STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003529	A. BUILDING: _____ B. WING _____	01/31/2022

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S 000	Initial Comments Complaint Investigation: 2220446/IL142564	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3)6) 300.2210b)2) 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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S9999	Continued From page 1 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: 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. Section 300.2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. These Requirements were not met as evidenced by: 1. Based on observation, interview and record review, the facility failed to ensure facility exit door alarms were activated, failed to increase supervision/monitoring after recognizing an alert and oriented resident's change in mental status and failed to follow its policy for elopement prevention and door alarms for one of three	S9999		

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S9999	Continued From page 2 residents (R1) reviewed for elopement in the sample of three. These failures resulted in R1 exiting from the facility on 1/15/22 around 6:45 P.M. after sunset, in freezing temperatures and snow covered grounds for approximately 45 minutes. R1 was found laying in the snow at the bottom of a hill in a residential yard approximately 30-40 feet from the facility. R1 required emergency medical transportation to an area hospital emergency room approximately 29 miles from the facility, warmed intravenous fluids and a forced air warming blanket to bring R1's core body temperature back to normal range. R1 subsequently acquired fluid filled blisters to R1's fingertips on R1's left and right hands consistent with frostbite injury. Findings include: The facility's "Emergency Care" policy, reviewed 1/22/18, documents, "Elopement: It is the policy of (facility company name) to provide for a secure environment in which residents incapable of responsibility for self are protected from wandering outside of the facility unattended. This is achieved primarily through door alarms and individual triggering devices. 3. A thorough search should be made of the facility, including under beds, in closets, bathrooms, storage areas and maintenance and laundry areas. Search of grounds should include any outside buildings and in cars." The facility's "Elopement Prevention Policy", revised 10/06, documents "It is the policy of (facility company name) to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and	S9999		

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S9999	Continued From page 3 interventions for prevention be established in the plan of care to minimize the risk for elopement." This policy continues with "Procedure: 2. A licensed nurse will complete the Elopement Risk Assessment upon and/or within eight hours of admission to the facility. 3. A facility staff member will take a photograph of the resident upon or within 8 hours of admission. The photograph will be placed in the Medication Administration Record. Any resident assessed to be at high risk for elopement will have their photograph and basic identifying information placed in a special folder or binder to be maintained at the nurse's station." The facility's "Door Alarm Policy", revised 10/06, documents, "It is the policy of (facility company name) to ensure resident safety and security through the use of door alarms. Facility Procedure: All doors leading to the outside must meet these requirements: 1. The alarm must only be disengaged at the door itself, either by push button code or key. No alarm may be disengaged from the nurse's station or any other location without physical evidence gathered by a staff member of reason for trigger reported directly to the person silencing the alarm. 2. The alarm must ring continuously until physically disengaging through key or code. 3. Immediate response requires any employee to physically go to the door that has an alarm sounding to establish why the alarm was triggered. 4. Disengaging the alarm is not allowed until the reason for activation is determined. Steps to be taken: Go directly to the door where the alarm is sounding. Go completely outside the door to view the environment. Initiate a search of the immediate area if no resident or visitor is visualized. Instruct visitors or vendors how to properly disengage the alarm before leaving the facility should they be	S9999		

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S9999	Continued From page 4 the source of activation. Conduct an immediate count of all residents. Initiate the Missing Resident Policy when unable to account for all residents. 5. Testing (including actual activation) and documentation of testing will be completed weekly. Any malfunctions are to be reported to the Administrator and repaired as quickly as possible." The facility's "Missing Resident Policy", revised 10/06, documents, "It is the policy of (facility company name) 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 alarm activation devices, staff intervention, staff education regarding response to door alarms, and individual resident intervention. It is the policy of (facility company) to demand immediate response to elopement attempts, door alarm activation and participation in search attempts in the event that a resident is deemed missing. Definitions: A resident shall be defined as "missing": When initial reasonable search of the facility interior and immediate grounds has not rendered physical evidence of the resident's person; there exists no evidence of the resident's whereabouts upon examination of documents including but not limited to the medical record, calendar of events and sign out books/sheets; AND after questioning of facility staff and residents evidence of whereabouts remains uncertain. DON (Director of Nursing) Responsibility: 1. Conduct a thorough investigation using the "Investigative Report of Missing Resident" and report the findings of the investigation to the Quality Assurance Committee with a timeline of occurrences, interventions, and responses. Prepare a summary of staff performance and policy/procedure strengths and	S9999		

