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S 000	Initial Comments Complaint Investigations: 2272290/IL144961 2272299/IL144973 2272270/IL144938 A partial extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident identified as an elopement risk was provided adequate supervision to prevent elopement from the facility. The facility also failed to ensure the staff is knowledgeable about alarming exit doors, that exit alarms are in working order, staff respond to triggered exit alarms and elopement binders are kept up to date as shown in the facility's elopement policy. This applies to 6 of 8 residents (R1, R2, R3, R4, R5, and R7) reviewed for safety concerns in the sample of 8. On March 18, 2022, at 8:25 PM, R1 eloped from	S9999		

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the facility without being witnessed by facility staff. R1 was found lying in a drainage ditch by two bystanders from the local community, who alerted 911 at approximately 10:40 PM on March 18, 2022. R1 required hospitalization due to hypothermia and has not returned to the facility.

The findings include:

1. On March 22, 2022, at 5:09 PM, V3 (Witness/Bystander) stated, "Me and a friend were walking home from a local restaurant around 10:30 PM on March 18. We saw [R1] close to the road, lying in a storm drainage ditch. There is a big ditch and a metal storm drain next to the road we were walking on. [R1] was mostly lying on his side and his entire body, except for his neck and head was in water. He was moving a little bit at that point. We walked over to him, and from a safe distance we said, are you okay? Should we call someone? He did not answer. We walked over to him and could see he was elderly and there was a very visible amount of blood coming from his arm. He said he couldn't get up and said he didn't have a cell phone. We moved him out of the cold water by pulling part of his body up onto the grass next to the drainage ditch. We then dialed 911. While we were waiting for the ambulance to arrive, we removed our winter coats and covered him. It was really cold out and we were without our jackets standing there waiting. I actually checked my phone to see what the temperature was, and my phone said it was 38 degrees out. [R1] was really stiff, especially his legs, when we pulled him out, and we thought he was almost dead. It was less than 3 minutes between our call to 911 and when the paramedics got there. I never saw anyone from the nursing home looking for [R1]. It was just the paramedics, firemen, and then the police. [R1] did leave his

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sweatshirt near the metal storm drain and we gave the police his sweatshirt. We discovered him at 10:35 PM."

On March 22, 2022, at 1:28 PM, V7 (Firefighter/Paramedic) stated, "We responded to a call by a bystander of a person lying in a drainage ditch. Upon our arrival to the area, we found [R1] lying in the grass next to a drainage ditch. The drainage ditch is near the road. His clothing was soaking wet. We recorded his oral body temperature as 90.0 degrees Fahrenheit. We warmed him up with warmed intravenous fluids, hot packs to his groin and armpits, and warm blankets. We searched for a wallet but could not find one. He did not have any identification on his body when we found him. He was not able to tell us his name or where he lived due to confusion. We noticed he was wearing an [incontinence brief] filled with feces, and we thought perhaps he had wandered from the nearby nursing home. I asked for someone to go over to the nursing home and see if they were missing anyone. A police officer went into the facility and returned with one of their staff members. Their staff member identified the resident as one of their residents. He was wearing pajama pants, slippers and a top. A sweatshirt was tossed over to the side."

V9's (Police Officer) documentation on the local police department's Case Report, dated March 21, 2022, shows, on March 18, 2022, at 10:40 PM, R1 was found in the "flood drain" located in the "northeast corner" of the facility. "The drain is located approximately 50 yards from the front entrance."

R1's hospital documentation dated March 18, 2022, shows R1's body temperature at 11:18 PM

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on March 18, 2022, was 89.5 degrees Fahrenheit. R1 was admitted to the local hospital with diagnoses of altered mental status, right elbow laceration, and hypothermia.

