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| S 000 | Initial Comments<br><br>Complaint Investigation:<br>2274803/IL148148<br><br>A partial extended survey was conducted. | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br>300.610a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | Attachment A<br>Statement of Licensure Violations | |

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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.

These Regulations are not met as evidenced by:

Based on observations, interviews, and record reviews the facility failed to identify a newly admitted resident as an elopement risk and provide supervision and safety for R1. As a result of this failure, R1 was able to elope from the facility after admission from a local hospital for dementia, falls, and memory care. R1 was able to travel to a family member's home from the facility and during this time suffer a fractured clavicle and rib. R1 required Emergency Room (ER) treatment.

This applied to 1 of 4 residents (R1) reviewed for elopement in the sample of 4.

The findings include:

R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on April 14, 2022, with diagnoses that included dementia in other diseases with behavioral episodes, unspecified lack of coordination, Wernicke's encephalopathy, and anxiety. R1 was discharged from the facility

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| S9999 | Continued From page 2<br>on June 10, 2022, and was not able to be interviewed at the time of this investigation.<br><br>R1's Hospital records showed that on April 12, 2022, R1 was admitted to the ER (Emergency Room) from another nursing home. The progress notes written from April 12, 2022, until transfer to facility on April 14, 2022, showed various progress notes documenting R1 wandering the hallways, climbing out of bed, removing clothing, and removing the medical equipment needed to monitor his heart. R1 had a 1:1 sitter for safety while in the ER up to his discharge from the ER.<br><br>R1's progress notes document that R1 was admitted to the facility on April 14, 2022, at 7:04 PM without any family present. V6 (LPN/Licensed Practical Nurse) charted that R1 was alert and oriented times two and admitted to the facility with dementia and risk for falls. V6 went on to document that R1 was orientated to his room.<br><br>Hospital records document on April 14, 2022, that R1 arrived in ER at 8:38 PM and was discharged at 2:18 AM. ER Social worker documented, "Patient to the ED via EMS after daughter called stating {R1} had made it to her house from {facility}. {R1} was there for nursing home placement and memory care. {R1} complained of right shoulder pain and noted a bruise to face."<br><br>On April 15, 2022, at 3:12 AM, V12 (RN/Registered Nurse) documented that R1 had returned from the local hospital at 2:35 AM with a sling on the right arm due to right clavicle and right second rib fracture.<br><br>On April 15, 2022, at 10:27 AM, V31 (Physician) documented that R1 was status post fall with fractured right clavicle and right rib. | S9999 | | |

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| S9999 | Continued From page 3<br><br>On June 30, 2022, at 10:58 AM, V14 (R1's wife) reported on April 14, 2022, sometime in the late afternoon, the local hospital let her know that R1 was going to be transferred to the nursing home. Later that same evening, V14 reported she received a call from her daughter letting her know that R1 had shown up at her house with a bruise on his face and was complaining of right shoulder pain. V14 stated, "I called the facility around 8:20 PM, and asked the nurse (unknown name) if R1 was in the facility. The nurse told me he was there. Not long after I talked to that facility nurse, the hospital called to tell me R1 was back in the ER and had arrived at 8:38 PM. Later that night V3 (DON) called me to let me know they had seen R1 get into a black SUV (Sport Utility Vehicle) on their parking lot camera and wanted to know who I knew that drove a black SUV. I told her no one that I know of."<br><br>On June 30, 2022, at 11:07 AM, V13 (R1's daughter) reported on April 14, 2022, at approximately 8:00 PM, "R1 showed up at my house and started pounding on the front door saying, 'let me in'. I called the local hospital to ask them why R1 was at my house. The hospital told me, he had been transferred to the nursing home earlier that evening and then told me to call 911. I noticed a bruise on R1's face and he was complaining of shoulder pain. The paramedics arrived and took R1 back to the local ER. V13 went on to add that R1 does not have access to any money or credit cards because of his dementia. V13 continued to add that R1 would not know what a (request a ride) driver is and would not know how to call one. V13 added, "He can barely answer his cell phone by himself."<br><br>On June 28, 2022, at 2:32 PM, V1 (Administrator) | S9999 | | |

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reported on the night of the incident R1 told V8 (Receptionist) his daughter was picking him up. V8 opened the door and let him out. V8 was new at the time and is no longer working here. According to V1, R1 had only been in the facility about one hour when he left the building.

