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	IL6006878	A. BUILDING: _____ B. WING _____	C 04/02/2024

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S 000	Initial Comments Complaint Investigation #2451988/IL170761 Complaint Investigation # 2452137/IL170941	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999		

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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 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. (Section 3-202.2a of the Act)

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.

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.

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These Requirements were not met evidenced by:

Based on interview and record review, the facility failed to ensure residents with psychiatric diagnoses, who were at risk of elopement, were accurately assessed and appropriately supervised for 1 of 3 (R2) residents reviewed for accidents and supervision in the sample of 17. This failure resulted in R2, who has a diagnosis of schizoaffective disorder and a history of suicidal ideation's exiting the facility without staff knowledge on 3/8/24 sometime between 4:45 AM and 5:30 AM. R2 was located slightly more than two tenths of a mile from the facility at approximately 6:30 AM, sitting outside an abandoned building on top of a truck camper shell, in the rain. R2 had to cross a busy highway to get to this location.

Findings Include:

R2's Elopement report dated 3/8/24 documents, "Resident was not located in her room and had been having some odd behaviors up ambulating (sic). Resident was assessed ambulating in the hallways. Resident was observed at 4:54 AM in the dining room by our transport driver. At approx. (approximately) 5:00 AM resident was not able to be located and staff were attempting to do a visual check on resident. At this time Management notified and local authorities to do a search of the resident's location. Resident Description: Resident stated she had gotten her jacket and just needed to take a walk. Resident is baseline independent with care. Resident does sign self out for outings, and shopping with family. Resident stated it was just a hard morning and

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she had been thinking about her deceased husband and friends." Under Immediate Action Taken this same report documents, "Immediately sent out team on foot and vehicle to locate resident. At this time resident was located at 6:30 AM walking in the alley of the post office in (name of town). She stated she was not in a good head space and attempting to clear her head. Resident was sent out to ER (emergency room) for evaluation due to increased depression .... No injuries observed at time of incident." Mental status, Predisposing Environmental Factors, and Predisposing Situation Factors are not assessed on this report. This report documents under Notes, "ADHOC (as needed) QAPI (Quality Assurance and Performance Improvement) completed, timeline completed, wander guard placed, door alarms checked, door code changed, elopement assessment completed, elopement policy education, 15 min (minute) check policy education, door alarm education."

R2's Admission Record with a print date of 3/18/24 documents R2 was admitted to the facility on 3/12/24 with diagnoses that include epilepsy, diabetes, hypertension, insomnia, chronic kidney disease, schizoaffective disorder, unspecified psychosis, macular degeneration, bipolar disorder, major depressive disorder, and cataracts.

R2's MDS (Minimum Data Set) dated 01/16/2024 documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R2 is cognitively intact. This same MDS documents under Section C 1310 Delirium, R2 has inattention and disorganized thinking.

R2's current Care Plan documents a Focus Area dated 1/2/22 of, "(R2) has a history of self-harm

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ideations and/or behaviors. This appears related to recent loss of spouse/caregiver and son. She has a mental health dx(diagnosis)/Cancer dx and poor impulse control. These problems are manifest by voicing thoughts if (sic) self-harm. (R2) has been evaluated/is currently being evaluated in (name of local hospital) ..." The interventions for this care area dated 1/2/22 include "Arrange for assessment by mental health professional, as warranted ... As warranted conduct/carryout: daily monitoring, room safety checks, behavior tracking/monitoring looking for any changes, evaluate mental/mood status/thought content. As warranted conduct a room check and remove any sharp objects, alcohol/drugs (including over the counter medications), cleaning supplies (that could potentially be poisonous) and any other objects that in the health care professionals may pose a potential threat to safety. Engage resident in activities that she may enjoy to encourage resident spending time in a productive manner." This same care plan documents a Focus Area dated 3/14/24 of, "Potential Risk of elopement exit seeking behavior (w/(with) purpose to leave)." Interventions for this Focus Area, date initiated 3/8/24, date created 3/14/24, include, "Place electronic sensor device to alert staff of exit attempt (or if unavailable, place on 1:1 observation: Routinely. Check Device Placement, Check Battery Function, Eval (evaluate) effectiveness ... Identify any patterns of exacerbating factors ...Maintain adequate I. D .... Provide re-direction and diversion as needed .... Respond to any alarm activation promptly ...try to identify reasons when possible. Address physical needs such as hunger, thirst, pain, toileting, hot/cold, emotional needs, fear/distress, loneliness, worry ..."