On March 23, 2022, the facility's surveillance video was reviewed with V1 (Administrator). V1 also provided a timeline of the events regarding R1's elopement. V1 stated, "[R1] left the building at 8:25 PM on March 18, 2022. [R1] was found outside the facility more than two hours after he left the building. The door alarm did not sound because the door alarm was never activated by our staff. [V15] is the receptionist. She left the facility at approximately 8:15 PM that night. She is supposed to alarm the doors before she leaves, but she did not do that. She did not have enough training, and that is why the front door alarms were never set, and why no alarm sounded when [R1] left the building. The front door has a double entrance. The outside doors are supposed to be manually alarmed from behind the nurse's station, and the inside doors are supposed to be alarmed using a battery-operated box attached to a pull cord. If the inside door is opened, the alarm cord is pulled from the alarm box and alarms loudly, alerting facility staff. Also, staff should do bed checks, and residents should be seen by our staff every two hours at least."

The surveillance video reviewed with V1 shows the following events on March 18, 2022:

8:08 PM-The receptionist turned off the lights in the reception area.

8:24 PM-An unidentified staff member is observed sitting at the nurse's station near R1's room. The staff member appears to be looking at something in her hand. R1 is observed walking in

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the hallway, carrying a sweatshirt over his arm. R1 walks past the staff member, waves in the direction of the staff member, and continues walking. The staff member does not acknowledge R1 when he waves or walks past her. R1 is observed walking towards the facility's front reception area.

8:25 PM-R1 is observed walking out the front door of the facility carrying a sweatshirt over his arm. No facility staff are present in the video. No facility staff are observed to respond to R1 leaving through the front doors of the facility.

10:48 PM-A police officer enters the facility.

10:49 PM-The police officer walks out of the building with two facility staff members.

On March 24, 2022, at 11:54 AM, V11 (APN-Advanced Practice Nurse) stated, "I am at the facility twice a week. I saw [R1] on March 9, 2022. He has severe dementia. I saw him walking randomly around the facility. You cannot hold a conversation with him, due to his dementia. He is only able to mumble. Due to his dementia, he has poor safety awareness. If he walked outside the facility, he would not know he needed to turn around and go back inside."

On March 24, 2022, at 5:35 PM, V14 (LPN-Licensed Practical Nurse) stated, "I was caring for [R1] the evening of March 18. He was aggressive at the beginning of my shift. I calmed him down and he walked back to his room. Later, I saw him walking in the hallway while I was passing medications to other residents. He had attempted to go out the front door earlier that evening, but the aide directed him to come back. Usually, we can walk him back to his room and

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he will stay there. I saw him around 8:00 PM. We are supposed to do rounds on our residents every two hours. I was going to check on him at 10:00 PM, but I had other work to do so I did not check on him. Then, around 10:45 PM, a police officer came in and asked if we were missing anyone. I started doing my rounds. When I saw [R1] wasn't in his room, I went outside with the officer to check if [R1] was outside. [R1] was the resident found in the drainage ditch. No alarm was sounding in the facility to notify us the door alarm had been triggered or that a resident had left the building. I don't know whose job it is to turn on the alarm. It used to be when the receptionist leaves, then the alarm gets turned on."

On March 28, 2022, at 1:16 PM, V15 (Receptionist) stated, "I work from 4:00 PM to 8:00 PM. [R1] came to the reception desk a couple of times on that day (March 18, 2022). He came up two or three times. Two of the CNAs escorted him back behind the reception area doors. When I go home, I use a little wrench to lock the outer front door. This keeps intruders from coming into the facility, but it doesn't set an alarm to alert anyone if someone leaves the building. After that I turn off the lights, transfer the telephones into night mode, and walk out the front door. I never had to tell anyone I was leaving. I was never taught to set any alarms when I leave the building. Since [R1] eloped, I now have to set an inner door alarm by connecting a wire to the two alarm boxes. This alarms the inside door, but not the outside door. I don't know who sets the alarm on the outside door. As for door alarms going off while I am working, if I hear a door alarm sounding, sometimes I announce overhead there is a door alarming, and then the alarm stops, so I assume everything is okay. I don't have to keep track of

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door alarms on a log or anything like that. I did not receive any training about the door alarm going off or that anyone has to check the alarm and let me know the alarm is all clear. If I need to use the restroom during my shift, I don't have anyone to cover for me, so I just leave the reception area. I don't have to set the alarm before I leave the reception area."

