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	IL6010094	A. BUILDING: _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNING WHEELS	701 EAST 3RD STREET PROPHETSTOWN, IL 61277

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S 000	Initial Comments Complaint Investigation 2117580/IL139179 A partial extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

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.

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

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S9999	Continued From page 2 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 Regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a cognitively impaired resident exhibiting exit seeking behaviors was supervised to prevent elopement. The facility also failed to ensure interventions were effective to prevent an elopement for one of three residents (R1) reviewed for elopement in the sample of 3. The findings include: R1's 10/14/21 face sheet showed a 67-year-old male admitted to the facility on 4/26/21. R1's diagnosis included Metabolic Encephalopathy, Alcoholic Cirrhosis of the Liver, Protein Calorie Malnutrition, and Altered Mental Status. On 10/14/21 at 3:36 PM, R1 was seated alone on a bench outside the facility's main entrance. The bench less than 10 feet from a gate that exits into an open parking lot and adjacent road. R1 had an elopement alert bracelet around his left ankle. The elopement alert detectors were located inside the facility main entrance. The gate utilizes a key code to unlock the gate to exit the facility grounds. R1 was asked how he was able to exit the facility on 10/12/21. R1 said "It's pretty easy to crack the code to that. I've done it lots of times.	S9999		

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I'm not stupid. I hope I don't get anyone in trouble". R1 then stood up, walked over to the gate and after pulling it twice, the gate opened up. R1 did not use the keypad to enter a code and was able to open the gate by pulling on it. R1 was without elopement prevention measures on 10/14/21 when he opened the exit gate (the only barrier between himself and leaving the facility grounds). No facility staff responded to the front gate area after R1 opened the gate. This surveyor asked R1 to walk back into the facility with her.

Once inside, V9 Business Office Manager was standing near the entrance and said she observed R1 open the gate and that she told V4 Social Worker about it. V4 was also standing near the front office/entrance area. No administrative staff responded to the area. The facility is located in a rural farming community. The area R1 was found on 10/12/21 involved R1 walking over a creek and along a two-lane road with ditches, wooded areas and corn fields along the roadway.

On 10/14/21 at 11:30 AM, V1 Administrator said there haven't been any recent elopements that were "reportable". V1 said R1 "got out the front gate and was brought back" (on 10/12/21). At 2:09 PM, V1 said he's still investigating how R1 "got off grounds" and he planned to "put it into QAPI (Quality Assurance Performance Improvement) and try to figure it out". V1 said on 10/12/21, V5 Certified Nursing Assistant (CNA) called V6 Registered Nurse on the phone to notify her that she saw a person resembling R1walking along the road outside the facility. R1 was located by staff members "less than a mile" from the facility. R1 "used to live out there". R1 was about three miles from his home". V1 said R1 was

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allowed to be out front. He'd (R1) "sit and watch". R1 was "not at risk for elopement". V1 said the facility video showed R1 going out the front door at 3:30 PM on 10/12/21 and where R1 was found was about "three miles from his home" (previous residence).

At 2:15 PM, V2 Director of Nursing said interventions are put in place if a resident is at risk for elopement. The IDT (Interdisciplinary team) determines on a case-by-case basis if interventions are needed. V2 said R1 was not "exit seeking at that time and did not need to be supervised". R1 now had an elopement alert bracelet on.

At 2:20 PM V3 Admission Coordinator said R1 "would always talk about going to his farm. He still thinks he has cows and needs to do something with the animals".

V2 and V3 said R1's 10/1/21 elopement assessment showed he was at risk for elopement, the IDT determined that no interventions were needed.

At 1:55 PM, V4 Social Worker said R1 would occasionally ask about going home.

Elopement alert detectors were located at the front and rear entrances of the facility. V4 said R1 was gone from the facility "about 30 minutes from the time I was aware he was gone and the time he returned". R1 talked about leaving and how to be discharged. V4 said she isn't 100% sure how "he got out". "I'm guessing he was at least a mile away from the facility when he was found in the direction of his old house and farm".

