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	IL6000970	A. BUILDING: ______ B. WING ______	C 08/13/2024

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CASEY HEALTHCARE CENTER	**100 N.E. 15TH CASEY, IL 62420**

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S 000	Initial Comments	S 000		
	Complaint Investigation 2465961/IL176151			
S9999	Final Observations	S9999		

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

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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.

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.

Section 300.3100 General Building Requirements

d) Doors and Windows

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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.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide supervision of a severely cognitively impaired resident, with a history of elopement, to prevent the resident from leaving the facility unnoticed and unattended. Due to R1's frontal lobe dementia, V20 physician stated (R1) could have been hit by a car, fallen and obtained a fracture, or been injured in a multitude of ways. This failure affects one (R1) of three residents reviewed for supervision.

Findings include:

R1 was admitted to facility on 3/14/24. R1's Electronic Medical Record (EMR) documents medical diagnoses as Dementia, Major Depressive Disorder, Altered Mental Status, Cognitive Decline, Colostomy Status and history of Cerebral Vascular Accident (CVA) and Chronic Ulcerative Enterocolitis.

R1's admission Minimum Data Set (MDS) dated 3/21/24 documents R1 as severely cognitively impaired. This same MDS documents R1 as independent in transferring and ambulating.

R1's Elopement Evaluation dated 3/21/24 documents R1 as high risk for elopement.

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R1's Social Service Progress Note dated 3/21/24 documents "(R1) has a behavior of exit seeking but is able to be redirected." R1's Medical Record does not include any further social service progress notes.

R1's Care Plan dated 3/25/24 documents R1 has wandering behavior and may demonstrate a risk for leaving unattended/elopement due to Altered Mental Status. R1's Care Plan documents an intervention dated 3/25/24 for R1 to have every 15 minute checks. R1's Care plan was first updated on 7/29/24 to include an intervention for staff to monitor R1 at all times when off the Dementia unit.

R1's Physician Order Sheet (POS) dated August 2024 documents a physician order dated 7/29/24 of "(R1) not to leave facility unless with staff or Power of Attorney (POA) for appointments per POA, (V17)." This same POS documents a physician order to start Aspirin 81 milligrams (mg) daily.

R1's Nurse Progress Notes document on:

3/23/24 at 9:45 PM "(R1) exited the facility via the service door. (R1) was harder to redirect than the other four times. Semi combative. (R1) was assisted by staff to her room."
5/21/24 at 7:00 PM "(R1) exit seeking. (R1) went out the front door and over by the trees on our property. Redirected back inside."
5/27/24 at 8:00 PM "(R1) exited the building two times with more attempts."
6/1/24 at 6:50 PM "(R1) exited out the Northwest service door. Easily re-directed back into the building."
6/16/24 at 'evenings' "(R1) in and out of the South

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(Dementia) unit. (R1) did exit the building one time."
6/18/24 at 5:00 AM "(R1) adamant to exit the south hall door. (R1) did get out the front door, exiting the building. (R1) is very swift. Escorted back inside with some difficulty."

The facility Investigative Report of Missing Resident dated 7/29/24 documents R1 alert and oriented times one, ambulates independently and eloped from the facility on 7/28/24. This same report documents "Family of (R1) called facility to notify (facility) of location (of R1). This same report documents R1 was found at V17 (R1's daughter) house.

R1 left the facility unnoticed and unsupervised, at night, after dark in extreme heat and high humidity. R1 walked to a family member's house approximately 11 blocks (0.9) miles from the facility, crossing multiple streets, near a highway/culverts/guardrails/deep ditches.

The public website titled www.timeanddate.com documents the high temperature for 7/28/24 was 85 degrees with 88% humidity.

On 8/6/24 at 2:00 PM V15 Certified Nurse Aide (CNA) stated, "I pushed the code into the door alarm on the Dementia Unit so that (R1) could go out into the main nursing home and sit on the couch. We (staff) do that all the time. I didn't know (R1) was supposed to be supervised when she was off the unit. (V16) CNA and I decided at around 7:30 PM that V16 CNA could go on lunch since it was so quiet on the hall. Right after (V16) left for break, residents started getting up and it became very busy. I didn't check on (R1) or let any other staff know she was sitting alone out there. I guess I should have." V15 stated when

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R1 returned to the Dementia unit, she continued to pace up and down the hallway.

