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
	IL6009328	A. BUILDING: ______ B. WING ______	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET REHABILITATION & HLTH C	129 SOUTH 1ST AVENUE CANTON, IL 61520

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S 000	Initial Comments Complaint Investigation 2222018/IL144612	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.510a) Section 300.510 Administrator a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to employ a full time licensed Administrator. This had the potential to affect all 74 residents residing in the facility. Findings include: The Facility Assessment Tool, dated 3/15/22, documents, "The facility uses various staff members, healthcare providers, and medical practitioners to provide the necessary support and care for the residents: Administration-Administrator." The facility's Job Description Administrator, no date available, documents, "The Administrator is responsible for managing, planning, organizing,	S9999	**Attachment A** **Statement of Licensure Violations**	

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staffing, directing, coordinating, reporting, budgeting and the physical management of the facility, residents, and equipment in a way that the purpose of the facility shall be maintained in accordance with all established practices, polices, laws, and applicable State Regulations."

On 3/10/22 at 8:30 a.m. upon entrance to the facility, V1 (Regional Clinical Coordinator) and V3 (Regional Director of Operations) both stated V26 (Former Administrator) is no longer in the position as Administrator, and she now works the floor as a nurse as of this past Monday (3/7/22).

On 3/17/22 at 8:55 a.m., V1 and V3 both stated there is currently no licensed Administrator working in the facility.

The facility's CMS (Centers for Medicare and Medicaid Services) Resident Census and Conditions of Residents Form 672, dated 3/10/22 and signed by V5 (Care plan coordinator), documents 74 residents reside in the facility.

(B)

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300.610 a)
300.1210 b)
300.1210 d)6)
300.1220 b)2)
300.1220 b)3)
300.3240 a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the

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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 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

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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.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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 observation, interview, and record review, the facility failed to identify a resident at high risk for elopement, failed to assess for the safety of a newly admitted resident with a history of delusional behavior, and failed to ensure a resident room was free from accidents and hazards for one of three residents (R1) reviewed for elopement in the sample of 12. As a result of these failures, R1 attempted to exit seek from the building and suffered a fall from a second floor

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window resulting in Bilateral C2 (2nd Cervical Vertebrae) Lamina fracture, T4 (Thoracic Lumbar 4)-3 Column Comminuted fracture, T8 (Thoracic Lumbar 8) 3 Column fracture with dislocations, Numerous Thoracic Spinous Process fractures, Posterior Element fractures of T2-3, ASIA (American Spinal Injury Association) A SCI (Complete Spinal Cord Injury) at T8 (Thoracic Lumbar Vertebrae 8), Sensory Level, leaving R1 paraplegic. R1 was also diagnosed Spinal Shock, Paraspinal Hematoma, Right Hemothorax (collapsed lung) requiring a Chest Tube, Left sided 9th Rib fracture, Right sided 3rd, 5th-9th Rib fractures, Left Pulmonary Contusions, and Bilateral Pleural Fluid/Hemorrhages. These failures have the potential to affect 11 residents (R1, R3-12) that are at risk for elopement.

Findings include:

R1's Hospital Inpatient Psychiatry History & Physical note, dated 2/22/22, documents, "(Hospital) Admission date: 2/19/22. Reason for hospitalization: Psychosis. Chief Complaint: 'I was hearing voices.' History of Present Illness (HPI): Brought to the ED (Emergency Department) with reports of ongoing disorganized thinking, hallucinations, and was admitted for further stabilization and safety." The note also documents, "Diagnosis: Schizoaffective disorder, Bipolar type. Plan: Requires inpatient psychiatric admission due to risk of self harm, for stabilization and ongoing medication titration and monitoring."

R1's PAS (Pre-Admission Screening) Level II Assessment, dated 3/7/22, documents, "(R1) reported that in January 2022, (R1) ran away to Indiana as she believed her brother was trying to

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kill her."

