MDS documents R8 requires the assistance of one staff member for transfers and is able to propel herself independently in her manual wheelchair.

R8's Physician Order Sheet (POS) dated December 2024 documents a physician order starting 9/1/23 for Aspirin 81 milligrams (mg) daily. This same POS documents a physician order starting 10/17/23 for R8 to use a chair sensor pad and for staff to check every shift.

R8's Fall Risk Assessment dated 9/15/24 documents R8 as being at risk for falls.

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R8's Careplan intervention dated 7/13/23 instructs staff to use a bed and chair alarm for R8 and to check it every shift and to replace it as needed if a defect is noted. R8's careplan does not include a focus area, goal nor interventions for R8's known wandering, or history of early rising and entering the kitchen unattended.

R8's Elopement Risk Assessment 6/15/24 documents R8 as a risk for elopement. R8's medical record documents R8's most recent completed elopement risk assessment as dated 6/15/24.

R8's Physical Therapy Evaluation and Plan of Treatment dated 10/21/24 documents R8 was able to ambulate 10 feet, 50 feet and 150 feet with set up or clean up assistance using her roller walker with a normal gait pattern.

R8's Nurse Progress Note dated 12/1/24 at 8:42 AM documents "(R8) was noted not in her room around 4:40 AM. Staff began searching for (R8) as she wanders at times. (R8) was found in the kitchen near outside door laying on her Right side. Upon body assessment no injuries were noted. (R8) was unable to explain what she was doing due to her Dementia. Assisted (R8) to bed as she was asking to go to bed. Neurological Assessment initiated per facility protocol for unwitnessed fall. On call nurse (V3) as well as (V2) Director of Nurses (DON) and (V1) Administrator notified due to location of fall. The on call (V32) Physician was notified due to (R8) being on Aspirin and (V32) advised to observe for changes and notify if any worsening noted."

R8's Post Fall Evaluation dated 12/1/24 documents R8 had an unwitnessed fall on

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12/1/24. This same evaluation documents staff noticed R8 was not in her room at 4:40 AM and staff started searching for her at that time. This same evaluation documents R8 was found laying on the floor on her Right side in the kitchen by an outside door. This same evaluation documents R8's wheelchair alarm was not in place. This same evaluation documents the plan of care for R8 should be to apply a (departure alert system) for when R8 goes near exit doors, check the wheelchair for alarm when R8 self transfers and to keep alarms out of reach of R8.

The public website www.timeanddate.com documents the facility location was 21 degrees Fahrenheit (F) at the time of R8's fall on 12/1/24.

On 11/27/24 at 2:30 PM R8 was self propelling throughout hallways in the facility. R8 did not have a personal alarm on her wheelchair.

On 12/2/24 at 9:20 AM The facility mechanical room contained multiple kinds of chemicals including floor cleaner, bleach, Rinse Additive, dishwashing detergent, liquid drain opener, insect killer, carpet shampoo, snow and ice melt sprinkles, waste liquefier drain maintainer, oven and grill cleaner and floor finish/sealer all within reach of where R8 fell on 12/1/24. Other items in the mechanical room include electrical cords, circuit breakers, floor buffers, boilers, holding tank, sprinkler system and water softeners. There were double doors located directly next to the internal mechanical room door with a red 'EXIT' sign placed above the doors. Outside these doors was a concrete slab that leads to two large generators as tall as the building and beyond that sits a dumpster. The facility dumpster is approximately 20 steps from the exit door of the mechanical room and 25 steps from

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the back EXIT doors. The double doors that separate the dining rooms from the kitchen were not locked, coded and had no (departure alert) system in place. The facility mechanical room's internal and external doors were unlocked. The facility double EXIT doors located directly next to the facility internal mechanical room door were not locked, coded and had no (departure alert) system in place. There were multiple chemicals that would be within arms reach of the location of R8's fall. A five gallon bucket was approximately one quarter filled with a blue/green liquid and had no lid present. This same bucket labeled 'Rinse Additive' was propped against another bucket. A large pile approximately three feet tall of white large bath blankets soiled with a blue/green color were laying in a pile next to where R8 had fallen.

On 12/3/24 at 11:43 AM The facility mechanical room contained all the same chemicals as observed on 12/2/24. The five gallon bucket of 'Rinse Additive' was sitting in an upright position with no lid covering the blue/green chemical inside. The double doors that separate the dining rooms from the kitchen were not locked, coded and had no (departure alert) system in place. The facility mechanical room's internal and external doors were unlocked. The facility double EXIT doors located directly next to the facility internal mechanical room door were not locked, coded and had no (departure alert) system in place.

