Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006910	A. BUILDING: ______ B. WING ______	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIAHEALTHCARE OF OLNEY	410 EAST MACK OLNEY, IL 62450

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S 000	Initial Comments Complaint Investigations: 2157669/IL139282 2157714/IL139341 2157759/IL139393	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210c) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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,	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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 monitor for and prevent an elopement for 1 of 4 residents (R2) reviewed for elopement risk in the sample of 8.

Findings include:

R2's face sheet documents that she is a 44-year-old female who was admitted to the facility on 06/07/2021 with diagnoses including Huntington's disease, Schizoaffective Disorder, Psychosis, Abnormalities of Gait and Mobility; Lack of Coordination and History of repeated falls. R2's Minimum Data Set (MDS) documents a Brief Interview for Mental Status score of 99, indicating R2 has a severe cognitive impairment. R2's MDS documents R2 is limited assistance of 1 person for ambulation. R2's Elopement Risk Assessment dated 8/11/21 documents under Cognitive Skills for Daily Decision-Making documents: Moderately impaired-decisions poor, cues/supervision required. R2's Progress Note dated 10/17/21 at 11:57 AM, documents that R2 had exit seeking behavior on the day shift. R2 was walking the halls attempting to exit out the hall D door and she kept pushing the staff away when they tried to help R2. R2 is to be assisted during transfers and ambulation. R2's Physician's

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Orders document that R2 has orders for Pressure Alarms at all times related to R2 having a safety awareness deficit.

R2's Progress Note dated 10/18/21 at 3:56 AM documents the following: "while walking down the hallway and past R2's room, staff noticed resident (R2) was not in her room. R2's bed pad alarm was in place and intact in resident's room but failed to alarm. Staff began attempting to locate resident. Once staff checked indoor the building staff member began looking outside the facility for resident. Resident was located in arch parking lot sitting next to the facility vehicle. Injuries noted to the left ankle, right eye and right shoulder. On call doctor called and resident was sent to E.R. (emergency room) for evaluation. POA (Power of Attorney) notified, DON (Director of Nursing) notified administrator attempted to be notified. Resident is currently in the hospital."

On 10/19/21 at 3:55 AM, V3 (Certified Nurse's Aide) demonstrated to this surveyor where R2 exited the facility. V3 walked out of the hall D exit door, walked to a wooden fence that had an open gate, turned to the right toward the end of the Arch wing, walked around the Arch wing toward the middle of the parking lot near the Arch entrance.

On 10/26/21 at 8:30 AM, V9 (Maintenance) measured the distance from the hall D exit door, toward the wooden fence, around the end of the Arch wing, to the middle of the parking lot was 92 yards.

The temperature registered 46 degrees Fahrenheit at 2:00 AM on 10/18/21, according to the local weather reports.

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On 10/27/21 at 8:45 AM, at the local police station, the video from the park across the street, dated 10/18/21 at 2:10 AM, was observed and it shows a small framed figure at the exit door outside the hall D exit. The figure was then seen on the ground, crawling, and there was no one else seen on the video. At 3:25 AM the staff were seen outside searching for R2, then the ambulance was seen arriving at 3:55 AM.

The facility's Event Report dated 10/18/21 documents under Safety Events-Fall and Investigation that R2 had an unwitnessed fall outside the facility on facility grounds at 3:54 AM. Prior to the elopement and fall R2 was lying in bed at last bed check. Once R2 was found, she had swelling and an abrasion to her left ankle, a laceration on right side of her forehead, swelling to her right eye and R2's nose was bleeding. R2 also had an abrasion to the front and back of R2's right shoulder and both lower legs. R2 was alert and responded appropriately to stimuli, both right and left pupils were equal and responsive. The Fall and Investigation documents that R2 has a history of falls and her last fall was on 8/8/21. The contributing factors for R2's elopement and fall were the use of antipsychotics, anxiolytics, recent room change and a history of falls in the past 31-180 days. R2's vital signs at the time of the fall were: Pulse 122, Temperature 97.3, Respirations 20, Blood Pressure 89/60, O2 Saturation 98%. There is no description of R2's exit from the facility or how she ended up in the parking lot near the Arch entrance.

