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| ST JAMES WELLNESS REHAB VILLAS | 1251 EAST RICHTON ROAD CRETE, IL 60417 |

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| S 000 | Initial Comments<br><br>Complaint Investigation<br><br>2371238/IL156396 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br>300.1220b)3)<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 | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. | S9999 | | |

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| S9999 | Continued From page 2<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure that a resident with a dementia diagnosis and a wander monitoring device was prevented from eloping from the facility in the night. This failure resulted in R1 exiting the facility unnoticed and unsupervised and walking across an intersection to a gas station until a person from the community notified the police.<br><br>This applies to 2 out of 3 residents (R1, R2) reviewed for elopement risk in the sample of 8.<br><br>The findings include:<br><br>1. On 2/14/23 at 6:28 AM, V13 (Responding Police Officer) stated that he was dispatched at 12:22 AM on 2/10/23 and reached the area where R1 was located between 12:25 AM and 12:30 AM. V13 stated R1 was on the grassy area or sidewalk outside the gas station. V13 stated that R1 was very confused and did not know where she had come from. V13 stated he saw R1 had four numbers written on a paper in an opened envelope (mail) with the facility address on it. V13 stated that R1 told him that the four numbers were the passcode for the door in her facility. V13 stated R1 told him she saw someone put in the code, but she did not know who the person was. V13 stated R1 also had the pass code memorized. V13 stated R1 thought the gas station was an outlet for a cab station or train station. V13 stated R1 started talking about her son and could not remember his phone number. V13 stated he called the paramedics because he wanted someone to assess R1. V13 stated when | S9999 | | |

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| S9999 | Continued From page 3<br><br>R1 was returned to the facility, he talked to V6 (Registered Nurse/RN) and another unknown nurse and they could not tell him how R1 obtained the pass code and left the facility.<br><br>V13's (Responding Police Officer) case report number 22-000094 report showed he "was dispatched to the crossroads near the facility (a two-lane county highway which crosses a four-lane divided highway with a median) for a welfare check. The caller stated that there was a woman with a walker (R1) in the middle of the road on (named road) ... [V13] spoke with [R1] who stated in summary: [R1] was trying to catch a train 'over there' (from gas station, and to another city). [V13] informed [R1] that the gas station was a gas station and not a place for transportation. [R1] could not remember who she was going to see, her address, how long she had been outside, or what direction she came from. When asked these questions, [R1] appeared to be confused and could not provide an answer."<br><br>The case report continued "While looking through the pockets of [R1's] walker, mail with the address of the nursing home was found. [V13] then asked [R1] if she came from the nursing home. [R1] stated to [V13] in summary: [R1] left that place because they did not treat her right. [V13] asked [R1] how she left the nursing home. [R1] stated to [V13] that she knew the passcode to the doors. [V13] observed the passcode written down on a piece of mail. The local paramedics contacted the nursing home and verified [R1]'s residency there. An employee from the nursing home told [V13] and paramedics they were not aware that [R1] had left the building. [V13] had paramedics transport [R1] to the nursing home..."<br><br>On 2/11/23 at 2:14 PM, R1 was asked where she | S9999 | | |

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| S9999 | Continued From page 4<br>got the code. R1 initially stated that an unknown man put the code in and let her out. R1 stated that she was 82 years old and could not remember and was unsure if she put the code in her mail, adding her "memory was bad." R1 stated she was trying to get out of the building and was looking for the train station because she wanted to go home. R1 stated she cannot sleep at night and sometimes she wakes up at 4:00 AM. R1 stated that day (2/9/23), she woke up and asked the nurse for some water. R1 was unable to tell surveyor the name of the nurse, only stating she "was a black nurse" and that she "hollered at me and did not talk to me in a nice tone." R1 stated she asked the nurse for some medication to help her sleep and the nurse told her to wait in the dining room. R1 stated she waited a long time and got fed up and walked out of the dining room. R1 stated she went to her room and put her coat on. R1 stated she "was not going to bother with those nurses because they just laugh and talk the whole shift." As the conversation continued, R1 changed the story and stated she put the code in herself. R1 stated that someone "gave it to me" and she did not remember the name of who it was. R1 stated she knew why she had a wander monitoring device, stating "it's because if I went away from the facility, staff would know where I was." R1 also stated she felt she was being targeted because she is a black woman. R1 stated she did not understand why the white residents were able to leave the facility and she was not. R1 stated she left the facility because she was upset and could not stand the attitudes of the staff. R1 stated she left the facility and crossed the street and reached the gas station. R1 said she saw a lot of lights and thought the gas station was the train station. R1 said she felt she was not doing anything wrong. | S9999 | | |

