STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003511	A. BUILDING: _____ B. WING _____	C 05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments Complaint Investigation: 2394037/IL159870	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 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 allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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: Based on interviews and record reviews, the facility failed to provide adequate supervision for a cognitively impaired resident assessed to be at high risk for elopement and failed to ensure the resident did not leave the facility without staff knowledge or supervision. This failure affected one (R3) of four residents reviewed for elopement risk and supervision. This failure resulted in R3	S9999		

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leaving the facility unsupervised. R3 was found by a bystander. R3 had fallen on the ground and sustained a right facial contusion which required hospital evaluation.

Findings include:

R3 is an 87-year-old, female, initially admitted in the facility on 11/03/2018 with diagnoses of Mild Cognitive Impairment of Uncertain or Unknown Etiology; Anxiety Disorder, Unspecified; and Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.
R3's Wandering Risk Scale dated 03/16/23 scored 18.0 which means high risk to wander.
MDS (Minimum Data Set) dated 04/05/23 documented that R3's BIMS (Brief Interview for Mental Status) score was 4, which means severe cognitive impairment.

R3's Elopement Risk and Community Survival Skills Assessment dated 04/18/23 recorded the following:
7.) Recommendations: Elopement risk decision. The resident presently appears to be: d.) At risk to elope and should be placed on the elopement risk protocol. A care plan for elopement is indicated. e.) Comments - high risk

According to progress notes dated 05/14/23, R3 left the facility around 8:12 PM, unattended.

Facility's Incident report dated 05/15/23 documented that R3 was last seen in her room at 7:45 PM resting comfortably with no signs and symptoms of distress or behaviors noted. The incident also indicated that when she was found missing, code pink was called immediately in the

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facility and search was made. R3 was seen outside on sidewalk; and was sent to the hospital for evaluation.

Ambulance report dated 05/14/23, time stamped 7:55 PM, documented that R3 was found on the ground near a nursing home facility. She was seen a block away from the facility. A bystander stated R3 was crawling on the ground thus paramedics were called and R3 was then transported to the hospital.

Per hospital records dated 05/14/23, it was recorded that R3 was brought in by paramedics after she was found outside facility, on the ground on all fours. R3 was disoriented, believed she was in her home country. Physical examination findings revealed that R3 sustained right facial contusion. Her hospital diagnoses were fall, initial encounter and facial contusion. She was discharged to the facility on 05/15/23.

V3 (Registered Nurse/RN) was asked on 05/22/23 at 12:30 PM regarding R3. V3 verbalized, she is alert, ambulatory, speaks her native language but confused. She walks back and forth in the hallway, goes to other residents' rooms. We always redirect her. She wanders a lot. During the day, I didn't see her use or touch the elevator. Exit doors are all working, one on the end of each hallway. V4 (RN) also mentioned during interview, she wanders, we do monitor her. She is usually in the dining room and walks back and forth in the hallways. I don't think she knows how to use the elevator. I did not see her use the elevator, open exit doors, or use the stairs during my shift. I am not aware the exit doors are not working.

On 05/22/23 at 12:41 PM, R3 was observed in

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the dining room. R3 is ambulatory, able to verbalize needs but speaks foreign language. An interpreter is needed to communicate with R3. V20 (Activity Aide) acted as interpreter. R3 was asked what happened when she was found outside the facility and was brought to the hospital. R3 stated she does not know and doesn't remember any incident. Per V20, R3 has an impaired memory. R3 stated she goes from room to room to check up on something and arrange chairs and tables; picks up litter and puts aside television remotes. R3 said she does not know how to use the elevator. She also stated that exit doors have stop signs so no one can touch it and should not be used. R3 was also observed making several attempts to follow surveyor around but she (R3) was redirected by V20 to stay in the dining room.

During interview with V7 (Certified Nursing Assistant/CNA) on 05/22/23 at 2:57 PM, he stated that R3 does wander on the unit but normally stays in the hallway. V7 added, from my experience with her (R3), she did not try to elope, she stays in the dining room. But when the dining room empties out with residents, she starts pacing back and forth in the hallway. I have not seen her attempting to use the elevators or exit doors. Exit door alarms were working at the time. On 05/14/23, I saw her around 7:15 PM to 7:30 PM and she was in the dining room. I was the one supervising residents at the time. I took my residents to their rooms and V19 (Agency CNA) came to supervise them. Later, V2 (Director of Nursing/DON) told me that she was missing. And she (V2) called the code for missing person.

