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S 000	Initial Comments Investigation of Facility Reported Incident of 9/20/24/IL178747 Investigation of Facility Reported Incident of 9/19/24/IL178757	S 000		
S9999	Final Observations Statement of Licensure Violations 1 OF 2 300.610a) 300.1210c) 300.3210t) 300.3240b) 300.3240c) 300.3240e) 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	S9999		

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements were not met as evidence by:

Based on interview and record review, the facility

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failed to protect residents from sexual abuse and failed to investigate allegations of potential abuse to prevent further sexual abuse for 2 of 5 residents (R3, R4) reviewed for abuse in the sample of 15. This failure resulted in R4 displaying sexual behaviors towards R3, including fondling her breasts, placing his hand in her pants and R3 and R4 observed in R4's room, both with their pants and underwear down and R4 kneeling in front of R3. R3 and R4 have moderate cognitive impairment and the inability to consent to sexual relations.

Findings include:

The Facility Reported Incident, dated 9/20/24, documents that on 9/19/24 at 8:00 PM, an allegation of a resident-to-resident altercation involving R3 and R4 was made. The initial and final report dated, 9/20/24, documents that R3 and R4 both have a diagnosis of Dementia and have POA (Power of Attorney) decision makers. The Incident report documented R3 and R4 have been in a "relationship", holding hands, kissing, staff encouraged to keep out of each other's rooms. On 9/19/24, R3 was noted in R4's room with pants down and R4 "on top" of R3. Both POAs made aware. Both are okay with the relationship if consensual. Care plan updated.

R3's Face Sheet, undated documents R3 has the following diagnosis: Other Symptoms and Signs Involving Cognitive Functions and Awareness, Major Depressive Disorder, Amnesia, and Altered Mental Status.

R3's MDS (Minimum Data Set), dated 7/1/24, documents R3 has a BIMS (Brief Interview for Mental Status) score of 8, indicating R3 has moderate cognitive impairment.

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R3's Care Plan, dated 7/23/24, documents the following: Resident is exhibiting problems as seen by cursing, hitting, grabbing others, rummaging, making disruptive sounds, screaming at others, wandering, looking for a boyfriend-has a relationship with another male resident. POA aware. There are no interventions in place to prevent R3 from sexual abuse or acts.

R3's Abuse Screener, dated 9/24/24, documents that R3 is at risk for abuse and care planning is required.

R3's Progress Note, dated 7/31/24 at 3:13 PM, documents the following: (V15, R3's Daughter) was notified that resident has been going in and out of men's rooms and will rub their legs or shoulders. Informed her that one of the male resident's entered her room and CNA (Certified Nurse's Assistant) observed him with his hand down her shirt. He was immediately removed from her room. Daughter informed of room move to (new room). Daughter's only response was "ok, thank you."

R3's Progress Note, dated 7/31/24 at 3:36 PM, documents the following: Administrator notified of situation with male patient earlier.

R3's Progress Note, dated 8/28/24 at 2:12 PM, documents the following: Resident sitting in common area prior to lunch time, resident had sexual behaviors with a male resident, this was reported to this nurse from activity department. Administrator aware, she is care planned with this type of behavior and is to be in common area with conversation with a male resident. SSD (Social Service Director) has had conversation with POA about this behavior prior. Resident is resting in

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bed at this time, her mood is pleasant.

R3's Progress Note, dated 8/31/24 at 2:58 PM, documents the following: Resident had sexual behaviors with another male resident this shift, she was in common area near nurses' station or resting in bed. PRN (As Needed) Ativan administered after lunch due to resident paranoid and yelling at nursing staff to quit talking about her. She was up in wheelchair for meals, appetite and fluid intake fair. She had to be redirected multiple times this shift due to following male resident in hallways. She is A&O (Alert and Oriented) times 1. Still awaiting return call from POA. She agitated and yelling at roommate for her treatment being on at night and not getting along. Administrator has been notified of her not getting along with roommates.

R3's Progress Note, dated 9/19/24 at 6:40 PM, documents the following: Notified (V16, R3's Daughter) that (R3) was in (R4's) recliner with her underwear and pants down, and (R4) was on top of her with his pants off. (V16) said she would notify her sister.

R3's Progress Note, dated 9/20/24 at 10:34 AM, documents the following: Family called and made aware of event that happened with another resident. Family is ok with the situation as long as resident doesn't mind. R3 considers the other male resident (R4) her boyfriend. Staff will continue to encourage them to remain in public and not alone.