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| S9999 | Continued From page 5<br><br>On 2/14/23 at 8:15 AM, V1 (Administrator) stated there were five staff caring for 26 residents on the night shift on 2/9/2023: V14 (Licensed Practical Nurse/LPN), V6 (RN), and V7, V15, and V16 (Certified Nursing Assistants/CNAs). On 2/15/23 at different times, surveyor attempted to reach out to V15 and V16 via phone. Surveyor was unable to reach them and left a message on their voicemail. V2 (DON) had stated that V14 would return to the facility after 2/19/23 because someone in her family was in an accident. Surveyor did not reach out to V14.<br><br>On 2/11/23 at 3:46 PM, V6 (RN) stated she started her shift at 10:45 PM on 2/9/23 and worked until 6:30 AM on 2/10/23. V6 stated that R1 came to her at the beginning of the shift, asking for something to help her sleep. V6 stated R1 had already received her scheduled dose of melatonin and told R1 that she would look if she had orders for anything else to help her sleep, and R1 waited in the dining room. V6 stated that R1 did have an additional medication, so V6 went to the dining room and R1 was not there. V6 stated she went to R1's room and found her under the covers sleeping, so V6 did not disturb her. V6 stated that around 12:45 AM (on 2/10/2023), V6 received a call from the paramedics who told her that R1 was outside walking. V6 stated when the CNAs did a head count, they were unable to find R1. V6 stated she was unaware that R1 was on elopement precautions, and she did not know that R1 wore an electronic monitoring device. V6 stated that when V13 (Responding Police Officer) came to the facility, V6 was informed that R1 had crossed the street and was at the gas station. V6 stated that whenever she has worked on R1's floor R1 would be up at night, sometimes asking for snacks and ice water, and R1 would get upset if | S9999 | | |

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V6 didn't give it to her right away. On 2/14/23 at 2:36 PM, V6 (RN) confirmed that the last time she saw R1 was at 11:30 PM on 2/9/23 and R1 was in her room in bed.

On 2/11/23 at 3:49 PM, V7 (CNA) stated she was the assigned CNA for R1 overnight on 2/9/23 into 2/10/23. V7 stated she was not aware that R1 was on elopement precautions or that R1 wore an electronic monitoring device. V7 stated she did not know what the electronic monitoring device was or what it is used for. V7 stated that she was in the dining room and R1 had come in and sat down. V7 stated R1 was waiting for sleeping medication and after a few minutes, R1 went back to her room. V7 stated she did not remember the exact time.

On 2/11/23 at 6:15 PM, V2 (DON) stated they were able to identify the door that R1 exited because of the specific code she had written down. V2 stated that on average, R1 is probably awake three out of seven nights a week. V2 stated that when that door is closed and locked from 8:00 PM to 8:00 AM, on the outside of the door (to enter R1's unit) is a red button to press to enter the unit. V2 stated if someone wears a wandering device, it will alarm when the person with the device enters the unit, but the alarm will not sound if a person with a wandering device typed in the code and exits the unit.

On 2/11/23 at 2:00 PM, surveyor went with V1 (Administrator), V2 (DON), and V4 (Maintenance Director) on an environmental tour and the front main doors were checked. A receptionist was behind a desk and the door was unlocked. V2 stated that after 8:00 PM and until 8:00 AM, there is no receptionist by the main door. V1 stated the front doors are not locked from the inside

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because they are fire doors. V1 stated that when R1 went out the front doors (after typing in the code and exiting her unit), the doors would not have alarmed because they are not "egress" doors (which would alarm and then open after 15 seconds). V1 stated there is no alarm on the door although it is locked from the outside starting at 8:00 PM to 8:00 AM.

