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
	IL6005037	A. BUILDING: ______ B. WING ______	C 12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING BRUWAERT HOUSE	6101 COUNTY LINE ROAD BURR RIDGE, IL 60521

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Z 000	COMMENTS Licensure Complaint Investigation 2199632/IL141794	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.1220 b)2) 300.3240 a) 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	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1	Z9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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 are not met as evidenced by:

Based on interviews and record reviews, this facility failed to attach the electronic monitoring device to the resident and failed to monitor and supervise a cognitively impaired resident by not

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Z9999	Continued From page 2	Z9999		

following the facility's hazardous wandering/elopement policy to prevent a resident with a history of wandering from leaving the building for 1 of 3 residents (R1) reviewed for wandering and elopement.

Findings include:

Review of R1's medical record notes R1 was admitted to this facility on 6/14/2021, with diagnoses including: Parkinson's disease, alcohol dependence with alcohol induced persisting dementia, generalized muscle weakness, and repeated falls. On 10/12/21, an additional diagnosis of dementia was added to R1 medical record.

Review of R1's admission wandering risk scale, dated 6/14/21, notes this document is to be completed on admission/re-admission, at 72 hours, and one month later, with change in condition, and annually on all residents. For residents at risk or high risk to wander, update quarterly. This document did not note R1 was ambulatory. This document noted R1 has no diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength. There is no documentation found noting the wandering risk scale at 72 hours, one month post admission, or on 8/12/21 when R1 had an electronic monitoring device attached to R1's walker due to R1 wandering incident.

Review of R1's wandering risk assessment, dated 12/13/21, notes R1 is at moderate risk for elopement. R1 is forgetful/short attention span; exhibits/expresses fear and/or anxiety; mobility is independent with walker; diagnoses: early dementia, Alzheimer's disease, and dementia with psychosis; receives antidepressant

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Z9999	Continued From page 3	Z9999		

medications. R1's history of wandering is not noted on this assessment.

There is no documentation found noting a previous wandering risk assessment was completed for R1.

Review of this facility's incident report, dated 12/12/2021, notes shortly after 4:00pm, R1, wearing a jacket, had exited R1's nursing unit without R1's walker (the walker that R1's electronic monitoring device was attached to) and took an elevator to the first floor towards the reception desk. As R1 passed by V6 (Receptionist), V6 told R1 to have a good evening (not recognizing that R1 was a skilled nursing resident), and R1 exited the building through the main entrance. R1 then proceeded to walk around the building from the west to the northeast side near the employee entrance where R1 attempted to climb the stairs to re-enter the building. While attempting to climb the first step, R1 fell forward striking the bridge of nose on the step. At 4:16pm, R1 was found lying on the ground with blood draining from nose.
Review of this V6 (Receptionist) statement, dated 12/13/2021, notes V6 observed a man leaving the building and said "goodbye" and "have a good evening". R1 was observed fumbling with the door and could not open it, so V6 opened the door from the reception desk. V6 assumed R1 was a visitor or family member and not a resident. V6 stated V6 knew where the elopement binder was located at the reception desk and the list of residents at risk for eloping noted on the first page. V6 stated V6 did not see R1's face and therefore would not have thought to look further to see R1 was a resident.

Review of R1's medical record notes:

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Z9999	Continued From page 4 On 8/12/21 at 7:47am, V7 (nurse) noted this morning at about 6:00am, R1 was found in an elevator by morning staff members. When asked where R1 was going, R1 stated 'to my truck'. R1 re-directed back to R1's room. On 8/12/21 at 3:27pm, V5 (nurse) noted social worker attached the wander guard to resident's walker after talking to resident for the reason of safety. On 8/26 notes around 9:30am, R1 was observed walking in the hallway without R1's walker. R1 able to go back to R1's room, but observed to be uncooperative, will not use R1's walker. On 12/9. V4 (social services) noted R1 was alert and oriented x 2 and displayed increased confusion. On 12/9, R1 wants to leave and "go home". Redirected but became upset. On 12/11 at 8:04pm, V8 (nurse) noted R1 observed coming out of R1's room with jacket on and without walker, stated "there is a woman who keeps opening my door so I'm leaving". R1 re-directed and escorted back to R1's room. Encouraged to use walker for support. On 12/28/21 at 12:00pm, V5 (Nurse) stated R1 had an electronic monitoring device attached to R1's walker. V5 stated R1 was alert and oriented with some confusion. V5 stated R1 was ambulatory. On 12/28/21 at 1:00pm, V3 (Senior Director of Resident Services) stated on 12/12/21, R1's family visited with R1 from 3:00pm until 3:45pm. V3 stated at 4:02pm, R1 exited the nursing unit wearing a jacket. V3 stated R1 did not take R1's walker which had the electronic monitoring device attached so the door alarm did not activate. V3 stated R1 took the elevator located on the other side of the nursing unit door to the first floor, and	Z9999		

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Z9999	Continued From page 5 exited through the front door of the facility. V3 stated there is an elopement binder kept at the receptionist's desk at the main entrance noting the photograph and name of each resident at risk for elopement. On 12/29/21 at 9:30am, V4 (Social Services) presented a copy of residents at risk for elopement document from the elopement binder kept at the receptionist's desk at the main entrance. V4 stated R1's photograph and name were listed on this document while R1 resided at this facility, but was recently removed. On 12/29/21 at 10:45am, V9, CNA (Certified Nursing Assistant) stated V9 worked 2:00pm-10:00pm shift on 12/12/21. V9 stated V9 went on first break from 4:00pm until 4:30pm. V9 stated during break, V9 left building to go to the staff housing on premises to get something. V9 stated V9 opened the employee entrance door and heard R1 calling out. V9 stated R1 was lying on R1's right side on concrete with head on grass. V9 stated R1 informed V9 R1 tripped on the top step of stairs that leads to the parking lot below. V9 stated R1 was unable to get up on own and R1's face was bloody. V9 stated V9 re-entered building and shouted for assistance. V9 stated staff immediately came. Staff called 911 EMS (emergency medical services). R1 was kept in lying position until paramedics arrived and R1 was transported to hospital. V6 is no longer employed at this facility and was not available to interview during this survey. Review of this facility's hazardous wandering/elopement policy, revised 11/01/2021, notes residents of skilled nursing units who are considered to be at higher risk for hazardous	Z9999		

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Z9999	Continued From page 6 wandering or elopement will be fitted with an electronic monitoring device. Each hallway in Rose Wing contains an electronic monitoring alert system. The photographs of identified at-risk residents will be placed discreetly in staff-frequented areas. (B)	Z9999		