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	IL6002943	A. BUILDING: _____ B. WING _____	C 05/22/2025

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S 000	Initial Comments Complaint Investigation 2553893/IL191682	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.1210b) 300.1210c) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide supervision of a cognitively impaired ambulatory resident in 1 of 3 residents (R4) reviewed for elopement risk in the sample of 3 residents. The failure resulted in R4 exiting the facility at approximately 6:30 AM on 5/6/25 and was followed by V3 (Licensed Practical Nurse) to a local business. While in the parking lot of the business, R4 left V3's line of	S9999		

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sight which resulted in R4 going unsupervised from approximately 6:50 AM until 9:10 AM when R4 was located in the garage of a local residence by the police.

Findings include:

R4's Admission Record documents an admission date of 3/28/2025 and includes diagnoses of unspecified dementia, unspecified severity without behavioral disturbances, psychotic disturbances, mood disturbance, anxiety disorder, major depressive disorder, single episode, unspecified and glaucoma. R4's MDS (Minimum data Set) dated 4/4/2025 documents a BIMS (Brief Interview for Mental Status) score of 7 indicating that R4 has severe cognitive impairment. Section GG documents R4 requires supervision or touching assistance with mobility. Section E, Behavior, documents under "Wandering" occurred 1 to 3 days during the assessment period and documents "yes" to "Does the wandering place the resident at significant risk for getting to a potentially dangerous place (e.g., stairs, outside of the facility)?"

R4's Elopement Risk Assessment effective date 3/30/25 documents that R4 has a history of previous elopement attempts at home and is considered at risk for elopement. R4's Elopement Risk Assessment effective date 4/1/25 documents that R4 has a history of previous elopement attempts at home and is considered at risk for elopement. R4's Elopement Risk Assessment effective date 5/5/25 documents that R4 has a history of previous elopement attempts at home and is considered at risk for elopement.

R4's Care Plan has focus area of elopement

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dated 3/30/2025 with goal for decreased elopement risk. Interventions dated 3/30/2025 list, photo taken and added to elopement book, wandering behavior, and resident likes hot tea with honey, offer to her when exit seeking or wandering.

R4's Progress Notes document on 5/5/2025 at 9:00AM, Note Text: Resident exit seeking, had her jacket on and purse in hand stating she was leaving now, due to this, I was watching her as she got to the door and was redirected. Authored by V3 LPN (Licensed Practical Nurse).

R4's Progress Notes document on 5/5/2025 at 09:02 AM, Note Text: Resident exit seeking, had coat on and purse in hand stating she was leaving now, resident got to the door and was redirected back to her room, will get urinalysis if possible due to acute confusion and this was out of the ordinary for this resident, will notify her son, power of attorney of incident. Authored by V3 LPN.

On 5/5/2025 at 12:15 PM, R4 was observed in the front lobby with staff around R4, R4 was saying she wanted to leave, and she had a birthday party to go to. Staff was intervening to keep R4 inside the facility. R4 was not easily redirected

On 5/5/2025 at 1:00PM, R4 was observed outside with 3 employees. R4 was stating she was leaving and not coming back. Staff was encouraging resident to return inside the building but R4 refused.

R4's Progress Note dated 5/6/2025 at 2:12PM, documents, alarm went off this morning at 6:30AM and resident had left the property, V3

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followed her to make sure R4 didn't get hurt but when V3 called the police and rehab resident took off and could not be found, resident found 3 hours later, taken to local hospital for evaluation then brought back to facility and stated R4 was going to leave again.

A document titled "Police Department" Incident Report, date reported 5/6/2025 at 6:56:44 via wire phone. Incident missing elderly woman at (Name of local street). Dispatched at 7:22:30 AM, Drone was deployed at 8:45:04, (R4) located at 9:10:13 AM in garage right behind local business, called ambulance.

R4's "Elopement" investigation dated 5/6/2025 at 6:30AM prepared by V19 (Regional Clinical Director) documents incident description: Resident (R4) exited A wing door, nurse immediately followed and attempted to re-direct resident back into the facility. Resident was very agitated and restless and would not re-enter the facility. Nurse continued to walk with resident and attempted to talk with her and attempt to redirect back to the facility. Resident description: Resident is unable to give description. Immediate Action Taken: Description: Medical Doctor (MD) and Power of Attorney (POA) notified. Police notified. Resident taken to the hospital. N. Mental Status section is not completed. Mental Status: oriented to person. Section titled Notes dated 5/6/2025 documents at 6:30PM staff assisting resident out to dining room for breakfast. Door alarm started sounding. Nurse (V3) immediately went to the A wing door and exited it and seen resident. Resident had on appropriate clothing, gray jacket, gray pants and tennis shoes. Temp outside was approximately 56 degrees. V3 immediately went to resident and attempted to re-direct her back into the facility. Resident was