On 2/11/23 at 2:07 PM, V2 and V4 described the control panel for the door leaving R1's unit into the hallway leading to front desk and lobby area. V2 stated that the control panel is to control both the wander monitoring system and egress door. The control panel showed "Exit Alarm Control Unit-Power, Signal, and Status" and number keys. To the right of the unit was the keyhole for staff to lock and unlock the doors.

On 2/11/23 at 2:13 PM, V4 (Maintenance Director) demonstrated how the electronic wandering device system works on the egress door that R1 used to exit. When V2 (DON) brought the device near the unlocked and opened door to leave the unit, the monitoring system sounded an alarm. V4 then closed and locked the door. When V2 brought the device near the closed, locked door to leave the unit, the alarm did not sound any warning. When V4 pressed the hand bar the door, the egress alarm sounded and after 15 seconds, the door opened. Then V4, still holding the wandering device, put in a code and opened the door with no alarm sounding.

On 2/11/2023 at 4:09 PM, V2 stated that the receptionist closes the unit doors and uses a key to turn the alarm box into the locked position at 8:00 PM. V2 stated when the door is closed and locked, it functions as an egress door and not a wandering alarm. V2 stated "I know that night

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| S9999 | Continued From page 8<br>(2/9/2023), the doors were locked."<br><br>On 2/11/23 at 3:00 PM, V11 (LPN/Nursing Supervisor) stated that she relieved V6 (RN) on the morning of 2/10/23 after R1's elopement incident. V11 said she heard that R1 eloped from the facility by putting in the code. V11 stated that "sometimes R1 will understand things and sometimes not." V11 stated R1 also gets agitated and hollers at the staff. V11 stated R1 wakes up frequently at night and demands ice water right away and if she doesn't get it right away, she stands right in front of you and yells. V11 stated R1 is confused most of the time and R1 wanders around the unit. V11 stated R1 even sneaks into the nourishment room and gets snacks. V11 stated R1 has a wandering device and walks all over, including all the way to the receptionist area and uses the bathroom there. V11 stated R1 is an elopement risk due to her wandering.<br><br>On 2/10/23 at 10:55am, V25 (Nurse Practitioner) stated she assessed R1 the morning after the elopement incident. V25 stated R1 was at her baseline when it came to her memory and added R1 knows people to a certain extent but is at times very forgetful. V25 stated that R1 had told her that she was going to the gas station. Surveyor asked V25 what the potential outcomes could be if someone like R1 left the facility unsupervised at night. V25 stated "There is serious danger. [R1] could have been injured, seriously hurt and could have fallen. She could have been injured by another person or vehicle."<br><br>R1's Face Sheet showed her diagnoses include unspecified abnormalities of gait and mobility, weakness, history of falling, repeated falls, cognitive communication deficit, difficulty in walking, unsteadiness on feet, unspecified | S9999 | | |

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dementia- unspecified severity and without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, essential hypertension, and cardiac arrhythmia.

R1's 1/25/23 care plan shows R1 "experiences bouts of wandering, seemingly oblivious to needs or safety." R1's listed goal is for R1 to wander safely within specified boundaries. R1's 1/27/23 approach showed "Equip resident with a device that alarms when wanders. Check for proper functioning..." A second 1/27/23 intervention showed "when resident begins to wander, provide comfort measures for basic needs ..."

R1's 1/28/2023 fall care plan showed R1 is at risk for falling related to a diagnosis of dementia, weakness, and history of falls. R1's 11/21/2022 cognition care plan showed she "displays deficits in the following areas: repetition of three words, temporal orientation and recall during the 7 days look back period."