R3's Progress Note, dated 9/26/24 at 8:17 PM, documents the following: Resident found in males' room on the floor. They both had their pants down. They were assisted up and separated. Resident is on fall precautions, she is

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confused and stands up to walk back to male's room. They are closely monitored, but they find a way.

R3's Progress Note, dated 9/28/24 at 3:41 PM, documents the following: 11:30 AM, called to dining room from dietary staff. Reported another male resident had his hand down in her pants touching her. Upon entering, seen male resident remove his hands from her pants. She was removed from the situation and taken back to her room. Resident upset and voiced "that's my husband, why can't we be together." Resident redirected, no trauma present. Body assessment completed as much as possible, no areas of concern noted. Resident did not want this nurse to assess skin. Administrator notified via phone, she voiced to have residents eat in separate dining rooms. 11:48 AM, On Call MD (Medical Doctor) notified, NNO (No New Orders) received. 11:50 AM, POA notified by phone, left VM (Voicemail). She did return call at around 12:45 PM and was notified of above sexual encounter, she voiced understanding, notified resident will try to be separated from other male resident.

R3's Progress Note, dated 9/28/24 at 10:27 PM, documents the following: Resident attempted to go to males' room, she tries to stand and walk, She punched this nurse in the stomach and scratched my arm which needed cleaned and a band aid applied. Male resident comes looking for her and they have sexual behaviors and then he goes to his room and wants nothing to do with her till their next sexual encounter. Female resident is hard to redirect and gets very physical and aggressive.

R4's Face Sheet, undated, documents R4 has the following diagnosis: Senile Degeneration of

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the Brain and Dementia.

R4's MDS, dated 9/6/24, documents R4 has a BIMS score of 8, indicating he has moderate cognitive impairment.

R4's Care Plan, dated 8/5/24, documents the following: Resident exhibiting problems as seen by wandering, pacing, public sexual acts self-directed, sexually inappropriate behavior toward others; has a relationship with another female resident. POA aware with an intervention that R4 is not allowed in room alone with a female resident.

R4's Progress Note, dated 7/31/24 at 3:28 PM, documents the following: Resident's daughter in law notified that resident was observed in a female's room with his hand down the front of her shirt. Informed that resident was immediately removed from the situation and taken back to his room and instructed him that he could not go back into her room or another female's room. Informed that the female was moved to a different hall. POA states, "Oh my, I just can't believe this-this does not even seem like him at all." POA states she will be in tomorrow to speak with resident. Administrator has been informed of above aforementioned also.

R4's Progress Note, dated 8/4/24 at 2:57 PM, documents the following: Patient is attempting to get another female patient to come into his room. Patient redirected to his room at this time.

R4's Progress Note, dated 8/5/24 at 2:58 PM, documents the following: Patient educated on not provoking female patients to follow him to his room. Educated on other patient having dementia and not being able to make decisions on her own.

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R4's Progress Note, dated 8/18/24 at 4:04 PM, documents the following: Resident was found kissing a female resident today in the dining room. This resident was removed from area and walked him down to his room to initiate a 1 and 1. A warning was initiated. Resident understood and acknowledged.

R4's Progress Note, dated 8/22/24 at 1:49 PM, documents the following: Resident continues to have sexual behaviors with another female resident. POA made aware of this. Staff to ensure that both residents are not alone in room. They must be present with staff to monitor. Will continue to monitor situation.

R4's Progress Note, dated 8/22/24 at 4:20 PM, documents the following: Resident continues on hospice with no change in status. Resident has sat in common area in front of desk with his female friend who is also a resident here. CNA reports that resident noted to have his hand on her leg above the knee underneath her skirt and this issue was immediately addressed and resident removed his hand. Resident then went back to his room. Resident making comments to female resident that he would like to take her to bed to, which she did not reply. Resident currently in his room.

R4's Progress Note, dated 8/25/24 at 2:57 PM, documents the following: Resident remains under the care of hospice with no change in status noted. Resident has been ambulating up and down halls with a slow, steady gait with walker. Resident frequently sits in common area in front of nurse's station talking with female resident. Resident noted earlier to be following female resident into her room and he was redirected.

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Informed resident they need to stay in common area and resident compliant.