At 2:34 PM, V5 CNA said she left the facility

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S9999	Continued From page 5 around 3:30 PM on 10/12/21. I saw someone walking on the side of the road and I thought it was R1. I called the facility at 3:42 PM and spoke to V6 RN. I told her to check and make sure R1 was in the building because it looked like him (walking down the road). R1 was not authorized to be off grounds by himself. V5 CNA stated it probably isn't safe for him (R1) to be out walking along the road by himself. At 2:48 PM, V6 RN said V5 CNA called her on the facility phone and asked if R1 was supposed to be out walking along the road. I started looking for him in the facility and asked the aides to help. V1 was out of town at a meeting and V2 was not in her office. I checked all the courtyards. I hopped in my car and started driving around looking for him. R1 was always talking about having to go check the cows and the fields. R1 always said he wanted to go home and needed to go home. I returned to the facility after searching the area for him. The police were notified. V1 arrived where they found him and was able to get him (R1) into his pickup truck. At 3:04 PM, V7 Social Worker said V8 CNA found R1 (on 10/12/21) about a half a mile away walking on Lyndon Road trying to get home. R1 did not stop. He kept walking. At 3:11 PM, V8 said she was dropping her daughter off at the facility on 10/12/21 before 4:00 PM. I heard they were looking for R1. R1 told me last week where he used to live. I realized he may head toward his old home. I got about a mile down the road (toward his old house) and found him walking along the road. He seemed upset and he wouldn't stop walking. I could tell he was annoyed with me interrupting his purpose but he was polite. V1 arrived and was able to get R1 into	S9999		

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S9999	Continued From page 6 his truck. On 10/15/21 at 9:10 AM, V9 Business Office Manager said R1 left the facility grounds on 10/12/21. V9 said she was monitoring R1 from leaving the facility grounds. V9 said she was seated inside the facility and R1 was alone outside the facility near the exit gate. V9 said the alarm bracelet R1 wore would not prevent elopement as he was in front of the building and past the detector. V9 said there were no interventions in place the afternoon of 10/14/21 to prevent R1 from leaving the facility grounds. V9 said her watching R1 would not prevent R1 from leaving the grounds again. At 9:13 AM, V2 said there was nothing in place to prevent R1 from leaving the facility grounds yesterday (10/14/21). The facility's elopement assessment determines if a resident is at risk or not at risk for elopement. The software does not determine a level of risk i.e., low or high as the facility policy indicates. (The facility Policy and the facility elopement risk assessments are incongruent). At 12:20 PM, V10 Safety Director said the front gate "mag lock" is not consistently locking. V10 said he became aware of the problem on 10/14/21 when R1 opened the front gate. Normally, the keypad unlocks the gate from the inside and an "automatic eye" opens the gate from the outside. "We haven't been using the gate. We've had the control shut off to keep people from using the front entrance". Even with the control shut off the mag lock should engage and keep the gate secured. The mag lock is powered at all times. V10 said he doesn't believe there is a policy for maintenance and safety checks on the gate. V10 is not aware of any	S9999		

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S9999	Continued From page 7 manufacturer's recommended maintenance schedule or safety check requirements on the gate. At 12:37 PM, V11 Maintenance said the gate is 16 years old and has lots of wear and tear the past two months. We resurfaced the back parking lot, so everyone was in and out the front gate. V11 said he is responsible for checking the gate weekly. He did it last week and does not keep a log. V11 said he does not know the manufacturer's required maintenance and safety check schedule for the gate. At 1:09 PM, V4 Social Worker said they don't do a life skills assessment for the residents. R1 will ask the same questions every day. R1 doesn't understand why he is here, why his brother has guardianship and why he doesn't live on the farm anymore. He asks me these questions almost every day. R1's orientation fluctuates. He remembers a lot of his past but confuses other things. R1 believes he still operates a dairy farm. R1's cognition and memory are impaired. He confuses a nurse as being his former wife and said I look like a relative. R1 is not safe to be off facility grounds unsupervised. At 2:40 PM, V12 Nurse Practitioner said R1 has a history of Dementia and is unsafe to be off facility grounds unsupervised. R1 is only oriented to person and believes he is at his farm. He is able to walk independently but due to his cognition he wouldn't be safe. A directional map showed the distance from the facility to where R1 used to live was five miles. The facility map indicates V9 was seated inside the facility while R1 was alone outside the facility	S9999		

