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
	IL6008155	A. BUILDING: ______ B. WING ______	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARGO HEALTH CARE CENTER	1512 WEST FARGO CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation: 2281680/IL144189	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)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 care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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Section 300.1220 Supervision of Nursing Services

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

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

These Requirements were not met evidenced by:

Based on observation, interview, and record review, the facility failed to visually monitor and check every two hours for a resident present in the facility who was at risk for elopement, failed to implement its missing residents and elopement policy regarding the use and response to electronic monitoring devices. This applies to 1 of 5 sampled residents (R1).

As a result, on 2/25/2022, R1, a cognitive impaired resident, eloped from the facility without the facility staff being aware the resident was missing. A local emergency medical service (EMS) found R1 in a snowbank which put the resident at risk for frostbite or hypothermia.

Findings include:

1. The following information was obtained from R1's medical record: R1 is a 72-year-old female who was originally admitted to the facility on

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7/14/2016. R1 has a diagnosis including Essential hypertension , Anxiety Disorder , Schizoaffective Disorder , Restlessness and Agitation. R1 had a BIMS score of 3 which indicated severe cognitive impairment. R1 speaks Lithuanian with some broken English. R1 is assessed as a high risk for elopement and has an electronic alarm safety device on the left wrist.

According to R1's care plan dated 2/25/22 the following was identified: wandering (8/27/21) and elopement (8/27/21).

A facility incident report dated 2/25/22 7:31PM states Resident noted not to be in the facility. A code green was called, and a search was conducted inside and outside of the facility and the resident was not located. Facility received a phone call from a neighboring nursing home facility, and they described a resident that fit the resident's description. The resident was transferred to a local hospital for evaluation. Facility called the hospital who identified the resident and stated the resident is being evaluated in the emergency room. An ongoing investigation will continue to follow. The first time the facility knew R1 was missing was at 4pm on 2/25/2022 after receiving a call from the neighboring nursing home.

R1 On 3/1/22 11:40AM stated, I went for a walk to the park. When I was in the park I tripped and fell in the snow. I was lying in the snow. People came to help me. The ambulance came and took me to the hospital. I was cold that day. I got cold when I was in the snow. I am ok now. (This resident was able to be interviewed through broken English without interpreter).

On 3/2/22 10:45AM surveyor inquired from

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interview of R1's physician if the elopement of R1 had the potential of serious injury. V15 (physician) 3/2/22 10:45AM stated I don't know anything about R1 as far as eloping from the facility. I do know R1 suffered no serious injury based on emergency room report. R1 is confused and could have suffered hypothermia or frostbite from laying in the snow outside. It is common sense.

R1's hospital record dated 2/25/22 3:06PM documented: Patient (Pt.) arrives to the ED (emergency department) via EMS (emergency medical service) from the street. Per EMS patient is Russian/Lithuanian speaking. She was found face down on ice. Pt has an electronic monitoring bracelet on the left wrist. She is alert but unable to provide further history of where her nursing home is. She says she walked outside to go home to see her children. She denies having any pain at this time. She is feeling comfortable. No sign of trauma other than mild bruise to both knees. She denies having any pain there. Patient was covered in ice, so her body felt cold but temp reveals normal thermal in the ED. Patient is found to be hypoxia down to 87% on room air . She says she is not on oxygen at baseline.
HPI (history and previous illness) was obtained through Russian interpreter. Pt is a poor historian and unable to provide any further history. We later found patient's real ID (identification) and contacted PCP (primary care physician). He states patient is known to be non-compliant with medications and does not take any.

The surveyor reviewed the local weather history on 3/2/22 from the Now Data-NOAA online Weather website. The website indicated the local outside temperature at time of R1's elopement was 29 degrees Fahrenheit.

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2. V1 (Administrator) was interviewed regarding R1's elopement. V1 on 2/28/22 at 11 AM stated, on 2/25/22 it was reported to me, R1 left the building without any staff or residents knowing. R1 was later found at another facility. The other facility called to report they had one of our residents. The other facility called the hospital. R1 was transferred to hospital . R1 was re-admitted to the facility on 2/28/22 at 3:30PM. R1 is now in bed on the second floor. V1 stated, V1 did not know how R1 got out of the facility at this time.

According to the hospital report, R1 was not taken from this other facility but transferred from the local park to the emergency home. The EMS staff contacted the other facility to see if R1 was a resident, since the facility was close to the park.