R4's Progress Note, dated 8/28/24 at 3:42 PM, documents the following: Resident remains under the care of hospice with no change in status noted. Resident ambulates up and down hallway frequently throughout the day looking for his female friend. They sit in common area and resident will make sexual suggestions and female resident just sits and smiles at him. Administrator aware and this is care planned. Family also aware.

R4's Progress Note, dated 8/31/24 at 11:45 AM, documents the following: Patient walks up and down hallway looking for female friend/patient. Makes gestures to female to come with him to his room. Patient is redirected to either sit in common area with friend or go back to room alone.

R4's Progress Note, dated 9/19/24 at 6:36 PM, documents the following: Notified POA that female (R3) was in (R4's) recliner and had her underwear and pants pulled down, and (R4) was on top of her with his pants off. (R4's) bilateral knees had abrasions. Cleansed with wound cleanser and applied mupirocin and dressings. Administrator is aware.

R4's Progress Note, dated 9/20/24 at 10:37 AM, documents the following: POA made aware of relationship with another female resident. They voiced no concerns at this time and understands that they have a relationship with each other.

R4's Progress Note, dated 9/26/24 at 8:12 PM, documents the following: Resident remains on hospice. Resident and a female resident were in room on the floor with their pants down. They

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were assisted up, dressed, and separated. Even though they are closely monitored, they find a way.

R4's Progress Note, dated 9/28/24 at 11:36 AM, documents the following: Patient observed in dining room with his hands on another patient's vagina. Patients were separated at this time. 1137- nurse manager on call notified. 1145- Admin notified, 1148- Doctor on call made aware. POA updated on situation. POA stated it was female initiating contact. Updated on things patient says to female trying to get her to go in his room.

R4's Progress Note, dated 9/29/24 at 12:42 PM, documents the following: Patient's POA in facility and stated she was taking patient out of facility and that he would not be returning.

On 10/3/24 at 4:30 AM, V5, LPN (Licensed Practical Nurse) stated she was not here when the alleged sexual abuse occurred between R3 and R4 but had heard about it. V5 confirmed that R3 was R4's "girlfriend."

On 10/3/24 at 11:40 AM, V8, CNA, stated she did not witness the sexual interaction between R3 and R4. V8 stated R3 likes to leave her hallway to seek out R4 and is unable to be redirected. V8 stated R4 is consistently stating that R4 is her (R3's) husband and she will have the staff from R4's hall come and get her, telling her that R3 won't leave R4's hallway.

On 10/3/24 at 11:55 AM, V17, RN (Registered Nurse), stated she was in the dining room when a CNA called her stating that there was a problem with R3 and R4. V17 stated upon entering R4's room, R3 was observed sitting in the recliner with

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her pants and underwear down, R4 was on his knees on the floor by R3 with his pants and underwear down. V17 stated R3 and R4 seemed "embarrassed" by the incident. V17 stated R4 was complaining of knee pain, so she had him sit on the floor and he had abrasions to both knees that she cleaned and applied bandages to. V17 stated that neither R3 or R4 stated what happened and she (V17) did not know if penetration had occurred, and she did not witness the sexual interaction between them. V17 stated she assessed R3, and she was smiling, acting silly and didn't have any complaints of pain or areas of trauma noted. V18 stated after the incident, she notified V1, Administrator, R3 and R4's family but did not notify either resident's physician or local law enforcement. V17 stated she spoke with V16, R3's Responsible Party/Daughter, who apologized for her mom's behavior but didn't give any instructions or voice concerns to her. V17 stated this type of behavior is not a common thing for R3 or R4. V17 stated R3 would pursue R4, followed him wherever he was at but neither resident ever displayed any behaviors like this before.

On 10/3/24 at 12:30 PM, V2, Director of Nursing, DON, stated she does not have any investigation on R3 or R4 other than the one on 9/19/24.

On 10/3/24 at 1:45 PM, V2 stated there have not been any events, investigations regarding R3 or R4's sexual behaviors. V2 stated they have just been putting progress notes in, they tried to do the right thing and would notify their MD and POA.

