STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007413	A. BUILDING: _____ B. WING _____	C 05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DEKALB	1212 SOUTH SECOND STREET DEKALB, IL 60115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2313530/IL159244	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 requirments are not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident with dementia and exit seeking behaviors was supervised and failed to ensure a service door was alarmed or monitored. These failures resulted in R1exiting the building through the non-supervised and non-alarmed door and was found approximately 0.3 miles from the facility by staff at a local school. This applies to 1 of 5 residents (R1) reviewed for safety/supervision in the sample of 5.

The findings include:

R1's face sheet shows she is a 61 year old female who was admitted to the facility on 12/6/2022. R1 has diagnoses including: Alzheimer's Disease, unspecified dementia, altered mental status, and adult failure to thrive. R1's active fall risk care plan initiated on 12/7/22 shows she is at risk for falls and requires the use of a wheelchair. R1's activity of daily living (ADL) care plan initiated 12/7/22 shows she requires staff assistance and a gait belt for all ADL activities.
R1's impaired cognition care plan initiated on

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S9999	Continued From page 2 12/7/22 shows she has short term and long term memory impairments and her decision making is impaired. R1's elopement risk/wanderer risk care plan initiated on 1/31/23 shows she is at risk for elopement due to dementia, she is disoriented to place, and exit seeking with an impaired safety awareness. R1's facility assessment completed on 1/31/23 shows her cognition is severely impaired, her gait is unsteady, and she requires the use of a wheelchair and 1 staff assistance with transfers. R1's Progress notes from her electronic medical record shows the following: 4/4/23- 1:08 PM, a social service note states, "Spoke with health surrogate pertaining to {R1's} need of a secure unit due to increased wandering and exit seeking." 4/7/23- 4:00 PM, a nursing note states, "This RN saw the resident from the nurses' station trying to get up from her wheelchair and walk by herself when she lost her balance and ended up falling. Resident reminded on the importance of using her wheelchair and not to walk alone without assistance." 4/10/23- 4:53 PM, a behavior note states, "The resident keeps standing from her chair, going out through the alarmed door, refusing and fighting back when asked to sit back on her chair. This resident needs a 1:1 care." 4/10/23- 10:22 PM, a nursing note states, "Resident wandered, walked without assistance and went from one resident's room to another. A CNA (Certified Nursing Assistant) has been assigned to monitor the resident." 4/11/23 1:00 PM, a behavior note states, "Resident had an episode of restlessness and agitation, upon entering other resident's room, trying to stand up on her chair and putting her at	S9999		

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risk to fall."
4/19/22 at 6:15 PM, a nursing note states, "This writer notes resident restless, anxious showing signs of aggression and elopement behaviors, she is at risk for hurting herself or harming other residents."
4/20/23 at 3:04 PM, care plan meeting note shows a care plan was held and states, "Also discussed elopement risk due to recent nicer weather and resident desire to exit facility."
4/21/23 at 10:33 PM, a behavior note states, " Resident started roaming around after dinner and tried to go out the exit doors twice."
4/22/23 at 12:36 PM, a psychiatric note states, "Patient appears mostly confused."
4/23/23 at 5:28 AM, a behavior note states, "She {R1} wanted to go out with her mum, she attempted going out twice."
4/24/23 at 5:21 AM, a nursing note states, "Resident has made requests to go out and smoke, go out for breakfast and believes the call light ringing is a phone."

A Wandering Risk Scale assessment was completed for R1 on 4/24/23 at 10:19 AM and shows she is at risk for wandering.
The facility's 15 minute monitoring sheets show R1 was started on 15 minute checks on 4/19/23. On 4/26/23 the 11:45 and 12:00 checks show R1 as "Missing."

An Elopement incident report was completed by V5 (Registered Nurse/RN) on 4/26/23 and shows at 11:50AM, V5 was alerted by a CNA {V10} that she could not find R1. The incident report states, "CNA notified this writer that {R1} is not at the nurses station. This writer went with CNA to check the resident's room and common bathroom where this resident usually also (go), but resident is nowhere to be found. Call the receptionists to

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initiate code pink to alarm all staff that the above mentioned resident is missing. All rooms were checked, and several staff went out to search for the resident. The resident was found at a park next to the facility."

