STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009922	A. BUILDING: _____ B. WING _____	C 10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE	2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701

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S 000	Initial Comments Complaint: #1866317/IL106078	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 a)b)d)6) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 REQUIREMENTS were not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide supervision off a unit, failed to communicate an increase in exit seeking behaviors, failed to ensure a door alarm sounded per policy, and failed to develop a care plan for wandering/exit seeking behaviors for one of three residents (R1) reviewed for safety on the sample of three. This failure resulted in R1 exiting a supervised unit and entering an unsupervised area of the building which resulted in R1 falling down a flight of stairs and R1 sustaining a Comminuted (splintered/fragmented) Nasal Bone Fracture, Facial Contusion, Facial Lacerations, Bilateral Lower Extremity Lacerations, and Multiple Contusions which required emergency care and hospitalization.

Findings include:

On 10/1/18 at 9:00 AM. R1 was sitting in R1's wheelchair. R1 had a bandage on the forehead. R1 had multiple yellow green bruises to R1's brow bone, under both eyes, cheeks, chin, and neck.

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R1's incident report dated 9/24/18 at 4:40 PM, documents, "found (R1) on the floor at the fire exit of the (adjacent independent living section). (R1) is on (R1's) belly, right side of head was bleeding and wheelchair was seen on the next flight."

The facility's Final Incident/Accident Report dated 9/27/18 documents, "On Monday 9/24/18 at approximately 4:45 PM, (R1) was found on the floor in a stairwell by the Independent Living dining room. Dining Room Host (V16) heard a sound and opened the door to observe resident (R1) on the stairwell landing between the first and second floor. (V16) observed (R1) on the floor with (R1's) wheelchair sitting upright in it's normal position directly beside (R1). (V16) also reported seeing the second floor door to the stairwell open. Maintenance staff (V17) was near the stairwell when (V16) responded and was able to recognize there was a resident emergency and called for a nurse. (R17) called 911 (emergency services) at 4:49 PM." This report documents that emergency staff arrived and that R1 was sent to the hospital and admitted for observation and R1 had a Comminuted (splintered/fragmented) Nasal Fracture and twelve sutures to the forehead." This report also documents that R1's electronic monitoring device was on R1's wheelchair.

R1's hospital history and physical form dated 9/24/18 documents under history of present illness that, "98 yo (year old) lives at NH (nursing home) and rolled (self) in wheelchair to assisted living facility, took an elevator up and wheeled into a stairwell falling 12 steps below. Discovered after unknown amount of time. (R1) cannot provide a complete history." This form also documents that R1 had a Comminuted Nasal

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S9999	Continued From page 3 Bone Fracture, Facial Contusion, Facial Lacerations, Bilateral Lower Extremity Lacerations, and Multiple Contusions due to a fall down stairs. On 10/1/18 at 9:38 AM, V2 ,Director of Nursing, stated on 9/24/18 between the hours of 4:30 PM to 4:40 PM, R1 exited through the doors on the A-hall and entered the independent side of the building. V2 stated R1 then took the elevator up to the second floor of the building. V2 stated there is not an alarm or key to open the elevator. V2 stated R1 then propelled self down the hallway on the second floor to the exit door leading to the stairwell. V2 stated there is not a lock or alarm on the stairway door. V2 stated R1 fell down 10 steps to the landing. V2 stated V16, Dining room host, heard a noise coming from the stairwell. V2 stated V16 saw R1 laying on the landing and obtained help. On 10/1/18 at 9:38 AM, V2 was accompanied by surveyor while V2 walked from the dining room to the elevator. The distance from the dining room located in the long term/skilled part of the facility to the elevator entrance located on the independent living side of the facility is 316 feet. The walk from the dining room to the elevator took seven minutes. V2 then took the elevator to the second floor. The second floor was unoccupied and no staff was present. The second floor was quiet and lighting was diminished. When exiting the elevator, V2 then walked a straight path down the hallway which led to the emergency exit door. This doorway led into a concrete stairway with metal handrails that descended to the first floor. The distance from the elevator door on the second floor to the stairwell entrance is 94 feet.	S9999		

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S9999	Continued From page 4 On 10/2/18 at 10:33 AM, V2 stated R1 requires supervision. V2 stated R1 is continuously going to the doors. V2 stated it is not safe for R1 to go to a unsupervised area as R1 is not cognitively intact enough to know where R1 is at. V2 stated no one lives or works on the second floor and at the time of R1's incident there was no one present on the second floor. On 10/1/18 at 11:06 AM, V14, Certified Nurse's Assistant, stated V14 worked on the A hall from 7:00 AM to 3:30 PM on 9/24/18. V14 stated R1 attempted to exit the skilled care part of the facility to the independent side of the facility by going through the A hall door. V14 stated on 9/24/18 between the hours of 2:00 PM to 3:00 PM in a twenty minute time period that R1 attempted to exit through the A hall door four times. V14 stated that R1 was agitated and resistant to redirection and that R1 was wanting to leave. V14 stated V14 went down to the D hall to talk to the nurse (V6, registered nurse) and the CNA (V19, Agency Certified Nurse's Assistant) because R1 was agitated with redirection. V14 stated R1 is usually easily redirected. V14 stated R1 was trying to stop V14 when V14 would push R1 back through the A hall doors. V14 stated V14 told V6 and V19 because V14 felt that R1 needed increased supervision. V14 stated R1's electronic monitoring device was on R1's wheelchair. On 10/1/18 at 11:26 AM, V6, Registered Nurse stated R1 has cognitively declined and the decline started in July of 2018. V6 stated R1 is very quick in the wheel chair. V6 stated on 9/24/18, V14 did tell V6 that R1 was trying to get out the A hall door. V6 stated the A hall doorway is the busiest hallway because of construction.	S9999		

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R1's medical record did not document that R1 was having increased wandering/exiting behaviors and that R1 was agitated and not easily redirected from the A hall door.