R1's Nurses' Notes, dated 3/8/22 at 3:30 p.m., documents, "Arrived to facility via facility transport. (R1) was admitted from hospital behavioral health. Alert to person, place, time-unable to tell me date of birth and gave incorrect name for daughter. Primary diagnosis of Psychosis, Bipolar, Schizoaffective. Admitted to hospital for auditory delusions, visual hallucinations, and increased paranoid thoughts. Per (V13, R1's Power of Attorney)-(R1) was scared to be alone at home and was unsafe and trying to 'flee' with her belongings and car. Goal for (R1) and (V13) is to get medications stable and behaviors decreased to be able to return home independently." R1's Nurses' notes also document, "Transfer/Ambulate independently with cane." R1's Nurses' note was signed by V7 (RN-Registered Nurse). R1's Nurses' notes have no other entries made to R1's medical record after this initial entry.

R1's Elopement Evaluation, dated 3/8/22, documents a score of 5 putting R1 at a high risk for leaving the facility unattended. The evaluation also documents the interventions of visual checks every 15 minutes. R1's evaluation has a designated spot for the staff member who completed the assessment to sign, however there was no documentation of a staff member's signature. That line was blank.

R1's Baseline Care plan, dated 3/8/22, documents, "Identified Safety Risks: Safety plan of care: high risk fall assessment, poor safety awareness, high risk elopement assess, initiate behavior monitoring, 15 minute checks, psychotropic medication use, gait, balance, elopement book." R1's Care plan has a

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designated spot for the staff member who completed the care plan to sign, however there was no documentation of a staff member's signature. That line was blank.

R1's Ambulance Pre-hospital Care Report, dated 3/9/22, documents, "Alarm time: 1:13 a.m.; At Scene: 1:17 a.m.; Patient contact: 1:18 a.m.; Leave Scene: 1:31 a.m. Narrative: Dispatched to facility for a 58 year old female patient (R1) fall from building. (R1) states that she jumped out of window. (R1) relates she was going to see God. (R1) relates she struck the ground and felt like her legs were floating. (R1) is unsure how long she was on the ground. (R1) complains of pain to spine directly between the shoulder blades, and not being able to feel from abdomen down. (R1) denies any head, and pelvic pain by palpation. Arrived on scene to find (R1) lying on the ground on her left side. Window is broken on 2nd story of building. (R1) appears to have landed on dirt. (R1) is conscious and alert but not fully oriented. Skin normal in color, cold, and dry. (R1's) back exposed with no bruising or swelling noted. (R1) does have significant pain while palpating in between shoulder blades. (R1) complains of pain while neck is palpated. (R1) is able to move upper extremities, but cannot move or feel lower extremities."

R1's Emergency Department (ED) Intervention/Assessments, dated 3/9/22, documents, "Time patient is triaged: 1:38 a.m. EMS (Emergency Medical Services) called (V13, R1's POA-Power of Attorney) of (R1), stated was called to facility for (R1) who fell out of 2nd story window onto ground. Reports unsure of how long (R1) was outside on the ground before staff aware (R1) was gone from her room, but her room window was open. Reports (R1) was

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admitted to facility just yesterday, and had been trying to get out all day. No report received from staff from facility. (R1) states she was, 'On her way to see God'."

R1's Emergency Room Note Report, dated 3/9/22, documents, "Chief Complaint Comments/Description: 59 year old female patient (R1) facility resident, history of Schizoaffective disorder, Hypertension, jumped from second floor of the facility as she wanted to meet God. (R1) was lying in the cold weather for approximately 20 minutes. On arrival to the ED, (R1) is awake alert. She has no strength or sensation from the mid chest down. She also complains of neck pain and mild upper back pain."

R1's Emergency Department note-Disposition/Discharge, dated 3/9/22, documents, "3:52 a.m.: Life flight arrived. 4:06 a.m.: Temperature 91.8. (R1) transferred."

R1's Discharge Information, dated 3/9/22, documents, "Emergency Discharge Disposition: Discharge/Transfer to General Hospital. Clinical Impression: Multiple vertebral fractures, Spinal cord injury, Neurogenic shock, Hypothermia. Emergency discharge comment: transfer to general hospital trauma."