On 2/28/22 at 11:30AM V1(Administrator) notified surveyor stating now I know how R1 left the facility. At 11:30AM the facility camera video recordings was observed. The camera system was viewed by the surveyor in the administrator's office. The camera clock showed at 1:26 PM R1 was observed walking up the ramp leading from the back exit service door. R1 was fully clothed with a large sweater or coat on . The basement exit door could not be viewed since it was in the shadow. R1 walked up the ramp. The front facility camera showed R1 walking between the two buildings to the front of the facility. R1 headed east on the sidewalk for approximately 20 yards then continued to the street. R1 continued walking down the north side of the street east until no longer in view. No staff or residents were observed in the front of the building during this time. Cars were observed passing R1 within 3 feet while R1 was walking on the street .

3. The following staff interviews were conducted

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regarding R1's elopement on 2/25/2022 and interventions in place for monitoring the resident.

On 2/28/22 12:53PM surveyor inquired on how R1 got out of the facility unnoticed and if facility elopement plan was followed . V2 Director of Nurse(DON), On 2/28/22 12:53PM stated at 3PM we were in a meeting. At approximately 4PM I went to first floor office . The office manager told me that someone called from another facility to see if we were missing a resident. This resident had a wander guard. I called facility back and asked who was there . She said the person was Lithuanian speaking and had a wander guard on. I asked our staff and they said it must be R1. I called code green. We searched inside and out . We found R1 was missing. Another facility told me R1 was sent to the hospital . I can't tell you how R1 got from that other facility to the hospital . I assumed other facility called 911. I called hospital . I gave residents name and R1 was the resident at the hospital. She told me I should have social services come over and pick her up. Social services went there. " You will have to ask him what happened after that ." Right after the knowledge of the incident I in serviced staff to do immediate rounds to make sure residents are present when the staff come on shift at 3PM , 11pm and 7 am shift. I then created an incident report to send to IDPH. That is all I did .

V3 (Social Service Director) On 2/28/22 1:13PM stated I was on third floor at time of the incident . I was attending a meeting. The office manager told me another facility called and said they might have one of our residents . This resident had a wander on . I notified the DON. She told me to go to hospital and retrieve the resident . I called the hospital . They stated the resident was being

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S9999	Continued From page 6 admitted . No further action took place. V1 (Administrator) On 2/28/22 1:19PM stated I got a call from V2(DON) on 5/25/22 . She reported she called code green after she received a call from another facility stating they believed that they had one of our residents . They sent her to the hospital. V2(DON) called local emergency room . They were able to establish R1 was our resident. After knowledge of the incident, we began a head count every two hours. We initiated our investigation into the incident. The next day V2 talked to the hospital to get admitting diagnosis which was hypertension. R1 remains in the hospital. V6 (Laundry Person) On 2/28/22 2PM via V4 (Spanish interpreter/maintenance director) stated, on 2/25/22 around 1:20PM I was in the bathroom near the basement back entrance. The back entrance door alarm went off. By the time I came out of the washroom the alarm was off. I did not see any staff at the exit. I did not see anyone in the area. I continued with my laundry duties. V6 did not confirm on interview any investigation done to see what caused the alarm and/or reported it to anyone else. In addition, V6 not able to report how the alarm was stopped before exiting the bathroom. V5 (Office Manager) On 3/1/22 9:57AM stated around 4PM I received a call from someone from another nursing home stating she wanted to talk to administrator or DON . I told her the administrator was already gone for the day. I transferred the call to the DON. I have access to the computer system facility cameras. They are on the computer at my desk in the reception area . I wasn't monitoring the cameras since I was busy with tasks. I don't remember hearing any	S9999		

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S9999	Continued From page 7 door alarms. The guard takes her break around 1:00PM to 1:30PM but I watch the door. I never saw R1 that day in the front entrance area. I have seen R1 come to the door wanting to leave. I then contact staff to intervene. R1 has never left the building while I have been watching the front entrance. I am aware that there is a procedure to follow when a resident elopes. V7 (Security Person) On 3/1/22 10:11AM stated I was at the front door at time of elopement on 2/25/22 . I check the front of facility and the patio for residents. I monitor the front door . I saw R1 on 2/25/22 in the morning. She was in the hallway at the front door and was trying to go outside . I stopped her and sent her back on the elevator to the 2nd floor. That was the only time I saw her . I never saw her in the afternoon . I don't remember the alarm going off around 1PM that day(2/25/22) . I leave the facility at 3PM . There is another guard that takes over after 3PM. I am aware of the code green . I know the procedure . V8 (LPN) On 3/1/22 10:30AM stated we have electronic monitoring devices for residents on the 2nd floor. There are 2 on my floor. I check to see the electronic monitoring device function every shift. I check by the red light flashing on the electronic monitoring device . These alarms go off when a resident wearing one goes to the 1st floor front door and the Basement back door. I was taking care of R1. There was no indication that anything was wrong. She ate breakfast. She was compliant with her medications . During lunch time R1 was in the day room. I saw her again after lunch in the dayroom. That was last time I saw her. There was no indication of agitation or anxiety. She went into a bedroom to sleep after lunch. There was no indication that R1 was gone. The nurse had a meeting in the	S9999		