On 12/4/24 at 11:58 AM The facility kitchen had gallon jugs of bleach, cans of stainless steel cleaner, portable heater, electrical outlets under food preparation table, ovens, warmers, fryer, dry food storage, large metal sheet pans, floor stand mixer and counter microwave that would all be within reach of a person in a wheelchair. The

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double doors that separate the dining rooms from the kitchen were not locked, coded and had no (departure alert) system in place. The facility mechanical room's internal and external doors were unlocked. The facility double EXIT doors located directly next to the facility internal mechanical room door were not locked, coded and had no (departure alert) system in place.

On 12/5/24 at 3:00 PM the facility mechanical room's internal and external doors were unlocked. The facility double EXIT doors located directly next to the facility internal mechanical room door were not locked, coded and had no (departure alert) system in place.

On 12/3/24 at 3:25 PM V32 Certified Nurse Aide (CNA) transferred R8 from her wheelchair to her recliner in R8's room. V32 CNA positioned R8's wheelchair several feet from R8's recliner chair. R8 used her walker to walk six steps with hands off stand by assistance from V32 to her recliner. V32 CNA did not place R8's personal alarm in R8's recliner before leaving R8's room. On 12/3/24 at 3:35 PM V32 Certified Nurse Aide (CNA) stated R8 is supposed to have her personal alarm underneath R8 when she is sitting in her wheelchair, recliner or when in bed. V32 stated V32 should have placed the alarm in R8's recliner. V32 CNA stated "(R8) has had her personal alarms for a year or so but only has one pad alarm so we (staff) have to move it from the wheelchair to the recliner to the bed each time. (R8) really needs one for each because we forget many times."

On 12/2/24 at 9:00 AM V21 Licensed Practical Nurse (LPN) stated R8 had an unwitnessed fall in the mechanical room on 12/1/24. V21 stated R8 had been in her recliner in her room prior to her

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getting up independently. V21 stated V21 was on R8's hall due to another resident having behavior problems. V21 stated V21 did not hear R8's personal alarm sounding. V21 stated "I don't know if (R8) shut off her own personal chair alarm or if the staff just didn't put the alarm in her chair." V21 stated R8 routinely will shut off her personal alarm and get up independently. V21 stated R8 frequently gets up at night to look for snacks. V21 stated the staff will offer R8 snacks and drinks but if the staff are busy, R8 will go to the kitchen and help herself to whatever snacks are left out. V21 stated when they (V28, V29 Certified Nursing Assistants) found R8, she was laying on her Right side in the mechanical room, with her wheelchair outside by the dumpster. V21 stated V21 did not see and/or assess R8 until R8 was back in her room and in bed. V21 stated R8 was not assessed by a Licensed Nurse prior to the staff (V28, V29) moving R8 after her unwitnessed fall. V21 stated the staff (V28, V29) told V21 that the back door to the mechanical room was propped open. V21 stated by the time R8 was back in her bed, her skin was warm with no signs of injuries. V21 stated "I called (V31) Physician and reported (R8's) unwitnessed fall. I didn't report that R8 had been outside in 20 degree F temperature, that R8 had chemical spilled on her or that a nurse had not assessed her prior to moving her. I should have but I was so panicked about the whole situation in general. Those were important details (V31) Physician should know."

On 12/2/24 at 9:25 AM V27 Cook stated V27 clocked in at 4:17 AM on 12/1/24. V27 stated (V28, V29) came around 4:30 AM to ask if V27 had seen R8. V27 stated she replied 'No, I have not seen her'. V27 stated she was the only one in the kitchen at that time. V27 stated V27 heard

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noises coming from the back of the kitchen area so she went to investigate. V27 stated V27 opened the mechanical room door and found V28, V29 CNAs standing over R8 who was laying on the concrete floor. V27 stated the back exit door of the mechanical room was propped open prior to this incident so that V25 Care assistant for Assisted Living area could come in without having to bother any of the staff. V27 Cook stated "Those girls (V28, V29) were just standing there looking at (R8). I grabbed some blankets and put over her because (R8's) whole body was shivering and her face was gray/blue colored. I told those two (V28, V29) to call an ambulance but they didn't. I used a bunch of bath blankets and shop towels to help clean up the chemical that spilled on (R8). It was all over her pants and side that she was laying on. (R8) also wet herself but that was up over her private area. I saw the open five gallon bucket of Rinse Additive laying right next to her. That is what was spilled on (R8). There were lots of chemicals right there around where (R8) was laying. There are no alarms or locks on our kitchen doors so (R8) or anyone else can just walk through the dining room, into the kitchen, into the mechanical room or through the exit doors without any of us knowing."