On 8/2/24 at 2:45 PM V10 Licensed Practical Nurse (LPN) stated R1 eloped from facility the evening of 7/28/24. V10 LPN stated R1 was sitting on a couch in the resident lounge area of the main nursing home about 7:30 PM prior to her eloping. V10 stated R1 resides on the alarmed Dementia unit and does occasionally wander through the main nursing home area unsupervised. V10 LPN stated V16 Certified Nurse Aide (CNA) had left the Dementia Unit at 7:30 PM and saw R1 sitting on the couch as she walked by to go to a break. V10 LPN stated it was reported to V10 that no other staff were present with R1 and that V16 did not stay with R1 nor report to anyone that R1 was not being monitored. V10 LPN stated R1 has a long history of 'escaping' the facility. V10 LPN stated R1 has been known to watch staff punch in the alarm codes, wait for the area to clear and then let herself out of the alarmed doors without the alarms sounding. V10 LPN stated the door alarms had not sounded that evening prior to R1 being reported as missing. V10 LPN stated, "(R1) has eloped from the facility multiple times before 7/28/24 due to the lack of supervision and (R1) being very sneaky." V10 LPN stated, V16 CNA reported to V10 LPN at 8:30 PM that R1 could not be located. V10 LPN stated, "I took off on foot looking around the outside of the building. It was so hot that night. It was dark out by the time we (facility) realized (R1) had eloped. There were dozens of people searching for (R1) including the police, emergency medical services (EMS), off duty facility staff, community neighbors and the facility staff. We (staff and volunteers) searched all over for her. I came across a couple walking their dog and they helped look for (R1)

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also. I walked about five blocks and then had to come back to the facility because it was miserably hot outside. My clothes were drenched. I don't know how (R1) ever made it as far as she did without passing out. (R1) had just gotten back from the hospital earlier that day for a Small Bowel Obstruction. (R1) was found by her family through (V17's) (R1's) family member's home camera system. (V17) notified the facility of (R1's) whereabouts and then we went to go pick her up. (V17) told us to hurry up and go get her because she was with (V18) (R1's) family member and (V18) did not know how to deal with (R1). (V17) stated 'you never know what (V18) will do'. I called (V2) Director of Nurses (DON) at 9:09 PM after (V17) reported (R1's) whereabouts and then (V2) and I went to get (R1). When (V2) Director of Nurses (DON) and I got to (V17's) house, (R1) looked hot and tired. (R1) looked exhausted. (R1's) face was red and somehow her colostomy bag had come off and she was just a mess with BM (bowel movement) all over her."

On 8/6/24 at 9:30 AM V2 Director of Nurses (DON) stated R1 admitted to facility on 3/14/24. V2 DON stated R1 has exited the facility and left the property 'multiple times' prior to 7/28/24. V2 DON stated R1 was supposed to be on 15 minute checks since admission. V2 DON stated, "I got the call from (V10) Licensed Practical Nurse (LPN) at 8:30 PM stating (R1) could not be located. We (facility) started a search throughout the building and could not find (R1). There were a lot of people out on the streets looking for (R1). (R1's) family (V17) was the one who called the facility and let us know where (R1) was. I believe (R1) was back inside the facility at 9:30 PM. Otherwise, we would still be looking for (R1). (R1) had left the building so many times before that night, I think she knew right where to go." V2

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DON stated no resident should be allowed off the Dementia Unit without staff monitoring them. V2 DON stated, "The reason why people have to stay back on the Dementia Unit is because they don't know any better. We (facility) are supposed to keep them safe. (R1) is a tough one because she is alert, ambulatory and determined to leave. (R1) gets physically aggressive when staff try to re-direct her but that is our (facility) problem to solve. We have to do better or (R1) is really going to get hurt." V2 DON stated R1's care plan had not been updated since her admission. V2 DON stated, "We (facility) have talked about (R1's) exit seeking and previous elopements in morning meeting but that was never brought back to the staff. The staff rely on the care plan to be able to know what interventions to use. If the care plan is not updated, then the staff have to rely on word of mouth and that is not always accurate."

On 8/6/24 at 10:20 AM V1 Administrator stated, "(R1) has Frontal Lobe Dementia and really does not belong in our facility. (R1) is too much risk due to her being so mobile, having very poor safety awareness, Dementia and being sharp enough to be able to obtain the codes to the security doors on the Dementia unit. The night (7/28/24) (R1) eloped from the facility, R1 was sitting on the couch unattended by staff out in the main area of the nursing facility. We (facility) aren't even sure which door (R1) exited from. (R1) is quick. The staff had previously been in serviced on the need to always have two staff members on the Dementia unit at all times. That night there was one nurse (V10) Licensed Practical Nurse (LPN) and two (V15, V16) Certified Nurse Aides (CNA) on that unit. (V10) was on another hall and the two CNA's (V15, V16) were supposed to stay on the Dementia

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Unit. Apparently, V16 CNA left the hall to take a break which left V15 CNA on the hall by herself. That is when (R1) eloped. (R1) was supposed to be checked on every 15 minutes and wasn't. (R1) has been on 15 minute checks since she admitted. There is no reason my staff shouldn't have done those. (R1) gets confused every time she leaves the facility. (R1) had just came back from the hospital that day due to having a Small Bowel Obstruction. That paired with the fact that (V17) was on vacation, I think (R1) was even more adamant on leaving the facility."