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not redirected. Resident was very agitated and stated that she was going to Texas. V3 stayed with resident and walked beside while she continued to redirect. V3 and resident came to the main highway Route 51 and nurse and resident safely crossed the main highway. V3 and R4 went to local business where resident was trying to open their door. V3 saw an employee sitting in his truck in the parking lot so V3 and resident walked over to the employee so V3 could ask him to call 911. Employee opened the door to speak to V3 and R4 started walking towards the front of the truck and then took off running east. On 5/6/2025 at 7:00AM Facility Administrator (V1) and Director of Nursing (V2) notified, and police called. V1, V2 and several staff members immediately began searching for resident in their cars as well as on foot. MD and resident's son immediately notified. At 7:30AM Police have notified the Illinois State Police, and they have begun a search as well. At 8:30AM IDPH notified. At 9:10AM R4 located behind local business in a garage. Resident appears safe and without injuries. Police and ambulance at location and EMS (Emergency Medical Services) transported resident to the hospital to be checked out further. MD and POA updated immediately. At 11:30AM R4 returned from the ER (Emergency Room). No injuries or acute conditions noted. Full assessment completed and noted no injuries, etc. MD and POA notified of resident's return to the facility.

On 5/6/2025 at 8:30AM, this surveyor received a call from V17 (Owner of Facility) stating R4 had eloped and was missing. V17 stated a staff member was with the resident the whole time but then the resident got out of sight and now they can't find her. V17 stated the staff, police department, and fire department were on the

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scene in the area looking for R4.

Upon entering the facility on 5/6/2025 at 9:10AM, V19 (Regional Clinical Director) stated "have you heard about (R4)?" V19 stated well R4 went out the door and the nurse (V3) responded to the door alarm and followed the resident all the way to the local tire shop. V19 stated at that time V3 flagged down an employee and as the employee was opening the door to let R4 in, V3 turned around and R4 was just gone. V3 stated the search then started so they could find R4, but she has not been found yet. V18 stated, "We don't know where she could be."

On 5/6/2025 at 10:40AM, V18 (Director of Operations) approached this surveyor and asked if this surveyor knew what had happened. V18 stated R4 went out the door and the nurse (V3) responded to the alarm. V18 said the nurse could not convince R4 to come back in so V3 followed R4 down to the main road. V18 stated they then crossed the road and V3 still could not convince R4 to go back so V3 went into the local tire shop to ask them to call for help. V18 stated when V3 quickly came back out then R4 was gone, so the search began and was finally found.

On 5/7/2025 at 12:45PM, V3 (Licensed Practical Nurse/LPN) stated she was the charge nurse for R4 the morning of 5/6/2025. V3 stated she heard the alarm going off at the door at the end of "A" hall. V3 stated it was around 6:30AM. V3 stated she ran out the door and R4 kept walking so she walked with her. V3 said R4 walked up towards the local tire store going down roads and alleys. V3 stated R4 said "I am going to see my son." V3 stated, "We crossed the main highway, but I was with her." V3 stated, "(R4) did look both ways before crossing the road, and I had her arm the

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whole time." V3 stated, "I see a gray truck parked at the tire shop and I went to the man in the truck to call 911 and in a matter of seconds R4 disappeared as I was walking around the gray truck." V3 stated she looked for R4 but could not find her anywhere. V3 stated others from work came to help search for R4. V3 stated she looked for about an hour and had to go back to the facility to return to work. V3 stated the police were involved too. V3 stated R4 was not an elopement risk before this and has never known R4 to try to elope out of the facility. V3 stated when they brought R4 back, R4 stated she was leaving again so they got her a puppy, V3 stated R4 didn't try to go out anymore. R3 stated she had worked on 5/5/2025 as well.

On 5/7/2025 at 11:00AM, V9 (local business employee) stated the store opens at 7:30AM. V9 stated he got to the store close to 7:00AM on the 6th of May 2025. V9 stated when he got there his coworker told him that an older female and a nurse were just there, and the older female went missing. V9 stated he pulled up the camera and watched the nurse and older female on camera. V9 offered to allow this surveyor to watch the video of the camera film of the morning of the 5/6/2025. V9 stated the man that talked with the nurse will be at work tomorrow (5/8/2025). V9 stated when the police knocked on the garage door that resident yelled "Come in." V9 then stated the police got in and got her.

On 5/7/2025 at 11:00AM while obtaining interviews at the local business where R4 was last seen, review of camera footage from 5/6/2025 was done. The camera footage at 6:49AM R4 and V3 was noted to be walking on sidewalk on Washington street, at 6:50:05 R4 tried to enter a house going up 2 steps, V3 stayed

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on walkway. At 6:50:21AM R4 advanced towards the 4-lane highway, V3 was beside R4 at this time and tried to hold R4's arm but R4 resisted. The two then advanced out on the highway to cross the highway, the two separated about midway across the road leaving approximately a 6-foot distance. At 6:51:03AM V3 held up arm to stop oncoming traffic. At 6:51:27AM R4 was noted to be walking to the front door of the business and V3 was out in the parking lot looking at the traffic on the 4 lane road. At 6:52:07AM R4 was seen walking beside a gray pick up truck on the driver's side and continued on around the back of the truck and on out of view of the camera off the parking lot. At this time V3 was standing out on the parking lot looking at the 4-lane road. At 6:52:31 AM V3 walked up to the gray truck and stood beside driver's side door, at 6:53:06 AM V3 came running out from the side of the truck out onto the parking lot looking for R4.