On 4/28/23 at 1:10 PM, V8 (local school employee) said she was outside of the school on 4/26/23 (at around 11:56 AM), during a student recess period and noticed an elderly woman (later identified as R1) pushing a wheelchair on school grounds. V8 said at first, she thought the woman was a student's grandparent because a class field trip had just returned to the school. V8 said the woman was walking around by the door to the school, she saw another staff person go up and talk to her. A few minutes later the principle then came out and spoke to the woman and then went back inside the school. V8 said the woman (R1) then began walking again pushing her wheelchair down the sidewalk along the building. V8 said she started thinking something is not right, she went up to the woman and started talking with her and realized that the woman was very confused mentally and kept asking to go inside because she was cold and shivering. She said the woman also appeared unsteady while she was trying to walk. V8 said the woman was wearing a short sleeved shirt, no jacket, and it was a chilly day that day. V8 could not recall what footwear if any that the woman had on. V8 said she contacted inside the building to the principle and recommended that they call the nursing facility down the street to make sure they were not missing anyone. V8 said shortly after that (around 12:08 PM), 2 staff from the nursing facility came running towards them and confirmed the woman was a resident of the facility.

Google maps show from the middle of the facility

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to the main entrance of the local school that R1 walked to is approximately 0.3 miles and a 5 minute walk. On 5/1/23 the surveyor observed the route from the facility to the school. The school is on the same side of the street as the facility and there is a concrete sidewalk with several uneven (raised) areas. The school had multiple entrance doors and a playground in front of and to the side of the school.
Wunderground.com a weather history website shows the weather in Dekalb, Illinois on 4/26/23 at 11:55 AM, was 48 degrees and cloudy skies.

The facility's elopement risk resident binder show R1 is at active risk for elopement.

On 5/1/23 at 8:20 AM, V4 (Receptionist) said on 4/26/23 she was asked by several CNA's at the facility if she had seen R1 and she had not. The facility staff were not able to find R1, so a Code Pink was paged over head to alert all staff of a missing resident. V4 said R1 is a wanderer, and everyone knows you have to watch her close. She said it is presumed that R1 got out of the building through a service door that was not alarmed. V4 said she did not hear any door alarms go off around the time R1 left the facility. V4 said staff were all looking for R1 and then the local school called her to ask if they were missing a resident, so staff were alerted and went immediately to get R1.

On 5/1/23 at 8:50 AM, V6 (CNA) said on 4/26/23 at around lunch time she was getting another resident up and when she came out of that residents room the nurse was looking for R1 and asked if she had seen her. V6 said the nurse had been in the hallway passing medications so no one was directly observing R1. V6 said the last time she had seen R1 was approximately

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11:45-11:50 AM sitting in a wheelchair by the nurses station. V6 said the staff checked the north side of the building in resident rooms and bathrooms and they couldn't find her, so a Code Pink was called. V6 said she heard that R1 went out a service door that was not alarmed. V6 confirmed that no alarm went off around the time R1 exited the building.

On 5/1/23 at 8:35 AM, V7 (CNA) said on 4/26/23 she was assigned to resident showers, after giving a shower she observed the franticness between a nurse and a CNA looking for R1. She said the staff searched the north unit resident rooms and bathrooms and realized she was not there so they searched the south unit and could not find R1, so a Code Pink was called. V7 said staff went outside and began looking for R1. She was alerted that R1 was found at the school, and she ran as fast as she could towards the school where she found R1 walking and pushing her wheelchair. V7 said R1 is extremely confused and requires more frequent monitoring. V7 should not be walking without staff assistance she is not steady.