On 8/6/24 at 1:50 PM V20 Medical Director stated, "There was failure from the facility to maintain the safety of (R1). The facility policies and Centers for Medicaid and Medicare Services (CMS) regulations were not followed." V20 stated, "In a general statement, anything could have happened to (R1). (R1) could have been hit by a car, fallen and maybe obtained a fracture, or been injured in a multitude of ways. If there was adequate staff the night in question, the facility did not supervise (R1) as she needed to be and therefore (R1) eloped without the knowledge of the staff."

On 8/7/24 at 1:40 PM V23 Nurse Practitioner stated, "(R1) has a very specific type of Dementia with Frontal Lobe involvement. I have met with (R1) several times and can say that (R1) should not be allowed outside of the Dementia unit unsupervised. (R1's) Dementia would prevent her from being able to make safe decisions. (R1) should not be walking unsupervised off the facility property. (R1) has a higher risk than others due to her Dementia and impulsivity." V23 NP stated R1 is not able to make sound, safe decisions without the assistance of staff. V23 stated R1 could have been injured from falling, hit by a car,

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or tripped due to her shuffling fast pace. V23 NP stated R1 could have had heat related symptoms like a heat stroke due to her being unable to recognize those symptoms due to her Dementia.

On 8/7/24 at 3:10 PM V24 Director of Psychiatry program for facility stated V24 is familiar with R1. V24 stated R1 should never be allowed to be unsupervised when out of the alarmed Dementia Unit. V24 stated, "There are not only environmental factors that (R1) may be injured from while walking outside of the Dementia Unit but (R1) has what you call 'excitable agitation.' (R1) has increased agitation with verbal and physical aggressive behaviors when anyone attempts to redirect (R1). If (R1) were out in the community by herself and came across another person who attempted to redirect (R1) that would most likely agitate (R1) and the other person may respond negatively to that interaction possible creating harm for (R1) from a physical altercation. (R1) has impulsivity along with very poor judgement and decision making efforts. (R1) thinks like a small child with no impulse control. (R1) would have significant risk of harm due to her aggressive behaviors related to her Dementia."

On 8/2/24 at 1:10 PM V9 (R1) Power of Attorney (POA) stated R1 left the facility on 7/28/24 without any staff aware of her elopement. V9 POA stated, "My other sister (V17) lives about a mile from the facility. (V17) normally visits regularly and takes (R1) back to her house. (V17) has cameras at her house and that is how we found (R1). (V17) saw (R1) on the front porch of (V17's) house. (V17) then called (V18) (R1's) family member to go over to (V17's) house and I called (V10) Licensed Practical Nurse (LPN) to let the facility know where (R1) was. I don't believe

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(R1) was badly hurt at all. (R1) has escaped that facility lots of times but this is the furthest she has gone. I don't know what we are going to do with (R1). The staff know (R1) leaves all the time and can't seem to stop her. Maybe they (staff) need more training or something. They (staff) are trying but I want (R1) to be safe too."

On 8/2/24 at 10:25 AM V7 Maintenance Director stated the alarms are not checked on the weekends so there is no way to know if the alarms were working on the weekend R1 eloped from facility.

On 8/2/24 at 2:06 PM V14 Certified Nurse Aide (CNA) stated, "(R1) tried to leave the unit all the time. (R1) sits out in the main resident lounge area off the Dementia unit. The staff out there are supposed to keep an eye on her. I don't know how much good that does since (R1) knows the codes to the doors."

On 8/2/24 at 10:17 AM R1 was walking up and down the hallway on the Dementia unit. R1's room is located at the end of the hall directly next to the exit door. R1 walked up to exit door on the Dementia unit and attempted to push the door open.

On 8/6/24 at 11:30 AM R1 was pacing the hall of the Dementia Unit. R1 pushed another resident in a wheelchair out of her way to get to the exit door. R1 opened the exit door slightly as staff redirected R1 away from the door.

On 8/7/24 at 2:25 PM R1 pushed a heavy wooden chair out of her way in the hallway to walk up to the exit door on the Dementia Unit. R1 attempted to open the door as staff redirected R1.

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