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S9999	Continued From page 5 weaknesses. 2. Report as required by State and Federal regulation to appropriate regulatory agencies." The "Resident Monitoring" policy, revised 10/06, states, "It is the policy of (facility company name) to initiate monitoring of residents as a nursing measure upon the clinical decision of the Charge Nurse and/or Interdisciplinary Team to assist in providing safety to residents that are identified to be a potential threat to self or others or an elopement risk. Procedure: 1. Assess the resident and document the need and rationale for monitoring. 2. Initiate resident monitoring and document date, time, resident location, and as deemed necessary, behavior and response to monitoring. 3. Initiate monitoring as indicated by need, 15 minute, 30 minute, 1 hour increments, or one on one monitoring if deemed necessary. 4. Depending on established need, behavior or response, increasing or decreasing of time frame may be necessary. Document reason for change and frequency of monitoring in the resident's medical record. 6. Notify Physician, legal Power of Attorney/Guardian, DON (Director of Nursing) and Administrator when the need for monitoring is indicated due to potential threat to self or others. 7. Continue monitoring the resident until the Interdisciplinary Team can determine the status of the resident and develop other appropriate measures for intervention determined by resident need. 8. Document all assessments, needs, interventions, and resident responses in the resident's medical record." 1. R1's Facesheet documents R1 was admitted to the facility on 1/10/22. R1's "Cognitive Assessment" signed and dated by V10 (Social Service Director) on 1/10/22	S9999		

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S9999	Continued From page 6 documents R1's Brief Interview for Mental Status (BIMS) as a score of 15 out of 15; indicating R1 is cognitively intact with no memory impairments. R1's "Cumulative Diagnosis Log" documents R1 with diagnoses to include but not limited to: Bipolar Affective Disorder, Depressive Disorder, Glaucoma, Insomnia, and Altered Mental Status. R1's hospital records document additional diagnoses of: Dementia and legally blind (left eye). R1's Physician Order Sheet, dated 1/10/22, documents R1 is taking Amitriptyline and Citalopram for Depression, Olanzapine for Bipolar, Ativan for anxiety, Triazolam and Melatonin for Insomnia, and Restasis for Glaucoma. R1's Elopement Assessment is documented as being completed on 1/13/22. R1's Elopement Assessment completed on 1/16/22 documents R1 as being a high risk for elopement. On 1/19/22 at 4:29 P.M., V10 (Social Service Director) verified elopement assessments should be completed on a resident's admission and that the elopement binder is being updated. R1's A.I.M. (Assess, Intercommunicate, Manage) for Wellness form, signed and dated by V5 (Registered Nurse) on 1/16/22 at 12:00 A.M., states, "(R1) noted to have exit seeking behavior, exit through North hall-East doorway where he ambulated per self Eastwards outside. (R1) was transferred to ER (Emergency Room) for eval (evaluation) and treatment. Staff had attempted to transfer (R1) to ER for last fall at 3:15 A.M. (on	S9999		

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S9999	Continued From page 7 1/15/22) but he refused to go. (R1) was noted to have pain in the left hip." R1's Nursing Note on 1/15/22 states, "(R1) sent to (area hospital) for poss. (possible) hypothermia to tx (treat) and eval. (evaluate). Temp (temperature) = 95 (degrees Fahrenheit). R1's "Investigative Report of Missing Resident", signed and dated by V1 (Administrator) on 1/15/22, documents R1 with a diagnosis of hallucinations. This same form documents on 1/15/22, R1 was last seen at 6:30 P.M. and declared missing at 6:55 P.M. by V5 (Registered Nurse). This form also documents R1 was found across the street and the (facility exit) door alarms were "disengaged." R1's Emergency Medical Services/EMS Report, dated 1/15/22, states EMS was dispatched at 7:22 P.M. for a "man down". This report also documents, "responding immediately to (address of location) for a male found on the side of the road in a snow bank. (R1) was found by a person driving by. (R1) was found in the street with bystanders and (local police department) with him. (R1) was wearing a T-shirt, sweat pants, a stocking hat and slipper socks. The bystander states that she was driving by and spotted (R1) lying on the side of the road in a snow bank. She stopped to help him. She helped (R1) up and out of the snow but (R1) could not walk to her car. He just sat down in the road on his knees. She then states she called 911 for help. (R1) states that he was at (name of skilled nursing facility) for (sic) weakness treatments. (R1) then states (R1) was out at a restaurant and got lost. (R1) states that he can't feel his feet or hands. (R1) states he has trouble with circulation on his feet and legs normally. (R1) states he has pain in his left hip.	S9999		

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He has abrasions on his toes, legs, knees, arms, and fingers. He has bruising on his legs, left hip, back, arms, and stomach. (R1) states that he falls a lot. (R1) states that he was at (an area hospital) a couple of days ago for a fall and that he just got to the nursing home. (R1) states that he is blind in his left eye and only has 10% (percent) sight in his right eye. (R1) knows his name, date of birth, the days date, his home address and why he is at the nursing home. (R1) does make states (statements) about being at a restaurant and walking around a store while being at the nursing home. (R1's) skin is pale, cold, and wet. His lips, fingers, and toes are cyanotic in color. (R1's) clothes were taken off of him and he was dried off with towels. (R1) was then covered by dry blankets. (R1's) temperature was taken orally and axillary but the thermometer did not register a temp (temperature). (R1) was transported emergent to (area hospital Emergency Room)."