On 5/8/2025 at 9:50AM spoke with V14 (employee at local business) about the morning of 5/6/2025 when R4 went missing. V14 stated he was sitting in his truck a little before 7:00AM, waiting for the store to open. V14 stated he saw the nurse and the elderly lady walking in the parking lot. V14 stated the nurse (V3) came up to him and asked him to call the facility she worked at to get help getting R4 back to the facility. V14 stated V3 did not have her phone so he had to google the phone number. V14 stated R4 was not with V3 at that time. V14 stated he then let V3 call the facility to get some help. V14 stated 911 was not called from his phone at that time. V14 stated when V3 was done with the phone call she looked up and did not see R4, so she took off running looking for her. V14 stated he then went and looked himself and did not see the resident, but he saw footprints in the wet

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grass that led to a garage behind the house next door. V14 noticed the door was cracked open. V14 stated he then went to the business parking lot at 7:09 AM, and V1 and V3 arrived, and he told V1 about the footprints in the grass and advised her to go talk to the homeowner and ask permission to go back in the garage and look. V14 stated V1 went to the house and spoke to the homeowner but did not go around back and look in the garage. V14 stated V1 then left in her car. V14 stated he went back out a little later to see if anyone had found R4, but nobody had found her. V14 stated he looked at the garage door and noticed the door was now shut. V14 stated when the police arrived a little after 10AM he told them that he had reported to the nursing staff that he suspected R4 may be in the garage due to the footprints in the grass earlier in the morning and the door now being closed. V14 stated the police officer then went to the back of the house and knocked on the garage door and they heard R4 say "Come on in." V14 stated the police then helped R4 and called the ambulance to transport the resident to the hospital.

On 5/7/2025 at 12:03 PM, V1 stated she found out that R4 had eloped when she was coming to work on 5/6/2025 at around 7:00AM. V1 stated she went to local tire shop where she was told that R4 was last seen. V1 stated she started looking immediately for R4. V1 stated she looked all around the building and even went and looked in building behind the tire shop. V1 stated she looked in sheds behind the house next door but did not look in the garage because close to the garage was the back door and it had a sign that said, "this house is protected by guns." V1 stated so she was afraid to enter any of the doors. V1 stated the police called her for information on R4. V1 stated she was out the whole time looking for

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R4 except when she came to the facility to use the restroom. V1 stated her boss notified the owner and his assistant. V1 stated they have since put interventions in place like a stuffed dog for R4, a pilfer box with nursing supplies as R4 is a retired nurse. V1 stated someone is with her at all times, a banner for R4's door with alarms which is ordered and not in place yet, and a medication review.

On 5/7/2025 at 1:50PM, V12 (Certified Nurse Aide/CNA) stated she was not working on 5/6/2024 but when she works, she normally works A hall where R4 resides. V12 stated R4 is one of the wanderers. On the days she is exit seeking we try to let all the staff know so we can all watch her. V12 stated she doesn't recall R4 ever actually getting out of the building. V12 stated R4 normally walks safely and doesn't use assistive devices. V12 stated she noticed R4 had a cane today but not sure why. V12 stated the last time she was educated on elopement was when the other DON was here.

On 5/7/2024 at 1:40PM, V11 (CNA) stated she normally works A hall where R4 resides. V11 stated R4 was up and dressed when she got to work on 5/7/2025 at 6:00AM. V11 stated she never heard the alarm that morning as she was either outside cooling off or in the bathroom. V11 stated she was notified a little after 6:30AM that R4 had eloped. V11 stated R4 has never tried to elope before. V11 stated the last time she saw R4 was before she went out and she was at the front of the hall. V11 stated when R4 returned she was agitated but she didn't try to exit anymore. V11 stated R4 is on 1:1 right now and she hopes they keep it that way for a while.

On 5/7/2025 at 2:10PM, V2 was asked when

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elopement assessments are due, V2 stated he was not sure. V2 was asked what prompts an elopement assessment that is not scheduled and V2 then stated, " When someone attempts to elope." V2 was asked who does the elopement assessments when a resident attempts to elope. V2 stated, "I am not sure, but I would think the nurses do but mostly social services." V2 then stated if an attempted elopement happens on the weekends, he was not sure if the nurses do it or if they wait until a business day when social services is at work. V2 was asked when the last time elopement training had been done with staff and V2 stated, "I don't know, I haven't been here in the position of DON very long." V2 was asked if R4 has had any changes since she has been back, V2 stated she is calmer today because we added Xanax 0.5mg twice a day. V2 was asked if R4 was ever complaining of pain, V2 stated no she has not complained of pain or anything today. V2 stated R4 was not exit seeking today but she was yesterday. V2 stated R4's interventions for the elopement from yesterday was 1:1 but not sure how long, offer pilfer box, a stuffed dog, tab alarm while in bed, frequent checks, offer cup of coffee, talk with resident about nursing as resident is a retired nurse.