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on June 3, 2021. R1 had multiple diagnoses including dementia with behaviors.

R1's MDS (Minimum Data Set) dated January 7, 2022, shows R1 had severe cognitive impairment. R1 required extensive assistance with personal hygiene, bathing and dressing, and supervision with walking in the room and corridor, locomotion on and off the unit, and eating. R1 did not use any mobility devices for ambulation.

R1's care plans dated June 9, 2021, show R1 was an elopement risk/wanderer, with disorientation to place, impaired safety awareness, and aimlessly wandering. The goal of R1's care plan shows: "The resident's safety will be maintained through the review date." Interventions in R1's care plan included: "Check for proper functioning of the audible alarm system regularly and PRN (as needed). Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, PRN."

An elopement risk assessment completed February 23, 2022, shows R1 was at risk for elopement. R1's elopement risk assessment score was 15.0. The elopement risk assessment tool shows a score greater than 5.0 means the

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S9999	Continued From page 8 resident is at risk for elopement. Facility documentation of R1's behaviors for the period February 24, 2022, to March 18, 2022, shows the following responses: 1) "Has the resident wandered?" Facility staff answered "Yes" on the following dates: February 24, 2022 February 25, 2022 February 27, 2022 March 1, 2022 March 2, 2022 March 5, 2022 March 8, 2022 March 10, 2022 March 17, 2022 March 18, 2022 2) "Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?" Facility staff answered "Yes" on the following dates: March 1, 2022 March 2, 2022 March 8, 2022 March 17, 2022 On March 24, 2022, at 9:49 AM, V2 (DON-Director of Nursing) stated, "In reviewing [R1's] chart, there was an elopement risk assessment conducted in February 2022. The nurse scored [R1] very high. He scored 15. Anything over 5 is considered an elopement risk. If someone triggers as a high risk for elopement, it should be communicated and discussed with the IDT (Inter-Disciplinary Team) within 24 hours and the information should be carried over to the elopement binders. We put elopement risk	S9999		

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binders in place towards the end of February 2022, when I started working at this facility. The binders are kept at the front reception desk, and one at each nurse's station, and one in the therapy gym. There is a picture of each resident identified as an elopement risk, to assist facility staff in identifying the resident. The resident's face sheet with all pertinent medical and contact information is also in the binder. [R1's] information was not in the elopement binder at the time of his elopement. Based on the elopement assessment done in February, he should have been placed in the binder to identify him as an elopement risk."

On March 23, 2022, at 9:34 AM, all facility exit doors and alarms were checked with V12 (Housekeeping Supervisor). V12 stated V13 (Maintenance Director) has been on vacation since March 18. V12 stated he believes V13 does maintenance checks on the door alarms to ensure the alarms are in working order, including working batteries. V12 stated he was unable to locate any maintenance logs to show when the door alarms had last been checked. V12 stated he does not have any log sheets and has not checked the door alarms since V13 left for vacation five days earlier. V12 showed the exit doors are equipped with a battery-operated alarm. Each battery-operated alarm has a cord, approximately two feet long, attached to the door with a small bracket. A separate alarm box is affixed near the door. One end of the two-foot cord is attached to the door by a small bracket, and the other end of the cord is inserted into the alarm box. As a door is opened, the tension on the cord attached to the door pulls from the alarm box, resulting in a very loud, piercing alarm sound. The only way to stop the alarm is to reinsert the cord into the battery-operated alarm.