The local hospital Emergency Department report dated 10/18/21, documents under HPI (History of Present Illness): 44 yF (year old female) with Huntington's disease presents from nursing home via EMS after being found outside. Patient has

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unsteady gait at baseline but is ambulatory. Per NH (nursing home) she was in bed at last bed check but was found outside an hour later. Patient is verbal, per daughter who is POA (Power of Attorney), she fed herself yesterday, will answer yes and no questions and sometimes communicates needs with sentences. Under Past Medical History: R2 has a diagnosis of Asthma, History of Deep Vein Thrombosis, Gastroesophageal Reflux Disease, History of headaches, History of Schizophrenia, Huntington's Disease, Retinitis. Under Review of Systems: Physical Exam: She is not in acute distress; Extraocular movements intact. Pupils are equal, round, and reactive to light. Abrasion over right shoulder and abrasion over left ankle. Abrasion and ecchymosis over right side of head/face/eye. Skin cool to touch. Patient will not follow commands but resists movements and will move freely in the bed. Under Medical Decision Making: During the evaluation of this patient, other medical conditions were considered as possible causes of this patient's medical complaint including but not limited to Intracerebral brain hemorrhage (ICH), Subarachnoid hemorrhage (SAH), acute worsening of Huntington's. Chest Xray Impression: 1. No evident displaced fracture. 2. No evidence for acute cardiopulmonary pathology. Xray of right and left ankle Impression: No evidence of acute skeletal injury. CT (Computed Tomography) Brain without Contrast Impression: Trace left frontotemporal subdural hematoma with adjacent subarachnoid hemorrhage in the sylvian fissure and a combination of subarachnoid hemorrhage and contusion of the posterior left temporal lobe with surrounding vasogenic edema.

R2's History and Physical from the larger hospital she was transferred to dated 10/18/21,

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documents under CT Facial Bones without Contrast; Bones/Joints: There are mildly displaced and comminuted fractures involving the right sphenoid bone with extension along the right posterior orbital roof and right lateral orbital wall. There is a fracture of the right posterior lamina papyracea. Fracture involves the left sphenoid roof and anterior wall of the left sphenoid sinus. There is a nondisplaced right zygoma fracture. CT Chest/Abdomen/Pelvis with Contrast; under findings; Bones: Acute fractures of the anterior right fifth, sixth, seventh ribs and the lateral ninth and tenth ribs. Healing fracture of the left sixth rib. Acute, mild compression fractures of the T1, T2, T3 and T4 vertebral bodies. CT Brain without Contrast; Stable, moderate size: intraparenchymal hematoma within the left temporal lobe measuring up to 3.5 X 2.5 centimeters in the axial plane with surrounding vasogenic edema. There is a new subdural hematoma coursing along the falx that measures 4 millimeters in thickness. Stable subdural hematoma coursing along the left frontal temporal convexity. There is a new subdural hematoma coursing along the right frontal convexity measuring 3.2-millimeter thickness.

On 10/18/21 at 12:22 PM, V8 (Registered Nurse, Emergency Room) stated she spoke with V11 (Family) and V11 reported to her that the morning of 10/18/21 around 3:15 AM, R2 walked past 2 Nurses stations and out of the building which doesn't make sense because R2 can't walk very far without falling. V8 stated R2 has a diagnosis of Huntington's Disease and she has severe spasticity. V8 stated V11 also reported that R2 went out of the exit door without an alarm sounding and R2's bed alarm also didn't sound when she got out of bed. V8 stated the facility staff reported that R2 got out of the facility and

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she was found in the front parking lot. V8 stated they brought R2 back into the building instead of calling the Emergency Medical Service (EMS) right away. V8 stated she didn't talk to the facility staff about the incident involving R2 and stated she got the information from the EMS report. V8 stated the facility's explanation regarding R2's injuries wasn't consistent with the injuries she sustained, and this information came from V14 (Emergency Room Physician) and V15 (Emergency Room Physician). V8 stated V14 and V15 thought the injuries were from an assault. V8 stated the report documents that R2 had abrasions on her right shoulder, a laceration to the right side of her head, bruising and swelling to R2's right eye, abrasions to both shins, and an intracranial subdural hematoma on the left side of her head. V8 also stated R2 had bruises on her ribs that appeared to be handprints.

