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	IL6009815	A. BUILDING: _____ B. WING _____	C 08/08/2024

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APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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S 000	Initial Comments Facility Reported Incident of 6-18-24 IL176050	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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	S9999		

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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.

These requirements were not met as evidence by:

Based on observation, interview, and record review the facility failed to supervise a known elopement risk resident and complete wander guard tests to ensure a wander guard was working for 1 of 5 residents (R1) reviewed for supervision in a sample of 5. This failure resulted in R1 eloping from the facility, falling down three steps onto asphalt in R1's wheelchair, and sustaining a laceration to the head requiring sutures.

Findings include:

1. R1's face sheet documented an admission date of 6/30/21 with diagnoses including: dementia, hypertension, atherosclerotic heart disease, type 2 diabetes mellitus, hyperlipidemia, presence of cardiac pacemaker.

R1's 7/8/24 Minimum Data Set (MDS)

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documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment.

R1's care plan documented an initiated 8/30/23 focus area documenting in part " ... I am an elopement risk/ wanderer due to exit seeking, Resident wanders aimlessly ..." and an initiated 7/6/21 focus area documenting in part " ... I am at risk for fall/ injury (related to) wandering and poor safety awareness ..."

R1's Order Summary Report documented an 8/6/23 order for Wanderguard (elopement alert device) check function on dayshift every Sunday.

On 7/26/24 at 1:04 PM, V5 (Certified Nursing Assistant/ CNA) said she was caring for R1 during the night of 6/17/24 to 6/18/24. V5 said the facility was short staffed on the night of 6/17/24 to 6/18/24 and V5 and V4 (Licensed Practical Nurse/ LPN) were the only two staff working on R1's unit. V5 said R1 had been in R1's wheelchair ambulating around the facility. V5 said V6 (CNA) arrived at the facility at 2:00 AM. V5 said she was giving V6 report when V6 asked where R1 was in the facility. V5 said after looking around V4, V5, and V6 started a facility wide search. V5 said at approximately 2:36 AM, R1 was found lying in the parking lot in a pool of blood with R1's wheelchair on top of R1. V5 said R1 had fallen down three concrete steps in R1's wheelchair. V5 said the doors leading to the loading dock, where R1 fell, were usually locked but the locking mechanism was not working. V5 said there was no wanderguard alarm sounding and there was no other alarm on the loading dock doors. V5 said prior to the 6/18/24 incident R1 had exit seeking behaviors but R1 had never managed to get out of the facility.

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S9999	Continued From page 3 On 7/30/24 at 9:11 AM, V4 (LPN) said she was the nurse caring for R1 on the night shift from 6/17/24 to 6/18/24. V4 said she was sitting at the nurse's station charting at approximately 2:30 AM when V5 (CNA) and V6 (CNA) alerted her R1 was missing. V4 said she assisted V5 and V6 with a facility wide search for R1. V4 said at approximately 2:36 AM, V4 was called to the loading dock doors by V5 and found R1 to have fallen down three concrete steps in her wheelchair and was lying in a pool of blood with R1's wheelchair on top of R1. V5 said she could not recall if R1 was lying on R1's back or side but R1's "head was busted and bleeding quite a bit." V5 said she immediately called Emergency Medical Services (EMS) to transfer R1 to the hospital for further evaluation. V5 said she was not sure if R1 had a wanderguard on 6/18/24 at the time of this incident but was sure the wanderguard alarm was not sounding. V5 said the door to the loading dock had malfunctioned at the time of the incident on 6/18/24. V5 said when exiting the building a button was pushed to unlock the door and a code had to be entered to unlock the door from the outside but during this incident she and other staff had went out of and back in the door without having to push any buttons or enter any codes. On 7/30/24 at 11:09 AM, V7 (Maintenance Director) said he hadn't received any work orders pertaining to the loading dock doors locking mechanism or the wanderguard system not functioning at the loading dock doors. V7 said prior to R1's 6/18/24 incident the facility did not have any logs of checking the wanderguard alarming system at points of exit in the facility. V7 said he did not have any logs of checking door locking mechanisms and was unsure how often	S9999		

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the locking mechanisms were to be checked. V7 said he was not sure who was responsible for checking door locking mechanisms.

On 7/30/24 at 11:25 AM, V7 measured the height from the top of the loading dock platform to the asphalt pavement, where R1 fell, to be 24.5 inches.