On 12/2/24 at 9:53 AM V25 Care Assistant for Assisted Living stated "I was walking to work that morning (12/1/24) and saw (R8's) wheelchair sitting half on the concrete and half on the grass out by the dumpster. The back door to the maintenance room was wide open. I could see (V28, V29) standing over (R8) inside the mechanical room. (R8) was shivering and looked very cold. (R8's) face and hands looked blueish. I called (V24) Assisted Living Director to let her know what was going on so she could get help. I

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didn't know who else to call, so I just called my boss (V24). I got (R8) some blankets and so did (V27) Cook. (V28, V29) just stood there. We (V25, V27) told (V28, V29) to call 911 but they just stood there. I saw (V28, V29) get (R8) back in her wheelchair before a nurse saw (R8). There wasn't a nurse around."

On 12/2/24 at 1:15 PM V2 Director of Nurses (DON) stated the staff should ensure that any resident with a personal alarm keeps that alarm in place and functioning. V2 stated the staff should have reported that R8 was previously known to remove her personal alarm and also that she had entered the kitchen prior to R8's 12/1/24 fall. V2 stated anytime a resident falls, that resident should be assessed by the Licensed Nurse prior to assisting the resident up. V2 stated moving a resident who has an unwitnessed fall prior to the nurse assessing that resident could lead to (further) injury. V2 DON stated V21 Licensed Practical Nurse (LPN) called V2 the morning R8 fell on 12/1/24. V2 DON stated "I was out of town that morning so I referred (V21) to (V1) Administrator since he was closer to the facility. I was told later that (V21) did call (V1) but I don't know what was said during that conversation. I only know that (V21) LPN did not report to me that (R8) had been outside, had chemical spilled on her or that the staff had gotten (R8) up after her unwitnessed fall without having had the nurse (V21) assess her first. All of those things are big problems. (R8) should have been sent to the emergency room for further evaluation."

On 12/2/24 at 2:35 PM V28 Certified Nurse Aide (CNA) stated V29 CNA asked V28 to help look for R8 at 4:30 AM when she was found to not be in her room. V28 stated V28 and V29 CNAs found

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R8 laying on the concrete floor of the mechanical room at around 4:55 AM on 12/1/24. V28 stated staff searched inside and also went outside with flashlights to look for her. V28 stated "We (V28, V29) found her laying on the floor in the mechanical room. (R8) looked pretty cold so (V27) Cook put some blankets on her. (R8) had her personal blanket over her but her pants and side were wet. I think (R8) had wet herself (urinary incontinence episode) but that big bucket of some kind of blue chemical was also spilled over right next to her. It was all over the side of (R8). The side of the bucket was touching (R8's) leg. I don't know why it didn't have a lid on it but it sure didn't. I was in panic attack mode. I just couldn't believe what I was seeing. (R8) is known to shut off her personal alarms. I said 'Let's go check the kitchen' because (R8) will get herself up early in the morning from 4:00 AM-6:00 AM, go in the kitchen and get some coffee to drink. I don't know why they (facility) don't put locks on those doors. (R8) was wearing her street clothes, not a nightgown. (R8's) wheelchair wasn't in the mechanical room. Somebody got it from outside to bring in so we (V28, V29) could put her in it and take her back to her room. That is when the nurse (V21) assessed her."

On 12/3/24 at 10:45 AM V23 Certified Nurse Aide (CNA) stated V23 was assigned to R8 the night she fell in the mechanical room. V23 stated the last time V23 saw R8 was during routine rounds at 2:30 AM. V23 stated V23 began the next set of rounds at 4:00 AM at the opposite end of the hall from where R8 resides and reached R8's room about 4:30 AM. V23 stated R8 was first noticed not in her room at 4:30 AM. V23 stated V23 told V21 Licensed Practical Nurse (LPN) that R8 was missing at that same time. V23 stated V23, V28 and V29 CNAs started searching for

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R8. V23 CNAs stated V28 and V29 both found R8 first and V23 arrived a few minutes later. V23 stated V23 saw R8 laying on her Right side on the concrete floor of the mechanical room. V23 stated the mechanical room is located on the back of the kitchen area. V23 stated "(R8) was cold. (R8) was shivering and her face was gray looking. There was some kind of blue/green chemical that was spilled all over (R8) on her side and on her legs and buttocks. (R8) had her blanket covering her but it wasn't wet. (R8) had also been incontinent of urine but that was up by her private area. (R8's) pants were wet with chemical not urine. This would have been a few minutes before 5:00 AM. There wasn't a wheelchair in the mechanical room with (R8). (R8) didn't look like she was injured so (V28, V29) got her up into her wheelchair that one of them (V28, V29) brought in from the outside. We (V23, V28, V29) took (R8) back to her room and put her to bed and let (V21) LPN know where (R8) was."