On 5/8/2025 at 11:35AM spoke with V15 (R4's daughter), as they sat with R4. V15 stated the care at the facility was good, and she was not aware of R4 trying to elope before 5/6/025. V15 stated she did know that on 5/5/2025 R4 had packed a bag and told everyone she was leaving and was just recently told this. V15 was asked if she was concerned with the care that R4 received at the facility. V15 stated it is worrisome with R4's room being close to the door that she went out. V15 was asked if anyone has offered a room change and V15 stated, "No not yet." V15

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stated she has even thought of another facility for R4 because she is not settling down here and she won't take her medications. V15 did mention another nursing home that is near the other son that they may move R4 too. V15 stated, "Who can I talk to about this because nobody has mentioned moving R4 to me." V15 was advised to talk to the staff.

On 5/8/2025 at 12:50PM, V16 (CNA) stated her first day of work was 5/6/2025. V16 stated she was in the dining room helping serve breakfast around 7:00AM when V3 came in and stated a resident was missing. V16 stated that was the first time she was made aware of anyone missing. V16 stated she did not hear any alarms going off.

On 5/8/2025 at 12:54 PM, V17 (CNA) stated she was in the dining room serving breakfast when V1 and V3 came in and told us all that R4 was missing. V17 stated she never heard an alarm, but she had been in other residents' rooms getting them dressed for breakfast. V17 stated she didn't know R4 that well and she was unaware of R4 trying to elope before the occurrence on 5/6/2025.

R4's Nursing Note dated 5/6/2025 at 11:30 AM documents, Note Text: Resident returned from the ER. No injuries or acute conditions noted. No new orders received from the hospital. MD and POA notified of her return. Resident directed to the dining room to have lunch.
(B)
Statement of Licensure Violations (2 of 2)

300.1210a)
300.1210b)
300.1210d)3)6)

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S9999	Continued From page 12 300.1610a)1) 300.1630a)2) 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 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. 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	S9999		

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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 300.1610 Medication Policies and Procedures

a) Development of Medication Policies

1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 300.1630 Administration of Medication

a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to

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S9999	Continued From page 14 residents. 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 300.1810.) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident was free from unnecessary psychotropic medications for 1 of 3 residents (R4) reviewed for medications in a sample of 3. This failure resulted in R4 sustaining a fall due to a loss of balance, resulting in a hip fracture requiring surgical intervention. Findings include: R4's Admission Record documents an admission date of 3/28/2025 and includes diagnoses of unspecified dementia, unspecified severity without behavioral disturbances, psychotic disturbances, mood disturbance, anxiety disorder, major depressive disorder, single episode, unspecified and glaucoma. R4's MDS (Minimum Data Set) dated 4/4/2025 documents a BIMS (Brief Interview for Mental Status) score of 7 indicating that R4 has severe cognitive impairment. Section GG documents R4 requires supervision or touching assistance with mobility. R4 requires supervision or touching assistance with ability to walk 10 feet, 50 feet with 2 turns, and 150 feet once standing. R4 is independent to roll left to right. R4 requires supervision or touching assistance with sit to lying position changes, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and tub/shower transfer.	S9999		

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R4's "Fall Risk Evaluation" dated 4/3/2025 at 8:34PM Category: NA, Level of Consciousness/mental state: Alert (oriented x3) , History of falls past 3 months: No falls in past 3 months, Ambulation/elimination status: Ambulatory/ continent, Vision status: Adequate with or without glasses, Gait/balance: Gait/balance normal, systolic blood pressure: no noted drop in blood pressure between lying and standing, Medications: none of these medications taken currently or within 7 days, Resident has had a change in medication or change in dosage in the past 5 days (Not checked), Predisposing disease: None present.

R4's Care Plan documents a focus area of, "I am risk for falls Gait/balance problems." Initiation date of 3/31/25. Interventions include anticipate and meet my needs initiated 3/31/25, walk with resident if she keeps pacing assist to chair with activity, initiated 4/3/25. R4's Care Plan documents another focus area of, "Resident requires use of Box Warning Medications." Initiation date of 3/28/25. Goal: No injury or adverse effect related to medication usage. Interventions include: administer black box medications as ordered by medical doctor (MD), see Physician order sheet. Assess for adverse side effects, document and report to MD. Behavior tracking in place for psychotropic medications and reviewed per facility protocol. Labs as ordered by physician to monitor efficacy of medications. Medication list reviewed routinely with resident and /or resident representative/ Power of Attorney of Healthcare, Pharmacy consultant review medications use and potential side effects. Resident medications are to be reviewed monthly and as needed by pharmacist and physician. Teach about side effects of medications with family member/responsible

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party. Verbal consent received before initiation of any new or increased psychotropic medications and consents updated per facility protocol. R4's Care Plan also documents a focus area, "I use anti-anxiety medications Anxiety disorder." Initiated 3/28/25. Interventions include: "I am taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs. Monitor FREQ (frequently) for safety. Date Initiated 3/28/25."