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basement until about 4PM . I then went home . The residents are checked every two hours. R1 was checked at 1PM and it was documented on the checklist. R1 tried to elope frequently. But she was always stopped at the front door and sent back. I am aware of code green and the procedure to follow when there is an elopement.

V9 (C N A) On 3/1/22 10:42AM stated I take care of R1. R1 was needing redirection on 2/25/22. R1 gave no indication that she was trying to elope that day. R1 speaks some English and can communicate . She did not say she wanted to leave that day. The last time I saw R1 was 1PM. R1 went into her room from the dining room. I think she was sleeping in her bed at that time. I am not aware of anytime that she left the floor that day. The residents can go from floor to floor to do activities. They come back to the floor after they are done. When R1 leaves the floor I or the nurse goes with her. That day the only activity was on the 2nd floor. We didn't allow her to go to another floor that day. I am trained in elopement procedures when a code green is called .

V10 (CNA) On 3/1/22 10:59AM stated work on the 2nd floor. I help take care of R1 . R1 always states I want to go out of the facility. I saw R1 on the floor until 1PM . R1 was in her room. That was the last time I saw her. Sometimes R1 goes on the elevator to the 1st floor. We have to follow her and redirect her to the 2nd floor. R1 is not supposed to leave the 2nd floor by herself . I am trained in elopement procedures .

V11 (RN) On 3/1/22 11:18AM stated I was in facility 7AM to 3:30PM 2/25/22. I never saw R1 that day. I cannot remember the basement exit door alarm go off that day . We had the security guard at the front door that day. I am trained in

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S9999	Continued From page 9 code green . V12 (LPN) On 3/1/22 11:24 AM via phone stated I was on the 2nd floor on 2/25/22. I never saw R1 that day . I went to a meeting and went back to 2nd floor about 3:50PM. I was about to do rounds. Both CNAs told me everything was ok. I was notified by the office person to see if anyone was missing. I immediately thought about R1 . I asked again if they saw R1 . We went to the room and R1 was not there. V2 (D O N) called code green and searched . R1 was gone . V13 (CNA) On 3/1/22 2:33PM stated on 2/25/22 I worked the 7-3PM shift and 3-11PM shift . I worked the 2nd floor 3-11PM on this day . I didn't see R1 when I came on my shift . I did rounds but I didn't see R1 . I assumed she was at activities on another floor . Around 4:00PM or 4:30PM they called a code green . We searched for R1 and didn't find her . That is all I know. R1 is able to speak a little English . R1 used to pack all her belongings like she was leaving. We had to redirect her at times. V14(Restorative Aid) On 3/2/22 10:09AM stated on 2/25/22 R1 was on the 2nd floor at around 12:30PM . R1 was talking to a nurse. R1 can speak some English but she can't hold a conversation. I didn't see R1 after that. I don't know anything about a code green. I am familiar with the code green procedure. V16 (nurse) On 3/2/22 11:11AM stated I check the electronic monitoring device on the left wrist of R1 . The way I check is by looking at it and make sure a red light is blinking . I do not check the electronic monitoring device at the alarm to see if it is activated . On the day that R1 eloped I was not working . I do not know anything about	S9999		

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her elopement .

4. The surveyor toured the facility on 2/28/22 and noted there are 3 resident floors and a basement. The following observations were made:

The basement houses facility service areas (laundry area, dietary area offices etc.) There is one exit to the outside that leads to a concrete ramp. This exit door has an alarm that can be heard from the door area and the 1st floor nurses station. There is an electronic monitoring device alarm on this door that can be heard at the door itself and no other location. When the door is opened the alarm triggers. A keypad entry deactivates the alarm. The alarm can be deactivated, and the door can be propped open.

The first floor has an exit at the back from the stairwell. An external alarm is on this exit door with a keypad . There is an electronic monitoring device alarm on this door . The front entrance door has an electronic monitoring device alarm. There is a security person that is stationed at the front door . The receptionist desk is at the entrance in office with a glass window for visual of the area . This is a total of 4 exits from the building . The facility has security cameras located to provide visual control of the back basement entrance, the back 1st floor entrance, and the front entrance location . The facility has camera visual access from the reception computer and the administrator office on screen located on the office wall.