R1's Level 1 Trauma note, dated 3/9/22, documents, "(R1) brought to Trauma 1 by EMS. R1 arrived to trauma room alert, disoriented to situation, fully immobilized in cervical collar. Per life flight, (R1) jumped out of a second story window, presumed suicide attempt. Life flight reports (R1) was down for approximately 30-45 minutes and found by staff of nursing home facility. In report from local hospital, (R1) has a

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C2, T4 fracture, T8 spinal cord injury and broken left sided 4 and 5 ribs, received 2 Liters Normal saline and was started on a Levophed (medication to treat low blood pressure) drip. In report from lifeflight, (R1) has bilateral Hemothorax (collection of blood in chest wall). (R1) arrives alert but confused. On arrival, (R1) was noted to be hypothermic and placed on a bear-hugger; chest tube placed on right lateral side, bloody drainage observed in chamber and ART(Arterial) line placed for Blood pressure management."

R1's Neurosurgery Consult Note, dated 3/9/22, documents, "(R1) with a history of Hypertension, depression, and hypothyroidism who presents after presumed suicide attempt jumping from a 2nd story window and found to have T2 lamina fracture, T4 3 column burst fracture, and T8 3 column fracture dislocation with associated ASIA (American Spinal Injury Association) A SCI (Complete Spinal Cord Injury) at approximately T8. Given patient is ASI A SCI, no emergent Neurosurgical intervention. Patient will need fixation of her fractures when she is medically stable from her other injuries. HPI: (R1) states she is unable to feel her legs and unable to move them. She has no issues with her arms. She denies sensation changes in her arms. Most of her pain/complaints come from her right ribs where a chest tube was just placed prior to exam."

R1's Hospital Physician progress note, dated 3/10/22, documents, "Critical Care Attestation: The patient has critical illness or injury with acute organ system dysfunction. There is a high probability of imminent or life-threatening deterioration in the patient condition. Critical Care Diagnoses: Neurogenic shock, spinal cord injury,

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paraplegia (paralysis of the legs and lower body)."

R1's Surgical/Trauma ICU (Intensive Care Unit) Daily Progress note, dated 3/10/22, documents, "List of Acute Injuries/Acute Problems: Bilateral C2 Lamina fracture, T4-3 Column Comminuted fracture, T8 3 Column fracture with dislocations, Numerous Thoracic Spinous Process fractures, Posterior Element fractures of T2-3, ASIA A Spinal Cord Injury T8 Sensory Level, Spinal Shock, Paraspinal Hematoma, Right Hemothorax status/post Chest Tube, Left sided 9th Rib fracture, Right sided 3rd, 5th-9th Rib fractures, Left Pulmonary Contusions, Bilateral Pleural Fluid/Hemorrhage."

R1's Psychiatric Consult note, dated 3/10/22, documents, "(R1) presented to the hospital after being life-flighted from a hospital in nearby city on 3/9/2022 with injuries from a fall from a 2nd story building. (R1) sustained serious back injuries. (R1) states she was at her nursing home when she jumped out of a window because she wanted to go home. (R1) indicates, 'Sometimes you just have to take a leap of faith.' (V13, R1's Power of Attorney) indicates (R1) has had problems with believing there are demons around her and may have been trying to get away from the demons. The same day she arrived (to the facility), all the windows had been opened because of the warm weather, and this allowed (R1) to clear the screens and exit out the window."