On 10/3/24 at 3:15 PM, V15, R3's Representative/Daughter, stated the facility has called her a couple of times regarding R3 another

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male resident (R4), but she feels as though it isn't R3 that is instigating these behaviors, it is R4. V15 stated she told the facility it was okay for R3 and R4 to spend time together in the hallway, but she did not give permission for any type of sexual encounters or advances. V15 stated the first time she was notified of anything, she was told that R4 was in R3's room, R3 was in bed and R4 was fondling R3's breasts, unsure of the date. V15 stated the next time, she was notified, she was told that R3 was in R4 and both residents were partially undressed, R3 had just a top on and that they (facility staff) didn't think anything happened between them. The next time V15 was notified was recently that both residents were in the dining room and R4 pulled R3's underwear down and was touching her. V15 stated R4 looks like R3's late husband and R3 thinks R4 is her husband and even calls R4 her late husband's name. V15 stated R3 has declined over the past 6 months and isn't with it or able to make her own decisions. V15 stated all R3 would tell her was she (R3) and R4 had been "naughty", but it is because R3 believes R4 is her husband. V15 stated if R3 knew that wasn't her husband, she would have been embarrassed by those incidents occurring and she wouldn't have done them.

On 10/4/24 at 7:45 AM, V2 stated she has only observed R3 and R4 together, talking and holding hands. V2 stated R3 and R4's families were notified each time they were doing more than that, and the families told the facility to "let it play out." V2 stated R4's Daughter, got tired of the facility calling her about the sexual behaviors, she came and got him and took him home. V2 stated the staff provided privacy for R3 and R4 when they would have sexual encounters. V2 stated R3 and R4's BIMS were not high enough to give consent but R3 and R4's families were okay with

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it. V2 stated R3 would often say she just loved R4, and both of their families were aware of the sexual encounters and R3's family just wanted her to be happy. V2 stated she never spoke with either R3 or R4's family so she isn't sure if either one said it was okay for R3 and R4 to perform sexual acts with one another. V2 stated she and V1, Administrator, decided it was time to report it and believed they were doing it right by documenting it in the progress notes. V2 stated they did train and told the staff to keep R3 and R4 apart, it was hard, and it wasn't what R3 or R4 wanted. V2 stated they made an activity center and would take R3 to that and she enjoyed that but when staff would find R3 and R4 together performing sexual acts, they would provide privacy for them. V2 stated both R3 and R4's physician was aware. V2 stated either the Nurse Practitioner or the Physician was notified of the incident on 9/19/24 but local law enforcement was not notified. V2 stated R3 was not sent to the hospital or examined to see if sexual penetration had occurred, the nurse did do a physical assessment and didn't notice any injuries. V2 stated it was reported that R4 was on top of R3 with both of their pants and underwear down but when staff went into the room, R4 was on his knees and couldn't get up off the floor.

On 10/4/24 at 9:50 AM, V20, Medical Director and R3 and R4 Physician, stated he was aware of the boyfriend/girlfriend situation with R3 and R4. V20 stated that both R3 and R4 had confusion but were consenting and he was told by the facility that both R3 and R4's families were okay with their relationship. V20 stated he was notified of the incident on 9/19/24 and opted not to send R3 or R4 to the hospital. V20 stated that knowing they were both consenting adults and their families were okay with their relationship, he

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would have only sent them out if they had displayed signs or symptoms of an STD (Sexually Transmitted Disease), which was highly unlikely.

On 10/9/24 at 9:35 AM, V1, Administrator, R3 and R4 had a relationship and were hard to keep apart. V1 stated knew they had to keep them apart, so they kept a close eye on them, and they weren't to be in each other's room alone. V1 stated R4 was alert and oriented times 2 and R3's confusion came and went. V1 stated R4 ambulated with a walker and R3 was in a wheelchair and could propel herself. V1 stated the relationship started out with them just holding hands and kissing. V1 stated they notified both R3 and R4's family. V1 stated the report that was submitted on 9/19/24 to (State Agency), she wasn't sure who to report as the victim/perpetrator because both wanted it. V1 stated R3 referred to R4 as her boyfriend and would say that she loved him. V1 stated R4 referred to R3 as his girlfriend and neither resident sought out other residents, it was just each other. V1 stated even though R3 and R4 had Dementia, staff would still tell them they couldn't be alone with each other and had to be in public. V1 stated the staff tried their best to divert them. V1 stated there were only two incidents where they were caught with their pants down, the first was when they were in R4's room and R3 was in the recliner and both R3 and R4 had their pants and underwear off. V1 stated the other incident occurred after that incident and R3 and R4 were found in R4's room, on the floor with their pants and underwear off. V1 stated both resident's families were aware, they did not give permission for R3 and R4 to have sex, but they could have a "companion." V1 stated it was never witnessed whether or not actual penetration occurred. V1 stated they would let the family

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know what was going on with R3 and R4 and they (the facility) assumed they were okay with it. V1 stated after the last incident, R4's family discharged him from the facility, and she isn't sure if it was because they got tired of all the phone calls regarding R4's behavior or of the relationship between R3 and R4. V1 stated neither R3 nor R4 had the cognitive capacity to consent to a sexual relationship. V1 stated only the incident on 9/19/24 was reported to (State Agency) and it was not reported to local law enforcement because they didn't know if it was abuse or not. V1 stated after the incident on 9/19/24, they had R3 and R4 on different hallways, they were not allowed to be in any room, including the dining room alone, they were not on one-on-one observation, but staff watched them and tried to keep them separated.

