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	IL6003800	A. BUILDING: _____ B. WING _____	C 01/09/2018

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S 000	Initial Comments Complaint#1860019/IL99236 Complaint#1860032/IL99251 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)6) 300.2900d)2) 300.3100d)2) 300.3240a) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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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.
Section 300.2900 General Building Requirements
d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. (B)
Section 300.3100 General Building Requirements-elopements
d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. (B)
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

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Based on observation, interview and record review the facility failed to effectively monitor the whereabouts of one of five residents (R1) with known wandering behaviors reviewed for elopement and supervision in the sample of eight. R1 left the facility without staff knowledge on 12/30/2017. R1 was found dead outside an opened exterior kitchen door in sub-zero weather. R2, R3, R4, and R5 were also potentially at risk due to the facility's failure.

Findings include:

R1's Physician's Order Sheet (POS) for December 2017 documents that R1 was 89 years old with diagnoses listed as Alzheimer's Disease and Dementia with Behaviors.

R1's Brief Inventory of Mental Status (BIMS) dated 10/17/2017 documents R1 scored a 1 of a possible 15 which indicates R1 was severely cognitively impaired.

R1's Minimum Data Set (MDS) assessment dated 10/17/2017 indicates that R1 exhibited wandering behavior that "places resident at significant risk of going to potentially dangerous places." This assessment also documents that R1 was independent with ambulation.

R1's "Elopement Risk" assessment dated 10/17/2017 documents R1 as severely cognitively impaired, independent with locomotion, and exhibiting the following behaviors: "History of leaving the facility" and "wandering in the past sixty days."

R1's Care Plan last revised 10/27/2017 documents "Resident experiences wandering (moves with no rational purpose, seemingly

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oblivious to needs or safety)."

The interventions for wandering are as follows: "1) When resident begins to wander, provide a sensory box for (R1) to go through. (R1) enjoys babies so (R1) enjoys the box with baby clothes. 2) Personal Alarm in place. 3) Convey an attitude of acceptance toward the resident. 4) Encourage resident to sit down in an activity to take a break from wandering behavior. 5) If resident looks for family/significant other reassure that others know where to find him or her. 6) Maintain a calm environment and approach to the resident."

This document also states "(R1) walks through the building independently with no assistive device. Some supervision is required especially after family visits."

The facility policy "Safety and Supervision of Residents" dated 10/2017 states "Resident supervision is a core component of the systems approach to safety. The type and frequency of the resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment."

R1's Progress Notes document the following:

On 10/11/17 at 12:45PM V19, Licensed Practical Nurse (LPN) documented "(R1) resistant to being redirected. Wandering in and out of resident's rooms."

On 10/17/17 at 9:48PM V17, Registered Nurse (RN) documented "(R1) has a Personal Alarm on leg for security. (R1) does not need help to get up from bed. (R1) wanders in the facility all day."

On 11/2/17 at 10:05PM V10, Licensed Practical

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Nurse (LPN) documented "constant redirection of (R1) during shift. (R1) up and ambulating without difficulty at this time."

On 11/3/17 at 3:09PM V18, Nurse Practitioner documented "(R1) ambulating in hall all day today."

Per facility's incident report dated 12/30/17 at approximately 11:00PM R1 was found "laying on the ground near the North second door of the kitchen."

On 1/3/18 at 12:53PM V2, Licensed Practical Nurse (LPN), who verified that she was the one who discovered R1 on the night of 12/30/17 stated "(On 12/30/17) I was the charge nurse. I got here (the facility) at 10:00PM. I was the only nurse on nights. V3, Licensed Practical Nurse (LPN) was still here. At approximately 10:25PM V4, Certified Nurse's Aide (CNA) told me (R1) was missing. We did room checks. I asked (V3) when (R1) was seen last. (V3) said (V3) had not seen (R1) for a while. (V3) went out the front door to do a perimeter search. I could not determine the exact time (R1) was last seen. I (V2) walked with (V9), Certified Nurse's Aide (CNA) to the kitchen. The kitchen door was wide open and the lights were on. The North West kitchen door was cracked and I saw a body lying there. (V9) screamed. (V2) went to call 911. I stepped outside and saw (R1). I went to (R1). (R1) was lying flat on (R1's) back. (R1) was as cold as ice. (R1) had no pulse."

On 1/8/18 at 10:00AM V3, Licensed Practical Nurse (LPN) who worked 2:00PM to 10:00PM 12/30/17 stated "I think I last saw (R1) on 12/30/17 in the hallway at around 7:30PM when I gave her medication. The door between the

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dining room and the kitchen has been left open most of the time until now. I was still here (at the facility) charting when they found (R1). (R1) wandered from hallway to hallway all the time. (R1) had a Personal Alarm. I have known (R1) to set off the alarm on the front door at times. I am not aware of what time other staff saw R1 (on 12/30/17)."

A written statement dated 1/2/18 signed by V12, Dietary worker describing the evening of 12/30/17 documents "I (V12) had clocked out at 7:00PM." This statement also documents that V12 recalled seeing R1 in the dining room at "6:50PM."

