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	IL6001341	A. BUILDING: _____ B. WING _____	C 01/09/2025

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S 000	Initial Comments Complaint Investigation 24410410/IL182987	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal 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:

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 requirements are not met as evidenced by:

Based on interview and record review the facility failed to monitor and supervise 1 of 3 residents (R4) reviewed for elopement in a sample of 10. This failure resulted in R4 leaving the facility unattended, on 12/20/2024 from 2:00 AM to 3:30 AM, falling outside the facility, sustaining multiple abrasions to both lower extremities, a dislocated left wrist, and a laceration to R4's forehead and left cheek that required sutures.

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S9999	Continued From page 2	S9999		

Findings include:

R4's diagnoses are Unspecified Injury of Head, subsequent encounter, Bipolar Disorder, History of Falling, Violent Behavior.

R4's Care Plan, dated 10/17/2024, documents Resident is at risk for elopement r/t (related to) increased confusion. 10/17/2024 15-30 min checks as needed (PRN). Monitor where abouts PRN. 12/20/24 resident assessed, (local) PD called resident sent to (local) hospital for eval and treatment. Medication review upon return to facility.

R4's Minimum Data Set, dated 11/27/2024, documents that R4 is severely cognitively impaired.

R4's August and November 2024 Elopement Assessments, documented R4 was at high risk for elopement.

The facility's Elopement Book, located at the 300/400 hall nurse's station, documents Elopement Evaluation, dated 8/20/2024 High Risk, R4's Picture on Resident Elopement Risk Information with description of R4 and Admission Record.

Per National Weather Service on 12/20/2024 from 2:00 AM to 4:00 AM it was 32- 36 degrees Fahrenheit.

R4's Incident Report, dated 12/20/204, documents that R4's mental status was confused/forgetful, not oriented. Predisposing Physiological Factors: poor trunk control, gait imbalance, impaired memory. Predisposing Situation Factors: Active Exit Seeking

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S9999	Continued From page 3	S9999		

R4's Progress Note, dated 12/20/2024 at 3:30 AM, documents Nurses Notes Note Text: This nurse was on break and I then received a phone call from 300 hall CNA(Certified Nursing Assistant) stating that resident eloped and was found outside the building by staff; resident confused and forgetful; resident has a laceration to the forehead and abrasions to his arms and legs; 911 immediately notified; DON (Director of Nursing) notified; Administrator notified; Resident transferred to (local) Hospital in Belleville; plan of care continues.

R4's Local Hospital Emergency Department report, dated 12/20/2024, documents History of Present Illness Chief Complaint Patient presents with Fall 9:16 AM (R4) is a 65 y.o. (year old) male presenting to the ED (emergency department) c/o (complaints of) fall onset PTA (Proir to Arrival). EMS (emergency medical service) states pt (patient) came from NH (nursing home) where he hit staff there. He ran away, tripped, and hit his head on the ground. He has multiple abrasions to BLE (bilateral lower extremities). Also has a few lacs (lacerations) to his left side of face. Sutures to R4's forehead and cheek.

R4's Progress Note, dated 12/20/2024 at 10:37 AM Nurses Notes Note Text: Resident returned from (local) hospital r/t fall with laceration to face. Resident is up with walker. Skin w/d to touch. Rest (sic) even unlabored. No c/o pain or SOB noted. Resident agreed to take a shower and after will speak to his ex-wife via phone.

R4's State of Illinois Department of Public Health Long-Term Care Facility & 110 - Serious Injury Incident and Communicable Disease Report, dated 12/20/2024, documents staff noted resident

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S9999	Continued From page 4	S9999		

was agitated all evening shift. nurse stated that she tried to redirect him from doors and when she did this, he tried to hit staff. staff noted the last time seen was 2:30am. around 3:00-3:30am staff noted resident outside of facility and resident had fallen. staff brought him into facility. nurse completed assessment. he had multiple lacerations on face and abrasions on legs. staff denied hearing any door alarms going off. resident was sent to ER for evaluation and returned with sutures in one laceration.

R4's Progress Note, dated 12/21/2024 at 5:19 PM, documents Nurses Notes, Note Text: Resident Left wrist is bruised and swollen and will point to the left wrist area when you ask where it hurts. Resident has kicked one staff member and another resident. NP (Nurse Practitioner) notified, (local) ambulance and (Local) pd notified.

R4's Local Hospital After Visit Summary, dated 12/21/2024, documents Reason for visit: Altered Mental Status. Diagnosis Dislocation of wrist and aggressive behavior. It also documented Patient Education for Preventing falls in adults.