The Abuse Prevention Program Policy, dated 9/29/22, documents the following: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Protection of Residents: The facility will take steps to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress and will immediately take appropriate steps to remediate the non-compliance and protect residents from additional abuse. Residents who allegedly mistreated another resident will be removed from the situation and will have limited contact with the targeted individual during the course of the investigation. Residents have the right to engage

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in sexual activity. If the facility has reason to believe or suspect that a resident does not have the capacity for consent, the facility must take steps to ensure the resident is protected from abuse and must evaluate the resident's capacity for consent. The facility must revise the resident's care plan if the resident's medical, nursing, physical, mental, psychosocial needs or preferences change as a result of an incident of abuse.

The Abuse Prevention Program Policy, dated 9/29/22, documents the following: Any incident or allegation of abuse, neglect, or misappropriation will result in an abuse investigation.

(A)

2 OF 2

300.610a)
300.810a)
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

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and dated minutes of the meeting.

Section 300.810 General

a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. As a minimum, there shall be at least one staff member awake, dressed, and on duty at all times.

Section 300.1210 General Requirements for Nursing and Personal Care

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 interview and record review, the facility failed to provide supervision/monitoring to prevent an elopement for 1 of 6 residents (R5) reviewed for supervision to prevent elopement in the sample of 15.

Findings include:

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The Facility Reported Incident Investigation, dated 9/24/24, documents the following: On 9/20/24 at 6:00 AM, R5 eloped from the facility. R5 has a BIMS (Brief Interview for Mental Status) Score of 11, which indicates moderate cognitive impairment. R5's POA (Power of Attorney) states that he does have confusion and forgetfulness most days. Staff did rounds at 3:00 AM and went back for another round at 5:00 AM, when they noticed R5 was not in his room. Staff completed an outside and inside perimeter sweep with no findings. They call the DON (Director of Nurses) and Administrator and notified the local police. R5 was noted behind the building in the parking lot by a passerby, who brought R5 back to the facility. Staff stated that the door alarm was not activated and later found that another resident had turned the alarm off. An assessment was completed upon return with no injuries noted. R5's POA was made aware. R5 was moved to a room closer to the nurse's station, the door code was changed and R5 was placed on 15-minute checks for 24 hours. Initial report 9/20/24 - Resident unable to recall why he left. Written statement by V7, LPN (Licensed Practical Nurse), undated, aide alerted me at 5:40 AM, that patient wasn't in room, we then began to check all the room but were unsuccessful with finding patient in building. We then went outside and walked around the whole building, meeting each other multiple times. After not finding outside, aide called supervisors to see what step to take. Police were then contacted. We then went outside again to look when a truck pulled up and patient was inside the vehicle. The man stated that resident flagged him down in the back parking lot by 200/400 hall exit. When resident returned to building and asked where he had been, resident stated he didn't know how he got outside, nor for how long he had been out there.

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The POA was contacted unsuccessfully. Also, vital signs and head to toe assessment were completed with no findings and normal vitals. Written statement by V8, CNA (Certified Nurse's Assistant), undated, at approximately 5:55 AM - 6:00 AM, I was doing rounds and was approached by the charge nurse who stated she was attempting to locate a resident from 4 south. I stopped what I was doing and immediately began to search. Written statement by V9, CNA, undated, I went back to 400 South at around 2:30 AM, after I got back from lunch, then went back there at around 5:30 AM, R5 was there at around 2:30 AM sleeping and at around 5:30 AM was missing. Written statement by V10, Passerby, undated, I was driving down (street name) at about 6:20 AM when I saw R5 standing at the corner of (street name) and (street name), waving his arms to get my attention. I pulled over to assist R5. After asking R5 a couple of questions, I was approached by staff of the facility. I then drove R5 to the front of the building where I helped him out of the truck and to the front doors where we entered the building and after entering the building, I then handed R5 off to a staff member on duty.

