STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	C 04/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING EG	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

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S 000	Initial Comments FRI of 3/25/2022\IL145439	S 000		
S9999	Final Observations Statement of Licensure Violations 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. 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 Requirements wer not MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident with recent attempt of elopement was provided adequate supervision to prevent elopement from the facility. The facility also failed to ensure all facility exit alarm systems were monitored by staff to be able to respond to residents exiting the facility from the X00/XXX unit. This applies to 6 of 6 residents (R1- R6) reviewed for supervision in the sample of 6. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on 3/11/22 and R1 had multiple diagnoses including dementia with depression, symptoms and signs involving cognitive functions and awareness, difficulty in	S9999		

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S9999	Continued From page 2 walking, metabolic encephalopathy, attention-deficit hyperactivity disorder, and lack of coordination. R1's MDS (Minimum Data Set) dated 3/17/22, shows R1 had short and long term memory problems, could not recall staff names/faces, and made decisions regarding tasks of daily life with modified independence. R1 had moderate difficulty hearing, only sometimes made himself understood, and only sometimes understood others. The MDS showed R1 did exhibit wandering behaviors during the assessment period. On 4/5/22 at 9:31 AM, V10 (Receptionist) stated on 3/25/22 at approximately 1:45 PM while speaking with a family in the facility reception, V10 saw R1 attempting to leave the facility unaccompanied. R1 was walking toward the front exit door to the facility and when R1 approached within a few feet of the exit door, V10 stated she yelled, "Sir, stop!" V10 stated she asked where R1 was going and if she could help. R1 replied, "I'm going home. I'm going home." V10 stated she recognized R1 was most likely a resident because the temperature outside was cold, R1 had no coat, and R1 was wearing only a white short sleeved T-shirt and gray sweatpants while attempting to go outside. V10 stated she redirected R1 through the double doors between the reception area and the resident room area of the facility and instructed R1 to report to the Y00 nursing station to speak to a nurse. V10 stated she did not remember if there were any staff visible on the unit when she ushered R1 towards the Y00 nursing station. V10 then returned to her desk, called the Y00 unit nursing station, and spoke to V11 (Social Services) V10 informed V11 that R1 was directed to the nursing station	S9999		

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S9999	Continued From page 3 because he was trying to leave the facility. V10 stated V11 responded R1 was probably confused because his scheduled discharge date was 3/26/22. V10 stated she did not see V11 until later after R1 was returned to the facility by the police. On 4/4/22 at 1:27 PM, V11 (Social Services) stated on 3/25/22, V10 called V11 at the 100 hall nursing station and stated she was sending R1 back to the 100 nursing unit because he was trying to leave the facility. V11 stated R1 may have been confused because he was scheduled to be discharged the following day and the family just concluded a meeting with R1 discussing discharging from the facility. V11 stated he never saw R1 after he received V10's call that she was sending R1 to the Y00 unit nurses station. V11 stated at approximately 2:00 PM, V11 left the Y00 unit to attend a staff meeting but had still had not seen R1. V11 stated at approximately 3:00 PM, V1 (Administrator) came to the Y00 unit and informed staff that R1 returned to the facility with his family and the police. V11 stated facility residents were assessed for elopement risk based on their history of elopements, their cognitive impairments, and their ambulatory status. V11 stated if staff observe residents trying to open doors, the facility staff assess for root causes of the exit seeking and provide interventions such as exit alarm bracelets, placing residents on the elopement risk program, and assessing resident room placement to build in staff supervision. Door alarm system log, dated 3/25/22, shows the Main Dining Room door alarm was forced open at 2:00 PM. The log shows the alarm was silenced on 3/25/22 at 2:06 PM.	S9999		

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S9999	Continued From page 4 On 4/7/22 at 9:52 AM, V18 (Police Dispatch Officer) stated a community member called 911 at 2:20 PM on 3/25/22 regarding R1 walking in the road and reporting his car was stolen. On 4/6/22 at 1:36 PM, V16 (Police Officer) stated on 3/25/22 he responded to a call from a motorist that was concerned about a male wandering in the middle of the road who reported that his car was stolen. V16 stated the motorist stated R1 was wandering in the middle of the road which had a 40 mile per hour speed limit. V16 stated when he arrived, R1 appeared dazed and not engaged. V16 stated another officer had responded to the call first and informed V16 that he did not believe a car was stolen but it seemed that R1 had some type of altered mental status which he thought was dementia. V16 stated R1's answers were not precise, R1 was confused, and it was apparent R1 had dementia or was having some type of mental condition. R1 provided his name and home residence address and told V16 his car had been stolen. V16 drove R1 to his home residence and V14 (Wife) told V16, R1 was supposed to be under the care and supervision of the facility. V16 returned R1 to the facility. V16 stated the weather was very cold and estimated R1 had been walking outside for approximately twenty minutes. On 4/5/22 at 7:15 PM, V13 (Police Officer) stated on 3/25/22, R1 was found near the intersection of Nerge and Greenbrier, approximately two blocks west of Plum Grove Road (approximately 0.5 miles from the facility), by a motorist in the local community who alerted 911 approximately between 2:00 PM and 2:30 PM on 3/25/22. V13 stated R1 told the motorist R1's car had been stolen. V13 stated V16 (Police Officer) originally responded, R1 provided V16 with his home	S9999		