On 1/7/18 at 3:16PM V4, Certified Nurse's Aide (CNA) who came in at 10:00PM 12/30/17 stated that prior to the 12/30/17 incident the door from the dining room to the kitchen was usually open all the time."

On 1/8/18 at 11:50AM V1, Director of Nursing stated "There is no (policy) to check wandering residents except every two hours or if we assess that there is a need to check more often." V1 stated that a need to check more often means if a resident makes increased attempts to leave the building or increased statements that the resident wants to leave. V1 stated "for instance, if a resident has a family visit and then tries to follow the family out. We check all of our residents every two hours." V1 identified R2, R3, R4, and R5 as additional residents at risk for wandering.

On 1/8/18 at 12:24PM V20, Certified Nurse's Aide (CNA) stated "we don't document how often we check residents who wander. We just chart if we see the resident try to get out."

On 1/9/18 at 10:10AM V5, Certified Nurse's Aide

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(CNA) stated "I worked that night. I really didn't know (R1) was out of the building that night (12/30/17). The way I found out was when a coworker called me at home after (R1) was found. The last time I saw (R1) was around 7:00PM. (R1) was talking to (V3) at the end of A hall."

V11, Dietary Worker was on duty 12/30/17 for the evening meal. On 1/9/18 at 10:15AM V11 stated "When I went to clock out (R1) was sitting at the dining table with food in front of (R1). I clocked out at 5:15pm."

On 1/9/18 at 11:49PM V11 stated that (R1) had a habit of opening the kitchen door and that V11 often had to ask (R1) not to come in the kitchen.

Written statement by V10, Licensed Practical Nurse documents that on 12/30/2017 when V10 "clocked out" at 10 PM V10 noticed the door leading from the dining area to the kitchen was open and the kitchen lights were on.

On 1/9/18 at 10:34AM V7, Certified Nurse's Aide (CNA) who was working 2:00PM to 10:00PM 12/30/17 stated "The last time I saw (R1) was between 7:50PM and 8:00PM. Another resident had asked me what time it was. I had checked my phone for the time just before going into the resident's room. At that time (R1) came up and said hello to me."

Undated written statement by V7 indicates that V7 was on C Hall when she last saw R1 on 12/30/2017. This statement notes that R1 "followed me to a room, looked around to see what we were doing and then walked away." According to this statement, V7 "ended up clocking out around 10:20. (V7) did not see (R1)

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S9999	Continued From page 7 between 8PM and 10:20PM." A tour of the Dietary Department was conducted on 1/3/18 at 1:30 P.M. with V15 Maintenance Director and V13, Dietary Manager. The kitchen has three exterior doors to the outside. On 1/4/18 at 8:45 A.M., V15 and V16, Cook stated that the kitchen exterior doors had not previously been equipped with door alarms during their employment at the facility. V15 and V16 stated they have been employed at the facility for 18 years. At the time of the 1/3/2018 observation, these doors were now alarmed. V15 Maintenance Director stated on 1/4/18 at 10:20 A.M. that it is the practice of the facility to lock the door between the dining room and the kitchen when dietary staff are not present in the Dietary Department. V13 confirmed V15's statement on 1/4/18 at 10:40 A.M. that the dining room door to the kitchen was to be locked. V15, stated "prior to the 12/30/17 incident the three exterior doors to the outside were not alarmed. The interior door from the dining area to the kitchen was equipped with a lock which locks by a button on the kitchen side only and did not automatically lock when closed as of 12/30/17." The facility is a single story building with a central common area. There are four resident room halls off the main area with nurses station and resident rooms down on all four corridors. There are alarmed exit doors at the end of all 4 halls and an alarmed door off the dining area. To the west of the common area is a dining room. There is a solid door which opens from the west wall of the dining room into the dish/preparation area of the kitchen. This door separating the dining area and the kitchen does not have an	S9999		

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automatic closure device. This dish/preparation area opens into the room where refrigerators are located. The door located in this room opens to the outside and onto a cement pad. R1 was found on 12/30/2017 outside this kitchen door.

On 1/3/18 at 9:52AM V14,County Deputy Coroner stated "There is no final cause of death in this case (the death of (R1) pending toxicology results. At this point we can say that there was no obvious trauma or physical cause of death at the scene. By the time I (V14) arrived (R1) had been in the ambulance for approximately an hour. The Emergency Medical Technicians (EMTs) could not obtain a core temperature, but I did a surface temperature of (R1's) skin and it was 8 degrees Fahrenheit. (R1's) hands and forearms were still frozen solid. (R1) was wearing a light blouse and pants, and a pair of light socks. One of the socks was dirty on the bottom as if (R1) had walked on it without a shoe and one was not. Only one shoe could be located. There was no other clothing located."

The Weather Underground a web based weather Internet site, documents the temperature in the area, around the time R1 was discovered, was -8 degrees Fahrenheit with North Westerly winds at 10.4 miles per hour at 9:53PM and -8 degrees Fahrenheit with North Northwesterly winds at 9.2 miles per hour at 10:53PM on 12/30/17.

(AA)