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R2's Elopement Risk Assessment dated 10/16/23 and 1/15/24 document a score of 02, which indicates R2 is not considered at risk of elopement. R2's Elopement Risk Assessment dated 3/8/24 documents a score of 16, which indicates R2 is considered at high risk of elopement with IDT (Interdisciplinary Team) recommendations for a wander guard to be placed. R2's Elopement Risk Assessment dated 3/12/24 documents a score of 02, which indicates R2 is not considered at risk of elopement. This assessment documents under IDT (Interdisciplinary) Notes: "Unable to complete due to resident went out to the hospital." R2's Elopement Risk Assessment dated 3/14/24 documents a score of 14, which indicates R2 is considered at high risk of elopement.

R2's progress notes document on 3/8/24 at 8:15 AM, "Resident (R2) sent to ER (emergency room) for Psych (psychiatric) evaluation, DR (doctor) and POA (power of attorney) notified of patient transfer to (name of local hospital) ..." There is no documentation in R2's progress notes related to R2 leaving the facility without staff knowledge.

R2's emergency transport Patient Care Record dated 3/8/24 documents at 7:40 AM the ambulance service received a call from the facility "for a patient who had eloped earlier that morning and was having homicidal and suicidal ideations. Patient made no statements to EMS (Emergency Medical Services) ... Patient has a history of eloping ...Patient (R2) answered questions for EMS with good cooperation ...."

R2's local hospital record dated 3/8/24 to 3/12/24 documents on 3/8/24, "Precipitating Factor/event for this admission: (R2) ...was admitted due to the fact she got aggressive with staff at (name of

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facility) and tried to elope. Patient (R2) has a history of schizoaffective disorder. Patient (R2) believes her family was killed because of a sexual act when she was young. Patient (R2) believes she is responsible for multiple deaths. It was reported patient made suicidal statements, but the patient (R2) denies this now. Presenting Problem: Patient (R2) is delusional believing she is the reason people are dying. Duration of Problem: gradually getting worse over the past month. Reason for Admission: Danger to self ..." Under Surrogate Decision Maker/Power of Attorney R2's medical records document R2 is not able to make informed decisions regarding his/her care and treatments.
R2's electronic health record documents a Task of "Behaviors" with a check mark next to "no behaviors observed" from 2/25/24 to 3/24/24.

On 3/14/24 at 1:18 PM, R2 was sitting in a chair in her room and appeared clean and well-groomed with no obvious signs of distress. R2 stated she had been at the facility about a year and a half. R2 stated she had left the facility last night (3/13/24) because "My mind said, just get out of here." R2 stated she didn't remember where she went. R2 stated she walked back into the facility, and she didn't remember any alarms sounding. R2 stated it was the last time she would do that and when asked why, R2 stated, because they will find you. R2 stated they found her "down the road." R2 stated she wasn't hurt, and she was gone for about an hour. R2 stated it was raining and she couldn't recall if it was light outside. R2 stated she wasn't sure if it was last night (3/13) or the night before. R2 then stated it was Tuesday (3/12/24) when she left. On 3/20/24 at 8:54 AM, R2 stated when she left, she used the front door and she put the code in, so it didn't alarm. When asked how she knew the code to

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the door, R2 stated someone at the facility had told her but she couldn't remember who it was.

On 3/19/24 at 1:59 PM, V22 (CNA-Certified Nursing Assistant/Shower Aid) stated she was the one who realized R2 was missing on 3/8/24. V22 stated around 5:30 AM (this time does not coincide with the time documented in the elopement report) she went to R2's room to get her for a shower. V22 stated R2 wasn't in her room so she asked the staff if they knew where R2 was. V22 stated she told them she couldn't find R2, and they started looking for her. V22 stated the nurses acted like they really didn't care that she was missing. V22 stated when they realized she wasn't in the building they got in their cars and started looking for R2. V22 stated around 6:00 AM she asked V11 (LPN/Licensed Practical Nurse) if she had called administration and the local authorities and V11 said she hadn't. V22 stated she wasn't sure who called administration but V3 (ADON/Assistant Director of Nurses) came to the facility shortly after that. V22 stated R2 had never attempted to elope before. V22 stated R2 didn't usually sign out to go out in the community alone and she didn't think R2 would be safe to be in the community by herself.

