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	IL6009401	A. BUILDING: _____ B. WING _____	C 06/10/2021

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SYMPHONY AT THE TILLERS	4390 ROUTE 71 OSWEGO, IL 60543

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S 000	Initial Comments Facility Reported Incident Investigation to Incident of May 25, 2021, IL134325	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident identified as an elopement risk was provided adequate supervision to prevent elopement from the facility. This applies to 1 of 4 residents (R1) identified by the facility as high risk for elopement in the sample of 8.	S9999		

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S9999	Continued From page 2 The findings include: The facility's initial incident report dated May 25, 2021 shows, "Description of Occurrence: On 5/25/2021, at approximately 10:45 PM, staff observed [R1's] empty wheelchair at the nurse's station. Staff began search for the patient and found patient outside in front of the building in the parking lot lying down face up. Head to toe assessment was completed with no apparent injury. Resident did not have signs of any bleeding. Resident complained of bilateral knee and right hip pain. MD was notified and 911 was called. Patient was transferred to [Local Hospital]. Resident returned with no injuries." The facility's final incident report dated May 31, 2021 shows: " Investigation and Conclusion: Based on all the evidence and staff reports, it is most likely that a staff member must have disarmed the alarm at the nurse's station instead of going to the front door to check if it was a staff member since it was during the change of shift." The facility is located on Illinois Route 71, a four-lane highway. The distance from the front door to the highway is approximately 160 feet. On June 1, 2021 at 10:37 AM, R1 was lying in his bed fully dressed. Attempts to interview R1 were unsuccessful due to R1's confusion. R1 does not recall leaving the facility on May 25, 2021, falling in the parking lot, or going to the local hospital. V2 (DON) was standing outside of R1's room and said the resident has a history of trying to leave the building and frequently states he is going out to look for his wife in his van. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on April 4, 2019 with	S9999		

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S9999	Continued From page 3 multiple diagnoses including, dementia, cognitive communication disorder, Alzheimer's Disease, history of falling, PVD (Peripheral Vascular Disease), major depressive disorder, history of TIA (Transient Ischemic Attack), hypertension, and COPD (Chronic Obstructive Pulmonary Disease). R1's MDS (Minimum Data Set) dated May 12, 2021 shows R1 has severe cognitive impairment, requires supervision with locomotion off the unit and eating, is totally dependent on facility staff for bathing, and requires extensive assistance with all other ADLs (Activities of Daily Living). R1 has no functional limitation in range of motion on the upper or lower extremities, and normally uses a wheelchair for mobility. R1 is frequently incontinent of bowel and bladder. R1's elopement screenings dated November 11, 2020, February 5, 2021, and May 6, 2021, show R1 is an elopement risk. Nursing documentation shows multiple concerns regarding R1's wandering/elopement behavior including: April 6, 2021 at 6:23 AM, nursing documented, "Resident was up on and off the whole night with very little sleep. He was restless, looking for his wife. Reoriented and assisted to bed multiple times this shift. He attempted to go out the back door twice." April 27, 2021 at 4:02 AM, R1 was seen wandering up and down the hallway. Staff found the resident coming out of another resident's room. On June 1, 2021 at 10:07 AM, V1 (Administrator)	S9999		

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stated that all employee badges used to swipe in and out of the facility through locked doors had been disabled to ensure staff entered and exited through the front door. V1 stated badges had been disabled since March or April 2020 because of COVID screening procedures.

V1 stated that since the badges are disabled, employees now set off the door alarm if they open the front door between 8:00 PM and 7:30 AM because the doors are automatically locked by the alarm system.

V1 continued to say, "The alarm was not sounding at the time the resident was outside the building, so someone shut it off at the nurse's station and didn't go check the door. That is the only conclusion I could come to."

On June 1, 2021 at 10:47 AM, observations of the door alarm system were made with V11 (Environmental Services Director). Every exit door in the facility was observed. V11 demonstrated how the facility has multiple alarm keypads throughout the facility. V11 said any sounding door alarm can be disabled from any keypad throughout the facility without physically going to the alarming door to investigate the reason for the sounding alarm.