R1's local police department report #2022-000137, dated 1/15/22 and timed 7:26 P.M., documents, "I (V7/Local Police Officer) got dispatched to a 911 ambulance call on a report of a male subject laying on the side of the road in the snow in the (specific address block) across from (name of skilled nursing facility). Upon my arrival, I observed (R1) laying in the snow on the east side of the roadway in the yard of (neighboring address). The 911 caller, was trying to help (R1) to get him our of the snow and help warm him up. (R1) was wearing a green T-shirt, gray sweat pants, slippers, and had a jacket over him. It is unknown if the jacket and slippers belonged to (R1) or had been given to him by a passerby. I asked (R1) if he could tell me his name. He (answered appropriately). He told me he had been outside for 45 minutes to an hour.

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(R1) told me he was trying to find a nursing home. It was hard to understand what nursing home he was referring to. (R1) was covered in melting snow and was shaking from being cold. Although (R1) could not walk to a vehicle to warm himself, he was covered with a blanket to help until EMTs (Emergency Medical Technicians) arrived. I had dispatch call (name of skilled nursing facility) to check if (R1) is a patient. Dispatch informed me (R1) is a patient at that facility. A few minutes later, (name of EMS company) arrived on the scene. I informed the EMTs that (R1) told me he had been laying in the snow for about 45 minutes to an hour. I told them (R1) is a patient at (name of skilled nursing facility). The EMTs informed me that (R1) would need to be transported to (specific name of an area hospital located 29 miles from facility) due to that facility having better equipment to treat (R1). (R1) agreed with EMTs that is where he wanted to go. I went to (name and address of skilled nursing facility) and spoke with (V9/Licensed Practical Nurse), an employee at the facility. (V9) told me that around 20 minutes until 7:00 P.M. she was in her vehicle that was parked in the northwest parking lot. She told me that she saw a kid or a person walking around the hill near the east side of the facility, but did not think of the person as being one of their (facility's) patients. (V3/Licensed Practical Nurse) was mentioned to me by (V9) who said that (V3) said she last saw (R1) around 5:45 P.M. before the end of her shift. While investigating the incident, (V1/Administrator) called the facility to speak with me. I talked to (V1) who informed me she found out the alarm to the east door that (R1) had exited from had malfunctioned and an electrician will be working on it. (V1) said she would have someone posted at the door at all times until the alarm was fixed. I told (V1) that EMTs did an

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emergent transfer to (area hospital) due to (R1's) condition and (name of hospital) having better equipment. It should be noted that the outside temperature at the time of the incident was approximately 10-15 degrees Fahrenheit."

A website weather.com documents the high temperature on 1/15/22 as 26 degrees Fahrenheit and a low temperature of 7 degrees Fahrenheit. This website also documents sunset as 4:56 P.M.

R1's Hospital Records from R1's 1/15/22 Emergency Room visit documents R1 arrived to the Emergency Room at 8:23 P.M. These records document that on 1/15/22 at 8:38 P.M., R1's rectal body temperature was documented as 95.8 degrees Fahrenheit. R1's chief complaint was documented as "cold exposure and altered mental status." V21's (Emergency Room Nurse Practitioner) Emergency Room note and assessment stated, "(R1) is a 79 year old male with a chief complaint of cold exposure. (R1) is from a nursing home. (R1) reportedly snuck outside and was found laying in a snow bank. (R1) has baseline Dementia. (R1) states, 'I left the nursing home and it was really cold outside. I was waiting for them to finish the railroad project.'" R1's skin assessment was documented as bilateral upper and lower extremities were cold to the touch and all fingers were bright red. R1's neurological status was documented as alert to place and person and disoriented to time and events. R1's Nursing Notes document R1 was treated with warmed intravenous fluids and a forced air warming blanket.

R1's report to the local State Agency on 1/19/22 documents R1 to have redness to fingertips with intact fluid filled blisters on R1's right and left hands status post R1 exiting the building on

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S9999	Continued From page 11 1/15/22. On 1/19/22 at 10:33 A.M., R1 was noted to be laying in bed with eyes open, wearing a T-shirt, gray sweat pants, nonskid socks. R1 was noted to have obvious red/maroon discolored finger tips and blisters to R1's left and right hands. R1's left and right elbow were noted to have open abrasions covering the entire elbow. The right elbow abrasion was draining a serous fluid. Multiple red scabbed areas/scratches were noted to R1's forearm. R1's entire right lateral pinky (5th digit) finger was noted to have reddish purple/maroon discoloration. At this time, R1 stated discoloration to fingertips and side of pinky finger was "frostbite". R1 stated, "They told me they found me in a ditch." When asked about the 1/15/22 elopement, R1 stated, "I don't remember leaving at all. I don't remember wanting to leave. I'm back here now (secured Dementia unit) because I need to be protected from myself. I lived at home alone before here. I don't want to leave here until I'm done with rehab and it's safe." R1 denied remembering being at the hospital. "The last thing I remember was coming into this room (R1 motions his hands to mean the room he currently resided in)." R1 stated R1 is happy here and states, "I want to be here." On 1/19/22 at 10:47 A.M., a head to toe skin assessment was performed by V3 (Licensed Practical Nurse/LPN) and the above skin impairments were noted. On 1/19/22 at 10:20 A.M. V8 (LPN) stated, "I was not here the night (R1) left. I was here Friday, Saturday, and Sunday (1/14/22-1/16/22) 6:00 A.M.-2:00 P.M. On Saturday (1/15/22), the day (R1) left, (R1) had intermittent confusion. He kept fixating that he wanted to go to the pharmacy.	S9999		

