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	IL6002299	A. BUILDING: _____ B. WING _____	C 11/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL PINES REHAB & HCC	335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014

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S 000	Initial Comments Investigation of Facility Reported Incident of November 20,2022/IL153573	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)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.	S9999		
	Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which		Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. This REQUIREMENT is not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interview, and record review, the facility failed to accurately assess a resident at risk for elopement and failed to implement interventions to prevent a resident from eloping. These failures resulted in R1 eloping from the facility and being found two blocks away in 34-degree Fahrenheit (F) weather while crawling across a heavily traveled highway. This applied to one of three residents (R1) reviewed for safety in the sample of three. The findings include: The facility's initial incident report sent to the Illinois Department of Public Health (IDPH) showed R1 went missing on 11/20/22 at approximately 3:45 PM after a physical therapist was unable to locate the resident. The report showed staff called an Elopement Code and started looking for the resident. The report showed local police came to the facility to inform the staff that the resident had been taken to the local acute care hospital emergency department by paramedics the same day. R1's face sheet printed on 11/22/22 showed an admission date of 11/19/22 and diagnoses that included, but were not limited to, laceration of the scalp, anxiety disorder, repeated falls, symptoms, and signs involving cognitive functions and awareness, restless leg syndrome, and polyneuropathy. R1's nursing admission assessment of 11/19/22 showed an unsteady gait and a wheelchair required for mobility. R1's hospital discharge summary, dated 11/19/22, showed he was sent to the local hospital following an unwitnessed fall at home	S9999		

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S9999	Continued From page 3 and "has been developing issues with cognitive impairment per the wife." The summary showed a scalp laceration that was stapled in the emergency room with five staples. An outpatient neurology evaluation of cognitive impairment was recommended. R1's elopement risk assessment, dated 11/19/22 (facility admission), showed the resident was not cognitively impaired and not independently mobile. On 11/22/22 at 10:30 AM, R1 was seated in a wheelchair in his room. Staff were present and the door was closed. R1 stated he was being held a prisoner against his will. R1 said he wanted to get out of here and nobody will let him go. R1 was able to converse but was confused on details and specifics throughout the interview. R1 said he did walk out the front door a few days ago during rush hour. R1 said he was walking home to see his wife and get his glasses. On 11/22/22 at 1:40 PM, V3 (Licensed Practical Nurse/LPN) stated she was working the day R1 was admitted. V3 said R1 was alert but clearly confused and talked of leaving the facility right away. R1 wandered up and down hallways and was not sure where his room was. R1 would not stay in his room and repeatedly said he was going home. V3 said she was also working the next morning when R1 opened the front door in the lobby and walked out of the facility. V3 said it was between 11:00 AM and 12:00 noon. V3 said she and another staff member had to run out the front door to get R1 back inside. R1 was walking quickly away from the building and refused to come back inside. R1 was pushing away from her and was insistent his wife was on the way to pick him up. V3 said R1 was not wearing a hat or	S9999		

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S9999	Continued From page 4 gloves and it was very cold outside. On 11/22/22 at 11:05 AM, V4 (LPN) stated she was working the morning R1 was attempting to walk out the front door alone. V4 said R1 had been walking in a confused manner around her unit earlier in the day. R1 was fully ambulatory and kept pushing his wheelchair from behind, rather than remain seated in it. R1 was forgetful and kept looking at exit doors. R1 repeatedly asked what is outside the doors. V4 said R1 was upset he was not getting any physical therapy and his focus was to get out of the building. V4 said V5 (Physical Therapist) met with R1 later that day to distract him from leaving the facility. V4 said she was notified by V5 after the therapy session that R1 was missing from his room. V4 said she called V1 (Administrator) and V2 (Director of Nurses) to report the missing resident. V4 said she called an elopement code and went to the front lobby area to look for R1. V4 said V6 (Receptionist) stated she saw R1 walk out the front door with two unknown women. V4 said R1 was not stopped or questioned while he exited the facility. On 11/22/22 at 10:37 AM, V5 (Physical Therapist) said that he met with R1 in the afternoon the day R1 went missing. V5 said R1 was able to converse but slipped in and out of cognition. V5 said R1 was able to ambulate alone but required a walker or wheelchair for safety. V5 said he last saw R1 sometime after 2:45 PM when he finished his therapy session. V5 said he realized R1 was not in his room at 3:45 PM and alerted V4 (LPN). On 11/22/22 at 9:30 AM, V1 (Administrator) stated he was notified that R1 was missing from the facility on 11/20/22 in the afternoon. V1 said R1 was last seen by a staff member around 3:10	S9999		

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S9999	Continued From page 5 PM when a CNA (Certified Nurse Aide) helped him in the bathroom. V1 said staff members told him R1 walked out the front door with two unknown female visitors. V1 said the receptionist thought R1 was a visitor and therefore let him leave with the females. V1 said the local police arrived at the facility at around 4:00 PM and reported R1 had been found up the street. Police reported R1 had fallen while crossing a heavily traveled road and a bystander called 911. R1 was taken to the local emergency room. V1 said R1 was wearing a light sweatshirt, jeans, and rubber shoes. On 11/22/22 at 1:55 PM, V6 (Receptionist) said that she saw R1 leave the facility on 11/20/22 without any staff present. V6 said it was between 1:00 PM and 4:00 PM and he was with two females. V6 said she did not ask names or identify who the individuals were. V6 stated the females knew the door code and so V6 thought they must be routine visitors. V6 said R1 did not sign himself out when he walked out. V6 said R1 was using a walker and exited the front door. V6 said R1 was wearing a red, long sleeve shirt, stained pants, and rubber shoes. The website Weather History and Date Archive (wunderground.com) showed the temperature on 11/20/22 was 34 degrees Fahrenheit. The facility is located approximately two blocks north of a heavily traveled main highway and with a heavy wooded area outside the front parking lot. On 11/22/22 at 2:05 PM, V2 (Director of Nurses) stated she was notified on 11/20/22 that R1 was missing from the facility in the afternoon. V2 said R1 had been trying to leave the facility earlier and did get out the front door earlier that morning. V2 said R1 had been a resident in the past (2021)	S9999		

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S9999	Continued From page 6	S9999		

and admitting staff thought he was at the same levels. V2 said his most recent admission was on a Saturday and his referral documents were not reviewed thoroughly at admission. V2 said R1's admitting documents showed he had impaired cognition, increasing forgetfulness, and a history of falls per his wife. V2 said the weekend admission process "had holes in it." V2 said staff should have waited until a weekday to admit R1 so a full assessment could be done. V2 said R1 should have been put on one-to-one supervision and in room near the nurses' station as soon as his exit seeking behaviors were seen. V2 said the elopement interventions should have been implemented immediately but were not done until he was found and returned to the facility.

R1's care plan showed a focus area for risk for elopement due to an elopement event on 11/20/22. The initiation date and interventions were dated 11/21/22.

The facility's "Elopements Policy," with a revision date of 12/2007, states: "All residents will be assessed for behaviors or conditions that put them at risk for elopement." The procedure section states: "1. Using the MDS resident assessment schedule, all residents shall be reviewed for safety concerns and precautions. Residents at risk for elopement shall be identified and documented in the individual plan of care. 2. Unless otherwise identified in a plan of care, residents who are at risk for possible elopement shall be accompanied when leaving the facility grounds. The resident representative shall sign the resident out of the facility on the resident sign-out sheet. 3. Residents at risk for elopement shall be identified on a Resident "Watch" list as well as in the clinical record. This list shall be updated whenever new resident safety issues are

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S9999	Continued From page 7 identified and shall be located at nursing stations and the reception area." "A"	S9999		