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S9999	Continued From page 5	S9999		

residence address so V16 initially transported R1 to his home where his wife informed the police R1 was supposed to be under the care and supervision of the facility. R1 was then transported back to the facility. V13 stated meanwhile the police department received a complaint from V15 (Son) regarding R1's elopement from the facility and V13 met V16 and R1 at the facility to investigate.

On 4/6/22 at 11:05 AM, V17 (Advanced Practice Nurse) stated R1's safety awareness was compromised and R1 would not be able to understand the safety risks of walking out of the building unsupervised when he eloped. V17 stated he was at risk for falls, walking into the road, and being hit by a car because of his lack of cognitive ability to understand what he was doing. V17 also stated she was told the outside temperature was approximately 40 degrees and R1 therefore may have been at risk for mild hypothermia. V17 stated she previously witnessed R1 independently walking to/from the bathroom and V17 reminded R1 he needed staff assistance for safe toileting assistance.

On 4/4/22 at 12:08 PM, V1 (Administrator) stated V6 (Contract Worker) shut off the door alarm sounding at the main dining room door because he thought the door alarm was activated by the wind and not a resident leaving the building. V1 stated V6 looked around outside the door but did not see any residents outside the building. V1 stated V6 did not inform the staff he turned off the alarm and no resident head count was initiated. V1 stated contract workers were given alarm key cards to be able to disarm the facility alarms when entering and exiting the facility while performing work in the facility. V1 stated R1's family visited prior to R1's elopement to speak

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S9999	Continued From page 6 about his discharge the following day and V1 felt the meeting may have suggested to R1 that he needed to leave the facility. Final Investigation Report, dated 3/30/22, shows between 2:00 PM and 2:30 PM, R1 exited the building and was recovered by police nearby. The report shows at approximately 1:50 PM on 3/25/22, R1 was at the front of the building indicating he was leaving the facility. At that time, R1 was redirected back to the nursing unit at that time by the receptionist. Facility Behavior Management Guidelines, dated 3/2022, shows "Wandering and exit seeking are behavioral symptoms of special concern in the elderly and, or dementia population. Patients are evaluated upon admission for a history of, or risk factors for wandering and, or exit seeking. Interventions to consider include: Structured activity programming, patient room placement in relation to egress doors, personal security bracelet, safe wandering interventions. Patients that have been identified as at risk for unsafe wandering or elopement are included in the Center Watch Process .... Personal security bracelets serve as an alert to the patient for safe boundary limits and as an alert to staff if the patient is close to an alarmed door .... Exit doors and stairwell doors are alarmed. Door alarms are checked for functionality per manufacturer's guidelines. Staff response drills are conducted monthly, encompassing each shift, and as needed. Findings are documented and submitted to the Safety and, or QAPI (Quality Assurance and Performance Improvement) Committee for review and follow-up as needed .... In the event a patient experiences a new or escalating behavior ... Place the patient on Alert Charting, determine the root cause and implement non-pharmacologic	S9999		

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S9999	Continued From page 7 interventions ... Initiate modifications in the patient's plan of care as indicated or ordered ...." 2. On 4/4/22, V10 (Receptionist) provided the document "Patients with Exit Seeking" which included the resident names of R2-R6. V10 stated there were five residents in the building who were at high risk for elopement, their pictures were kept in a binder at her desk, and each of the residents wore elopement alarm bracelets to assist in preventing elopement. Facility document "Patients with Exit Seeking," dated 4/4/22, shows R2-R6 were all identified as residents at high risk for exit seeking/elopement. On 4/5/22 at 1:07 PM, on the empty Q00 unit with V12 (Maintenance Director), when the exit doors were opened the exit doors alarm sounded and the Q00/South nursing station alarm panel sounded, however no staff were present at the Q00 nursing station because the Q00 unit was vacant of residents. V12 stated the Q00 unit exit door alarms were only wired to alert staff at the Q00 unit nursing station, but no other nursing units received an alarm signal on their door alarm panels. The Q00 unit was isolated in proximity to the rest of the building and the unit had one staff office in use. V12 stated the staff in the office on the Q00 unit were not physically present at all times on the Q00 unit. On 4/5/22 at 1:35 PM, V12 (Director of Maintenance) and V1 (Administrator) stated they were unaware the exit doors on the Q00 unit did not alarm at the Y00 unit nursing station for staff to be alerted that someone was attempting to exit on the Q00 unit. V1 stated there were two staff with offices on the vacated Q00 unit, but those staff were not present on the unit during nights or	S9999		