R1's Psychiatric Progress note, dated 3/14/22, documents, "(R1) reports she was following the voice of God that she hears through her third eye, telling her that she needed to get out of the (facility) by midnight to come
be the Queen by his side or she'd not see him again. (R1) used her cane to get the window

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S9999	Continued From page 10 cover out of the way, was having trouble getting out the window, prayed for assistance to shimmy down the wall 'like Spider-Man' and took 'a leap of faith'. She reports she was going to be with God physically, not trying to end her life to go with God in that manner. She denies she was suicidal or that she has any desire to end her life at this time." R1's State Agency Notification, dated 3/9/22, documents, "Date of Incident: 3/9/22. Time of Incident: 12:55 a.m. 59 year old newly admitted alert and oriented female (R1) with diagnoses to include Schizoaffective disorder, Major mental health disorder, Depression, Chronic back pain, Hallucinations, Delusions, and Insomnia was noted on the ground outside her bedroom window. Staff immediately responded and called 911 per Physician order. In conclusion, it is determined (R1) was attempting to exit the facility to return home and to go to God. (R1) has long standing history of delusions that include going to God or receiving messages from God. No history of any suicidal ideation's or attempts. Facility concludes that (R1) went out the window not realizing it was a 2nd story window. (R1) was noted to be on the ground on her side/back with no visible injury with complaints of loss of feeling in her feet. CT (Computed Tomography) at local ER concludes acute non-displaced fracture extending across C2 lamina and the base of C2 Spinous process, acute comminuted distracted fracture extending obliquely through the T8 and T9 vertebral bodies, acute non-displaced fractures involving T1-T4 Spinous processes, acute mildly displaced fractures involving the right T4-T10 transverse processes, and acute minimally displaced fractures involving the medial aspects of the left 4-9 ribs."	S9999		

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S9999	Continued From page 11 Incident Investigation Form, dated 3/9/22, documents, "Person Being Interviewed: (V7, Registered Nurse/RN). Describe: (R1) arrived and I went to her room, and introduced myself. Pleasant. Disheveled. Cooperative. Answered questions appropriately. Confusion with dates. Explained her psychiatric history to me, and said she was trying to get adjusted. I left and went back after medication pass and did her full assessment. She was cooperative. I went over her medications with her and talked about pharmacy's concern related to a potential drug interactions. (R1) was calm, no attempts to leave her room. Said she was waiting for her daughter (V13)." On 3/10/22 at 1:50 p.m., V7 stated, "I did (R1's) admission. I asked if she was having hallucinations or delusions. She didn't mention auditory, but said she said she was having visual hallucinations. (R1) was alert but had some confusion. She was calm, but she was disheveled. I had her from 3:30 p.m. to 6:00 p.m. I did not do (R1's) elopement evaluation. I put her on 15 minute checks because its just protocol for the first 3 days, but I didn't know that she was at risk for elopement. I started to fill out the initial care plan. I didn't know (R1's) required assistance so I didn't do that area. Under Safety plan of care, I only marked psych medication usage. I didn't mark any of this other stuff about elopement (pointing to the baseline care plan). I didn't finish the care plan so I passed it on to (V8 LPN-Licensed Practical Nurse). When (R1) got there, I discussed with the CNAs (Certified Nursing Assistants) to make sure they were doing their 15 minute checks right away. (V10-CNA-Certified Nursing Assistant) was on my hall that evening that was assigned to (R1). I	S9999		

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never got any information from management regarding (R1's) behaviors or anything. I got a packet of papers when she got here from the hospital and that was it. No management staff was here when (R1) got here."

On 3/10/22 at 2:45 p.m. V10 (CNA) stated, "(R1) was on my hall that evening. She stayed in her room the whole night with the exception of when she needed her medication because (V13, R1's Power of Attorney) brought her dinner. She did not exhibit any behaviors. I spent some time with her. No wandering. (R1) did have me crack her window, because it was really hot in her room. I opened the window about two inches around 6:00 or 7:00 pm. We can open the windows at the request of the resident. A lot of the residents request their windows to be opened because of how warm it is up there (Second floor). I was assigned to doing her 15 minute checks when she got to the facility." V10 confirmed that (R1's) 15 minute checks started at 7:00 p.m. on the 15 minute check sheet. V10 stated, "Honestly I don't do the 15 minute charting thru the night, I don't have time. So, I do it at the end of the night and I estimated that she had gotten to the building at approximately 7:00 p.m. I was surprised that this happened. I didn't get any information about her when she got to the facility. I thought she was just being admitted from home. I didn't even know she had a psychiatric background and behaviors until after the incident. We don't normally get that kind of information given to us, we have to feel the residents out for ourselves. I didn't know any of her history, so I couldn't pass it on to the next CNA working."