The facility is located on a main highway, heavily trafficked area, less than a half mile from train tracks that are currently in use by the railroad.

R5's Face Sheet, undated, documents R5 has the following diagnoses: Displaced Fracture of the Right Foot, Dementia, Abnormalities of Gait and Mobility, Hearing Loss, Diabetes, Hypertension, Giddiness and Dizziness.

R5's Minimum Data Set (MDS), dated 9/22/24, documents R5 has a BIMS score of 12, indicating R5 has moderate cognitive impairment.

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R5's Elopement Assessment, dated 9/13/24, documents the following: R5 is ambulatory, is a new admission who has made statements questioning the need to be here, displays behavior that may indicate an attempt to leave, body language, etc., that an elopement may be forthcoming. Elopement care plan to be initiated.

R5's Progress Note, dated 9/14/24 at 3:00 AM, documents the following: "Resident slept most of the night without issues. Resident was restless and attempting to get out of bed most of the evening requiring one to one care until he went to sleep. Alert and oriented to self, time, and situation. Able to communicate needs, appetite and fluid intake is good. Resident asked for cigarette and ash tray, I advised res (resident) that there is no smoking inside the facility, resident does not have own supply of cigarettes."

R5's Care Plan, dated 9/17/24, documents R5 is cognitively impaired due to Dementia with interventions for a wander guard as needed and to observe whereabouts.

R5's Progress Note, dated 9/20/24 at 6:34 AM, documents the following: "At 5:40 am aide alerted me that resident was not in his room and that she checked his room and the rooms on the hall. We then went outside and walk the entire building without success of locating resident. At this time all personnel was alerted and police were contacted. When outside a truck pulled up with resident in car stating that the resident was outside in the area of 200/400 by smoking area. When resident returned the resident didn't know why he was outside or how he got out. Head to toe assessment completed with no open areas, scrapes, or abrasions Pain level is 0 out of 10, vs

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(vital signs) - b/p (blood pressure)- 132/64 p (pulse)-58 o2 (oxygen saturation level) - 96% t (temperatures) -96.8. POA (Power of Attorney) was called but didn't answer a voicemail was left. Resident is now sitting at nurse's station."

R5's Progress Note, dated 9/20/24 at 10:58 AM, documents the following: "DON (Director of Nursing) and Administrator spoke with (POA) contact 1, who came to the facility to see the resident. (POA) did state she didn't listen to the message we left for her. We explained the resident did get out of the facility and another resident turned off the door alarm. We explained a head to toe assessment was completed, he was showered, and the steps we are taking for the safety of this resident. (POA) stated he was always trying to get out at home and did get out at the last facility he was in by climbing out of a window. (POA) stated she understood and had no questions or concerns."

R5's Progress Note, dated 9/20/24 at 11:09 AM, documents the following: "Resident got a room move today, from (previous room to new room), due to safety reasons, family was made aware. Resident will continue to be monitored; any changes will be made in next care plan meeting."

On 10/3/24 at 4:25 AM, V4, CNA, stated 2 CNAs and 1 nurse is not enough staff for 47 residents. V4 stated it's hard to get the call lights answered, care provided and to supervise the residents.

On 10/3/24 at 4:30 AM, V5, Licensed Practical Nurse, LPN, stated the layout of the building is a problem because the residents are scattered, not in one area making it very difficult, impossible to supervise them. V5 stated they all answer call lights, but if they are at the front nurse's station

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(100/200/300 hall), you can't hear the call lights going off on the 400-hall until you get to that nurse's station, so if someone needs help, you might not know it.

On 10/3/24 at 4:35 AM, V6, CNA, stated there aren't a lot of residents on the 400-hall but the 200-hall is a heavy hall. V6 stated it is just him, another CNA and nurse working. V6 stated that is not enough staff and there are a few "unruly" residents and residents that are up and moving about so if they are dealing with one of those residents, they can't supervise the other ones, it's very difficult to manage. V6 stated if he is on the 100, 200 or 300-halls, he can't hear the call lights on the 400-hall so he tries to be by the nurse's station so he can hear them. V6 stated R5 was independent, strong willed, doesn't really need help.

On 10/3/24 at 8:00 AM, V11, MDS Coordinator, stated they do not have any residents currently at risk for elopement.