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S9999	Continued From page 8 most weekends or when they were on other units seeing residents. Behavioral Symptoms Assessment, dated 3/31/22, shows R2 was exit seeking and wandering without intent or purpose and R2 had a history of disruptive behavior that could be unprovoked and purposeful, anxiety, delusions, recent change, departure from normal activities, Progress note, dated 3/31/22, shows "Noted patient walking toward [Unit] Exit door. Patient stood by the door for a long time as if looking for something. [Personal security bracelet] strapped on left ankle with orders to check placement." R3's Care Plan shows, "Exit seeking/elopement risk related to cognitive impairment ... wandering." R3's Interventions include, "Added to facility Exit Seeking Program on 9/5/2020. Alert bracelet 9/5/20" On 4/7/22 at 2:26 PM with V3 (Director of Nursing), R3 was slowly walking near her room and back and forth between the 300 and 100 nursing stations. R3 had a personal security bracelet on her right wrist. Behavioral Symptoms Assessment, dated 3/29/22, shows R4 was identified as having exit seeking behaviors. Progress notes, dated 3/13/22 and 3/15/22, show R4 was observed as being confused, restless, and wandering. On 3/15/22, R4 attempted to get into the bed of her roommate, said she was going home, and was packing her belongings. Progress note, dated 3/24/22, shows R4 was awake during the night, confused, slightly agitated, restless, and wandering and R4 was	S9999		

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S9999	Continued From page 9 brought to the nursing station for closer monitoring. Physician progress note, dated 3/29/22, shows R4 was moved to a room close to the nursing station due to wandering into other residents' rooms. Nurse practitioner note, dated 3/31/22, shows R4 showed signs of confusion and was observed wandering around the facility. Behavioral Symptoms Assessment, dated 3/29/22, shows R5 was identified as exhibiting exit seeking behaviors, agitation, irritability, or hyperactivity. The assessment shows, "Patient regularly becomes upset, crying and searching for her family. This most often occurs in the mid-late afternoon .... When upset, patient is most often searching/waiting for her family members." Progress notes, dated 2/7/22, shows, "Pt [Patient] found on the floor from her wheelchair. Pt was wandering to go outside. When I went to open the front door for other patient's family member, I found [R5] on the floor hallway ...." Behavioral Symptoms Assessment, dated 3/30/22, shows, "R6 regularly approaches staff and states that she would like to leave. She has been noted to approach exit doors, but not directly attempt to leave. This most often occurs at night." Progress notes, dated 4/1/22, shows, "Up all noc (night). Refuse to go to bed. She is looking for a way out, looking for the door, she wants to go home. Always asking where is the door .... Wandering around the unit."	S9999		

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S9999	Continued From page 10 On 3/25/22, door alarm function was checked on all outdoor exits and all door alarm key cards were deactivated with the exception of active facility staff. Door alarm annunciator panels at nursing stations were updated to reflected current names for designated areas for staff to identify from where the alarm is coming. Staff education began immediately to include Behavior Management Guidelines, Missing Person Protocol, and Response to Door Alarms/Panels - as of 4/5/22, 141/142 employees were educated. Agency staff will be educated at the start of their next scheduled shift by staffing scheduler, weekend supervisor, PM supervisor, or human resources director. On 3/25/22, residents not currently identified as a risk for exit seeking in the facility were re-assessed for current risk (based on cognitive status, mobility and exit seeking history) and no additional residents were identified as at risk for elopement. Review of the Center Watch Binder was completed to validate all current residents on the program. Personal security bracelets were validated for placement and function. Residents identified as exit seekers received complete review of plan of care and updated exit seeking assessments. Ongoing evaluation will be performed for newly admitted residents for elopement risk during the admission evaluation, with change of condition; any identified risk reducing interventions are put into place upon admission and added to the Center Watch Binder. On 4/5/22 at 2:00 PM, a staff member was assigned to remain at the South nurses' station to monitor the door until the alarms could be re-wired to a staffed nursing station. On 4/5/22	S9999		

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S9999	Continued From page 11 by 5:47 PM, the door alarm annunciator panel at East nursing station was updated to include alarms for the exit doors at rooms 321 and 328. At 5:30 PM, a door alarm check was completed to validate the doors alarm at the panel. On 4/6/22, staff education regarding responding to the South Unit door alarms heard at the East unit alarm panel was initiated - as of 4/7/22, 127/147 (86%) staff completed their education. Agency staff will be educated at the start of their next scheduled shift by staffing scheduler, weekend supervisor, PM supervisor, or human resources director. (A)	S9999		