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S9999	Continued From page 12 (R1) kept saying, "I gotta (got to) get my meds." I would remind him that he was in the nursing home and that I had his meds. I remember one time, he was standing outside his room near the rail, and he was again saying that he needed to go to the pharmacy. I escorted him back to his room and he laid down on the bed." At this time, V8 verified that all exit doors should be alarmed at all times. On 1/19/22 at 12:26 P.M., V1 (Administrator) stated, "I was at home (on 1/15/22). I received a call from the nurse on duty (V5/Registered Nurse) that (R1) was missing. On Sunday (1/16/22), I talked to (R1). He said he was tired. I believe I asked him where he was trying to go (when R1 left on 1/15/22). I think he might have stated, 'I don't remember.' R1 exited out the short hall, east exit door. I was not notified that the alarms were sounding. We increased to daily checks on the alarms after this. The alarms should have gone off. All doors were tested immediately. We did not report this to (the local state agency) because we didn't feel it was elopement and he was dressed properly and the doctor agreed he has abilities to community access. The resident had fallen that morning and refused to go to hospital. I don't believe he told anyone he wanted to go. No exit seeking or wandering behavior was noted prior. We were told he was wearing a dark coat, sweat pants and some type of footwear (shoe or slipper). I think it was close to 20 degrees (Fahrenheit) that evening around 7:00 PM on Saturday 1/15/22." At this time, V1 again verified the facility exit door alarms were not sounding and they should have been. V1 verified the facility exit door alarms should always be on. On 1/19/22 at 2:15 P.M., V15 (Certified Nursing Assistant/CNA) stated, "I was his CNA that day	S9999		

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he left. I worked from 2:00-10:00 pm. (R1) was really talking off his head. I was surprised to hear that he was alert and oriented. His behaviors seemed odd. He was talking to himself and talking to people that weren't there. I just kept watching him, kept a close eye on him because he didn't seem right. He did not have a roommate. He was in his room, mostly on the bed. I last saw him right before 5:00 PM. I did rounds before supper to make sure everyone was ready. I got busy picking up trays and answering call lights. Two others were helping passing trays, The nurse (V5, Registered Nurse) had asked us where (R1) was. I looked out the door and saw cop lights and I thought 'Oh no, this isn't happening'. I just had a gut feeling it was him. I did not go outside at all to check-I saw the cops were there. I did have visual eye contact on him. I saw him sitting on the ground. He was covered with a blanket. When I saw him last he was wearing a yellow shirt, gray sweat pants and I didn't pay attention to his feet. He had gone out the side door outside his room. He was down the hill. The alarm did not sound. I asked (V5) 'why didn't we hear the alarm go off?' and (V5) said he didn't know. (V17/Maintenance Director) was there and came and checked the alarms. (V17) verified the alarm wasn't going off. The alarm wasn't working and it should have gone off immediately so we could have been there (outside) immediately. I don't remember the temperature outside but it was cold. (R1) went straight to the hospital."

On 1/19/22 at 2:35 P.M., V13 (CNA) stated, "The first time I saw (R1) (on 1/15/22) he was asleep. Then later he asked me for eye drops, I went to tell the nurse. I was floating in between the two units. I gave him his dinner tray and he said he was going to take it home with him. I didn't think

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S9999	Continued From page 14 much of it. I helped him get set up with tray and then left. I last saw him around 6:30 P.M., he was laying down in bed. I was just finishing up picking up trays and then I'm being told he was gone (by V5). Me, (V5) and (V15) asked 'How did he get out?' No alarms were ever going off. We opened the door to try and set the alarm off again and it didn't go off. It was disengaged. (V17) was in the building and said that they disengaged (the alarms) doing the checks and then forgot to turn it back on. (R1) was different this day (1/15/22). He was talking to his wall. I was told he had a mental illness history. I saw him before this day and he seemed alert and oriented, he knew his meds, the day, and why he was there. He seemed different, laying on his side talking to the wall. (R1) was also reaching out and trying to grab things that weren't there. I told (V5) and he said, 'Ok that makes sense because of his mental history.' The last I saw (R1) he was wearing a short sleeve yellow shirt and gray sweat pants. I didn't see his feet. The neighbors ended up finding (R1), and the cops were called. He was taken by ambulance to (nearby city), I think. We are doing 15 minute checks on the unit for him now. It was a cold day the night he got out. He had some falls and it seemed his personality switched after the fall." On 1/19/22 at 3:05 P.M., V7 (Local Police Officer) stated, "I was dispatched on 1/15/22 around 7:30 P.M. for a male subject (R1) laying in the snow across from the nursing home. (R1) was laying on the east side of the roadway. When I arrived, bystanders were helping him up. The bystander stated she was driving home and saw something laying in the snow. Paramedics arrived and he was agreeable to go to the hospital. He told me he had been outside for 45 minutes to one hour. I wanted to talk to staff, dispatch called to confirm	S9999		