On 10/3/24 at 4:05 PM, V9, CNA, stated she was not the aide assigned to R5 but all the CNAs care for all the residents. V9 stated she checked on R5 at around 2:30 AM, he was sleeping, when she went back to check on him around 5:30 AM, he was nowhere to be found. V9 said she notified the nurse. V9 stated there were no alarms going off. V9 stated V10, Passerby, is also V2, DON's, son, was on his way to work and saw R5, who was waving him down. V10 placed R5 in his truck and drove him to the facility and walked him back into the facility. V9 stated R5 was fine, had no injuries, and was fully dressed with a coat and shoes on. V9 stated R5 was alert for the most part until he returned to the facility and couldn't remember how he got out of the facility or why he

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left the facility, couldn't remember anything. V9 stated she knew R5 could walk with assistance but didn't know he could walk like that.

On 10/3/24 at 4:10 PM, V8, CNA, stated she was working when R5 eloped. V8 stated it was a weird situation, she had just done rounds. R5 was there and then she went to do final rounds around 5:30 AM - 6:00 AM and he was gone. V8 stated her and V9, CNA, were working the halls together. V8 did the round at 3 AM and V9 did the round at 5:30 AM and notified her (V8) that R5 was gone. V8 stated she looked everywhere and couldn't find R5, so she called the police, she was freaking out because he couldn't be found, and she wasn't going to wait for anyone else to call. V8 stated a community member (V10, Passerby) is somehow familiar with the facility, was on his way to work and R5 flagged him down so he (V10) brought R5 back to the facility and walked him inside. V8 stated when R5 returned to the facility he was lethargic, didn't know what he was doing or what was going on. V8 stated normally V5 isn't that confused but is never alert and oriented x 2 or 3. V8 stated she normally works evening shift but stays over for nights at times and staffing on nights is horrible, there isn't enough staff to supervise the residents or do what they need to do. V8 stated if there would have been more staff, she doesn't believe the incident with R5 would have happened.

On 10/4/24 at 7:45 AM, V2, DON, stated when staff went to check on R5, it disturbed him and woke him up, so he got up, changed out of his pajamas into regular clothes, put a coat and shoes on and left the facility. V2 stated the door alarm did go off and another resident, who comes in later at night, turned off the alarm when it was sounding, and she believes the CNA thought the

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other CNA turned it off, so they didn't check to make sure none of the residents had gone out. V2 stated she watched the cameras, and it shows the CNA going into R5's room to do a check and R5 wasn't there. V2 stated she doesn't remember when R2 exited the facility, she wrote it down but isn't sure where it is at. V2 stated the CNA then called V1, Administrator, herself (V2), and the local police department. V2 stated R5 was already back in the building by the time she arrived at the facility. V2 stated V10, Passerby, is her (V2's) son, he was on his way to work and R5 was waving him down, so he (V10) pulled over and R5 told him he needed help, upon further questioning, V5 told V10 that he didn't know where he was going but he was from the home right there, pointing to the facility, so V10 brought R5 back to the facility. V2 stated afterwards V21, R5's Significant Other, told her that R5 had busted out a window at another facility to get out and R5 would often try to leave while he was at home so V21 had alarms placed on the doors so he couldn't go out on his own. V2 stated they did not know this until after R5 eloped on 9/20/24. V2 stated R5 would often tell V21 that he wanted to go home but she isn't aware of him making any prior elopement attempts while in the facility. V2 stated R5 was alert and oriented x 2, sometimes he was fine, other times he was confused. V2 stated R5 was on the back half of the 400 hall and after the elopement, he was moved to the 300-hall to a room next to the nurse's station.

On 10/4/24 at 8:10 AM, V7, LPN, stated she was working when R5 eloped from the facility. V7 stated the CNAs checked on him around 4:30 AM - 5:00 AM, and R5 was in bed, asleep. V7 stated when the CNA went back into the room around 6:00 AM to get R5 up for the day, he wasn't in his room. V7 stated the staff looked for him inside

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE NSG & REHAB CENTER	1001 SOUTH STATE STREET JERSEYVILLE, IL 62052

(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
S9999	Continued From page 24	S9999		

and outside of the building but did not see him. V7 stated after that a car pulled up, V10, Passerby/V2's son, and stated R5 was out there at the smoking gait, and he picked him up. V7 stated she is not aware of any alarms going off on the 400 hall doors but the residents on that hall know the door code because their families come in often and they go in and out that door. V7 stated she isn't sure if R5 was trying to go out and smoke because he used to smoke but recently V21 told the facility he couldn't smoke anymore. V7 stated R5 told her, he didn't know where he was going and R5 isn't capable of knowing the door code to get out. V7 stated R5 didn't have any injuries and was fully dressed with a coat and shoes on. V7 stated R5 was alert and oriented x 2-3 and had no prior attempts to elope that she is aware of.

