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	IL6008056	A. BUILDING: _____ B. WING _____	C 05/04/2023

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S 000	Initial Comments Complaint Investigation 2323544/IL159267	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3100d)2) 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. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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.	S9999		

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S9999	Continued From page 2 Section 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Noncompliance resulted in two deficient practices. 1. Based on observation, interview, and record review, the facility failed to provide supervision when an impulsive, confused, cognitively impaired resident exited the facility, failed to ensure the main front exit door's green release button was monitored at all times, and failed to notify police per facility policy for one of four (R1) residents reviewed for elopement in a sample of four. These failures resulted in R1 exiting the facility without a mobile device or staff knowledge and being placed at risk for injury. Findings include: The facility's undated Code Green (Elopement) policy documents "II. Elopement Definition: Elopement occurs when a resident leaves the premise or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold	S9999		

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exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. If the resident never leaves the sight of the facility staff this is not considered an elopement...Procedure: 3. "When the resident is found: b. The DON (Director of Nursing) or Administrator will notify the resident's representative and the police."

R1's Face Sheet documents R1 admitted to the facility on 3-31-23 with diagnoses including: Unspecified sequalae of Cerebral Infarction, Major Depressive Disorder, Anxiety Disorder, Anxiety and Agitation, Attention and Concentration deficit following Cerebral Infarction, Other Symptoms and Signs Involving Cognitive Functions following Cerebral Infarction, Other Abnormalities of Gait and Mobility, and Altered Mental Status.

The facility's incident report dated 4-15-23 by V1 Administrator, documents "Allegation Details: (R1) stated he was going to go and wait for his daughter, went to bus stop located at the top of hill. Found within 15 minutes with no injuries. Investigation Scope: (R1) interviewed, he let himself out of the building by pushing green button at front door. Receptionist had gone to lunch/break."

R1's BIMS (Brief Interview of Mental Status) evaluation, dated 4-4-23, documents R1 has moderate cognitive impairment with a BIMS score of 10.

R1's Minimum Data Set, dated 4-11-23, documents R1 requires limited assist with one-person physical assist for walking in corridor and for locomotion on and off the unit, is not steady and only able to stabilize with staff

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S9999	Continued From page 4 assistance for walking (with assistive device if used), and requires use of a walker. R1's Progress Note, dated 4-8-23 at 9:20am, documents, "Resident impulsive with transfers and leaving the room, entering hallway..." R1's Psychiatry Note, dated 4-12-23, documents, "Chief Complaint: Establish care and evaluate current treatment of depression and anxiety. Staff report intermittent impulsivity, agitation, yelling, threatening to hit staff." R1's Physician Note 4-13-23, documents: "Physical Medicine & Rehabilitation Evaluation. CC (Chief Complaint): Altered mental status... (R1) presented to the ED (Emergency Department) on 3/24 with altered mental status. Per ED notes, patient's family and home health nursing reported a slow decline in his mentation over the past 5-6 years, but over the past 2 weeks they have noticed a more rapid, significant decline." R1's Progress Note, dated 4-15-23 at 9:26am by V10 Registered Nurse/RN, documents, "Mental Status: Resident is alert and oriented x (times) three. Resident is confused. Current state of confusion is considered baseline for Resident. Level of Cognition Impairment: Mild (some confusion) ...Mood/Behavior: Agitation noted...Resident agitated about being in COVID isolation..." R1's Progress Note, dated 4-15-23 at 2:36pm by V10 RN, documents, "This nurse alerted that resident (R1) was not in room. Resident was located outside of building. Resident states that he went outside to wait for his daughter..."	S9999		

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S9999	Continued From page 5 On 5-2-23, at 11:52am, V8 Registered Nurse stated that recently when R1 was in isolation R1 would say (R1) was going to leave. On 5-2-23, at 3:07pm, V11 R1's family member/emergency contact stated, "I spoke to (R1) later that day. (R1) was out of their parking lot and up at the main bus stop. (R1) walks with a walker and is very unstable. (R1) put pants, shoes and a hat on. (R1) didn't take his walker with him. (R1) told me the day before 'I'm getting out of here.'" On 5-2-23, at 3:18pm, V10 Registered Nurse/RN stated the following: V10 last saw (R1) during medication pass around 9:30-9:40am. (R1) was grumpy because (R1) was in isolation. This was an on-going issue with (R1) leaving his room and needing re-directed. Around 11:15am (V12 Certified Nursing Assistant/CNA) went to check on (R1) said (R1) was not in his room. We called a code and looked all over...They found (R1) around 11:30am. (R1) had gotten across the parking lot and to the bus stop...No receptionist was at the front desk. (R1) told me (R1) let himself out...(R1) is confused." On 5-3-23, at 2:05pm V14 Receptionist stated the following: V14 was working at the front desk the day R1 got out. V14 was on break sometime between 11 and 12. V14 stated, "I went out to my car. When I came back in everyone was freaking out...(R1) was found and said to be at the bus stop." On 5-3-23, at 2:18pm, V12 CNA stated the following: V12 worked 6am-6pm the day R1 left the building. V12 saw (R1) at the nurses' station around 11. Shortly after that V12 noticed (R1) was not in his room. V12 automatically got people	S9999		

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looking. V12 jumped in her car. V12 went up the hill and (R1) was sitting on a bench at the bus stop. (R1) said that his time here was up...He had been trying to get out of the building for a while, and I'd heard he'd gotten out before but didn't get far. They already knew (R1) was trying to leave. (V14) Receptionist was on break. (R1) knew how to press the button.