There is one elevator in the facility that goes from the 3rd floor to the basement. The elevator does not have an alarm for the electronic monitoring device at the elevator entrance on the 3rd, 2nd, 1st, and basement floors. All alarms at the exits

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S9999	Continued From page 11 were observed in functioning condition. The three electronic monitoring device alarms at the exits were observed in functioning condition . The 2nd floor stairwell exit doors have an audible alarm with a keypad. Basement, 1st and 3rd floor stairwell doors do not have alarms. 5. Facility policy titled Facility Policy Regarding Missing Residents and Elopement (Revised 8/20) states including Statement of Policy: It is a policy of this facility that all residents are afforded adequate supervision to meet each resident s nursing and personal care need . All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their care plans. Environmental Considerations for the Prevention of Missing Residents and Elopements. Residents who are at risk for elopement shall be provided at least one of the following safety precautions by the facility: An electronic monitoring safety device or other similar personal safety device that will notify facility staff when the resident has left the building without supervision; and/or door alarms on facility exits; and/or Staff supervision, either by visual contact or by video camera , of facility exits. As part of the facility's Preventative Maintenance Program, all electronic monitoring safety devices, door alarms, and video camera shall be maintained and tested in accordance with the manufacturer s instructions. The regular testing of all electronic monitoring safety devices, door alarms and video cameras shall be documented and included as part of the Preventative Maintenance Program. At no time shall an electronic monitoring safety alarm or other door alarm be turned off , without	S9999		

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S9999	Continued From page 12 the continual supervision of the appropriate exit. The person responsible for turning off or turning down an electronic monitoring safety alarm or a door alarm shall be responsible for resetting the alarm and ensuring that it is in working condition. Failure to reset and test exit alarms may result in serious employee disciplinary action. An electronic monitor device is considered a restraint and will be monitored and documented as such in the resident chart. Routine Procedures for the Prevention of Missing Residents and Elopements At the beginning of each nursing shift or medication pass or at each meal, charge nurses shall account for all at -risk residents under their respective charge. The electronic monitor should be checked every shift for placement and checked every week for functioning. The Procedures for the Response to Missing Residents and /or Elopements shall be implemented for any at -risk resident not accounted for. The incident shall be documented in the clinical record. Unless otherwise identified in a plan of care , all residents who are at risk for safety concerns who leave the facility property shall be accompanied and the responsible party shall sign the resident out the facility on a resident sign-out sheet . Should an alarm on one of the exits to the outside of the facility be sounded , staff shall immediately respond to and determine the cause of the alarm. After the facility staff investigates an exit alarm , and no reason can be found for the sounding of that alarm, they shall announce a specific missing resident alert Code Green over the facility s public address system . Upon the announcement of the facility's missing resident alert code, the Director of Nursing or designee shall coordinate the accounting of all residents at risk for elopement. If , after all at-risk	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008155	A. BUILDING: ______ B. WING ______	C 03/10/2022

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S9999	Continued From page 13	S9999		

residents are accounted for , the cause of the alarm is still indeterminate, the Director of Nursing or designee shall continue a reasonable investigation to determine the cause of the alarm.

Facility policy titled Daily Rounds Policy states including
Procedure:
1. The observation form must be filled out by the CNA every two hours to determine resident status, such as sleep, awake, pass, or hospital.
2. All residents must be accounted for at the beginning of each shift.
3. Any resident that is not accounted for during rounds, the charge nurse will be notified immediately .
4. Upon notification that resident is not accounted for, charge nurse and CNA will determine resident's whereabouts.
5. If resident whereabouts cannot be determined, a code green will be initiated. See elopement policy.

Review of facility 2-hour check sheet shows that on 2/25/22 R1 was observed up and about at 1PM. At 3 PM R1 was not observed on the floor. Facility did not know R1 was missing until around 4PM.

V1 (Administrator) On 3/3/22 at11:40AM stated staff are supposed to supervise the residents . If during the 2- hour head count they are not on floor the staff are supposed to alert other staff immediately, to see where the resident is at. If the resident can't be located a code green has to be called.
V2 (DON) On 3/3/22 at 11:33AM stated staff should have notified me when R1 was not on the floor at the 3PM head count. If I am not available,

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S9999	Continued From page 14 then my designee should have been notified. I was not notified. (A)	S9999		