On 3/18/24 at 4:45 PM, V13 (LPN) stated on the night of 3/8/24 there were four CNA's and two nurses working. V13 stated she had sent two other residents to the hospital and between 3:30 and 4:00 AM she was in R2's room checking on her roommate and R2 was in bed at that time. V13 stated she left R2's room and went back to her hall to notify V2 (DON/Director of Nurses) about R2's roommates' condition and to call the lab. V13 stated she was notified by staff at an unknown time that R2 was missing. V13 stated

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everyone started looking for R2 and when an unknown day shift nurse came in, she notified administration. V13 stated R2 didn't have an electronic monitoring device such as a bracelet and had not attempted to elope in the past. V13 stated R2 is alert and oriented but gets in "moods" sometimes. V13 stated the door alarm codes are to be changed monthly but it has been the same code since August 2023. V13 stated no alarms sounded during the time frame R2 would have left the facility. V13 stated R2 has never signed out and left the facility when she was working.

On 3/18/24 at 6:10 AM, V11 (LPN) stated she was working on the morning of 3/8/24. V11 stated she saw R2 at 9:30 PM and then again at 4:00 AM, walking with coffee. V11 stated she didn't see her again after that. V11 stated at 4:30 AM (this time does not coincide with the elopement report and/or V22's interview), she was alerted R2 was missing. V11 stated she called V5 (MDS Coordinator) who was on call, and V5 notified everyone else. V11 was not able to explain the time discrepancy with her interview related to the time she was notified R2 was missing and/or the time she notified V5. V11's written facility statement does not document when she was notified R2 was missing. When asked where she documented this information V11 stated she didn't document it. V11 stated she assumed administration documented it all. V11 stated R2 was not an elopement risk and had never attempted to elope before 3/8/24. V11 stated R2 didn't normally sign herself out and she thought R2 would be safe by herself in the community. V11 stated it was raining the day R2 eloped and when it started raining, she thought surely R2 will be back now.

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On 3/19/24 at 10:59 PM, V28 (CNA) stated she was working on 3/8/24 when R2 eloped. V28 stated there were four CNA's working and when that happens, they split the hall R2 is on. V28 stated two CNA's take (A) hall and the left side of (B) hall, and two CNA's take (C) hall and the right side of (B) hall. V28 stated she believed there were 34 residents on the full hall she had and 16 on her side of the hall they split. When asked if they had enough staff to meet the needs of the residents, V28 stated, "My personal opinion, no." V28 stated they can't keep an eye on residents if the residents are up and wandering. V28 stated they have residents with multiple behaviors, and it is hard to monitor them and ensure their safety. V28 stated they did a bed check on R2's hall around 3:30 AM and R2 was in bed at that time. V28 stated they went to the next hall and were doing bed checks on those residents. V28 stated around 5:30 AM an unknown day shift CNA came to them and was looking for R2 for a shower. V28 stated they got worried, so they stopped what they were doing and started looking for R2. V28 stated R2 had never attempted to exit the facility before this.

On 3/19/24 at 11:15 PM, V29 (CNA) stated she was in R2's room between 3:00 and 3:30 AM and R2 was in bed asleep. V29 stated she finished the bed checks on R2's hall then went with V28 (CNA) to the other hall to do bed checks. V29 stated V22 (CNA/Shower Aid) asked them if they knew where R2 was, and they told her R2 was in bed. V29 stated then another staff (unknown) again asked where R2 was. V29 stated at that time they stopped what they were doing, and it was all hands on deck with everyone checking the building for R2. V29 stated then it was chaos. V29 stated they never heard a door alarm go off. V29 stated she had never seen R2 up wandering

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at night. V29 stated as far as she knew R2 had not had exit seeking behaviors in the past. When asked if she knew how R2 had left without staff knowledge, V29 stated she heard R2 knew the code to the front door. When asked how R2 would know the code, V29 stated, "I honestly don't have an answer for that."

On 3/19/24 at 11:26 PM, V30 (CNA) stated she was working on 3/8/24 when R2 eloped. V30 stated she was working with another CNA on one hall doing bed checks and the other two CNAs were on another hall doing bed checks. V30 stated she saw R2 in bed with her eyes closed around 3:10 AM. V30 stated after she finished her bed check, she took a break, took the linens out and around 4:15 AM, she started getting people up. V30 stated at approximately 5:30 AM, V22 (CNA/Shower Aid), asked if they knew where R2 was. V30 stated she asked V22 if she had checked the bathrooms and the other side of the bed to make sure R2 hadn't fallen on the floor and V22 stated she had checked. V30 stated they all started searching rooms and outside the facility. V30 stated around 6:15 or 6:20 AM, they were told R2 had been located. When asked if she had any concerns with how the facility handled the elopement, V30 stated she felt like the local police should have been notified she was missing immediately, and she didn't know if they had been. V30 stated she didn't believe they had enough staff to monitor the residents. V30 stated with four CNAs they have to pull the CNA off R2's hall to help with bed checks on the other halls. V30 stated that leaves R2's hall unattended.