1. R4's Order Recap Report with a print date of 5/21/22 documents the following orders: Xanax (Benzodiazepines) 0.5 mg (milligrams), give every 12 hours PRN (as needed) for anxiety/agitation with a start date of 3/28/2025 (admission date) and an end date of 5/6/25. R4's March, April, and May 2025 Medication Administration Record (MAR) documents that R4 received 4 doses of the PRN Xanax from the time period of 3/28/2025 through 5/6/2025 on 4/7/2025 at 10:22PM, 4/21/2025 at 7:11PM, 4/28/2025 at 9:18PM, and 4/30/2025 at 7:53PM. The same Order Recap Report documents an order for Xanax 0.5 mg give 1 tablet by mouth two times a day related to anxiety with a start date of 5/6/25 and an end date of 5/8/25 and an order for Xanax 0.5 mg give 1 tablet by mouth three times a day related to anxiety with a start date of 5/8/25 and an end date of 5/16/25.

R4's Progress Note dated 5/6/2025 at 2:12PM, authored by V3 (Licensed Practical Nurse), documents "alarm went off this morning (at) 630 (6:30AM) and resident had left the property, I followed her to make sure she didn't get hurt but when I called the police and rehab resident took off and could not be found, resident was found

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about 3 hours later, taken to (name of local hospital) for eval then brought back to facility and stated she was going to leave again."

A document titled "Police Department" Incident Report, date reported 5/6/2025 at 6:56:44 via wire phone documents Incident missing elderly woman at (Name of local street). Dispatched at 7:22:30 AM, Drone was deployed at 8:45:04, R4 located at 9:10:13 AM in garage right behind local business, called ambulance.

R4's Progress Note dated 5/6/25 at 5:00PM, authored by V2 (Director of Nursing), documents "Spoke with V20 (Physician) regarding resident's anxiety. New orders received for 0.5 mg Xanax BID (twice a day). Spoke with family and obtained consent for this medication. Family stated they thought this was a good idea and was very pleased with today's outcome offering praise to the staff."

On 5/7/2025 at 1:58PM, R4 was observed ambulating with an assistive device of a cane. At that time R4 was with V13 (Activity Aide) who stated she is the one on one for R4 today. V13 was asked if R4 always used a cane. V13 stated no but R4 stated her foot hurt. R4 was asked what was hurting and R4 stated "my right foot is really hurting."

R4's Progress Note dated 5/7/25 at 2:22PM, authored by V10 (Licensed Practical Nurse), documents "Resident stated her right foot is hurting, I called (V20) and left VM (voicemail). Waiting for response."

R4's Progress Note dated 5/7/25 at 7:27PM, authored by V19 (Regional Clinical Director), documents "X-ray results reviewed to resident's

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right foot and right ankle and all results are negative for any acute fractures. MD and POA (Power of Attorney) both updated of results."

2. R4's Order Recap Report with a print date of 5/21/25 documents an order for Risperidone (Antipsychotic) Oral Tablet give 1 mg by mouth one time only related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety for 1 day with a start date of 5/8/25 and an end date of 5/8/25.

R4's Progress Note dated 5/8/25 at 8:39AM, authored by V2, documents "Spoke with family regarding residents exit seeking behavior and calling family all hours of the night. Family requested to call (V20). (V20) notified and one time dose of risperidone 1 mg to be given at this time. Resident will be monitored closely for any adverse effects and (V20) will be called this afternoon."

R4's May Medication Administration Record (MAR) documents a "1" on 5/8/25 for the Risperidone 1mg order. The "Chart Codes/Follow Up Codes" on the MAR documents that a "1" indicates refused.

On 5/15/2025 at 1:54AM, V10 (Licensed Practical Nurse) stated that on 5/8/2025 R4 did take her one-time dose of Risperidone. V10 stated on 5/8/2025, she crushed the Risperidone and mixed it in water so R4 would take the medication, but R4 still refused. V10 stated she marked refused on the Medication Administration Record. V10 stated R4 did finally take the Risperidone around 2:00PM with convincing by the family and a police officer. V10 stated she forgot to go back and document on the Medication Administration

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Record that R4 did actually take the Risperidone.

On 5/8/2025 at 10:20AM, R4 was observed in a wheelchair with V13 by her side. V13 stated she has R4 in a wheelchair due to R4 having unsteady balance and almost falling. V13 stated she was doing the one to one with R4. R4 was asked how her foot pain was and R4 stated, "It doesn't even hurt anymore." R4 was asked if it hurt when she walked on it and R4 stated, "No not at all."

On 5/8/2025 at 11:45AM, observed R4 sitting at the nurse's station with V15 (family member) and V22 (Power of Attorney). V15 was trying to talk R4 into taking her medication. V22 stated the medication was Risperidone. R4 stated "I am not taking that medication; I am a nurse, and you all are not doing that to me."

On 5/8/2025 at 1:40PM, R4 was observed at the nurse's station with V15 and V22 present with another person whom V13 identified at this time as a cop that is friends with V22. V13 said that R4 "likes cops so he is trying to talk (R4) into taking the rest of that medication."

On 5/8/2025 at 2:00PM, V2 (Director of Nursing/DON) and V19 (Regional Clinical Director) were sitting in a front office and V2 stated, "We have (R4) on Xanax now and gave Risperdal for the anxiety and elopement attempts." V2 was asked what diagnosis R4 had for the Risperidone and V2 stated "Dementia." V2 stated we don't know what else to do to keep R4 from eloping again.

On 5/8/25 at 2:10PM, V13 stated, "She took the medication for the cop so she must trust cops."