Incident Investigation Form, dated 3/9/22, documents, "Person Being Interviewed: (V9, CNA). Describe: Took report from (V10) about

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new resident (R1) that was very nice. I checked my paperwork to see (R1) was on 15 minute checks. I went and checked my other hall and (R1) was in the nurses' office with the nurse (V8, Licensed Practical Nurse). When I returned, (V8) had sent her to the bathroom. I went to check her room and she wasn't there. So, I started checking everywhere, and she was on another hallway downstairs. She then wouldn't respond to me verbally. So, I redirected her to her hall and room with (V8). (R1) was stating about God's will. I was doing cares and bed check and then we redirected (R1) back to her room. Helped her lay down. She complained of being hot and (I) cracked her window. I left with the door cracked open so I could see her. She was in the bed by the door, the other bed is vacant. (This was) at 12:45 a.m. When I came back for 15 minute checks, the door was shut. So I opened it and she was not in her room or her bathroom and the window was wide open. I went to the window and (R1) was outside on the ground. Myself and (V11, Licensed Practical Nurse) went to (R1) immediately."

On 3/13/22 at 11:55 p.m., V9 (CNA) stated, "When I got to work, the only report I got was that (R1) was a nice lady and possible one assist or a reminder to use the restroom. I had no idea of her psychiatric history and about leaving her home. I did not get that she was an elopement risk. She was 15 minute checks because she was new to the facility. When I got there she was talking to the nurse on the floor in his office. At that moment she was very talkative about her medicine so I had (V8, Licensed Practical Nurse) explain it to her. She asked me and I directed her to the nurse. I went to the other side of the floor, due to a resident needing my help during that time. (V8) directed (R1) to the restroom across

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from the office. When I came back to the hall around 12:00 am, I asked (V8) where (R1) was, and (V8) said he thought she walked towards me. I ran checked her room and she wasn't there. I went downstairs checked A wing she wasn't there, and as I was running to B wing I heard the door alarm on pathways. I ran that way as another CNA was meeting (R1) at the door before she went out. She wouldn't really talk to me she just kept saying 'Gods will God's will' over and over again. In my head, I was thinking maybe she's not all there. I redirected her upstairs to (V8) because she was adamant about her medications again. I went to do some cares. Then, I went back and directed (R1) to her room and helped her into bed. I asked if she needed anything, and (R1) said she was hot. (R1) asked if I could open the window for her, and I told her I could open the window just a bit. I put her roommate's, who was in the hospital, stuff like her wheel chair and bedside table in front of the window because I was afraid since she asked me to open the window and she tried to get out the door. At 12:45 a.m. I was leaving the room and (R1) asked if I'd shut the door. I didn't want to shut the door so I could still see her. I told her I would crack the door so I could still see her from the hallway. When I got back to my desk to check my 15 minute checks at about 1:00 a.m. her door was shut completely. I opened the door and the window was wide open. She wasn't in her bed. I ran to the bathroom, and I opened her bathroom door. She wasn't in there." At this time, V9 paused starting to cry, and stated, "I'm sorry. I looked out the window and saw her body laying on the ground." V9 was crying unable to speak for a moment. Then, V9 stated, "I immediately went to my nurse on the hall (V8) and told him (R1) had fallen out of the window. He was in shock, and ran to her room. Since we only have two

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nurses, one upstairs and one downstairs, in the building on third shift I ran downstairs and grabbed that nurse (V11) to run to her. When I got out there to (R1) she kept repeating, 'I can't feel my legs.' I let (V11) assess her because I had to take a step back and take a minute. (R1) didn't say anything about the fall she just kept saying she couldn't feel her legs. There was a pillow, her cane and a coin purse laying by her. The window screen was under her body. (R1) was facing the ground and her legs were twisted and her arms were weird. From the window view, you could tell something was going on with her spine. Her head was two inches from the cement block. I ran upstairs to get her paperwork and the nurse was getting a blanket for her when I got back out there. She didn't seem cold. It was cold outside." V9 also stated, "I didn't want to go past the point I opened it (R1's window) to. It was really warm during the day, and our heat was on so it was warm in the building. She was one of a few residents who wanted to have her window open to get some air flow because it gets pretty warm up there. As far as I know, all of the windows open all the way."