On 05/23/23 at 10:14 AM, V10 (RN) was also asked regarding incident on 05/14/23 regarding R3's elopement. V10 stated, on 05/14/23, I was

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working on the floor, but I didn't notice her that much because I was the floater that time.

On 05/23/23 at 11:24 AM, V2 (DON) was asked about R3's incident on 05/14/23. V2 stated, on 05/14/23, I worked on the third floor, 3-11 shift. I was the nurse assigned to R3 that time. From 3 PM to 7 PM, she was in the dining room, she had her dinner. At 7 PM, she went to her room and went to sleep early. Around 7:45 PM, she came to the nurses' station, I asked and figured out what she wants. I gave her water, and she took it then went back to her room. Around 8 PM, I was starting to do my medication pass. I passed by in her room and noticed she was not there. I called CNAs (V7 and V19). She (V19) was on the East Wing and V7 was at the nurses' station. We all started looking for her (R3), room to room and we couldn't find her on the unit, so I went to go outside the facility. When I came outside, by the parking lot, a police car was parked in front. So, I came back inside and asked police why they were here. The police showed me R3's picture to confirm if she was a resident in the facility and was told that she (R3) was on her way to the hospital. I don't know who called paramedics. I called the hospital emergency room to give reports and asked police to submit her (R3) paperwork to the hospital. She came back later to the facility during the 11 PM to 7 AM shift. I couldn't figure out how she got out of the building, it happened so fast. She ambulates very well. That time, it was me, V7 (CNA) and V19 (CNA) on the floor. I was not sure if V10 (RN) was on the floor or on the second floor. It was a busy day, there were a lot of visitors before dinner time due to Mothers' Day. It kind of slows down after dinner. There were other family members still visiting other residents on that West wing where she (R3) resides. V2 was also asked about what

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interventions are implemented on R3 for supervision. V2 replied, prior to this incident, she was not monitored every 15 minutes. During the day, we keep her in the dining room, and she sits there the whole time. In the evening, she goes to bed around 7-7:30 PM. We do frequent rounding - could be every 30 minutes or every hour. We do it by opening doors and check on residents or answer call lights. She (R3) never tried to open exit doors. But she can open exit doors. I have never had any episode of elopement on her (R3), but she is an elopement risk. She is redirected all the time since she goes to other residents' rooms. We keep her (R3) in the dining room for activities. She was assessed as high risk for elopement and was placed on the elopement risk protocol. According to the protocol, her risk factors are cognitive impaired individual who is a follower. She is very nice to strangers, and she follows them around. Sometimes, when other residents' family members come around, she follows them and talks to them. Another risk factor is inability to differentiate safe from unsafe situations due to her Dementia diagnosis. We don't provide personal alarm or ankle bracelet; we did not do the 15 minutes to one-hour observations; and one on one observation on her (R3) prior to incident. That incident on 05/14/23 happened so fast and I have no idea how it happened. I kept asking myself. She walks very fast.

On 05/23/23 at 10:35 AM, V13 (Social Services) was interviewed regarding R3 and elopement risk assessment protocol. V13 replied, we do the elopement assessment during admission and quarterly and anytime it happened. Assessing residents for risk factors for elopement and wandering. Once we identified a resident as high risk, we talk to IDT (interdisciplinary team) and let

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them know about the risk. Social Services do the care plan for elopement and wandering. Part of care plan interventions is to follow facility protocol. Facility protocol interventions includes faces of residents at risk posted by the staircase. Their faces are covered with paper, so staff must flip it to identify the residents. Other interventions include every 15-minute monitoring and a sheet for CNAs to sign; redirection; medications; activities; in services on staff about elopement. Everything on the elopement risk assessment protocol interventions should be implemented on each residents identified as wanderer including R3. R3 does not have an alarm on the arm but she should be provided with one on one. Usually, the one on one is implemented in the dining room that is why all residents high risk for elopement are placed in the dining area. After dinner time, residents are redirected to go into their own rooms. When they are in their rooms, one on one is still implemented by CNA or nurses who go to their rooms and make sure these residents stay in their rooms the whole time. CNA or nurses stay in residents' rooms also. R3 is alert most of the time but she does not remember things. She has a Dementia and confuse at times. She can go to her room by herself; use the bathroom by herself. She wanders around the unit, go to other residents' rooms and clean everything. She is ambulatory but unable to use the elevator or use exit doors and stairs. I have no idea how she got out of the facility. I was not working at the time it happened and off the following day too. I asked her on the day when I came back, and she does not remember. She was physically strong enough to push doors. Sometimes I went to her room, and I saw her pushing chairs and nightstands. I was assuming she was able to push exit doors and got out or that time it was Sunday and Mothers' Day, a lot of visitors came

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in the facility to visit other residents. She probably was able to join family in the elevator and got out. Door's alarm and at times, staff don't pay attention that much. She (R3) never eloped before. This was the first time. She wanders and talks to strangers/visitors. She is very nice to people, and she talks to strangers, always smiling, helping others.