On June 1, 2021 at 11:48 AM, V5 (LPN-Licensed Practical Nurse) said, "I was not assigned to care for [R1] on May 25, 2021. [R1] likes to roam around. I was at the end of the 100 hallway working and kept him with me for a while. He is a huge exit seeker. He can self-propel his wheelchair. He doesn't use his arms; he uses his feet and goes all over the place. I last saw him around 10:00 PM, sitting at the nurse's station with [V6] (RN-Registered Nurse) and [V7] (RN). I

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would say that after I did all my tasks, I got back to the nurse's station around 10:45 PM, and that was when I saw [R1's] wheelchair sitting at the nurse's station empty. [V3] (CNA-Certified Nursing Assistant) and [V4] (CNA) were sitting at the computers doing their charting. I did not see [the Nurses]. I said to the CNAs where is [R1]? His wheelchair is here but he's not. The CNAs said they did not know where he was. Sometimes [R1] will get up and he will try to walk. We started looking all over for the resident. [V7] (RN) went out the front door to look for [R1] and found him lying in the parking lot. The resident was found about 1-1/2 to 2 feet away from the rocks. Next is a small strip of grass, then the sidewalk, and then the highway. It was drizzling out, but it wasn't a downpour. His back was all wet, but he was not drenched. He was lying face up and the front of his body was damp from the rain. It was chilly. He was fully dressed. The front door always alarms once the receptionist leaves at 8:00 PM. The alarm is constantly going off. Could it have gone off? Yes. With the shift change, I truly believe we've become complacent with the alarm keypad code. I believe someone hit the code and didn't know [R1] went out. None of the cameras were working at the desk that night. They would rotate and it would just keep flip-flopping so we could see main areas like the lobby, front entrance, or parking area. At the end of every hallway there's a keypad that disables any door alarm. I have not received any elopement training or door alarm training since the incident on May 25, 2021."

On June 1, 2021 at 12:24 PM, V4 (CNA) said, "I was assigned to [R1's] hallway the night of May 25. I started working at 10:00 PM that night. I saw him sitting with the nurse at the nurse's station. I was answering the call lights for 200

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S9999	Continued From page 6 and 300 hallways. I went and answered some call lights. When I returned the empty wheelchair was sitting there and [V3] (CNA) asked me who's wheelchair was sitting there. [R1] likes to roam around. When we knew it was [R1's] we started looking for him. One of the nurses found the resident outside in the parking lot on the ground. I am not sure why the alarm didn't go off that night. There was no alarm sounding saying the door had opened when we saw the empty wheelchair. Sometimes if you put the code in the keypad, it will disable the alarm. After this happened there was no training that I'm aware of regarding alarms or anything. I only had to write out a statement of what happened. We've never been assigned to make sure the front door is locked." On June 1, 2021 at 12:47 PM, V6 (RN) said, "I was in charge of the hallway where [R1] resides. That evening I was at the nurse's station with [V7] (RN). [R1] was sitting there too. He was right next to my chair. It's the only way I can keep my eye on him. It was between 10:00 PM and 11:00 PM. It's a busy time. I hadn't had a break that night, and I was behind. I had to leave the nurse's station to look for a medication that needed to be given to another resident. When I left the station [V7] was sitting there. I did not ask him to supervise [R1] while I was away from the nurse's station. I went to the medication cart and then I went to the resident's room to give the medication. When I came back, the CNA said another resident wanted her CPAP (Continuous Positive Airway Pressure) machine so I had to go to that room. That resident asks a lot of questions and I ended up being in the room for a long time, putting her laptop away and doing other things for her, and then her roommate also wanted her CPAP machine put on so I had to do	S9999		

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that. It took me a long time to get both residents on the CPAP, and then I heard the other nurses saying [R1] was missing and only his wheelchair was left. I don't recall hearing the alarm. I have no idea how he got out the front door. The resident room I was in is all the way down at the end of the hallway and far from the front door. No one on our shift checks the front door to make sure the alarm is turned on at 8:00 PM. Since the resident eloped, I have not received any additional training on door alarms or elopement."