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S9999	Continued From page 8 and approximately 84 feet away when R1 opened the exit gate (on 10/14/21). R1's 10/1/21 facility assessment showed R1 had moderate Cognitive Impairment. R1's 4/26/21 Elopement Evaluation showed R1 was at risk for elopement. The evaluation showed a history of elopement or an attempted elopement while at home, wandering behavior, recent admission to the facility and not accepting the situation. R1's 5/5/21 Elopement Evaluation showed R1 was at risk for elopement. The evaluation showed wandering behavior and the wandering was goal directed (i.e., specific destination in mind, going home etc.). R1's 10/1/21 Elopement Evaluation showed R1 was at risk for elopement. This evaluation showed the resident had verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door. This evaluation showed to monitor the resident's location frequently. R1's Elopement Care Plan initiated 7/8/21 and revised 8/18/21 showed R1 is an elopement risk related to his cognition and not understanding reason for placement. R1 talks about wanting to leave. R1 enjoys sitting outside and walking laps on the front patio. R1's elopement intervention showed R1 is to be supervised when outside. R1's Elopement Care Plan had not been updated since his 10/12/21 elopement incident. R1's Fatigue Care Plan initiated 7/14/21 showed resident is wandering throughout the day and not sleeping well at night due to confusion and wanting to find his cattle. Due to constant movement, resident can become very fatigued with ambulating and requires use of a wheelchair. This care plan showed to provide supervised	S9999		

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assistance for ambulation. R1's Fatigue Care Plan had not been updated since his 10/12/21 elopement incident.

R1's Cognition Care Plan revised 5/18/21, showed R1 has impaired cognitive function related to Encephalopathy and history of alcohol abuse. R1 is not oriented to time or place and believes he is still working on his farm.

R1's Fall Care Plan revised 4/27/21 showed the resident had a fall, had poor safety awareness and an unsteady gait. R1's High Risk for Falls Care Plan revised on 4/27/21 showed R1 is a high risk for falls due to confusion, deconditioning, and gait/balance problems. R1 is unaware of safety needs and is unable to recall any education given about safety needs.

R1's 10/12/21 Social Service Progress Note showed at 2:30 PM (an hour before elopement), R1 questioned how he can discharge as he thinks he is physically fine. R1 was focused on his brother having guardianship and was getting upset. R1 verbalized he didn't understand and didn't want his brother as guardian and then continued to walk toward his room. R1's 10/12/21 incident authored by V6 showed at 3:50 PM, she was notified by phone by off duty staff that R1 was seen walking down the road. Multiple employees went in search of the resident in vehicles. Resident was located and brought back to the facility. R1's 10/13/21 at 1:14 PM Nurse's Note showed resident continues to exit seek non-stop, also verbalizing the desire to leave the facility. R1's 10/13/21 at 1:32 AM Nurse's Note showed resident appeared extremely agitated prior to bedtime and said, "I am getting out of here"! R1's 10/14/21 at 10:32 AM Nurse's Note showed resident continues to exit seek non-stop,

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also verbalizing the desire to leave the facility. The Administrator, Director of Nursing and Assistant Director of Nursing were made aware. R1 was unable to be redirected.

R1's safety skills/life skills assessment was requested, and none was received.

The manufacturer's recommendations for maintenance and safety checks for the front gate was requested and none was received.

R1's 7/2/21 Elopement Evaluation showed R1 was at risk. R1's 7/4/21 12:56 Nurse's Note showed resident had increased anxiety and exit seeking behavior. Resident continues to go out every exit door available that opens. R1's 7/9/21 1650 Nurse's Note showed exit seeking behavior this shift. R1's 7/13/21 3:04 AM Nurse's Note showed resident informed nurse he had to go feed his cows. Resident continued to be upset. R1's 7/15/21 13:01 nurse's note showed resident had increased anxiety and was exit seeking. R1's 7/21/21 18:33 Nurse's Note showed R1 had chronic wandering, was agitated, confused and had short term memory loss. This note showed disorientation was considered to be baseline for this resident.

The facility's 3/17 Elopement Policy showed it is the policy to assess each resident for the potential to wander and/or elope. The facility will provide preventative interventions as necessary for the safety of the resident identified. A resident who is identified as being at "High Risk" for wandering and/or elopement will have attached to their wheelchair, walker/assistive devices, or wear a "Code Alert" transmitter and/or other appropriate intervention as assessed by the Inter Disciplinary Team (IDT). If a "high Risk" resident

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S9999	Continued From page 11 attempts elopement their individual care plan will be reviewed to determine if current interventions are adequate to ensure their safety. Appropriate interventions will be implemented by the IDT and will be at the discretion of the Administrator or his/her designee and determined on a case-by-case basis. If a resident is observed attempting to leave the premises the IDT team will update the president's plan of care to include elopement precautions. The facility's 3/17 Safety and Supervision Policy showed the interdisciplinary team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks and hazards shall include ensuring that interventions are implemented. Monitoring the effectiveness of interventions shall include ensuring that interventions are implemented correctly and consistently and evaluating the effectiveness of interventions. Resident supervision is a core component of the systems approach to safety. (B)	S9999		