On 3/19/24 at 11:42 PM, V31 (CNA) stated on the night R2 eloped she was working on another hall and split R2's hall with the other CNA's. V31

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stated there were residents with behaviors that night, call lights, bed checks were awful, and they had to do laundry. V31 stated she saw R2 around 2:47 AM and again around 3:40 AM. V31 stated R2 was in bed but did get up and go to the bathroom. V31 stated she didn't realize R2 was gone until V22 (CNA/Shower Aid) asked where R2 was. V31 stated she told V22 to check R2's room and she said she had. V31 stated she called V12 (Transportation Aid) to see if she had taken R2 somewhere. V31 stated V12 told her she had seen R2 at the front door with her jacket on and R2 was walking back towards her room. V31 stated she asked V12 why she didn't tell anyone and V12 told her because they were doing bed checks. V31 stated she knew this occurred after 5:00 AM because V12 was gone with a dialysis patient who had to be at dialysis at 5:30 AM. V31 stated they all started looking for R2. V31 stated the nursing staff called administration. When asked if she had any concerns with how it was handled, V31 stated she did. V31 stated they (administration) weren't really concerned, then they wanted to blame the CNA's. V31 stated they have 90 something residents at the facility and can't be on two halls at one time. V31 stated after they left the facility the administration posted on WhatsApp that they needed a statement from them. When asked how she thought R2 left without staff knowledge V31 stated R2 is "with it" sometimes, she could know the door code. V31 stated they don't ever change the codes and the side door where residents smoke doesn't lock. V31 stated residents can just open it up and walk out. V31 stated with so many residents with so many behaviors, we can't watch them all. V31 stated we can't check on them properly.

On 3/19/24 at 11:08 AM, V12 (Transportation

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Aid/CNA) stated she clocked in on 3/8/24 and went down to get a resident who was going for dialysis. V12 stated about 4:45 AM, she noticed R2 with her coat on walking towards her room. V12 stated she left the facility around 5:12 AM to transport the other resident to dialysis. V12 stated she left the facility around 5:12 AM and drove straight across the highway. V12 stated after you cross the highway and go around the curve there are abandoned buildings and she saw someone sitting on a camper shell with a coat on and the hood of the coat pulled up. V12 stated it caught her attention because it was raining hard. V12 stated she took the other resident to dialysis and got a call at 5:45 AM asking her if she had R2. V12 stated she told them she didn't and that was when she knew the person on the camper shell was probably R2. V12 stated she went back and started searching for R2 where she had seen the person and then was notified, they had located R2. V12 stated she wasn't aware of R2 attempting to leave the facility prior to this incident.

On 3/14/24 at 3:07 PM, V9 (LPN) stated she came to work around 5:45 AM on 3/8/24 to complete some charting before she started her shift. V9 stated she was at the time clock and V33 (Housekeeper) asked her if she had heard R2 was missing. V9 stated she went straight to the nurse's station and unknown staff were standing at the nurse's station. V9 stated she asked them if anyone had seen R2, and they said the last time they saw R2 was at the 4:30 AM bed check. V9 stated she did a sweep of the facility and didn't locate R2, so she sent staff out to look for her. V9 stated she called V2 (DON). V9 stated R2 doesn't leave the facility without family or staff. V9 stated if R2 wasn't in a manic state she would be capable of leaving the facility and returning by

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herself. V9 stated she spoke with R2 when she returned to the facility and R2 said she didn't know why she did it. V9 stated she wasn't sure what the facility staff did to locate R2 prior to her arriving to the facility at 5:45 AM. V9 stated she sent R2 to the hospital for evaluation and R2 was admitted. V9 stated R2 had suicidal and homicidal ideations. V9 stated R2 returned after 3 days and now has a wander guard on to alert staff if she attempts to leave.

On 3/25/24 at 9:54 AM, V33 (Housekeeper) stated she came into to work on 3/8/24 and an unknown staff member asked if she had seen anyone walking on the highway as she drove to work. V33 stated they told her someone was missing. V33 stated, V36 (Housekeeping/Laundry Supervisor) told them all to start looking and to look until R2 was located. V33 stated this was at approximately 5:45 am. V33 stated she checked the barn, looked in rooms, cars, and then triple checked everywhere until R2 was located.

On 3/25/24 at 10:10 AM, V36 (Housekeeping/Laundry Supervisor) stated she was working as a housekeeper on 3/8/24 and was cleaning the nurse's station when an unknown CNA stated they couldn't find R2. V36 stated she thought maybe she was in a bathroom or the pavilion. V36 stated this was between 5:30 and 6:00 AM. V36 stated she had them check those places and then when they couldn't find her, she got everyone to stop what they were doing and to start searching for R2. V36 stated she told the nurses to call V1 (Administrator) about a half hour later.