On June 1, 2021 at 1:06 PM, V2 (DON) said, facility staff must enter and exit through the front door of the building to ensure employees complete COVID screening prior to the start of their shift. Employee swipe cards were deactivated sometime in March or April 2020, but the door alarms are still working. "After the receptionist leaves at 8:00 PM, the front doors automatically lock. I have no idea how [R1] got out of the building. No one saw him leave. My first call I received was from [V7] (RN) saying the resident was outside in the parking lot. The front door does not have to be in direct visual sight to be disabled. It can be disabled from any keypad in the building. No one is assigned to go around and make sure the doors are locked. Since the elopement of [R1] we have not done any training for facility staff regarding the procedure for door alarms when they are sounding or disabling the door alarms and ensuring all residents are accounted for."

On June 1, 2021 at 5:05 PM, V7 (RN) said, "I was sitting at the nurse's station with [V6] (RN). I was focusing on my charting and did not notice [R1] sitting there. I was doing my admission on the computer. [V6] left the nurse's station. She did not ask me to supervise [R1] during her absence.

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I left the nurse's station to use the restroom near the nurse's station. I heard the staff calling out for [R1] and looking for the resident. I immediately went outside because I had a suspicion. I did not hear any sounds or the door alarm before I went outside. When I went out the front door, the alarm sounded. When I looked in the parking lot, I saw someone waving at me in the lying position. I knew it was him. I called for help. Usually when a staff member leaves the building after their shift, we tell someone we are leaving, and that person will reset the door alarm. If no one says they are leaving, and you hear the alarm we should have a protocol. Possibly I think the alarm could have malfunctioned, I am not sure. It is possible I, or anyone, could have pushed the button to disable the alarm, I don't remember. The responsibility belonged to [V6] to watch the resident. He was assigned to her. I stick to the 400 hallway and I'm not familiar with him. Since the elopement, they reactivated our swipe cards, so the door alarms don't sound anymore when employees leave the building. I don't know why they didn't do that before. When you have call lights going off all the time and the alarms going off all the time and no receptionist, there's no way we can do it all. There just aren't enough of us."

On June 1, 2021 at 06/01/2021 2:57 PM, V10 (Service Technician) said he was called to the facility on May 28, 2021 for service. "They wanted a hard box over the keypad that is mounted to the wall behind the nurse's station. That way the staff would have to physically go to the doors to disable the alarm and not use the keypad at the nurse's station. They were having their maintenance guy put the cover over the alarm keypad is what I was told. They wanted to disable the keypad, so the staff physically must

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S9999	Continued From page 9 go to the front door to check the alarm. I did not disable the keypad. I did not check to see if the front door alarm was working properly. They told me the alarm was functioning completely and was disarmed by the staff, so I never had to check to see if the alarm was working. At no time did I check the door to make sure it was working. The facility staff should be checking the functionality of the door alarms that automatically lock. Especially after time changes." The keypad behind the nurse's station was observed on June 1, 2021. No clear cover was observed over the keypad. On June 1, 2021, the facility identified R1, R2, R3, R4, R5, and R6 as residents at risk for elopement. On June 8, 2021, V2 (DON) stated R4 and R5 were no longer considered to be elopement risks and would be removed from the elopement risk list. The facility's guideline entitled "Elopement" dated "8/05" and reviewed on "7/17" shows: "II. Elopement Risk Guideline: ...8. Residents at risk to elope will be checked at least every two hours or more based on needs and risks. 10. Access doors on each unit are alarmed so that staff can secure the environment rather than the resident and can intercede when a resident wants to leave the unit. 11. All facility staff are responsible for responding to a door/elevator alarm immediately. This response will include visual check of the immediate vicinity surrounding the door/elevator that tripped the alarm, including the stairwells and outside area. Elopement Procedure: ...3. When the resident is found: ...d. Upon return of the resident to the facility, the nursing department	S9999		

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S9999	Continued From page 10 will: Examine the resident for injuries. Appropriately document the event and update the care plan. Review the event with all staff who participated to ensure readiness for any future elopement. Institute a monitoring schedule for the resident." (A)	S9999		