On June 30, 2022, at 1:02 PM, V27 (Previous Administrator) stated "I was out to dinner (April 14, 2022) when the hospital called letting me know R1 was in the ER and asked me why he came from his daughter's house and not the facility? I called the facility to see what was going on. V8 (receptionist) told me R1 came to the front desk and told her he was going home. V8 stated she tried to call me, but she had already let R1 out the door. I called V14 (R1's wife) to let her know what was going on and she told me that R1 needs to be in the facility. I called the facility back and asked them to make some room changes so R1 could come back to the facility and be placed on the locked unit. The next day I called V13 (R1's daughter) to ask her exactly what happened. V13 told me that R1 just showed up at her house. V13 went on to add that she called 911 and the paramedics took R1 to the hospital and diagnosed him with a fractured right clavicle and fractured right rib. V27 went on to add that she tried to talk to R1 the next day and that R1 told me he fell when he went home. According to V27, R1 started to get agitated with V27 when I was asking him questions, so I stopped. The receptionist and staff who cover the desk when the receptionist takes her break were all trained that even with an alert and oriented resident, staff at the front desk are to call the nurse to see if it is ok to let the resident go outside the facility. I thought R1 was an AMA (Against Medical Advice) discharge and that is why I called V32 (Human Resources) to start an in-service on AMA policy

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| S9999 | Continued From page 5<br>and procedure. V27 continued and stated, "I know it should have been documented and it wasn't."<br><br>On June 27, 2022, at 1:17 PM, V3 (DON-Director of Nursing) reported on the day R1 left the facility, he waved to the receptionist and said, "I'm going to my daughters." I was told that V8 saw R1 get into a car. V3 stated that she was not sure how R1 set up getting a ride, but he made it to V13's house. V3 added that R1 either told V13 he had fallen, or she witnessed his fall. V3 stated that the facility was not sure how R1 fell but that we knew that V13 drove R1 to the hospital. V3 reported that the facility has parking lot cameras, but these cameras only record for two weeks and then tape over what was previously recorded.<br><br>On June 30, 2022, at 10:02 AM, during a meeting with V1 (Administrator) V1 presented the following information: R1 came in as an "Emergency Situation" R1 not appropriate for hospital admission and could not go home. V1 stated that the facility was not told that R1 had history of elopement. The hospital records in our system appear to have been printed prior to his discharge from the hospital so they must have arrived when R1 did but within one hour of his admission, R1 went to the front desk, told the receptionist he did not want to be here, called a (ride share driver), and left. V1 then added that the facility has 24 hours to assess a resident. V1 stated that the facility uses a triple check process-three set of eyes review documentation - hospital liaison, admissions, admitting nurse. V1 reported this was an AMA (Against Medical Advice) discharge. V1 stated "If hospital had given us accurate information, we would not have taken this resident or we would have placed on locked unit when he was first admitted to us." | S9999 | | |

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| S9999 | Continued From page 6<br><br>Facility provided policy titled "Elopement", with revision date of January 2021 showed "All residents will be assessed for elopement risk upon admission ..."<br><br>Facility provided policy titled "Admission Approval", with revision date of September 2021 showed: "General: The facility accepts the patient or resident for care, treatment, and services based on its ability to meet the patient's or resident's needs. Responsible party: IDT (Intradisciplinary Team), RN, LPN. Protocol: 1.) The patient screened prior to admission by at least one of the following: Marketing Director, Nurse Liaison, Admission Director, and/or Director of Nursing. 2.) The patient or resident is screened for acceptance based on the Bria clinical capabilities Policies ....<br><br>On June 28, 2022, at 10:57 AM, V5 (Admissions) stated, "We have a hospital liaison (V7) who the hospital contacts when a resident needs to be admitted to a facility. Once the hospital contacts her, she will contact me to see if we are able to accept this resident. I have access to the hospital EMR (Electronic Medical Record) should the hospital not provide us with the admission documentation. When we admit a resident for "memory care" the meaning varies based on the severity of the memory care needs. Sometimes we are told before arrival what their needs are and other times, we find out their needs once they are at the facility. I do not remember much about {R1}, but I know I was not in the building when he was admitted. We do have wander guards if required, but I am not sure how the need is determined. I believe the assessment is with the Administrator." | S9999 | | |