On 3/14/24 at 3:45 PM, V5 (MDS Coordinator) stated she was notified of R2 eloping by V11 (LPN) at 5:59 AM. V5 stated she was the first one

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in administration who was notified of the incident. V5 stated V12 (Transportation Aid/CNA) saw R2 at approximately 4:45 AM walking towards her room. V5 stated then V12 took a different resident to dialysis and when she was coming back from dropping that resident off, she saw someone sitting outside the post office on a truck camper topper. V5 stated when V12 got back to the building and was told R2 was missing V12 went back to see if the person on the camper topper was R2. V5 stated, V12 had first seen this person at 5:12 AM when she left the facility. V5 stated R2 has never been an elopement risk and they changed the codes on the front door after this incident.

On 3/19/24 at 9:07 AM, V5 (MDS Coordinator) stated at 5:59 AM on 3/8/24 she got a phone call from V11 (LPN) telling her they couldn't locate R2. V5 stated she asked if they had looked everywhere, and she told her she would message the administration team and be right there. V5 stated she texted V18 (Wound Nurse) and V2 (DON). V5 stated she got to the facility around 6:15 AM and saw CNA's walking around outside the facility. V5 stated some went to the local gas station to see if R2 was there and others got in their vehicles to look for R2. V5 stated she and V18 went to the post office to see if she was there since V12 had seen someone sitting there when she was taking a resident to dialysis. V5 stated R2 was there and was talking about killing everyone and how she wanted to die herself. V5 stated R2 agreed to walk back to the facility so they started walking. V5 stated once they got R2 back to the facility they had a staff member with her 1:1 until they sent her out to the local hospital for evaluation. V5 stated R2 was not assessed as being an elopement risk and had never attempted to elope prior to 3/8/24.

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On 3/14/24 at 1:26 PM, V6 (CNA) stated she came to work on 3/8/24 around 5:52 AM and was sitting in her car. V6 stated there was a knock on her window and other unknown facility staff asked if she had seen R2. She told them she had not, and they left her vehicle and was looking around facility grounds. V6 stated they searched for about 45 minutes and then found R2 and brought her back to the facility. When asked if R2 had ever attempted to elope before, V6 stated R2 had tried but hadn't succeeded. V6 stated R2 does have behaviors like that. V6 stated R2 is usually alert and oriented but she thought R2 was having behaviors that day. V6 stated they monitor R2 more when she is having behaviors.

On 3/14/24 at 2:47 PM, V7 (CNA) stated she was not aware of R2 attempting to elope before the incident on 3/8/24. V7 stated R2 does have behaviors and she didn't think R2 would be safe in the community by herself. V7 stated R2 has a tendency of saying she doesn't want to be here anymore, and she wants to kill herself.

On 3/14/24 at 2:53 PM, V8 (CNA) stated she wasn't aware R2 was an elopement risk and as far as she knew R2 had never attempted to elope before the incident on 3/8/24. V8 stated she had never seen R2 leave the facility and she wasn't one to sign out and go out and about in the community independently.

On 3/18/24 at 9:02 AM, V15 (Maintenance Director) stated he got to the facility after R2 had returned on 3/8/24. V15 stated he reviewed the elopement binders. V15 stated he believed R2 observed someone putting the door codes in and that is how she left without alerting the staff. V15 stated he implemented a procedure to change

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the door alarm codes monthly. V15 stated R2 could have also left through the door the smokers use since it isn't coded but does have a wander guard alarm on it.

On 3/20/24 at 9:07 AM, V18 (LPN/Wound Nurse), stated on 3/8/24 she got a call from V9 (LPN) around 6:00 AM notifying her R2 was missing. V18 stated she went to the facility and when she drove past the post office, she saw V12 (Transportation Aid) walking around looking for R2. V18 stated she met V5 (MDS Coordinator) at the facility and they started driving around looking for R2. V18 stated they drove in front of the post office and R2 was there. V18 stated V5 got out of the car and attempted to get R2 to get in the car with her but she wouldn't. V18 stated they walked with R2 and when they got almost back to the facility R2 stated she wasn't going in. V18 stated they were able to get R2 back in the building by telling her a peer was waiting for her to eat breakfast. V18 stated once they got R2 back in the facility they placed her on 1:1 until they sent her to the hospital. V18 stated R2 had never attempted to leave the facility before other than when she went on outings with her family.