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S9999	Continued From page 10 In addition, some doors are also alarmed with a second electronic alarm which sounds at the front reception desk whenever a door is opened. Multiple doors were opened and checked with V12, starting with door 4, 5, 6, 9, and 8. No overhead announcement was heard when the door alarms were triggered. It was not until 9:45 AM when the alarm to door 8 was triggered that an overhead announcement was made for facility staff to check door 8 due to an activated exit alarm. V12 stated the receptionist is supposed to make an overhead announcement each time a door alarm is triggered, and staff should respond to ensure a resident did not leave the building. No facility staff were observed responding to the door alarms as described by V12. The door alarm inspection continued with V12, and upon approaching door 1, the cord used to trigger the door alarm was hanging loose from the alarm trigger box, and not attached to door 1. V12 stated the trigger cord should be attached to the door. Door 1 was opened, and the battery-operated door trigger alarm did not activate. V12 stated, "Good thing you were here to notice the alarm was broken." On March 29, 2022, at 10:40 AM, the door alarm for entrance door 6 triggered at the front reception desk. A loud beeping sound could be heard at the reception desk, and a map of the facility showed a blinking light at entrance door 6 on the facility map. V16 (Receptionist) went to reach for the telephone to make an overhead announcement regarding the door alarm. The sound of the door alarm suddenly stopped. V16 did not continue with the announcement. V16 stated, "When a door alarm goes off, I am supposed to make an announcement announcing which door is alarming. Then, the facility staff is supposed to go to the door to ensure no resident	S9999		

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S9999	Continued From page 11 left the building through the alarming door. If the area is safe and all clear, then an announcement will be heard overhead by the staff saying the door is all clear. No one announced anything, so I guess everything is okay at door 6?" As of 10:51 AM, no overhead announcement was heard by facility staff to say the door alarm was all clear. On March 24, 2022, V2 (DON) provided a list of residents residing in the facility, identified as elopement risks. V2 identified R2-R8 as high risk for elopement. The facility's elopement binders were reviewed. The elopement binder located at the front reception desk did not have R5's picture or face sheet in the binder. 2. On March 23, 2022, at 3:23 PM, R2 was walking in her room. R2 was wearing a sweater and pants and was not wearing socks or shoes on her feet. R2 proceeded to leave her room in bare feet and walk around the facility. R2 stated, "I would like to go home. I don't know why I'm here." R2 was observed aimlessly walking around the facility with another resident for the next hour. R2 was not able to answer questions due to her cognitive status. The EMR shows R2 was admitted to the facility on August 26, 2021. R2 has multiple diagnoses including, vascular dementia, anxiety disorder, and major depressive disorder. R2's MDS dated January 18, 2022, shows R2 has severe cognitive impairment, requires limited assistance with bathing, and supervision with all other ADLs (Activities of Daily Living). R2's Elopement Risk Screening dated March 19, 2022, shows an elopement risk score of 8.0. The screening continues to show if a resident's	S9999		

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elopement risk score is greater than 5.0, the resident is considered to be an elopement risk.

R2's care plan, initiated January 31, 2022, shows: "The resident is at risk for elopement risk/wander due to severe cognitive impairment, poor safety awareness, wanders aimlessly."

3. On March 23, 2022, at 3:55 PM, R3 was sitting in his room. R3 was unable to answer questions due to his cognitive status.

The EMR shows R3 was admitted to the facility on December 24, 2021. R3 has multiple diagnoses including, multiple rib fractures, COPD (Chronic Obstructive Pulmonary Disease), emphysema, asthma, dementia, and personality disorder.

R3's MDS dated January 9, 2022, shows R3 has moderate cognitive impairment. R3's MDS continues to show R3 has wandering behaviors that place R3 at significant risk of getting to a potentially dangerous place (stairs, outside of the facility).

R3's Elopement Risk Assessments dated January 5, 2022, and March 19, 2022, show an elopement risk score of 10.0. Additional comments on R3's March 19, 2022, assessment show: "Even though [R3] hasn't been exit seeking, he is an elopement risk because he verbalizes almost daily wanting to leave and he is ambulatory."