On 5-3-23, at 2:30pm, V15 CNA stated that V15 walked up the hill to the bus stop. At this time V15 identified this bus stop on a map of the area. V15 stated, "I don't know how he made it up that hill. You can tell he's a bit confused when you talk to him."

On 5-4-23, at 3:50pm this surveyor drove out of the facility parking lot onto the road to the bus stop. At the top of the steep winding hill there was a bench at the identified bus stop. This area where R1 was found is approximately 300 feet away from the facility, next to a busy road with a speed limit of 35 miles per hour, and no visible sidewalks.

On 5-4-23, at 1:49pm, V16 Licensed Practical Nurse/ LPN stated the following: V16 came back from lunch around 11 and (V10 RN/R1's nurse) said (V10) couldn't find (R1). V16 called a code green and searched all rooms and courtyard. Then someone said (R1) was outside. V16 last saw (R1) maybe around 10:25am in his room. (R1) was wondering where his family was and if they were coming to see him that day...(R1) was home sick...(R1) was alert and oriented with some forgetfulness.

On 5-3-23 2:00pm V1 Administrator stated the following: (R1) told V1 that (R1) pushed the green button. The camera showed that (R1) did and that

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S9999	Continued From page 7 the Receptionist V14) was not at the desk. (V14) was on her break. On 5-4-23 at 11:24am, V1 Administrator stated that V1 got a call from V16 LPN that (R1) had left the building but was already found. (R1) had stated to (V16 LPN) that (R1) was done here, been here for two weeks. (R1) said (R1) was going to go get or see his daughter. They couldn't find him, but (V12 CNA) got in her car and found (R1) at the bus stop...V1 stated, "We did not call the police. The daughter would not have liked that and it is a dignity issue." V1 confirmed at this time that the facility's Elopement policy states to notify the police. 2. Based on observation, interview, and record review, the facility failed to ensure bed remote safety was in place for a confused, noncompliant, at risk for falls resident (R3) with known behaviors of readjusting the bed and failed to implement fall interventions for one (R2) resident of three residents reviewed for falls in a sample of four. This failure resulted in three repetitive falls for R3 with injuries to face and arm. Findings include: The facility's policy Fall Prevention Program, revised 1/23, documents, "Policy: To provide guidelines on preventing resident falls or injury...Action Steps: 1 Provide ongoing risk reducing interventions...3. Identify and implement related care link interventions. 4. Provide ongoing evaluation of resident response to interventions." The facility's policy Care Planning, revised 1/21,	S9999		

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documents "Purpose: To utilize the results of the comprehensive assessment to develop, revise and review resident's care plan. To provide a method for all staff to have needed information in caring for the residents...Responsibility: It is the responsibility of the staff to ensure that when providing care, the care plan information is utilized...Procedure: C. Approach/Plan: 1) List care to be provided for the problem listed. The care must be NECESSARY AND APPROPRIATE to accomplish goal stated. 2) Coordinate all care to be provided to the resident for the most effective, efficient utilization of resources. 3) Individualize care for the unique needs of the resident."

a. R3's Face Sheet documents R3 has diagnoses including Type II Diabetes Mellitus with polyneuropathy, Repeated falls, Weakness, and chronic kidney disease, stage three.

R3's Minimum Data Set/MDS assessment, dated 1-25-23, documents R3 requires extensive assist with two-person physical assist for bed mobility.

R3's Fall Risk Evaluations, dated 1-9-23 and 1-24-23, document R3 is at risk for falls with a score of 15.

R3's Fall Risk Evaluation, dated 4-13-23, documents R3 continues to be at risk for falls with a score of 10.

R3's Fall Investigation report, dated 1-14-23, documents, "Incident Description: Resident heard yelling from room, this nurse and CNA (Certified Nursing Assistant) went to check on resident, resident was lying on right side with head and foot off bed and with remote to bed in hand. Complete bed was tilted where head was up in air and feet

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completely lowered to the floor. Mats were in place but appeared that resident had pushed it towards roommates bed while trying to get up. Resident Description: Resident stated that he was trying to get up...Predisposing Physiological Factors: Confused...Root cause: (R3) was observed on the floor on the right side of his bed, his fall mats were in place but appeared to be pushed over towards residents side of the room...At time of incident (R3) was also noted to have his bed remote in hand with HOB (head of bed) all the way up and feet tilted down...Intervention: Air mattress removed due to skin resolved and scoop mattress place. Educate (R3) on importance of not pushing buttons on bed remote."