On 10/19/21 at 5:00 AM, V1 (Administrator) stated V4 (Licensed Practical Nurse) called him and V2 (Director of Nursing) on 10/18/21 around 4:00 AM, the morning R2 got out of the D hall exit door and R2 was found in the front parking lot near the Arch entrance. V1 stated the keypad for the alarm on the D hall exit door wasn't working, and they had a back-up alarm system on that door. V1 stated the back-up alarm has a key to turn the alarm on or off, and the alarm was turned off. V1 stated the key was kept on top of the red alarm box and anyone who could reach it could turn off the alarm. V1 stated someone turned off that alarm. V1 stated he had looked into who had potentially done it and no one had confessed to it at that time. V1 stated R2 also had a bed alarm on her bed that R2 managed to scoot away from, and it didn't sound either. V1 stated he didn't know how R2 got that far because he had never seen R2 walk. On 10/19/21 at 11:29 AM, V1

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stated he reviewed their camera's recording and it showed all of the night shift staff at the nurse's station located between hall A and hall B. V1 stated the Arch door was partially open, blocking the view of the B hall. V1 also stated the video recorded R2 walking down B hall toward D hall and turning toward the exit door on D hall at 2:04 AM.

On 10/19/21 at 4:00 AM, V4 (Licensed Practical Nurse/LPN) stated on 10/18/21 at 3:10 AM, she and V3 (Certified Nurse Aide/CNA) had just came back into the facility from outside, because they were taking a break. V4 stated that all of the night staff were at the nurse's station discussing their plan for getting the residents up for the day. V4 stated V3 (CNA) saw R2 in her bed at the 2:00 AM bed check. V4 stated V5 (LPN) noticed that R2 wasn't in her bed at 3:15 AM, and they started searching the facility to find R2. V5 stated they couldn't find R2 in the building so everyone took an exit door and went searching outside the building. V4 stated at 3:30 AM, V7 (CNA) found R2 in the parking lot on the Arch side. V4 stated it was very dark and cold and they couldn't really assess R2 very well, so they carried R2 inside the front door and sat her on a couch, and she went to get R2's wheelchair. V4 stated R2's nose was red and bleeding, she had abrasions on the front and back of her right shoulder, abrasions on both of her shins, abrasion on her left ankle. R2 had a cut on the right side of her head near the scalp and her right eye was swollen and red. V4 stated when they got R2 into the building to put her in the wheelchair, she stood up without any problems. V4 stated they immediately put blankets around R2 and cleaned the blood from her nose and wound on her head and then the ambulance arrived. V4 stated the door alarm didn't sound because if it had, they would have

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heard it because they were right next to the alarm box. V4 stated R2 had a bed alarm, and it didn't sound either. V4 stated R2 is so small that sometimes the alarm scoots away from her from her constant moving and because she is so small and doesn't weigh very much the alarm doesn't sound. V4 also stated V3 usually sits at the other nurse's station on D hall, but she and V3 just came in from outside after having a break and she wasn't at the nurse's station desk. V4 stated R2 never attempts to go outside of her room and the most she's ever seen R2 attempt anything was go to the bathroom by herself. V4 stated R2 usually sleeps through the night.