On 3/25/24 at 2:28 PM, V4 (Family Member) stated the facility notified her R2 eloped. V4 stated R2 had never attempted to leave the facility before. V4 stated R2 said she "just went nuts." V4 stated R2 never goes out of the facility independently and wouldn't be safe in the community. V4 stated R2 knew the door code and she thought R2 may have seen family enter the code when they left the facility. V4 stated after R2 eloped, she asked the facility to change the code, and they did.

On 3/20/24 at 10:05 AM, V2 (DON) stated she

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had worked at the facility since 1/29/24 and had been DON since 2/2/24. V2 stated she got a call at 5:59 AM from V9 (LPN) that R2 was missing. V2 stated staff had searched all the rooms and outside the facility. V2 stated R2 had been missing about an hour. V2 stated around 6:34 AM, she was almost to the facility and V18 (LPN) stated they were bringing R2 back to the facility. V2 stated R2 was assessed, placed 1:1, and because of the comments she was making they sent her out to the hospital for evaluation. When asked if an investigation was done on how R2 left the facility without staff being aware, V2 stated from her understanding R2 always signed out with family so they assumed she knew the code and changed it. When asked if anyone ever asked R2 how she left, V2 stated she didn't. V2 stated she wasn't aware of R2 attempting to elope in the past and wasn't able to answer if R2 would be safe in the community alone.

On 3/20/24 at 4:07 PM, V1 (Administrator) stated she got a call from the facility, and they said V12 (Transportation Aid) had seen R1 in the dining room but didn't think anything of it since R2 gets up and goes out with family at times. V1 stated V12 didn't leave until after 5 and didn't see R2 leave while she was at the facility. V1 stated V12 took the other resident to dialysis and when V12 returned to the facility, other staff asked V12 if she had seen R2. (This does not coincide with the other interviews). V1 stated V12 told them she saw someone outside when she took the other resident to dialysis. V1 stated staff got in their cars and drove to where V12 saw this person. V1 stated they also called R2's family to see if she had gone with them. V1 stated when they asked R2 why she left R2 stated her head was full and she wanted to go for a walk. V1 stated R2 said she was thinking about her

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deceased husband and her roommate. When asked if the local police were notified, V1 stated she had but they didn't respond immediately. V1 stated if R2 had been missing more than an hour she would have called the county officials. V1 stated she notified all the managers, regionals, and all staff. When asked if she talked with all staff on midnight shift and day shift after R2 eloped, V1 stated she didn't remember but she would think they did speak with all of them. V1 stated R2 will sign herself out and goes with family and doesn't always tell someone when she is leaving. V1 stated R2 had never done anything like this before and was not an elopement risk. V1 stated R2 was assessed at risk of elopement after this incident. When asked if four CNA's and two nurses were enough staff to monitor the residents on night shift, V1 stated, it was, and they use the state required minimum staffing sheet to determine their staffing numbers. This surveyor reviewed staff interviews with V1 and noted it was 30-45 minutes after R2 was missing before administration was notified. V1 began looking through her phone and stated the earliest notification she could find was 5:58 AM. V1 stated she thought 30 minutes was an acceptable time frame because it gave staff time to look in other rooms.

On 3/19/24 at 11:06 AM, V20 (SSD/Social Services Director) stated she reviewed the resident sign out logs and R2 had not signed out on the morning of 3/8/24. On 3/20/24 at 9:29 AM, V20 stated after R2 eloped they went through the elopement binders and made sure copies of the policies were available for the staff. V20 stated they checked all the wander guards and changed the door codes. V20 stated she thought they changed the door codes quarterly prior to this.

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S9999	Continued From page 19 On 3/20/24 at 1:00 PM, when asked if she had been made aware R2 eloped, V32 (Physician), stated she knew R2 had been sent to the local emergency room for behaviors recently, but she didn't remember them notifying her she had eloped. When asked if she would consider R2 an elopement risk she stated, "Yes, she has a diagnosis of schizophrenia so if she gets something in her mind that she wants to leave, I can see her doing that." Would you consider her safe in the community by herself? "No." The facility Protecting Residents: Wandering/Elopement Risk policy dated 10/15/21 documents, "All residents are assessed for risk of unsafe wandering and/or elopement and those who are identified as at risk will be assessed for utilizing the safety intervention of a Wander Guard bracelet to prevent unsafe exit from the center. In facility that do not have Wander Guard systems, an alternate method of protecting residents is used. Procedure: All residents are assessed using the Elopement Risk Assessment V-2 in (name of electronic health records) at the time of admission, quarterly, and with changes in condition, especially those affecting cognition, or with changes in behavior ....If a resident exhibits exit seeking behaviors or expresses the desire or determination to leave and if that resident is not cognitively able to support independent decision making, a new Elopement Risk Assessment and review by the interdisciplinary team will be conducted. Other safety interventions may be utilized pending the assessment. The facility shall not utilize Wander Guard or other similar interventions on a resident who is able to give consent based on cognitive level without further assessment to protect that resident's right to personal autonomy and decision making. This would include a BIMS assessment and CRSHC	S9999		