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On 5/8/2025 at 2:40PM, R4 was observed sitting at the dining room table in a wheelchair. R4 was sitting with V13. R4 appeared sluggish with her eyes halfway open. V13 stated at this time that R4 is unsafe for ambulation due to being unsteady on her feet.

R4's Progress Note dated 5/8/25 at 2:50PM, authored by V2, documents "Spoke with (V20) regarding Risperidone. Risperidone DC'd (discontinued) and new order obtained for Xanax 0.5 mg TID (three times a day). Family is aware. There are no further Progress Note entries for R4 on 5/8/25 and 5/9/25.

On 5/8/2025 at 3:00PM, V13 stated R4 is on medications, and she is sort of out of it. At that time R4 was sitting in a wheelchair in the dining room with increased confusion noted and eyes were hard for resident to keep open. R4's speech was more slurred than previous observation.

On 5/9/2025 at 10:25AM, R4 was asked how she felt today and R4 stated, "I am really tired."

R4's Progress note dated 5/10/2025 at 1:09PM authored by V3 (LPN) documents, resident was getting out of her wheelchair when she lost her balance and fell landing on her right hip and right arm, V13 tried to catch her but couldn't. Resident then was sent to local hospital to be evaluated, family and V2, V1 (Administrator), and V20 were notified.

An incident report sent to the Illinois Department of Public Health regarding R4 documents on 5/10/2025, at 1:09PM Resident observed on the floor by nurse's station. Resident was assessed immediately with noted pain to right hip.

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Resident's vitals were within normal limits. Medical doctor notified with orders to send resident to hospital for further evaluation and treatment. Power of Attorney notified. Emergency Medical Services arrived and transported resident to local hospital. Local hospital called the facility and notified staff that resident had suffered a right hip fracture. Medical doctor and Power of attorney. R4, 92, diagnosis Atrial Fibrillation, anxiety, Chronic Obstructive Pulmonary Disease, and age-related osteoporosis, BIMS 8. The resident ambulates about the facility independently. On 5/10/2025, around 1 PM, R4 was ambulating in A Hall and V13 was speaking with her and R4 stated her feet were tired and sore. There was an empty wheelchair sitting in the hall and V13 asked her if she would like to sit down and R4 said yes. After sitting in wheelchair, R4 said she wanted to speak with kids (they had just left the facility), so V13 asked R4 if she wanted to call them and R4 said yes. V13 pushed R4 up to the nurse's station to make the call. V13 went to retrieve a "regular" chair for R4 to sit in and R4 stood up, began to walk away. When V13 returned with the chair, R4 turned around, lost her balance, got her feet tangled together, and fell. At the time of the fall, R4 was wearing proper footwear, and the interventions were in place. After a thorough investigation that root cause of the incident is lack of balance and proprioception. Upon return from the hospital, a Medication Review will be completed by pharmacy consultant and results provided to the attending physician, hip protectors will be provided, and an order for physical therapy with a focus on balance and proprioception. The attending physician and power of attorney have been updated on the findings of investigation.

R4's Emergency Department Provider Notes

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records dated 5/10/2025 at 2:47PM, documents "Pt (patient) arrives via Ems (Emergency Medical Services) from (name of facility. Per EMS, pt got up from wheelchair, fell against a medcart, and fell to the ground on her R (right) side. Pt c/o (complains of) pain to R hip. R leg shortening and rotation noted." Under "ED Course" it documents Orthopedic surgery has been consulted; patient is to be admitted under the Trauma Service. Under "Clinical Impression" it documents "Fall, initial encounter, Closed fracture of right hip, initial encounter." A hospital "Procedure Note" dated 5/12/25 documents "Pre-operative Diagnosis: Right closed displaced intertrochanteric femur fracture" and "Procedure: Right short cephalomedullary nail."

On 5/13/2025 at 1:00PM, V13 (Assistant Activity Director) called this surveyor over where V13 was standing in the dining room. V13 stated, "Did you hear about (R4)? She fell and broke her hip, and I feel bad." V13 stated she was doing the one to one with R4 and R4 had been in a wheelchair all day. V13 stated R4's family member had left and R4 then wanted to call her family. V13 stated she pushed R4 up to the nurse's station but R4 wanted to call from her personal cell phone. V13 stated, "I went down to (R4's) room to get her cell phone, I wish now I would have just pushed her down there with me, but I left her at the nurse's station while I ran down there really quick." V13 stated she got the phone and headed back up by the nurse's station and as she was approaching R4, R4 stood up and took a couple of steps and fell. V13 stated, "I tried really hard to catch her, but I couldn't." V13 stated I feel so bad for leaving her.

On 5/14/2025 at 9:53AM, V13 (Assistant Activity Director) stated actually R4 was out of it and

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more confused on Saturday. V13 stated R4 didn't try to get up much on Saturday to try to walk, but I would help her walk if needed. V13 stated on Saturday R4 was mostly in a wheelchair but I helped her to sit in a regular chair for meals and activities. V13 stated "before the elopement (R4) moved pretty fast and on that day when she returned, I started the one on one and she was still the same, but then she became more sluggish with the medications." V13 stated she was working the day 5/8/2024 when the cop came in and talked R4 into taking a medication that R4 would not take for anyone else. V13 did not know what the medication was. V13 stated there was another girl at the nurse's station when R4 fell. V13 stated R4 was in pain after the fall, and she was trying to get up out of the floor.