Incident Investigation Form, dated 3/9/22, documents, "Person Being Interviewed: (V8/ LPN). Describe: (V9) was on (conducting) 15 minute checks and came running down the hall, and told me that the window was open and the resident (R1) was on the ground. I had her go down, get (V11/LPN) and go assess her because they could get there faster. I did look out the window, and (R1) was talking, and said she couldn't move her legs. So I went to nurses' station and called supervisors and started an incident report."

On 3/14/22 at 11:06 am, V8 (LPN) stated, "I came

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on (shift) at 6:00 p.m. I got in report that we had a new woman that was pleasant, very with it, but tends to wander in her mind in the way she talks. She had just got moved so keep an eye on her. (R1) was 15 minute checks that was about it. I did not do her physical assessment. I did not do the elopement nor the baseline care plan. I did not know she was an elopement risk. Shortly after I got to facility, (R1) wanted to know when her medicine would be in the building. I told her it should be anytime. She told me she'd wait until the medicine got here and she waited. I think it was around 11:00 p.m. that I gave her medications. We talked for about 45 minutes she was very lucid but every once in a while she would talk about people that weren't there. When she left she went to the right of the nursing desk towards D Hall, I told her she was going to the wrong way, because she lives on C Hall. I saw (V9/CNA) coming from the D Hallway. I told (V9) that (R1) had walked out of the wrong way. (V9) had soiled linens, so she had to get rid of those and then went looking for her. She didn't find her on C or D wing. When she got downstairs she checked A and B she heard alarm and (R1) was trying to go out Pathways door. (V9) got to her and redirected her back to the floor. (V9) took (R1) to her room. Next thing I know, (V9) came running up the hall and said the lady (R1) is outside laying on the ground and wasn't moving. I told her go downstairs and get (V11) that would be quicker. I went to (R1's) room, and the window was wide open. (V9) and (V11) were there at that time and (R1) was talking saying she couldn't feel her legs." V8 also stated, "Staff often open windows to let air in. I started to suspect she was an elopement risk when she went to the right when I was trying to redirect her."

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documents, "Person Being Interviewed: (V11/LPN). Describe: At 1:00 a.m., I was headed to B wing and (V9/CNA) came running and asked me to come with her and then she told me that the new lady (R1) 'fell out of the window.' Going past (V14/CNA) I told her to call 911. I go outside and (R1) was laying on her back towards her right side. She told me her name and that she couldn't feel her feet. I took (V14's) phone and called 911 myself at 1:11 a.m. They were here by 1:15 a.m., (R1) had her cane, coin purse, and a blind maybe. No distress. Calm. I got her a blanket and then she said her back hurt. Right arm was under her."

On 3/13/22 at 11:40 p.m., V11 (Licensed Practical Nurse-LPN) stated, "I saw her one time when I delivered medications to the C wing nurse (V8). (R1) was in the medication room. (R1) came down to pathways hall and tried to exit the building. I was on A or B wing at the time. The CNAs from C wing and pathways stopped her and got her back upstairs. Around 11:00 pm or 11:30 pm, (R1) tried to go out the door. The CNAs said they redirected her. At 1:00 am, I was going from pathways to B wing to relieve a CNA for lunch, on the way there (V9) met me halfway. (V9) came running and said to drop my stuff and go with her. She said the new lady (R1) had fell out of the window. We ran out A wing door and around the corner. Between A Wing and the welding shop building next door, (R1) laid on the ground in the grass. There was a cement block that the gutter sits on, her head was resting on the block. She said that she couldn't feel her feet. I asked her if she was hurting anywhere else and she said between shoulder blades and back. I got on the phone to 911 right after that. It was soggy outside. It was cold that night. (R1) was laying on the screen from her window. (R1's) cane was