On 10/19/21 at 3:45 AM, V3 (CNA) stated at 3:15 AM on 10/18/21, V5 was doing the 3:00 AM bed check and noticed that R2 wasn't in her bed and the bed alarm was at the head of the bed and it didn't sound. V3 stated R2 is so light that she scoots the alarm without it sounding. V3 stated once they searched inside the building and couldn't find R2, they started their search outside. V3 stated one reason R2 may have been more confused was because she got moved to another room on a different hall because of needing her room for an isolation. V3 stated R2 doesn't ambulate well, and she usually just goes to the bathroom, and R2 sleeps most nights. V3 said R2 somehow walked to the D hall and went out the D hall exit door. V3 stated the D hall keypad for the exit door alarm hadn't been working and V1 had the keypad for the alarm fixed 10/18/21 and the back-up door alarm was turned off. V3 stated R2 walked around the end of the building and ended up in the parking lot facing North, near the Arch entrance. V3 also stated it was cold outside and they carried R2 in the front door and V4 went to get R2's wheelchair. V3 stated they brought her inside and wrapped her in blankets and took her

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vital signs, and the ambulance came and took her to the hospital. V3 stated R2 was alert and scared, but she doesn't talk, so she couldn't tell them how she got hurt. V3 stated she didn't hear an alarm sound when R2 eloped, and she also stated she wasn't aware of a key to turn the red box alarm off and on. V3 stated she wasn't aware that the key was on top of the red alarm box.

On 10/20/21 at 2:55 PM, V5 (LPN) stated on 10/18/21 around 3:15 AM when she went to answer R5's call light, she noticed that R2 wasn't in her bed. V5 stated she saw the bathroom light on and thought she was in there, but when she looked, R2 wasn't there. V5 stated that R2 could ambulate, but she was very "wobbly" and had poor balance. V5 stated she yelled at the staff that they needed to look for R2 and V7 (CNA) came off of the Arch unit and checked the rooms on A hall and B hall, V3 and V4 searched D hall and went out the exit door on D hall to look outside. V6 (CNA) searched A hall and the Arch hall, and once they discovered that R2 wasn't inside the building, they went outside. V5 stated she headed for the park, V4 searched the church parking lot and V7 went to the parking lot and she saw R2 in the front parking lot in a parking space near V7's vehicle. V5 stated R2 was sitting on her knees. V5 stated it was dark and cold and she and V3 carried her to the front door and sat her on the couch while V4 went to get a wheelchair. V5 stated R2's socks were soaked so she took them off and R2's toes were very cold, and her left ankle was bruised and swollen. V5 also stated R2 had a nosebleed from both nostrils, and she got tissues and cleaned the blood and put pressure on her nose to stop the bleeding. V5 said they heated some blankets in the warmer and put them around R2 and they got R2's paperwork ready, called an ambulance, R2's

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doctor, R2's Power of Attorney, the Administrator and Director of Nursing. V5 stated when R2 eloped, V5 was on the Arch unit and was giving residents pain medication. V5 stated she didn't hear an alarm and she wasn't aware of a key to turn off/on the red alarm box at the D hall exit door.

On 10/20/21 at 3:05 PM, V13 (CNA) stated she and V3 did a bed check around 1:00 AM. V13 stated she saw R2 at 1:30 AM, and she was awake fidgeting with her blanket. V13 stated R2's bed alarm was on and under her at that time. V13 stated she wasn't aware that there was a key to turn the red exit door alarm on and off. V13 said she had no idea there was a key on top of the alarm.

On 10/20/21 at 3:10 PM, V7 stated on 10/18/21 at 3:15 AM, V5 went to answer R5's call light and she noticed that R2 wasn't in her bed or in the bathroom and V5 yelled for everyone to start looking for R2. V7 stated when they had searched inside the building, they all went outside to look for R2. V7 stated she and V5 went out the front doors and she went to the front parking lot where she found R2 sitting in a parking space next to her truck. V7 stated she noticed that R2's nose was bleeding and her right shoulder had been scrapped. V7 stated when they tried to have R2 stand, R2 couldn't bear weight on her left foot. V7 stated V3 and V5 carried R2 to the front door and sat her on a couch in the living room and V4 and V5 started doing First Aide on R2. V7 stated she didn't ever hear a door alarm sound and she also wasn't aware that there was a key on top of the red door alarm located on the D hall exit door.