On 5/13/2025 at 3:10PM, V3 (LPN) came to the room this surveyor was working in and asked if she could talk for just a minute. V3 was tearful. V3 stated, "I guess you know (R4) fell and broke her hip on Saturday (5/10/2025)." V3 stated, "I was working that day, and it was bad." V3 stated she knew that would happen and she even questioned the doctor about giving R4 the Xanax. V3 stated she told the doctor that R4 would end up falling. V3 stated you cannot give those drugs to residents that ambulate because it causes them to be unsteady. V3 stated, "I know they were trying to keep her from eloping but now she is hurt." V3 stated she hated giving R4 those medications because of the effects of the medication. V3 stated you cannot give the elderly residents that much Xanax without causing bigger issues. V3 stated R4 stayed in a wheelchair all day up until she fell.

On 5/14/2025 at 10:15AM, V3 stated she was R4's nurse on Saturday 5/10/2024. V3 stated, "I

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did not see the fall as I had run to answer the front door alarm, and it was a family that did not know the code to get out." V3 stated R4 was sitting up against the wall by the Oxygen room near the nurse's station talking with another resident. V3 stated they were keeping R4 in a wheelchair for safety. V3 stated R4 has never had a fall before. V3 stated "I had talked with the doctor with my concerns of the medications and contributing to possible falls, but he did not listen, ya know I am only a nurse." V3 stated, "I know how those drugs effect the elderly's coordination and balance." V3 stated the Xanax did effect R4's coordination and unsteadiness on her feet." V3 stated the Xanax did make her a lot calmer as far as that goes. V3 stated she never gave R4 a Xanax when it was ordered just as needed.

On 5/14/2025 at 9:35AM, V2 (DON) was asked what he knew about R4's fall. V2 stated he seen it on the video. V2 stated R4 was in a wheelchair across from the nurse's station. V2 stated V13 had gone to get a chair for R4 to sit in and when V13 came back around the corner she saw R4 stumble and fall. V2 stated R4 ambulates on her own anyway. V2 stated he told the nurses that if R4 started ambulating and going towards the door, to put her in a wheelchair. V2 stated nobody had reported to him that R4 had an unsteady gait. V2 stated when he left on Friday (5/9/2025), R4 was up ambulating all over the place. V2 was asked what diagnosis was used for the Risperidone medication and V2 stated Dementia with Psychosis. V2 stated since they didn't have a proper diagnosis (the diagnosis of Dementia with Psychosis), they didn't give but one dose. V2 stated Xanax was increased to three times a day.

On 5/14/2025 at 10:45AM, V20 (Physician) stated

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the last time he saw R4 was before the elopement. V20 was asked why he started Xanax routinely on R4. V20 stated, "Probably a suggestion to something to stop her from eloping and to make it easier to re-direct her." V20 was asked why he increased the dose of Xanax just 2 days later, V20 stated, "I guess it was not doing any good." V20 stated, "You normally give Xanax more time to evaluate the effects of the medication and dosage, 2 days is not really enough time to know that but they called and suggested the increase so I must have agreed. I depend on the nurses to assess the residents and make suggestions on what needs to be done." V20 was asked why he ordered Risperidone one time dose on 5/8/2025. V20 stated, "I don't recall ordering that but they must have called and suggested and I agreed." V20 was asked why he would agree to the dose of 1mg. V20 stated, "I can't imagine ordering that dosage for a patient of her size unless she was being very violent like trying to choke another resident or being aggressive uncontrollably." V20 stated, "When I do use anti psychotics like that I always start at the dosage of 0.25mg never 1 mg." V20 stated there may have been miscommunication or he was busy and didn't hear the suggested dose and just agreed. V20 stated that dose was a dangerous dose for R4. V20 was asked what diagnosis he used to justify Risperidone and V20 stated, "Dementia with Psychosis." At that time V20 was shown R4's diagnosis on the EMR (electronic medical record) which was Dementia without Psychosis. V20 stated, "Well I believe she was showing signs of psychosis, she was hiding in a garage." V20 was asked if he was aware that on 5/7/2025 R4 was using a cane for ambulation. V20 stated, "Yes, and I ordered an x-ray of her foot." V20 was asked if he was notified that R4 was then in a