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next to her and a coin purse. She was laying on her back towards her right side with her legs bent kind of like a side lying position. She didn't look like her legs were broken or anything. Her right arm was underneath of her, and her left arm was open back. She didn't say anything about what happened. I asked her if she was hurting, then got on phone with 911. After getting off phone I got her a blanket." V11 also stated, "I have opened windows in the building when residents complain of being hot. On B wing (locked unit) the windows are screwed shut, but there are no stops on any of the other windows. They look like newer windows but hard to open. Once the window is open a little bit it makes it easier to open them all the way. The window opened enough that (V8) had his whole upper body out the window talking to us while we were with (R1)."

On 3/10/22 at 10:00 a.m., R1's room had two windows that slide up to open. The left window had no screen in it. This window was able to be opened approximately 24 inches. Outside of the 2nd story window is a direct drop to the ground. Window on the right side partially opened approximately 6 inches with a screen in the window. V12 and V17 (Both CNAs) present in R1's room. V12 stated, "This is the window that (R1) went out. The one without a screen."

On 3/14/22 10:00 a.m. V18 (Maintenance) stated, "All of the windows with the exception of the locked unit and one room, are able to open all of the way with no stoppers. The residents get hot at times upstairs and want their windows opened for some fresh air and to cool it down."

On 3/14/22 at 11:25 a.m., V4 (Resident Care Coordinator) and V5 (Care Plan Coordinator) were outside explaining the area where R1 was

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S9999	Continued From page 19 found. V5 stated, "(R1) was found here." V5 was pointing to the wet ground directly underneath of (R1's) window. R1's window was approximately 15 to 20 feet from the ground. V4 and V5 confirmed the distance. Below the window to the right was a concrete gutter slab. V5 stated, "I was told her head either hit that block or was right by it when they found her." Directly to the left of the area, but still under the window, was an electrical wire containment post. On 3/10/22 at 2:30 p.m., V2 (Director of Nursing) stated, "Prior to (R1) coming (to the facility) we were aware that she had psychotropics and psychiatric diagnoses. The only thing in her (hospital) notes was that 'God would tell her to do things.' I accepted her weeks before she actually came. Her delusions and hallucinations were minimal. The admission process is to start all of their assessments, including physical, elopement, fall, Braden (skin risk) etc, Once high risk for elopement is identified the nurse will let us know (management). Every new admit is on 15 minute checks for the first 72 hours regardless. The interim care plan is marked by the nurse saying they are a high risk for elopement. The intervention put into place was 15 minute checks nothing else for (R1)." V2 also stated, "All of the windows open all the way. The windows should be closed with no staff in the room. (R1) had asked the staff member (V9/CNA) to open the window because she was hot. So (V9) cracked it open and left the door cracked open. When the door was closed (V9) knew something was up. When (V9) opened the door, she saw the window was completely open and the screen was pushed out. (V9) immediately looked out the window when she didn't see her in the room and saw (R1) on the ground."	S9999		

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S9999	Continued From page 20 On 3/14/22 at 9:00 a.m. V15 (Social Services Director) stated, "I saw (R1) for about five minutes, because she came at the end of my shift. My plan was to do her admission packet the following day. Prior to her coming, the behavior mentioned was God telling her to do things. She was hearing voices. If a resident comes in and they are an elopement risk we put them on B wing (locked unit) or put them close to the nurses' desk to be monitored. (R1's) room was not on the B wing or near the nurses' desk. Other than that, I don't know what we do for them. I would do behavior tracking for her, but I did not implement any behavior tracking for her prior to me leaving. Other than her hallucinations, I didn't get a whole lot of information that would trigger me to implement behavior tracking right away. Usually (V2) goes to the nurse directly on the floor to let them know the main thing they need to watch for. We knew she wasn't taking her medications and having highs and lows with the hallucinations that (V13) couldn't take care of her anymore. She seemed alert and with it. I didn't do the whole cognitive assessment. She answered the few questions appropriately that I asked her about. If there is an increase in behaviors, the staff are to fill out a behavior referral sheet so we can review it during the morning meeting to make any changes. I never did get one nor did I hear about her exit seeking. If she did attempt and opened the door, we normally move them to the secured unit, and there is a bed open at this time. If it happened during the day, we could have put a 1:1 with her but that's not feasible on third shift. The only windows in the facility that do not open completely are the windows on B wing because of the residents with Dementia. I'm sure there are other residents on the second floor that are elopement risks."	S9999		