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Safety Awareness Assessment, both in (name of electronic health record), consultation with a physician or psychiatrist and IDT review. A care plan problem, focus, and intervention are placed in the residents' clinical record that specifies the intervention to be used to protect a resident who is at risk for unsafe wandering or elopement ... non-Wander guard Protections: any systems of locking door or units is monitored on an ongoing by staff to assure it is operating correctly ...."

The facility Missing Resident Procedure (Code Pink) dated 9/2018 documents, "The following procedure is utilized when a resident is determined to be missing. 1. "Code Pink" is announced/staff notified if no overhead system is used. 2. Note the time that the resident was discovered to be missing. 3. The staff members assigned to the resident's unit report to the nursing station and verify that the resident has not been signed out. 4. Administrator and Director of Nursing are notified if not on the premises. Activate Recall Roster if necessary. 5. Facility management staff should report to the Incident Command Post for a briefing and instruction. 6. Activate the Incident Command System (ICS) to manage the incident. The most qualified staff member (in regard to the Incident Command System) on duty at the time assumes the Incident Commander Position. 7. A thorough search is initiated by staff members to locate the resident. If the resident is not located, proceed with the following: 1. Staff members search the entire facility and grounds. 2. All areas of the facility, grounds, and neighboring streets are systemically (sic) searched. 3. The Administrator/Incident Commander assigns each staff member a section when searching to minimize overlapping or overlooking of an area. 4. When conducting a search, it is important to look under beds and

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furniture, in walk-in refrigerators/freezers, in closets, under desks, behind doors, as well as in storage rooms, behind boxes, in boxes, and on shelves. A resident who has been identified as missing may be frightened and may be hiding. Being thorough is extremely important. 5. When finished searching a section, staff members report back to the Administrator/Incident Commander. a) If the resident has not been found after a complete search of the building and the surrounding area of the building including all exit doors, the Administrator/Incident Commander calls the police to report the resident missing. a) When the police arrive the Administrator/Incident Commander provides the officer with a picture and provide pertinent information such as: a) What the resident was wearing. b) How the resident was ambulating, i.e., with a cane, walker, etc. c) The resident's cognitive status, i.e., confused, alert. d) Information as to where the resident may be going, if known. e) Resident's previous address and family's address. Report the incident to the State Regulatory/Licensure Agency according to regulation. Report incident in Quality Assurance/Risk/Safety Committee. Director of Nursing: 1. Report to the Incident Command Post. 2. Assist with resident search and follow-up actions as directed by the Incident Commander. 3. Ensure the resident is examined for injuries. 4. Ensure the attending physician is notified of the resident's status. 5. Ensure the family/responsible person is contacted and informed of his/her status (ensure all the above steps are documented in the nursing notes). 6. Continuously remind nursing staff to remain calm and in control so as to not upset the residents. 7. Ensure care plan is updated. Nursing Staff: Report to the Incident Command Post. Assist with resident search and follow-up actions as directed by the Incident Commander. Examine the

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resident for injuries. Notify the attending physician of the resident's status. Notify the family/responsible person and inform him of his/her status (ensure all the above steps are documented in the nursing notes). Update the care plan. Evaluate implementing additional measures, such as the addition of a wander bracelet if not in current use and safety checks, and document in the resident record. Complete a Report of Incident and follow the facility's incident reporting process. Ensure the incident and events are documented objectively in the resident record, including Circumstances and precipitating factors. Interventions utilized to return resident to the unit. The resident's response to the interventions. Results of reassessment upon the resident's return and the condition of the resident. Care rendered. Notification of police, family, and physician. Additional prevention strategies implemented. Remain calm to not upset the residents ...."

(A)

Statement of Licensure Violations (2 of 2)

300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1210d)3)

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

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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 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. (Section 3-202.2a of the Act)

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These Requirements were not met evidenced by:

Based on observation, interview, and record review the facility failed to ensure staff were trained and the facility had the necessary equipment to meet the needs of a resident with a tracheostomy for 1 of 1 resident (R3) reviewed for tracheostomy care in the sample of 17. This failure resulted in R3 becoming short of breath shortly after admission with the facility unable to locate the necessary equipment to provide oxygen to R3 via the tracheostomy, causing R3 to be anxious and scared and then being transferred to the local hospital for oxygenation.