On 10/4/24 at 9:50 AM, V20, R5's Physician, stated R5 had a fractured foot, was wheelchair bound and in a boot for the fracture, or so they thought. V20 stated R5 got out of the facility because 1 busy body resident turned the alarm off when R5 went out, if that resident hadn't done that, R5 wouldn't have gotten out and that just set off a cascade of effects. V20 stated R5 had periods of confusion.

On 10/8/24 at 9:25 AM, V1, Administrator, stated the current elopement binder is not up to date and staff doesn't look at it anyway. V1 stated she has hung up instruction sheets at the nurse's station on what to do if they have a missing resident. V1 stated after R5 eloped, they looked at the residents that were at risk and determined they were no longer at risk. V1 stated they determined this by reviewing the resident's information. The surveyor asked if there were new elopement assessments completed to

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determine they were no longer at risk and V11, MDS Coordinator/Care Plan Coordinator, stated he believes so but would check to make sure. V11 stated the residents are assessed for elopement risk upon admission and then quarterly.

On 10/8/24 at 1:58 PM, V18, LPN, stated she knows a resident is at risk for elopement by looking in the elopement binder at the nurse's station.

On 10/9/24 at 9:35 AM, V1, Administrator, stated R5 was at the facility for skilled care due to a fractured foot and was non-weight bearing, wore a boot and staff thought he was a 2-assist, and he went along with it. V1 stated he was placed in a room on the 400-hall because that is where they put their rehab to home residents because the rooms are bigger. V1 stated on 9/20/24, the CNA, did rounds and stated R5 was in bed sleeping at that time, it was determined when the CNA went into the room to do rounds, the CNA, inadvertently woke R5 up and that is why he got up and dressed for the day. V1 stated at approximately 5:00 AM, the CNA went in to do the last round and R5 was gone and panic set in. After interviewing staff and residents, the CNA that was assigned to R5's hallway, went to help the other CNA in another resident's room, during that time, R5 went out the 400-hall exit door, setting off the alarm and R12, annoyed by the alarm, got up in his wheelchair, went to the exit door and shut off the alarm using the door code. V1 stated the CNAs on that hallway never heard the alarm because they were in a resident's room on a different hallway and R12 turned the alarm off before they came out of the room. V1 stated R12 could have told staff that he turned the alarm off but chose not to. V1 stated when R5 was

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S9999	Continued From page 26	S9999		

returned to the facility, he was immediately moved to a room on the 300-hallway, where more residents and staff were. V1 stated R5 was more engaged on that hall due to more residents and staff and did not try to elope again. V1 stated all the door alarm codes were changed at that time. V1 stated R5 was alert and oriented x 2 with confusion. V1 stated after R5 eloped, V21, R5's Significant Other, told the facility that when R5 was at home, she had alarms on all the exit doors because he would try to get out at night. V1 stated the staff didn't know R5 could walk.

The Elopement Prevention Policy, dated January 2018, documents the following: It is the policy of this facility to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and interventions for prevention will be established in the plan of care to minimize the risk for elopement. Any resident assessed to be at risk for elopement will have their photograph and basic identifying information placed in a special folder or binder to be maintained in a designated location. Responsibility for updating the folder/binder shall be assigned to a designated staff member by the administrator. Communication of interventions will be made to direct care staff through exposure to the resident's plan of care and periodic review and disclosure of the contents of the elopement binder.

The Missing Resident Policy, dated November 2017, documents the following: It is the policy of the facility that reasonable precautions are taken to minimize the risks of resident elopement attempts. Reasonable precautions include, but

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S9999	Continued From page 27 are not limited to: door alarms, personal door alarm activation devices, staff intervention, staff education regarding response to door alarms, and the resident interventions. A resident shall be defined as "missing" when the initial reasonable search of the facility interior and immediate grounds has not rendered physical evidence of the resident's person; there exists no evidence of the resident's whereabouts upon examination of documents including but not limited to the medical record, calendar of events and sign out books/sheets and after questioning of facility staff and residents evidence of whereabouts remain uncertain. (A)	S9999		