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| S9999 | Continued From page 7<br><br>On June 27, 2022, at 3:50 PM, V6 (LPN/Licensed Practical Nurse) stated, "I remember this guy being admitted to this facility close to shift change. When I was done with my part of the admission, I placed the hospital records and my nurse- to- nurse report sheet in the medical records box in the nurses' station. V33 (Medical Records) will come around during the day and pick up the records to scan into the computer. I later heard from someone that he had left the facility."<br><br>Interviews were held with V3 (DON), V10 (LPN), V11 (RN), and V23 (LPN) regarding the admission process.<br><br>On June 28, 2022, at 10:32 AM, V10 (LPN/Licensed Practical Nurse) stated, "with a new admission I have to assess the resident to see if they are alert and oriented and if the resident is confused, I will call the family. I will review transfer packet from hospital or facility resident arrived from, do a head-to-toe assessment, alert staff including the DON (Director of Nursing) and ADON (Assistant Director of Nursing) that we have a new admission and share any concerns, complete resident charting, document progress note, and round on the resident every 1-2 hours.<br><br>At 10:37 AM, V11 (RN/Registered Nurse) stated " when she gets an admission she checks on the patient and orients them to the room and call light, does a skin assessment, get vital signs including the weight, check orders with the physician including labs, enter orders, call pharmacy for STAT delivery of medications, round on resident every 2 hours, but if they have dementia round hourly for the next 72 hours, and write a progress note. | S9999 | | |

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| S9999 | Continued From page 8<br><br>At 1:37 PM, V23 (LPN) stated with a new admission I have to review nurse to nurse assessment, do a head-to-toe assessment, vital signs, skin assessment, fall risk assessment, start baseline care plan, hourly rounding for the first 72-hour, progress note (Admission note), medication reconciliation with physician, pain assessment, and dehydration assessment.<br><br>On June 29 at 12:34 PM V3 (DON) stated "when a new admission arrives at the facility the nurses are responsible for assessing the resident including vital signs, room orientation, reviewing the paperwork from the hospital, and if family is there orient them as well as resident to the facility, locations of bathroom, closet, daily schedules. If there is no family present and/or the resident has dementia, the nurse will still go over room orientation with resident, they will explain the call light system and make sure the resident is able to use it or see if they need an adaptive call light. Depending on what time the resident is admitted, if close to change of shift, the nurse on duty starts the admission process when resident arrives, and the oncoming nurse will need to finish the admission. There are seven assessments that need to be completed during the admission process: 1.) Falls 2.) Elopement 3.) Pain 4.) Dehydration 5.) Skin 6.) Call light and 7.) Head to toe assessment. The nurse needs to write an admission progress note that documents specifics about that resident, do a baseline care plan, initial nursing observation, and if resident is being admitted for rehab a skilled nursing note needs to be completed. If a resident is alert and oriented, the nurse can ask the resident questions as part of their assessment, but if not, the nurse needs to review the hospital records, and call the family. When we use agency nurses, | S9999 | | |

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| S9999 | Continued From page 9<br>the nurse on the unit will orientate them to the facility, the unit, and the residents assigned to. If they are working the day shift, once I get to work, I will check in with them and see if they need anything. Nurses will round on residents every hour or every 2 hours depending on their needs. If they are high risk falls or elopement risk, then we would round every hour (Nurse or CNA). R1 was an emergency admission which means the hospital was unable to find placement and R1 did not require hospitalization. We had basic information on R1, the nurse was responsible for reviewing the hospital paperwork that arrived with the resident. At around 8-9 at night on April 14, V27 (previous Administrator) called, and I was made aware that R1 had left the facility and said he was going to his daughter's house."<br><br>The facility's initial incident report dated April 15, 2022, showed "Description of Occurrence: {R1} sustained a fall with injury while out of facility; went to ER for evaluation and treatment; diagnostic findings include right clavicle fracture and right rib fracture."<br><br>The facility's final incident report dated April 19, 2022, showed: "Occurrence resolution: A thorough investigation was conducted which included interviews with {R1}, {V14 wife}, and {V13 daughter}. Facility medical record and hospital records reviewed. {R1} stated 'I was walking and fell.' {R1} returned to the facility from the ED (Emergency Department) with orders for sling to right arm and follow-up with orthopedic physician. {R1} monitored for pain and comfort, care plan updated. During the investigation there was no evidence of any form of abuse, neglect, or mistreatment."<br><br>The facility is located on Illinois Route 38 also | S9999 | | |

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| S9999 | Continued From page 10<br>known as State Street, a four-lane highway. The distance from the front of the facility to the highway was measured as 194 feet by V28 (Maintenance Director).<br><br>R1's MDS (Minimum Data Set) dated May 5, 2022, showed R1 had moderately impaired cognitive skills for daily decision making. R1 required supervision and one staff physical assistance for walking in corridors and locomotion off the unit.<br><br>R1's baseline care plan with an effective date of April 14, 2022, could not be provided. Per V1 (Administrator) "it does not appear as though (V6/LPN) completed all of the evaluations on the 14th. It appears as though the other nurse completed the assessment (April 28)."<br><br>(A) | S9999 | | |