On 7/31/24 at 2:29 PM, V9 (Physician) said he was familiar with R1. V9 said prior to R1 being moved to the locked unit in the facility it was possible R1 was an elopement risk. V9 said he expected the facility to follow their policy for checking wanderguards. V9 said he expected the facility would have a system in place to keep residents from eloping and the facility should follow their protocol.

R1's 6/18/24 hospital record documented in part " ... EMS states: (R1) eloped out the back door of (skilled nursing facility) and fell down 3 stairs causing trauma to the right side of (R1's) head .... Significant swelling noted to (right) eye. Multiple abrasions to right side of face with one deep laceration/ avulsion to the right forehead that is still bleeding a light amount. Moderate amount of clotted blood present in hair/ on wounds. Unknown if (R1) lost consciousness or not. According to EMS (R1's) cognition is at baseline ... wound repair of 6 (centimeter) ... subcutaneous laceration to face. Irregularly shaped .... Skin closed with 16 4-0 Ethilon using simple sutures ..."

R1's 6/18/24 reportable incident investigation folder contained 3 written statements by V4 (LPN), V5 (CNA), and V6 (CNA).

V5's (CNA) 6/18/24 statement documented in

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part" ...Around midnight (R1) was sitting on the side of the bed. I know she is a fall risk, so I asked her if she wanted to get up and she did. I placed her in her (wheelchair). She was moving about and I redirected her from other hallway and brought her back to sit by the birdcage. I last seen her sitting at the birdcage. I gave report and went and answered a call light. (V6) asked where (R1) was. We did not immediately see her so we began to search the building. I heard a voice out the dock doors as I was down that way looking. (V6) and I opened the door and (R1) was on the parking lot face down with her (wheelchair) on top of her. We called for help. Nurse came. EMS came. That was about 2:36 AM when we seen the resident ..."

V6's (CNA) 6/18/24 statement documented in part " ... I arrived to work at 2 AM. I received report from (V5). I then heard a call light going off. So (V5) and I went to assist that resident. As I was walking back up the hall I looked toward (R1's) room and noticed she was not in there. (V5) and I immediately began to search the building for her. After 2 passes we informed the nurse (V4) that there was a missing resident. (V5) was down the back hall near the dining room and she thought she faintly could hear something outside. We pushed the door open and seen (R1) down the 3 stairs onto the parking lot in a pool of blood. I opened the door back up and got the nurse to come. (R1) was face down with her (wheelchair) on top of her ... Did the door open when you pushed the buttons to get in and out? No all I had to do was open door several times. No code needed ..."

V4's (LPN) 6/18/24 statement documented in part " ...at about 2:30 AM I was at the computer charting. The 2 CNA's informed me that they

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could not find (R1) after looking for her in the building. I immediately got up to help with the search. I went down the halls toward therapy (department) and started to walk back up toward the nurse station when I noticed the CNA down the other hall by the dining room waving her arms for me to come. I seen resident lying on stomach and noticed a head injury. I immediately assessed resident. Splinted head (and) neck with a blanket to limit movement and called 911. EMS transported resident next door to hospital ..."

The facility's revised 9/13/19 Elopement Device policy documented in part " ... Purpose: To establish procedures for ensuring personal elopement devices are used in accordance with identified risk, physician orders and to ensure the security system is inspected to identify malfunctions should they occur ... Procedure: 1. Elopement alert devices will be used as an interventional tool to prevent resident elopements ... 3. The elopement alert exit door device will be inspected for proper working and documented by nursing ... 5. The ankle or bracelet device will be inspected by nursing personnel at least once each day by: a. Inspecting the location of the device on the arm or leg. b. Placing the transmitter tester near the anklet or bracelet to test the battery for proper working order. 6. In the event the test reveals a malfunctioning personal elopement device, the device will be removed and replaced ..."

The facility's undated Preventive Maintenance and Inspection policy documented in part " ... In order to provide a safe environment for residents, employees, and visitors, a preventative maintenance program has been implemented to promote the maintenance of fixtures and equipment in a state of good repair and condition

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S9999	Continued From page 7 ... The following are recommended guidelines and may be revised or adjusted as indicated by the individual needs of the facility or according to facility policy ... Inspections checklists are developed for at least ... the building ... exterior inspection will be conducted and documented weekly ... interior inspections will be conducted and documented weekly ... building inspection includes at a minimum ... electronic doors ... alarms are calendared on the routine inspection checklists on a weekly basis. Alarms are inspected to verify that they are in working order and are calendared for inspection in accordance with manufacturer's specifications ..." (B)	S9999		