R3's care plan documented the following:
Date initiated 02/07/23: Attempting to leave the facility without responsible escort (elopement) was identified: Interventions - Make room checks per facility protocol to minimize chance of unauthorized leave.
Date initiated 10/26/20: I am an elopement risk. I sometimes attempt to leave the facility without a responsible escort. I have a diagnosis of mild cognitive impairment and sometimes realize what I am attempting and sometimes not.
Interventions - Elopement risk; Staff will make rounds/room checks per facility protocol.

05/25/23 at 9:07AM V21 (Medical Director) was asked regarding R3 and prevention of elopement. V21 stated, "I was told she was missing and how it happened was because the alarm system was not working. You know, you can't easily leave the floor because it alarms. You can't easily use elevators because you need to do some forms of tricks to use it. You can't easily leave the first floor because door will alarm. We spoke to other staff to make sure all alarms are working. My expectations on staff in preventing elopement to occur from happening is if they hear any alarm, check where the alarm is coming from right away, faster. Notify supervisor and alert front desk. I was not sure if there was somebody at the front desk that time. When we discussed about R3 missing, I was told the alarm did not work that

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time. If it's not technical alarm issue, then once staff heard any noise, they need to listen and ask each other, and find out where alarm is coming from. Inspect and see, take time out to check where noise was coming from. Staff must also follow the interventions in the facility protocol regarding risk assessment in preventing elopement."

On 05/22/23 at 1:32 PM, V6 (Maintenance Director) was asked if there were issues regarding exit door alarms. V6 stated, in the months of February, March, April and May, there were no repairs pending for the exit door alarms on all floors in the facility. All exit doors alarm when opened. Daily maintenance records dated 05/11/23 to current showed that all exit door alarms are functioning properly.

Interview with V1 (Administrator) on 5/24/23 at 1:17PM, V1 confirmed that he is the person responsible for monitoring the facility camera surveillance videos. Surveyor asked to view footage of 5/14/23 - when R3 eloped from the facility and V12 (Regional Nurse Consultant/Registered Nurse) stated that they are not allowed to show video footage. V1 was then asked if he watched the video to determine how R3 left the building and he confirmed that he did. V1 was then asked to please walk surveyor along the path that R3 was seen leaving the building. At this time, V1 led surveyor up to the third floor and both surveyor and V1 walked out of the exit door on the 3west side of the unit. The door had a stop sign banner hanging across the door. V1 was asked when that was added to the door, and he did not remember. The alarm sounded off when the exit door was opened, as V1 and surveyor exited the door. It was noted that when the door closed behind, it did not shut all the way.

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It required to be pushed to catch the lock and close properly. Upon exiting the 3west door, it leads to a stairway that goes down to the first floor (ground level). V1 and surveyor walked out of the ground level door and ended up outside the facility, towards the back of the building. There were no exit alarms noted to go off when the door was opened, and it did not require any security codes to open. V1 was asked if anyone can just walk out this door and V1 said that life safety doesn't require that door to be alarmed. Upon walking out of the door, it was noted that there is a surveillance camera around the corner in the direction of the parking lot. V1 confirmed that he saw (via the camera footage) that R3 came around the back - meaning from the west exit door - so on the camera he saw her walking past the front entrance on over to the sidewalk and that was as far as he could see from the camera.

On 5/25/23 at 10:45AM, V1 (Administrator) informed survey team that on yesterday afternoon maintenance installed an alarm doorbell on the ground level exit door on the west side of the building - which is the door that R3 exited the facility from. Surveyor confirmed that the door was alarmed at that time.

Facility's policy titled, "Elopement Risk Assessment", undated, documented in part but not limited to the following:
Purpose: to identify residents who may be potentially at risk for elopement and at risk for harm. To use as a baseline to maintain a secure resident environment.
Procedure:
6. The Social Service Department will notify Facility Staff and initiate interventions necessary to protect the resident. Interventions include, however, are not limited to the following:

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S9999	Continued From page 11 e. Personal Alarm Arm or Ankle Bracelet f. 15 minute to 1-hour observations g. One on one observation "A"	S9999		