On 10/1/18 at 1:54 PM, V11, Certified Nurse's Assistant, stated V11 worked on 9/24/18 on the second shift. V11 stated V11 was R1's CNA for the evening. V11 stated V11 got report from V19 (Agency CNA). V11 stated V19 did not tell V11 that R1 was having increased exit seeking behaviors. V11 stated V11 last saw R1 at 4:25 PM in the dining room. V11 stated V11 then returned to the dining room around 4:40 to 4:50 PM to check on R1 and R1 wasn't in the dining room. V11 stated V11 then went to R1's room on the D hall and then started to check other rooms.

On 10/2/18 at 10:33 AM, V2 stated V6 and V19 should have told V11 that R1 was having increased exiting behaviors on 9/24/18.

The facility's (electronic monitoring device)/Procedure policy dated 8/26/18 documents, "A wing door, patio door, and front entrance are protected by a (electronic monitoring device) system that will alarm if a resident, determined to be at risk for wandering, should pass through or near the exit wearing a (electronic monitoring device) bracelet."

On 10/1/18 at 12:10 PM, the (electronic bypass) code to the A hall door was pushed and V2 Director of Nursing walked through the A hall door from the long term/skilled care side to the independent side holding an electronic monitoring device. At that time, the alarm did not sound. When the button from the independent side of the A hall door was pushed, V2 walked through the door and entered the A hall holding an electronic

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monitoring device. At that time, the alarm did not sound. The A hall door stayed open for 25 seconds after it was opened.

On 10/1/18 at 11:01 AM, V15, Floor Care person stated V15 has seen R1 trying to get through the double doors on A hall. V15 stated V15 has seen R1 attempt to push in the code to disable the alarm for the A hall doors. V15 stated R1 appeared to know the code.

On 10/1/18 at 2:17 PM, V10, Activity Assistant stated R1 knew the code to the door. V10 stated V10 has seen her try to get out. V10 stated a couple of weeks before R1's incident (fall on 9/24/18) V12, Certified Nurse's Assistant ,and a couple other people had seen R1 enter the code and disable the alarm to the A hall door.

On 10/1/18 at 3:15 PM, V12, Certified Nurse's Assistant stated R1 will attempt to get out the A hall door. V12 stated R1 knows the code to the door. V12 stated if someone puts in the code it will disable the door and then it won't alarm if a electronic monitoring device bracelet passes through it.

On 10/2/18 at 9:03 AM, V12 stated R1 wanders and is confused. V12 stated V12 has seen R1 attempt to put the code in. V12 stated R1 has made it past the doors on the A hall into the independent side of the building. V12 stated that if a visitor or construction worker would put the code in then R1 could pass through the doors without the alarm sounding. V12 stated R1 would sometimes make it down the hallway by therapy (15 feet).

On 10/1/18 at 2:55 PM, V8 Certified Nurse's Assistant stated V8 has heard that R1 knows the

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S9999	Continued From page 7 code which disables the alarm to the A-hall door. R1's medical record did not contain documentation of R1 attempting to push in the code to disable the alarm at the A hall door or that R1 knew the code to disable the alarm on the A hall door. On 10/2/18 at 10:33 AM, V2, Director of Nursing stated the managers found out after R1's incident (fall on 9/24/18) that if the code is punched in at the A hall door then the electronic monitoring device would not set off the alarm. V2 stated the A hall door that separates the skilled care unit and the independent living is very busy. V2 stated the beauty shop and therapy is on the independent side. V2 stated V2 would have expected staff to report that R1 was attempting the code at the A-hall door. V2 stated V2 would have expected the staff to report that the alarm would not sound when a resident wearing a electronic monitoring device passed through if the code was punched in. V2 stated V2 would have expected staff to report that R1 had made it past the A hall doors and down the hallway. R1's Minimum Data Set Assessment dated 7/18/18 documents that R1 has moderately impaired decision making. R1's Fall Risk assessment dated 7/14/18 documents that R1 is disoriented and/or wanders and that R1 is at high risk for falls. R1's nursing notes dated 7/14/18 at 3:44 PM, documented by V18 Licensed Practical Nurse, documents, "Has increase in confusion. Exited A hall door at 11:15 AM, assisted back to DR (dining room) for exercise. 15 minute checks initiated. (R1) pushed D hall door open,	S9999		

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S9999	Continued From page 8 reminded (R1) that (R1) can't go outside by self. (Electronic monitoring device) put on wheelchair." On 10/2/18 at 11:49 AM, V18 Licensed Practical Nurse stated on 7/14/18, R1 was trying to get out the door. V18 stated R1 got out the A hall door and got to the breezeway on the way to the independent living side of the building. V18 stated V18 put a code alert bracelet on R1 and started 15 minute checks. V18 stated R1 is confused and needs supervision. V18 stated it wouldn't be safe for R1 to be over there (independent side) by self. V18 stated R1 does not have safety awareness. R1's plan of care does not include that R1 has wandering or exit seeking behaviors until 9/25/18. This care plan does not include an intervention of 15 minute checks or use of the electronic monitoring device until 9/25/18. On 10/1/18 at 1:00 PM, V7 Care Plan Coordinator confirmed that R1 did not have a plan of care for exit seeking/wandering or an intervention for the electronic until 9/25/18. At that time, V7 stated R1 care plan should have been updated with the exit seeking/wandering behaviors and the electronic monitoring device in July 2018. (A)	S9999		