On 12/3/24 at 11:20 AM V1 Administrator stated V21 Licensed Practical Nurse (LPN) reported to V1 that R8 had an unwitnessed fall in the kitchen area with no injuries. V1 stated V21 did not report that R8 was outside, had a chemical spilled on her nor that R8 was not assessed by a Licensed Nurse prior to getting R8 back up after her fall. V1 stated "I am a nurse. That is Nursing 101. Anytime a resident has an unwitnessed fall, the nurse is supposed to assess that resident prior to moving the resident. I didn't find out until a couple of days later that (R8) had chemical spilled on her or was ever outside. The pieces match up though. (R8) had to have exited the facility for her wheelchair to be outside. I also found out that (R8's) personal chair alarm was not in place. Apparently the staff knew that (R8)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTHUR HOME, THE	423 EBERHARDT DRIVE ARTHUR, IL 61911

(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 12	S9999		

was removing and/or shutting off her personal alarm and entering the kitchen for coffee prior to (R8's) fall on 12/1/24. This should have been reported to management staff so that we (facility) could take precautions for (R8). (R8) has Dementia and is not safe to just wander around the facility into areas that she shouldn't be by herself. There are a lot of facility failures in this incident and I am trying to work through them to get some systems in place so this doesn't happen again."

On 12/3/24 at 11:35 AM V33 Physical Therapy Assistant (PTA) stated R8 was referred to Physical Therapy (PT) for an evaluation and evaluated on 10/21/24. V33 stated R8 does not remember to lock her wheelchair and has very poor safety awareness. V33 stated R8 should not be ambulating independently due to her high fall risk.

On 12/3/24 at 3:40 PM V31 Physician stated the facility called V31 on 12/1/24 to notify V31 of R8's unwitnessed fall. V31 stated V21 Licensed Practical Nurse (LPN) reported to V31 that R8 had an unwitnessed fall in the kitchen with no injuries. V31 stated the facility did not report that R8 had been outside in extreme temperatures, been exposed to chemicals and not assessed by a nurse prior to moving R8. V31 Physician stated R8 could have been injured worse without having been assessed prior to moving a Dementia resident after an unwitnessed fall. V31 stated V31 would expect the facility to immediately call 911 emergency services and then call V31. V31 stated "In these extreme cases, it is always best to notify emergency services first and then call the Physician, family and anyone else. It is most important to get the resident the emergency medical attention that they need. Even if they

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S9999	Continued From page 13	S9999		

hadn't called 911, I would have absolutely sent (R8) to the emergency room due to being exposed to frigid temperatures and the chemical. Those chemicals should have been stored properly to avoid accidents just like this one." V31 stated R8 could have had Hypothermia, Low Blood Pressure causing a change in her Level of Consciousness (LOC) or died from an internal injury, the exposure to the cold or falling on a concrete floor.

The facility policy titled Elopements and Wandering Resident Policy revised 4/25/23 documents the facility will provide a safe and secure environment for all residents. The facility will properly assess residents and plan their care to control wandering behavior and prevent elopement. Wandering is random or repetitive locomotion that may be goal-directed or non-goal directed or aimless. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. An elopement assessment will be completed on admission, quarterly and after a significant change in condition. The careplan will be modified as necessary. Notify the appropriate State Agency of any incident or accident which has, or is likely to have a significant effect on the health of a resident or any incident or accident requiring the services of a physician, hospital, police department, coroner or other service provided on an emergency basis. This notification of the appropriate State Agency by telephone or fax must be made within twenty-four hours of the serious incident/accident with a narrative

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S9999	Continued From page 14 summary forwarded to the appropriate State Agency within five days. Observe for aimless wandering, fear or anxiety about the surroundings. Review physical plant to be sure door alarms are working and that unauthorized areas are properly locked to prevent resident entry. (A)	S9999		