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S9999	Continued From page 15 (R1's) residence. (R1) went to (farther away hospital) for better accommodations. It was reported to me that the East alarm door was not working and did not sound when (R1) exited. (R1) was confused, knew his name and knew he was outside but couldn't say the name of the skilled nursing facility. (R1) kept asking if we were at a restaurant. None of the staff came out to help (once R1 was found). (R1) had a cut on his left elbow and he was bleeding. It was cold outside, I was wearing hat and gloves, it was pretty chilly. It was maybe 10-15 degrees. (R1) was stating that he was cold. (R1) was found in another person's yard. (R1) had exited the East doors, where there is a steep hill. I followed his tracks and could tell he fell down the hill. He must have gotten up, crossed the roadway. (The road) was cleared, so I lost his tracks for a second, but there is another hill. You could see that he fell down that hill as well and it looked like there was a struggle for him to get up and he couldn't get up, so (R1) just stayed laying there until he was found." On 1/31/22 at 10:50 A.M. V17 (Maintenance Director) stated, "I was here in the building on another call when (R1) got out (on 1/15/22). I came over right away to check the door alarm. The only thing I can think of (regarding why the alarm did not sound when R1 exited the building on 1/15/22) is the gear on the inside didn't trigger the cell. (At this time, V17 had removed the door alarm from its case and opened the back of it to expose the gears and triggering mechanism inside. V17 was pointing to the gears that he thought could possibly not have activated on the alarm.) V17 continued to say, "It (why the alarms didn't sound) could also have been from the cold outside. The alarm box inside had frost build up on it, so maybe that had something to do with it. I don't really know for sure what happened." V17	S9999		

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verified V17 did not hear the alarms sound (on 1/15/22 when R1 eloped). V17 stated, "Once the (facility) exit door alarms are activated you have to use the key to disarm it. It's how you shut it off." V17 verified V17 did not deactivate any alarms after R1 eloped on 1/15/22.

On 1/19/22 at 3:26 P.M., V9 (LPN) stated, "I was here the night (R1) eloped on 1/15/22. It was a quiet evening, I was doing (medication) pass with (V5). I was in training that night. I went outside on break 20 min until 7:00 P.M. I was sitting in my truck and I could see movement by the trees from my headlights. It wasn't enough to alert me but whatever that shape was that went behind the tree by the East door. I came in from my break at 7:05 P.M. Shortly after that the police had alerted us that (R1) was found. I wasn't sure where (R1) was found. No alarms were going off. It was cold that night. I was back here Sunday night and he refused his meds."

On 1/19/22 at 4:19 P.M., V12 (Unit Assistant) stated, "The first time I helped with (R1), he was mostly normal. The 2nd time, he was really out of it. This was the Friday night (1/14/22) before (R1) left. He kept talking about feces under the other bed in his room. I checked with a flashlight and nothing was under there. He kept apologizing for the mess he made and we kept reassuring him that nothing was there. He was really adamant that he had had a bowel movement under the other bed in his room. We notified (V6/LPN) and he went to check on (R1)."

On 1/19/22 at 4:29 P.M., V10 (Social Service Director) stated, "I was here the night before (R1) got out. (R1) had an episode. He was saying he wanted to go home, he kept trying to get out of bed. This was all the same morning of the day he

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S9999	Continued From page 17 got out. It was around 3:00 A.M. (R1) fell to the ground and was rolling around. The EMTs came and had him on the gurney. Once they said where they were taking him to the hospital, he just kind of freaked out. I came down and was asking him the questions and he could answer everything appropriately. EMTs stayed for about 20 minutes trying to get him to go get checked out. He kept refusing, so they said he was of sound mind and got him back into bed. He was normal and pleasant prior to all this." On 1/19/22 at 4:34 P.M., V11 (LPN) stated, "I would notify the doctor immediately if a resident had a change in behaviors different from their normal." V11 verified the exit door alarms should always be on. On 1/19/22 at 4:41 P.M., V14 (CNA) stated, "I was here the night (R1) got out. I worked 2:00-10:00 P.M. No alarms were going off after the east door was opened. When (R1) first got here he was alert and oriented, then he started seeming more confused. (R1) had thought he had defecated under the other bed in his room. Nothing was there. We reported to V6 (LPN) and V19 (LPN) Friday night (1/14/22) about (R1's) confused behavior." V14 verified the exit door alarms should always be on. On 1/19/22 at 4:45 P.M., V16 (CNA) stated, "(R1) seemed ok every once in a while and then he would seem a little confused. He was sweet, pleasant and cooperative. He tried to eat the remote once and use the urinal as a phone. I wasn't here the night he left the building. The nurses knew he was confused." V16 verified the exit door alarms should always be on. On 1/19/22 at 7:24 P.M., V5 (RN) stated, "I	S9999		