R3's Fall Investigation report, dated 2-8-23 and signed by V9 Registered Nurse/RN, documents "Incident Description: Housekeeping called this nurse into room because resident was laying on the floor. Resident was lying on left side off of fall mat with head against bedframe of B bed...Resident Description: Resident stated that he pushed the control on the remote to lift the bed up so that he could get up and then crawled out of the bed onto the floor and couldn't make it into his wheelchair...Predisposing Situation Factors - other info:...Raised bed up from low position as well...Root cause: (R3) observed by housekeeping staff laying on the floor on his left side off of the fall mat with his head against roommates bed frame. Resident stated 'he pushed the bed controls on the remote to lift his bed so he could get up and then tried to crawl to his chair'...Resident has history of repeated falls; he is impulsive and noncompliant. Intervention: Bed pressure alarm ordered."

On 5-3-23, at 12:38pm, V9 Registered Nurse/RN

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stated the following: "(V3 Assistant Director of Nursing/ADON) usually puts the fall interventions in place. (V3) added the intervention of bed pressure alarm. (R3's) bed remote is supposed to lock itself out after a minute or so. Two nurses have a key to unlock the remote to maneuver the bed. We give them (CNAs) the key and they give it back. They (bed remotes) are finicky. Most times they lock on their own otherwise you lock it yourself. Unsure why (R3's bed remote) was unlocked; I didn't give anyone a key. It will lock itself within a couple of minutes."

R3's Fall Investigation report, dated 4-29-23 and signed by V10 RN, documents, "Incident Description: Resident observed in bed with bed control unlocked, resident had raised HOB (head of bed) and 'crawled out of bed' onto the floor mat. Change of plane noted. Resident noted to have small bruise to left cheek, bruising to left upper arm, red mark to left upper arm. Blister to left shoulder...Attempting to get up for dinner. Resident Description: see above...Predisposing Environmental Factors: Furniture...Root Cause: (blank)...Intervention: ensure bed remote is in lock position when leaving the room."

On 5-3-23, at 3:30pm, V10 RN stated the following: (R3) said (R3) used the remote. The remote wasn't locked. (R3's) bed was low with mats down. (R3) got the remote and raised the HOB (head of bed) up and the whole bed was tilted up. discussed V3's fall on 4-29-23 - stated that R3 said he used the remote. The remote wasn't locked. We missed it. (R3) got the remote and raised the HOB up and the whole bed was tilted up. We have the keys and are supposed to lock it by scanning the bed remote. The CNAs ask us to unlock the bed remote to do cares. If I don't know if they have laid (R3) down, locking

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the remote back up gets missed...(R3) gets hold of the bed remote. It was a problem with (R3), that's why (R3) had a lock on (R3's) bed controller. The only way to lock it is to scan the key over the remote. The remote was to be kept outside the foot of (R3's) bed, but somehow (R3) could still get to it.

On 5-4-23, at 9:40am, V3 Assistant Director of Nursing/ADON stated the following: (V3) is the one who reviews the fall investigations and puts the interventions in place then it is discussed at team meeting. For (R3's) fall on 1-14-23, the root cause was (R3) having the remote and putting it (R3's bed) up...Putting the HOB (head of bed) up gave (R3) more leverage to push the mat away. So (R3) had a change in plane. Intervention was to remove (R3's) air mattress, put on a scoop mattress, and educated (R3) on pushing the remote. The education was to ask for assistance and verbal education not to push random buttons on it. (R3) didn't understand what (R3) was doing (R3) was just pushing the buttons. For (R3's) fall on 2-8-23, the root cause was (R3) having the remote to lift (R3's) bed and wanted to get up. Intervention was bed pressure alarm ordered...This intervention does not stop (R3) from using the bed remote. For (R3's) fall on 4-29-23, the root cause was (R3) raising the head of bed and crawling out of bed. (R3) was on the mat, but because the HOB was elevated, we treated it as a change of plane. Any change of plane is considered a fall. Intervention was to ensure (R3's) bed remote was in locked position once they leave the room.

On 5-4-23, at 3:04pm, V2 Director of Nursing/DON, stated the following: (R3's) bed remote had the potential to be locked; I don't know 100 % if ever locked. At this time, V2

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S9999	Continued From page 12 reviewed R3's fall investigations (1-14-23, 2-8-23, and 4-29-23) and confirmed that the root cause of (R3's) three falls was (R3) using the bed remote. (R3) was always wanting out of bed. V2 had no recall of talking with staff about placement of or locking (R3's) bed remote. (B)	S9999		