On 5/1/23 at 9:10 AM, V5 (RN) said on 4/26/23 he was doing his noon medication pass around 11:50 AM and was alerted by a agency CNA (V10) that she could not find R1. V5 said R1 was on 15 minute checks due to her behaviors and wandering. V5 said R1 had been seen by exit doors attempting to get out but this is the first time he is aware of that R1 successfully got out of the facility. V5 said the Code Pink was called around 12:00 PM after staff had searched both sides of the building without locating R1. He said V5 exited the building through a security door on the north side of the building that was not alarmed. R1 was found at the school and

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S9999	Continued From page 7 returned sometime around 12:05. On 5/1/23 at 9:30 AM, V3 (Maintenance Director) said all deliveries from vendors are made through either the front door or the service door which is down the hallway where the north dining area is. V3 said sometimes the door alarm to the service door is turned off while they carry in the deliveries, but a staff member should stay and monitor the door. V3 said after R1 exited the door it was found that the alarm to that door was turned off. He said only 4 facility personnel had a key to deactivate the alarm to that service door. V3 took the surveyor to the service door which is down the hallway towards the north nursing station and across from the dining area. The entry way consists of 2 sets of double doors. The interior doors are not alarmed but the second set of doors which lead outside had an alarm with a key code and box on the wall for a key to turn off or disable the alarm. V3 said he could not recall exactly what company had delivered supplies that day, but the alarm would have sounded if it was turned on. On 5/1/23 at 9:45 AM, V2 (DON) said she was alerted on 4/26/23 that R1 was missing from the facility. V2 said after R1 was found at the local school, V1 (Administrator) called an all staff meeting. It is believed R1 went through the service door that was not monitored or alarmed. V2 said R1 was on 15 minute checks due to behaviors and the facility believes R1 needs to be at a facility with a locked memory care unit. V2 said the service door should be monitored if the alarm is turned off. At 11:45 AM, V2 said that R1 had been having exit seeking behaviors for the past few weeks prior to her elopement from the facility.	S9999		

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S9999	Continued From page 8 On 5/1/23 at 11:45 AM, V10 (Agency CNA) said she was assigned to R1 on 4/26/23 and it was the first time she had worked with her. V10 was unable to recall times but said she check on R1 right before her lunch break and R1 was in her room. After her lunch break, she went to get R1 up and ready for lunch and she knew something was wrong because R1's shoes were there but R1 was not. V10 said she remained at the facility while staff were searching for R1. When R1 was brought back to the facility she did not have shoes on her feet. V10 said she was unaware of the service door alarm being turned off, but she did see a delivery truck outside at the time R1 was missing. On 5/1/23 at 12:02 PM, V11 (Medical Director) said R1 is very confused and is not safe to be out of the facility alone in her current condition, especially if she was not appropriately dressed. V11 asked the surveyor why the service door would be open and the alarm not on. On 5/1/23 at 10:26 AM, V9 (local school employee) said she had seen R1 on the cameras they have at the school, and she was on grounds for about 10 minutes or so. V9 said R1 was trying to enter the school because she was cold, and it was chilly out. V9 said a couple staff from the facility all spoke with R1 and then she called over to the nursing facility down the street from them to see if they were missing someone. She said the facility staff answered the phone and said, "oh my god you have her {R1}, we will send someone right over." On 5/1/23 at 1:33 PM, V1 (Administrator) said after R1 got out it was identified that a mattress company had been there delivering mattresses and the service door alarm they used to unload	S9999		

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S9999	Continued From page 9 the supplies was turned off. V1 said the alarm requires a barrel key to disable it and only certain staff have access to that key. V1 said the facility cameras do not record so the exact time R1 exited through the door is not certain. The facility's undated Elopement Risk Assessment policy states, "A Social Service Department will conduct the elopement assessment during the admission process, when there is a significant change in mood or behavior(s), and quarterly. 3. Should an elopement risk be determined; interventions will be immediately initiated to protect the resident in a reasonable manner and as approved by the physician. 6. The Social Service Department will notify facility staff and initiate interventions to protect the resident. Interventions include, however, are not limited to the following: relocation to secure unit, bed alarm and /or chair alarm, use sign in/out record, psychological consultation, personal alarm arm or ankle bracelet, 15 minute to 1 hour observations, one-on-one observation, behavior management." (B)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: APERION CARE DEKALB COMPLAINT #: 0159244
LIC. ID #: 0056150
DATE COMPLAINT RECEIVED: 04/27/23 14:11:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.