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S9999	Continued From page 18 started my shift (on 1/15/22) at 6:00 P.M., I was done with report around 6:30 P.M. I went to (R1's) room around 6:50 P.M. I noticed (R1) wasn't in his room. The bed was empty. I checked the bathroom and he wasn't in there. I checked with the CNAs and they didn't know where he was either. We started looking in the dining room and the blue room. We weren't finding him in the building, so we said he was missing and needed do a search. It was around that same time the phone rang and it was the (local police department) asking if we had a resident by (R1's name) and I told them we did. (R1) got out the east exit door adjacent to his room. If you go out his room, it's to the left a couple feet. He was a fairly new resident and I didn't know a lot about him. He seemed confused and forgetful at times. He had glaucoma so he said he had vision problems. I was told he had a coat on but I'm not sure whose it was. In the nurses' notes, you can see (R1) had fallen two times before this. They tried to get him to go to the hospital because they suspected injury and he refused. EMTs came and also tried to get him to go. I know (V19/LPN) was upset (R1) wouldn't go. The alarms were not sounding after he went out that door. We would have searched outside immediately if the alarms were going off. (V17/Maintenance Director) was in the building and he checked (the alarms). He said the east exit door alarm was off. We went and checked all the other alarms and they were working correctly. Sometimes when the batteries are dying, it will make a chirp noise or flash a light. It wasn't doing any of that. The door is normally alarmed at all times. (R1) was acting confused before he left. It seemed like he was talking to someone that wasn't there. He was hallucinating and thinking he was somewhere else he wasn't. We should report a change in condition to the Physician right away-we would	S9999		

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S9999	Continued From page 19 just call the doctor. We did a full head count to make sure the rest of the residents were accounted for as well. (R1) was admitted with altered mental status. CNAs reported his confused behavior but I had handed over my keys to (V19) already so I was going to let her handle it." On 1/20/22 at 8:32 A.M., V19 (LPN) stated, "The man (R1) is confused. (R1) was on the floor for me (Regarding the 1/15/22 fall). He was complaining of left hip pain and hitting his head. I called the ambulance. Two paramedics came and loaded him on the gurney. When they told (R1) they were taking him to the hospital, he refused to go. They tried talking to (R1) for about 25 minutes going back and forth. He was able to say the month, year, and that he had been at the nursing home for 5-6 days, so they said he was of sound mind. He's been odd since he's been there. I met him Thursday (1/13/22) when I came back. He was very polite and thanked me. Friday (1/14/22) when I came back, he was a little off. I introduced myself and he didn't remember me from the night before. He used the urinal and then tried to drink out of it. He was just a little odd. (R1) could answer questions appropriately, but then after he fell, I asked him why he got up and he said because he thought he heard his ex-wife in the hallway. I did not talk to the doctor after (R1) was on the floor and acting odd. If I had a resident who was acting different from baseline, I would get a full set of vitals, check neuros (neurological status), call the doctor and if don't hear back (from the doctor), I'm sending (the resident) right out. We have to check the alarm doors each shift now." At this time, V19 again verified V19 did not notify V4 (R1's Physician) of R1's change in behaviors and that the exit doors should always be alarmed.	S9999		

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S9999	Continued From page 20 On 1/20/22 at 11:55 A.M., V6 (LPN) stated, "(R1) kind of went south. They (facility staff) said (R1) was rolling around on the floor (regarding the 1/15/22 fall). (V19) reported to me that (R1) was seeing things that weren't there." At this time, V6 verified nursing should notify the doctor if a resident has a change in condition. V6 denied notifying a doctor of any changes (with R1). V6 stated, "CNAs normally chart on behavior tracking logs and nurses can add to (the behavior logs) if they need. You should chart when the behavior occurs." On 1/20/22 at 2:18 P.M., V18 (V4's Nurse) stated, "No notifications about (R1's) increased confusion or change in behaviors were given directly to (V4) or received via fax. The facility would usually just fax the sheets over. (V4) would expect the facility to follow their policy on notifications." As of 1/20/22 at 3:00 P.M., R1's medical record does not contain behavior tracking logs with nonpharmalogical interventions for R1's confusion, hallucinations, or delusional behavior nor does R1's medical record document R1 was placed on any increased monitoring for R1's behaviors. On 1/20/22 at 3:40 P.M., V3 (Licensed Practical Nurse) verified no behavior tracking logs for R1's behaviors could be produced before R1's elopement on 1/15/22. As of 1/19/22 at 10:15 A.M., the facility's two binders for residents at high risk for Elopement located at each of the nursing stations did not contain R1's picture, elopement assessment or other identifying information. At this time, V3 (Licensed Practical Nurse) verified V10 was	S9999		