V15's, CNA, written statement, dated 12/20/24, documents between 3 to 4:45 AM R5 pointed out that he seen someone outside of his window. V15 entered R5's room and looked out the window and saw another resident on the ground with a walker struggling to get up. V15 ran outside and assisted R4 up and other staff came and helped. V15 stated that he assisted with getting R4 back into the building. V15 then went back to his workstation.

V11's, Licensed Practical Nurse (LPN), written statement, dated 12/20/2024, documents Did you see (R4) leave his unit? Yes, he was wandering

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S9999	Continued From page 5	S9999		

all night long. I redirected him from the front door multiple times. He was being aggressive.

On 12/31/2024 at approximately 11:30 AM R4 stated that he left the facility and was trying to go home. R4 stated that he used his bike, pointing to his walker. R4 stated that he made it off the property and up the street. R4 stated that he was outside for a long time. R4 stated that he was "so cold." R4 stated that he fell and hurt himself badly. When asked how did R4 leave the facility? R4 refused to answer.

On 1/2/2025 at 1:00 PM R5 stated that he saw someone outside his window with a walker. R5 stated that he told the staff. R5 stated that he did not see R4 fall but that R4 was wobbly. R5 stated that he couldn't sleep that night and could not tell who it was but did see a man that was wobbly outside his window.

On 1/2/2025 at 2:56 PM V8, LPN, stated that she came in to work and observed R4's hand was swollen and bruised. V8 stated that R4 was pointing to the area and complaining of pain. V8 stated that she called and sent R4 to the Emergency room. V8 stated that she received a call from the hospital of R4 being combative and having to be placed in 4-point restraints while at the hospital. V8 stated that she was informed that R4 had fallen outside the day before and of him being combative and kicking staff and other residents. V8 stated that R4 was being monitored because of his exit seeking prior to the elopement. V8 stated that R4 was on 1 on 1 and was taken off the day prior to the elopement. V8 stated that she had not received or performed in servicing with staff on elopement or fall prevention since the incident.

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S9999	Continued From page 6	S9999		

On 1/2/2025 at 4:04 PM V14, CNA, stated that she came in on the end of it. V14 stated that R4 was sitting in a chair bleeding from his head, face, and legs. V14 stated that R4 was cold to touch. R4 stated that the concern was that R4 was cold and had been out of the facility for a couple of hours.

On 1/2/2025 at 4:18 PM V12, CNA, stated that R4 was having behaviors and attempting to leave the facility throughout the shift. V12 stated that there were several attempts to redirect without success. V12 stated that V13 put R4 to bed and V12 thought that everything was ok. V12 stated that she last saw R4 around 2 AM to 230 AM. V12 stated that she was in a room with another resident and was told that R4 was outside the building.

On 1/3/2025 at 10:15 AM V16, Nurse Practitioner, stated that she was notified of R4's swelling and injury to the left wrist. V16 stated that she was notified by V2 or V3. V16 stated that the injury was related to the fall that occurred the night before. V16 stated that if R4 was having behavior and exit seeking she would expect the staff to monitor the resident and not leave them alone. V16 stated with R4's severe cognitive impairment and cold weather it would not be safe for R4 to be outside for a long period of time.

On 1/3/2025 at 10:48 AM V13, CNA, stated that she was there when R4 fell outside. V13 stated that R4 was having behaviors and was trying to leave the building. V13 stated that this was several times throughout the shift. V13 stated that she had taken R4 to his room several times and he would go back to the door. V13 stated that she had taken R4 back to his room. V13 stated that she did not stay with R4. V13 stated that she did

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S9999	Continued From page 7	S9999		

not increase supervision but did address the behaviors when she was aware. V13 stated that the last time she saw R4 was around 2 AM. V13 stated that she was told that R4 was outside about 3:30 AM. V13 stated that she went outside to help. V13 stated that R4 was on the side of the building. V13 stated that she put R4 in her truck and drove R4 around to the entrance. V13 stated that R4 did not say what happened he would just keep saying he was "so cold."

On 1/3/25 at 4:52 PM V15, CNA, stated that R5 notified him he saw someone outside his window. V15 stated that he looked out R5's window and saw R4 outside on the ground. V15 stated that R4 was struggling trying to get up off the ground. V5 stated that he went up and got help and went outside and helped R4 up and inside the building. V15 stated that R4 did not say how he got out or what happened. V15 stated that once R4 was in the building he went back to his work area.

The facility's Elopement Policy, dated 9/2022, documents DEFINITION/GENERAL: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Elopement Risk: If the cause of the alarm is the resident attempting to leave the unit, the following measures will be taken: a. Resident will be redirected to the unit b. Additional monitoring of the resident as appropriate c. Update care plan as appropriate.

(A)