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wheelchair on 5/8/2025, 5/9/2025 and 5/10/2025. V20 stated, "No I was not aware of that." V20 was asked if he was aware that R4 was refusing the Risperidone from the staff and a cop friend of the family came to the facility and talked R4 into taking the medication? V20 stated, "No I did not know anything about that either." V20 was asked if he felt like the Xanax could attribute to R4's fall with hip fracture. V20 stated, "Yes, it is a high probability." V20 stated, "That is why I don't usually use Benzo's (benzodiazepines) in geriatrics because it can affect their gait and other side effects that I don't like." V20 stated "I used it this time as that is what they suggested due to anxiety, attempts to leave the facility and that is what the facility suggested." Physician orders were reviewed by EMR with V20 and V20 wanted to know who wrote all of the orders. Orders reviewed and orders were written by V2. V20 wanted to talk with V2 so V2 was summoned to the room at 11:02AM. V2 stated he had called for orders for medications to help with R4's continued exit seeking and anxiety. V20 checked his phone for calls received and validated the calls with the time the orders were placed and did not see any issues. V20 was asked if he was aware R4 was admitted (3/28/2025) with an as needed order for Xanax, V20 stated, "I was never called to renew that order and that would have had to be done every 14 days, so I assume the order fell off." At that time R4's orders were reviewed with V20, and the as needed Xanax was discontinued on 5/6/2025. V20 stated, "Again I don't like using Benzodiazepines in geriatrics because of the sedation effect."

On 5/14/2025 at 12:14PM, a document titled "Elopement" incident report for R4 with documentation highlighted under subtitle of "Notes" was presented to this surveyor by V21

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(Regional Clinical Director). The documentation highlighted was dated 5/8/2025, and authored by V19, documents "5/8/2025 Due to residents ongoing anxiety and wandering/exit seeking behavior the family requested (V20) be called and asked if there is anything to calm resident down. (V20) notified and initially gave a one time order for Risperidone then however he discontinued that and gave orders for Xanax 0.5mg 3x day. Family/POA and (V15) agreed with this. Resident being monitored for any adverse reaction or unwanted side effects such as gait changes, drowsiness, etc." On 5/9/2025, "Resident continues the routine Xanax, and it does appear to be helping. Resident continues to be monitored for any adverse or unwanted side effects, and none are noted. Gait appears at baseline. Resident attended the Mother's Day Tea and interacted well with her family and had a good time." On 5/10/2025 authored by V3, "Resident continues routine Xanax. Medication seems to be helping overall with resident's anxiety and behaviors. Resident continues to be monitored for any adverse or unwanted side effects and there have been one noted at this time. Gait appears to continue at her baseline."

On 5/14/2025 at 12:18PM, V3 was asked if she assessed R4's gait on 5/10/2025. V3 stated. "No, I had them to keep her in a wheelchair because I was worried about her." V3 was asked if she documented on the incident report that gait was at baseline, V3 stated, "No and how would I be able to assess her gait if she was in a wheelchair." V3 was shown the document titled "Elopement" provided by V21 and the section under notes with documentation, on 5/10/2025 authored by V3. V3 reviewed the documentation and stated, "I did not write that, someone has written that and put my name on it, and I did not

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do that."

On 5/15/2025 at 12:49PM, V22 (Power of Attorney) and V15 (family member) were interviewed via telephone call and V15 stated R4 is doing better after surgery for hip fracture. V15 was asked if when she was there on 5/8/2025 did she know if R4 took the medication that they were trying to get R4 to take and V15 stated, "Yes." V15 was asked if she knew what the medication was and V15 stated, "Yes it was Risperdal." V15 stated (R4) kept talking about the police so my brother who was a fire chief called a friend who is a police officer to come and talk with R4. V15 stated, "I guess (R4) trusted him because she took the medication for him." V15 was asked if she noticed any change in R4's mental status after the elopement. V15 stated on Thursday (5/8/25) she was sort of out of it and really sleepy. V15 stated she did ok through the Mother's Day event but yes, she had been more drowsy than normal. V15 asked if this surveyor knew exactly how R4 fell, V15 said the facility wasn't really sure. V15 stated she knew they still had one to one staff with R4 but thought that the staff member turned around and R4 stood up and just fell. V15 was asked if R4 was being sedated at the hospital and V15 stated no not really but she did have a sitter up until this morning. V15 stated, "we are going back to the facility this evening so I think she will feel better there."

R4's document titled "Fall Risk Evaluation" dated 5/10/2025 at 1:09PM, documents "Category: At risk. Level of consciousness/mental state: Intermittent confusion, History of falls: 1-2 in last 3 months, Ambulation: ambulatory/continent."

According to the FDA (Food and Drug Administration) website,

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https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/020272s056,020588s044,021346s033,021444s03lbl.pdf., the drug label for Risperdal (Risperidone) documents "Warning: mortality in elderly patients with Dementia-related Psychosis ... Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperdal is not approved for use in patients with dementia-related psychosis."

According to the FDA website, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/018276s052lbl.pdf. The drug label for Xanax documents "Geriatric Use: The elderly may be more sensitive to the effects of benzodiazepines. They exhibit higher plasma alprazolam concentrations due to reduced clearance of the drug as compared with a younger population receiving the same doses. The smallest effective dose of XANAX should be used in the elderly to preclude the development of ataxia and oversedation. Dosing in Special Populations In elderly patients, in patients with advanced liver disease or in patients with debilitating disease, the usual starting dose is 0.25 mg, given two or three times daily. This may be gradually increased if needed and tolerated. The elderly may be especially sensitive to the effects of benzodiazepines. If side effects occur at the recommended starting dose, the dose may be lowered."

The facility "Psychotropic Medication Use" policy with revision date of December 2016 documents, Policy statement: Psychotropic medications may be considered for residents after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and

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