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S9999	Continued From page 21 working on updating the binder and that R1's information should be in it. 2. Based on observation, interview and record review, the facility failed to notify a resident's Physician after a resident's fall, notify the Physician after the resident's refusal to be sent to the hospital for evaluation following the fall with injuries and notify the Physician after a resident's change in mental status for one of three residents (R1) reviewed for accidents and supervision in the sample of three. These failures resulted in R1 displaying an altered mental status and exiting from the facility on 1/15/22 around 6:45 P.M. after sunset, in freezing temperatures and snow covered grounds for approximately 45 minutes subsequently requiring transport to the hospital and treatment for injuries sustained to R1's extremities and fingers Findings include: The facility's "Notification for Change in Resident Condition or Status" policy, revised 12/7/17, states, "Policy: The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON (Director of Nursing), Physician, Guardian, HCPOA (Health Care Power of Attorney, etc) of changes in the resident's medical/mental condition and/or status. Procedure: 1. The nurse supervisor/charge nurse will notify the resident's attending Physician or on-call physician when there has been: a. Any symptom, sign or apparent discomfort that is: 1. Sudden in onset 2. A marked change (i.e. more severe) in relation to usual signs or symptoms 3. Unrelieved by measures already prescribed; b. An accident or incident involving the resident; e. A significant change in the resident's physical/emotional/mental condition. g. Refusal of	S9999		

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S9999	Continued From page 22 treatment or medications h. A need to transfer the resident to a hospital/treatment center; 2. The nurse supervisor/charge nurse will notify the DON, Physician, and unless otherwise instructed by the resident, the resident's next of kin or representative when the resident has any of the afore mentioned situations or: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychological status. e. It is necessary to transfer the resident to a hospital/treatment center. 3. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status." 1. R1's A.I.M. (Assess, Intercommunicate, Manage) for Wellness Form, signed and dated by V19 (Licensed Practical Nurse) on 1/15/22 states, "This change in condition, symptoms, or signs observed and evaluated are: Fall resulting in Lt (left) hip pain; scrape to Lt (left) forehead;confusion at times. Other relevant information: 911-ambulance called to send to ER (Emergency Room) for eval (evaluate) and tx (treat), (R1) refused to go. 1. Functional Status Evaluation: Falls-two. Other-Lt (left) hip pain. 2. Behavioral Evaluation: Other behavioral changes-increased agitation, increased confusion. Physician Recommendations and/or nursing interventions: (R1) assessed for injuries-c/o (complains of) Lt (left) hip pain, Lt (left) extremity appeared shorter in length. Also noted scrape Lt (left) side forehead, Ambulance (with) two attendants arrived to transport, assisted (R1) from floor to gurney, (R1) refused to go to hosp (hospital) for eval and tx (after) 25 min (minutes) of nursing home staff and two EMTs (Emergency Medical Technicians	S9999		

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S9999	Continued From page 23 questioning resident, (R1) still refused. EMTs refused to transport d/t (due to) (R1) is his own POA (Power of Attorney). (R1) has the right to refuse." R1's Nurses Notes on 1/15/22 at 3:15 A.M., signed by V19, documents, "(R1) found on floor, voices c/o Lt (left) hip pain and hitting head. Upon assessment Lt (left) extremity appears short in length. (R1) also states his head hurts. Noted scrape 0.3 cm (centimeter) x 0.3 cm Lt (left) forehead. R1's Nurses Notes on 1/15/22 at 3:25 A.M., signed by V19, documents, "911 called. Ambulance arrived (with) two EMTs, assessment done, (R1) placed on gurney, EMTs told (R1) they were taking him to a hospital here in (name of city). (R1) refused, stated, 'You can't make me.' EMTs spoke with (R1) for 25 mins (minutes). (R1) knew month, year, where he was at, (R1) then would ask where his ex-wife went to. Since (R1) is able to make his own decisions and refused medical tx (treatment) (at) hospital, EMT assisted (R1) back into his bed." R1's Nurses Notes on 1/15/22 at 4:45 A.M., signed by V19, documents, "Message left for (V4/R1's Physician), awaiting callback." R1's medical record does not contain further information that V4 was further notified of R1's 1/15/22 fall or R1's refusal to seek medical treatment after a fall with injury. 2. R1's "Investigative Report of Missing Resident", signed and dated by V1 (Administrator) on 1/15/22, documents R1 with a diagnosis of hallucinations. This same form documents on 1/15/22, R1 was last seen at 6:30	S9999		

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	IL6003529	A. BUILDING: _____ B. WING _____	01/31/2022

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S9999	Continued From page 24 P.M. and declared missing at 6:55 P.M. by V5 (Registered Nurse). This form also documents R1 was found across the street and the (facility exit) door alarms were "disengaged." R1's report to the local State Agency on 1/19/22 documents R1 to have redness to fingertips with intact fluid filled blisters on R1's right and left hands status post R1 exiting the building on 1/15/22. On 1/19/22 at 10:20 A.M. V8 (LPN) stated, "I was not here the night (R1) left. I was here Friday, Saturday, and Sunday (1/14/22-1/16/22) 6:00 AM-2:00 P.M. On Saturday (1/15/22), the day (R1) left, (R1) had intermittent confusion. He kept fixating that he wanted to go to the pharmacy. (R1) kept saying, "I gotta (got to) get my meds." I would remind him that he was in the nursing home and that I had his meds. I remember one time, he was standing outside his room near the rail and he was again saying that he needed to go to the pharmacy. I escorted him back to his room and he laid down on the bed." At this time, V8 verified that V8 did not speak with the Physician regarding R1's confusion. On 1/19/22 at 2:15 P.M., V15 (Certified Nursing Assistant/CNA) stated, "I was (R1's) CNA that day he left. I worked from 2:00-10:00 P.M. (R1) was really talking off his head. I was surprised to hear that (R1) was alert and oriented. His behaviors seemed odd. He was talking to himself and talking to people that weren't there. I just kept watching him, kept a close eye on him because he didn't seem right." On 1/19/22 at 7:24 P.M., V5 (RN) stated R1 seemed "Confused and forgetful at times." V5 stated, "In the nurses notes, you can see (R1)	S9999		