On 2/11/23 at 4:09 PM, V2 stated R1 is confused and not consistent in her ability to recall things. V2 stated R1 liked to walk in the closed-in courtyard and get fresh air. V2 stated she saw R1 walking outside wearing a fleece jacket once in November 2022 when it was around 35 degrees Fahrenheit. V2 stated she thought it was not a good decision by R1 to wear only a fleece jacket and she needed a thicker coat. V2 stated R1 was not wearing appropriate clothes and shoes either. V2 stated she called the doctor and obtained an order to place the wandering device. R1's February 2023 POS (Physician Order Sheet) showed a 11/21/22 order to place a wandering device and to check it every shift. V2 stated R1 received the wandering device in November after the interdisciplinary team determined R1 should

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| S9999 | Continued From page 10<br>be put on elopement precautions. V2 stated that she was unable to provide any notes of when she found R1 outside wearing inappropriate clothing.<br><br>On 2/11/23 at 5:30pm, V2 (DON) stated that staff should always make sure when they put the code in for the door that no one is around them. V2 stated if a confused resident elopes, she could get hit by a car, fall, be abducted, or be killed, adding R1's incident happened in February when there is cold and inclement weather. V2 said "I understand the gravity of the situation. It's serious." At 6:00pm, V2 (DON) stated elopement information is in the orders and care plans and her expectation is that nurses should be communicating with each other and the CNAs.<br><br>On 2/11/23 at 4:14pm, V10 (Social Services Director) stated that she now completes the Elopement Risk assessments upon admission, quarterly, and re-admission. V10 stated she was not the one who completed R1's Elopement Risk reviews and observation sheets on 1/27/22, 11/21/22, and 1/9/23, but she completed the one on 1/26/23. R1's 1/26/23 Elopement Risk review showed R1 is an elopement risk of 3, which means she is not at risk and "a monitoring device was not placed on her."<br><br>On 2/11/23, V10 continued she thought she checked "yes" when she checked R1 had no monitoring device for wandering after one was placed. V10 said she took over the assessments because she wanted to make sure they were accurate. V10 stated R1's assessment and prior assessments were not correct. V2 (DON) stated that she also disagreed with the assessments because if someone has a wander guard, then they should be classified as an elopement risk. V10 stated residents should have assessments at | S9999 | | |

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| S9999 | Continued From page 11<br>the time of admission, quarterly, when they return from the hospital, when a wander guard is placed, and whenever there is an elopement incident.<br><br>R1's 11/21/22 Elopement Risk review also showed R1 is an elopement risk of 3, which means she is not at risk, and a monitoring device was not placed on her. R1's 1/9/23 Elopement Risk review further showed R1 does not have dementia, does not have memory problems, and is not an elopement risk. The review also showed R1 is an elopement risk of 1, which means "she is not at risk, and a monitoring device was not placed on her."<br><br>On 2/11/23 at 6:55 PM, surveyor went to R1's room with V2 (DON), and V18 (R1's Son) was visiting her. Written on one of the pages in R1's purple notebook was "1251 to go out building." R1 changed her story and stated she saw someone put the code in and could not tell who it was. Surveyor asked R1 if she wrote the code on a piece of mail too and R1 stated she couldn't remember. V18 stated, "I'm not surprised that (R1) would write the code down. She's very detailed. She was a court reporter."<br><br>R1's 1/3/23 MDS (Minimum Data Set) showed R1's Brief Interview for Mental Status score was 04, meaning she is severely cognitively impaired. The same MDS showed R1's functional status as able to walk independently using a walker or wheelchair.<br><br>The facility's undated "Code Pink Elopement" policy showed "Elopement is defined when a resident's whereabouts is unknown. All nursing personnel are responsible for knowing the whereabouts of residents they are assigned to care for...Resident is not permitted to leave the | S9999 | | |

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| | IL6010664 | A. BUILDING: _____ B. WING _____ | C 02/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S9999 | Continued From page 12 | S9999 | | |

building alone unless the attending physician has given an order to go out on pass without supervision." The policy continued "Residents who have been identified as cognitively impaired and who have been assessed as an elopement risk will be provided with an alert elopement device or be placed in an area of the facility that has a door alarm device with audible sound..." The policy described "risk factors that will be assessed when determining for elopement risk: a. Independent ambulating with or without assistance. b. Pre-admission or history of elopement. c. Purposeful exit seeking. d. Restless, aimless pacing. e. Verbalization of wanting to leave the facility and/or go home...g. A cognitive impaired individual who is a follower. h. Inability to differentiate safe from unsafe situations. I. Diagnosis of Alzheimer's Dementia...J. Inability or refusal to follow instructions."