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S9999	Continued From page 21 On 3/15/22 at 9:15 a.m., V16 (Care Plan Coordinator-CPC) stated, "When a resident is admitted, the admitting nurse does the initial assessments including the elopement risk and does the interim baseline care plan. If a resident is an elopement risk, they will notify Social Services and Nursing. (V2) does the communication with the nursing staff prior to admission to inform the floor nurse, and the floor nurse receives report from the hospital." V16 also stated, "As far as I know all of the windows open completely because in the warm months, the rooms all have windows units so they would have to open. A few of the rooms get warm and the residents who would like it cooler want the windows opened." On 3/14/22 at 1:50 p.m., V2 stated, "(V7, Registered Nurse) or (V8, Licensed Practical Nurse) should have been the ones to complete the baseline interim care plan and the elopement assessment. I did not complete them, and I know that no department heads were here when she was admitted. So the only thing I can think of is that they were filled out the following morning after the incident." On 3/14/22 at 3:10 p.m., V3 (Regional Director of Operations) stated, "(V2, Director of Nursing) or (V4, Resident Care Coordinator) should be taking the admission screening paperwork, gather the information, and share it with the admitting nurse. Because of a late arrival of (R1), the floor nurse would do the initial baseline care plan. That nurse should be communicating that information with the other nursing staff. The nurse on duty would start the admission process and whatever doesn't get done would get passed on to the next shift to complete or get done as much as they can get done." V3 also stated, "The windows were never	S9999		

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assessed for potential accident hazards prior to this happening."

On 3/15/22 at 8:30 a.m., V3 stated, "No one is admitting to doing (R1's) elopement assessment prior to the incident. So it would have had to be done after the incident even though it should have been done before. (R1) still would have been considered an elopement risk prior to the incident though."

On 3/15/22 at 10:00 a.m., V19 (Medical Director) stated, "The windows opening up completely is a hazard. If their (facility) policy was to assess the resident for elopement and put actions in place they should have followed that."

The facility's room roster, dated 3/14/22 and provided by V5 (CPC), documents that R3-R12 are elopement risks. V5 confirmed that R3-12 are elopement risks and have windows that open completely.

The facility's Admissions policy, no date available, documents, "Nursing Admission Checklist: Complete Braden (Skin Risk), Elopement, Fall, Hydration, Pain and Side rail assessments. Initiate Baseline Care Plan and Care Plan Summary."

The facility's Elopement Prevention Policy, dated 10/2006, documents, "It is the policy of the facility 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 interventions for prevention be established in the plan of care to minimize the risk for elopement." The policy also documents, "A licensed nurse will complete the

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Elopement Risk Assessment upon and/or within 8 hours of admission to the facility. An interim plan of care for minimizing the risk for elopement will be initiated upon high risk determination."

The facility's Baseline Care planning policy, dated 11/1/17, documents, "The staff member completing Baseline Care Plan will seek to develop a person centered plan of care by including information gathered from resident and/or resident representative interview as well as from a variety of resources that may include: Initial goals based on admission orders; Physician's orders; Dietary orders; Therapy services; Social Services; and PASARR (Pre-Admission Screening and Resident Review) recommendations. The Baseline Care plan shall serve to briefly discuss the immediate assessed needs of the new resident, promote continuity of care and communication among nursing home staff, increase resident safety, safeguard against potential adverse events, and ensure the resident and/or resident representative are informed of the initial plan for delivery of care and services."

(A)