R3's care plan, initiated March 19, 2022, shows: "The resident is an elopement risk/wanderer. Impaired safety awareness."

4. On March 23, 2022, at 3:52 PM, R4 was sitting in his room. R4 refused to be interviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012835	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 The EMR shows R4 was admitted to the facility on October 24, 2020. R4 has multiple diagnoses including, leukemia, diabetes, kidney transplant, epilepsy, pancreas transplant, anxiety disorder, major depressive disorder, bipolar disorder, abnormal gait, weakness, dementia, anxiety, and suicidal ideations. R4's MDS dated February 14, 2022, shows R4 has moderate cognitive impairment and is able to walk with limited assistance. R4's Elopement Risk Assessment screening dated March 19, 2022, shows R4's elopement score is 8.0. Additional comments on the screening tool show: "Resident has behaviors and from time to time will attempt to leave when he is attention seeking." R4's care plan, initiated March 5, 2021, shows: "[R4] is a wanderer, elopement risk r/t (related to) impaired safety awareness." 5. On March 24, 2022, at 1:00 PM, R5 was sitting in his room with a visitor. R5 declined interview. The EMR shows R5 was admitted to the facility on November 22, 2021. R5 has multiple diagnoses including, lung cancer, malignant brain tumor, cerebral infarction, COPD, acute respiratory hypoxia, pneumothorax, heart disease, pneumonia, chronic kidney disease, and atrial fibrillation. R5's MDS dated March 2, 2022, shows R5 has moderate cognitive impairment. R5's Elopement Risk Assessment, dated March 19, 2022, shows, R5's elopement risk score is	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012835	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14 8.0. Additional comments on R5's risk assessment show, "Resident gets angry and threatens to leave." R5's care plan, initiated March 19, 2022, shows: "The resident is an elopement risk/wanderer, impaired safety awareness. Interventions initiated March 19, 2022, include, "Monitor for tailgating when visitors are in the building. Wander alert: Place resident identifier in elopement binder so that staff is aware of resident's elopement risk." 6. The EMR shows R7 was admitted to the facility in April 2021. R7 has multiple diagnoses including, dementia. R7's MDS dated December 17, 2021, shows R7 has severe cognitive impairment. R7's Elopement Risk Assessment dated March 19, 2022, shows R7's elopement risk score is 3.0. Additional comments on the assessment show: "Resident's dementia is in a place where she is not actually looking to leave but may walk out behind someone because she wants to be with them. She looks like she could be a visitor and may be seen as one. Resident is ambulatory." R7's care plan dated April 20, 2021, shows: "[R7] is a wanderer, disoriented to place. Wanders aimlessly." Interventions dated March 20, 2022, show: "Monitor for tailgating when visitors are in the building." The facility's policy entitled Standards and Guidelines: SG Elopement Assessment and ID, revised March 30, 2021 shows: "Standard: It will be the standard of this facility to identify residents admitted to the facility who have a potential to leave (actual or attempted) the premises either	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012835	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 15 per their own choice, or due to impaired cognition/unawareness of their actions: Guidelines: 1. Residents will be assessed upon admission, quarterly and PRN for risk of elopement if they display history of wandering, moderate to severe cognitive impairment with the ability to self-propel or ambulate, express desire to exit the facility or are noted attempting to exit the facility. (Refer to Elopement Screen)....4. Resident scoring 5 (five) or above will be considered at risk for potential elopement. 5. An elopement screen ranking 5 or above is brought to the attention of the DNS (Director of Nursing Services) or their designee and reviewed by an interdisciplinary team to determine appropriate follow-up/interventions and if the resident is truly an elopement risk....8. A picture of the resident should be obtained and placed in a binder that is maintained at the front desk or other secure location that is easily accessible for staff to identify residents at risk for elopement. 9. The "Elopement Binder" should be maintained/updated routinely to ensure a current listing of the high-risk residents is available." (A)	S9999		