R1's February 2023 Physician Order Report does not include an order permitting R1 to leave the building without supervision.

On 2/11/23 at 4:14 PM, V2 (DON) stated that R1 and R2 were the only residents who had wandering devices and were on elopement precautions.

2. On 2/11/22 at 6:51 PM, R2 was seen wearing a wandering device on his leg. R2's February 2023 POS showed an 11/18/22 order to check his wander monitoring device three times a day.

R2's Face Sheet showed he came to the facility on 5/11/2018. R2's Elopement Risk assessment was done on 5/22/18 and R2 scored a 4, indicating he was at risk for elopement. The next two elopement risk assessments completed were

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| S9999 | Continued From page 13<br>dated 11/8/19 and 12/30/19. In May 2021 and August 2021, R2 had no Elopement Risk assessments, and no Elopement Risk assessment was completed after R2 tried to elope on 9/30/22. No elopement risk reviews were completed at all in the year 2022 for R2. R2's elopement risk assessment dated 1/19/23 shows R2 was incorrectly scored as a 3, indicating he is not at risk. R2's 2/11/23 Elopement Risk assessment also scored him scored a 3.<br><br>R2's Face Sheet showed diagnoses of cerebral infarction, altered mental status, insomnia due to medical condition, psychotic disorder with delusions due to known physiological condition, unspecified dementia- unspecified severity and without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, bipolar disorder, unspecified psychosis not due to a substance or known physiological condition, muscle weakness, other speech and language deficits following unspecified cerebrovascular disease, and other symptoms and signs involving cognitive functions following unspecified cerebrovascular disease.<br><br>R2's 1/16/23 MDS score was 06, which means R2 is severely cognitively impaired. The same MDS showed R2 uses a wheelchair, he walks independently in his room and the corridor, and his balance is steady at all times when walking, turning around, or rising from a seated to a standing position.<br><br>R2 has an 11/9/19 dementia care plan and a 5/21/18 care plan that showed "Resident makes attempts to leave the facility." R2's 5/14/2018 fall care plan showed he is at risk for falls related to weakness and confusion and he ambulates with a | S9999 | | |

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| S9999 | Continued From page 14<br>slow gait and without an assistive device. R2's 12/2/19 care plan showed he may display maladaptive behaviors and mood distress due to his bipolar diagnosis.<br><br>R2's progress notes document the following:<br><br>"On 9/30/22 at 9:30 AM, (R2) was noted to have walked outside of gate by patio. When (R2) saw writer approach, he started to return to patio area. When asked where he was going, he smiled and said he was not going anywhere. (R2) returned to patio area and into building with nurse on duty. Discussed with (R2) the danger of walking in areas around building that could be unsupervised and unpaved..."<br><br>"On 9/30/23 at 10:30 AM, Writer spoke with (R2's) sister. She stated she already spoke with (R2) after speaking to nursing staff. She stated (R2) wants to go out and get a job... She knows and has explained to (R2) that it is not feasible for (R2) to get a job in community..."<br><br>On 9/30/22 at 11:00 AM, (Nurse Practitioner note) wrote of R2 "Chief complaint/Reason for this visit: Attempted elopement...seen today by request of nursing staff...Per nursing staff, attempted to elope this morning. Per (R2), he was trying to 'get out of here and get a job.' Laughs and states, 'I got caught.' Understands this was not appropriate. Reports he is feeling well. Per nursing staff, has attempted this one other time. Was redirected with good response."<br><br>On 9/30/22 at 3:48pm, "(R2's) sister added that she removed all gym shoes from (R2)'s belongings and replaced with stiff bottomed slippers. She stated that she felt he would not try to go anywhere if he did not have any gym shoes. | S9999 | | |

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| S9999 | Continued From page 15<br>Writer made sister aware that (R2) was wearing gym shoes today."<br><br>On 2/11/23 at 4:15pm, V2 (DON) stated if R2 had a wander guard placed on 11/18/22, then there should have been an elopement risk assessment after that. V2 stated she disagreed with R2's Elopement Risk assessments from 1/19/23 and 2/11/23, adding R2's score should have been at least a 4 because he's an elopement risk and he wears a wander device.<br><br>(B) | S9999 | | |