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S9999	Continued From page 25	S9999		

had fallen two times before this. They tried to get him to go to the hospital because they suspected injury and he refused. EMTs came and also tried to get him to go. I know (V19/LPN) was upset because(R1) wouldn't go. (R1) was acting confused before he left. It seemed like he was talking to someone that wasn't there. He was hallucinating and thinking he was somewhere else he wasn't. We should report a change in condition to the Physician right away-we would just call the doctor."

On 1/19/22 at 4:34 P.M., V11 (LPN) stated, "I would notify the doctor immediately if a resident had a change in behaviors different from their normal."

On 1/19/22 at 4:41 P.M., V14 (CNA) stated, "I was here the night (R1) got out. I worked 2:00-10:00 P.M. When (R1) first got here he was alert and oriented, then he started seeming more confused. (R1) had thought he had defecated under the other bed in his room. Nothing was there. We reported to V6 (LPN) and V19 (LPN) Friday night (1/14/22) about (R1's) confused behavior." V14 verified the exit door alarms should always be on.

On 1/20/22 at 11:55 A.M., V6 (LPN) stated, "(R1) kind of went south. They (facility staff) said (R1) was rolling around on the floor (regarding the 1/15/22 fall). (V19) reported to me that (R1) was seeing things that weren't there." At this time, V6 verified nursing should notify the doctor if a resident has a change in condition. V6 denied notifying a doctor of any changes (with R1). V6 stated, "CNAs normally chart on behavior tracking logs and nurses can add to (the behavior logs) if they need. You should chart when the behavior occurs. The CNAs reported (R1's) confused

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S9999	Continued From page 26 behavior but I had handed over my keys to (V19) already so I was going to let (V19) handle it." On 1/19/22 at 10:33 A.M., R1 was noted to be laying in bed with eyes open, wearing a T-shirt, gray sweat pants, and nonskid socks. R1 was noted to have obvious red/maroon discolored finger tips and blisters to R1's left and right hands. R1's left and right elbow were noted to have open abrasions covering the entire elbow. The right elbow abrasion was draining a serous fluid. Multiple red scabbed areas/scratches were noted to R1's forearm. R1's entire right lateral pinky (5th digit) was noted to have reddish purple/maroon discoloration. On 1/19/22 at 10:47 A.M., a head to toe skin assessment was performed by V3 (Licensed Practical Nurse/LPN) and the above skin impairments were noted. In addition, R1 was noted to have scattered ecchymotic areas to R1's abdomen, back, flank, and posterior upper arms in various ranges of coloring from purple to yellowish/green. R1 stated, "I fall a lot." On 1/20/22 at 8:32 A.M., V19 stated, "The man (R1) is confused. He was on the floor for me (regarding the 1/15/22 fall). (R1) was complaining of left hip pain and hitting his head. I called the ambulance. Two paramedics came and loaded him on the gurney. When they (paramedics) told him they were taking him to the hospital, he refused to go. They tried talking to (R1) for about 25 minutes going back and forth. He was able to say the month, year, and that he had been at the nursing home for 5-6 days, so they said he was of sound mind. He's (R1) been odd since he's been there (the skilled nursing facility). I met him Thursday (1/13/22) when I came back. He was very polite and thanked me. Friday (1/14/22)	S9999		

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S9999	Continued From page 27 when I came back, he was a little off. I introduced myself and he didn't remember me from the night before. He used the urinal and then tried to drink out of it. He was just a little odd. (R1) could answer questions appropriately, but then after he fell, I asked him why he got up and he said because he thought he heard his ex-wife in the hallway. I did not talk to the doctor after (R1) was on the floor and acting odd. If I had a resident who was acting different from baseline, I would get a full set of vitals, check neuros, call the doctor and if don't hear back (from the doctor), I'm sending (the resident) right out." At this time, V19 again verified V19 did not notify V4 (R1's Physician) of R1's change in behaviors or R1's fall. V19 stated, "(V4) never calls me back." On 1/20/22 at 2:18 P.M. V18 (V4's Nurse) stated, "The only fall that was reported to us (for R1) was (R1's) fall on 1/13/22. I do not have a fax for any falls on 1/15/22. (V4) said that he knew about (R1's) elopement but he didn't know anything about (R1) falling, EMS (Emergency Medical Service) coming, or (R1) refusing to go to the hospital on 1/15/22. No notifications about his increased confusion or change in behaviors were given directly to (V4) or received via fax. The facility would usually just fax the sheets over. (V4) would expect the facility to follow their policy on notifications." (A)	S9999		