On 10/20/21 at 3:15 PM, V6 (CNA) stated she heard V5 hollering that R2 wasn't in her bed or in

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her bathroom and that they all needed to search for her. V6 stated she had just finished bed check and was taking the linen barrel to the laundry room and was at the nurse's station. V6 stated that V3 and V4 had just came back in from being on break and they were all at the nurse's station when they heard V5 yell that they needed to search for R2. V6 stated she searched the A hall rooms and she stayed inside while everyone else went outside to search for R2. V6 stated she didn't hear an alarm sound and she also wasn't aware of a key on top of the red alarm box on the D hall that turns the alarm on or off.

On 10/19/21 at 5:45 AM, V9 (Maintenance) stated he checks the exit door alarms daily throughout the week. V9 stated the D hall door alarm works, but the door alarm was turned off. V9 stated they were having C.N.A. classes near that door and they may have been going in and out of that door. V9 also stated someone in that class must have left it off. V9 said he checks the alarms every week and the back-up alarm was working and has been working each time he has checked it. On 10/26/21 at 8:30 AM, V9 stated he measured the distance that R2 walked, and it was 92 yards from the hall D exit door to the middle of the parking lot near the Arch entrance.

On 10/19/21 at 11:50 AM, V10 (Physician) stated R2 is very unstable and has very poor coordination due to spasticity from diagnosis of Huntington's Chorea. V10 stated R2 is very unstable with walking and usually when he sees R2, she is lying in bed or sitting in her wheelchair. V10 stated R2's movements are very spastic, and she can't control the jerking and constant moving. V10 stated the injuries are probably a result of falling several times while R2 was outside. V10 stated the pictures he saw of R2's injuries after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006910	A. BUILDING: ______ B. WING ______	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF OLNEY	410 EAST MACK OLNEY, IL 62450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

her elopement are more than likely due to R2 falling. V10 also stated a lot of the areas are older bruises from repeated falls and hitting her extremities on bed rails or other objects due to R2's condition. V10 stated R2 is very fragile, has no fat pads, is very thin and boney and she bruises easily and could fracture easily. V10 stated that her injuries do not look suspicious and aren't due to someone treating her badly or assaulting her. V10 stated the swollen eye could have been due to hitting it on a vehicle since she was near the cars.

V12 (Police Officer) stated he hasn't been able to obtain R2's medical records from the larger hospital so he can finish his investigation. V12 stated he is of the opinion that R2 eloped and fell, maybe multiple times in order to sustain the injuries she had. V12 stated the camera located across the street at the park shows a small framed figure leaving the facility at the hall D exit door, then a dark shadow is seen crawling on the ground. V12 also stated he reviewed the camera recording from the facility, and it shows R2 at the end of hall B going around the corner onto hall D, then out the exit door. V12 stated he has also asked for the Rape Kit results and hasn't received them at this time.

On 10/28/21 at 8:50AM, V19 (Administrator at a different LTC facility) states R2 was admitted to their facility on Tuesday, 10/26/21 and she was admitted on Hospice. V19 states R2 was extremely restless the day she was admitted but is not responding at all now. V19 also stated R2 has old abrasions on her legs, left ankle, and her shoulders, and several old bruises.

The facility's Missing Resident Policy dated November 17, 2017 documents under Policy: It

Illinois Department of Public Health

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S9999	Continued From page 13 is the policy of this facility that reasonable precautions are taken to minimize the risks of resident elopement attempts. Reasonable precautions include, but are not limited to: door alarms, personal door activation devices, staff intervention, staff education regarding response to door alarms, and individual resident intervention. It is the policy of the facility to demand immediate response to elopement attempts, door alarm activation and participation in search attempts in the event a resident is deemed missing. (A)	S9999		