Findings Include:

R3's Admission Record with a print date of 3/21/24 documents R3 was admitted to the facility on 3/15/24 with diagnoses that include local

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infection due to central venous catheter, bacteremia, asthma, malignant neoplasm base of tongue, malignant neoplasm of larynx, tracheostomy, heart failure, depression, anxiety, hypertension, and atrial fibrillation.

R3 is in the assessment period so her MDS (Minimum Data Set) did not document a Brief Interview for Mental Status score. However, upon interview R3 was alert and oriented to person, place, and time.

R3's current Care Plan documents a Focus area dated 3/16/24, "Admission Baseline" the interventions for this Focus area include, "Resident is able to self-care for trach including suctioning, "and "The nurse will follow the MD (physician) orders for specialty care with oxygen, trach, suction." Both interventions are dated 3/16/24.

R3's Order Summary Report dated 3/21/24 includes the following physician orders dated 3/17/24, Change tracheostomy (trach) ties each day shift and as needed, clean or change inner cannula every day, oxygen at 2 liters per minute via tach mask as needed, trach site care with normal saline. May use trach kit every day shift and as needed for excessive drainage, trach: assess breath sounds every shift and as needed, change canister and tubing weekly and as needed, change trach tube every day shift every month and as needed, check oxygen saturation every shift and as needed, licensed nurse may reinsert trach tube as needed for dislodgment, may use trach dressing drain sponge to cover trach site or leave open to air, observe trach site/stoma for redness, bleeding, swelling, increased secretions, drainage, and skin breakdown every shift, and tracheostomy care

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every shift and as needed: clean or change inner cannula when needed. This same report includes the physician order dated 3/18/24 of tracheostomy site dressing change as needed if soiled as needed related to tracheostomy status.

R3's progress notes include the following:

3/15/24 at 4:33 PM, "Resident (R3) arrived at facility with her uncle in a private car. Mouth pink and moist LCTA (lungs clear to auscultation) trach in place, BS (bowel sounds) present x (times) 4 ABD (abdomen) soft nontender. Bruising from needle sticks to both arms, no excoriation or open areas noted."

3/15/24 at 11:20 PM, "The patient (R3) is being transferred out to hospital r/t (related to) SOB (shortness of breath). Patient (R3) is requesting to be sent out because she is having trouble breathing and complaining of chest pains. The nurse attempted to call the doctor twice. No answer. Awaiting doctor to return call. The nurse reached out to DON (Director of Nursing) and made her aware of the situation. DON stated to send the patient (R3) out per patients request at this time. SPO2 is at 90%, T (temperature) 97.8, R (respirations) 20, B/P (blood pressure) 128/76."

3/16/24 at 5:19 PM, "Client (R3) returned to facility with less than 23 hrs. (hours) stay at (name of local hospital) ..."

R3's emergency transport Patient Care Report dated 3/15/24 documents the following, " ...dispatched immediate response via private-line 911 to (name of facility) for report of a ...female trach patient with shortness of breath. Nursing home is having difficulty with patient's oxygen/trach equipment. EMS (emergency

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medical services) arrives on scene and patient (R3) is found sitting alone in her wheelchair at the main nurse's station. Patient (R3) waves down EMS as they approach, and she tells them that they are here for her. ALS (Advanced Life Support) assessment. Female (R3) is alert and oriented x 4. She has a tracheostomy, but she can speak when she occludes it with her fingers. Patient (R3) presents with slightly increased work of breathing. She is able to speak relatively clearly with short sentences. She is not connected to any oxygen at this time. Skin is pink, warm, and dry. Pulse strong and regular. She tells EMS that the nursing home staff is having difficulty connecting her oxygen to the supplied devices from her discharge today. Patient (R3) has been at (name of regional hospital) receiving treatment for an infection of her port which had to be removed. She has been discharged to (name of facility) for rehabilitation and has been at the nursing home for 7 hours. Patient (R3) requests EMS assistance connecting her oxygen equipment. EMS wheels patient in her wheelchair to her room. Nurse meets EMS in the room. Various pieces of equipment are found lying on the bed and in bags. There is a simple mask, a Venturi/aerosol trach-mask, and other miscellaneous oxygen tubing's. Nurse explains that the provided equipment is from her discharge from (name of regional hospital) and provided by family and she is not familiar with use of this particular equipment. Lungs sounds reveal rhonchi in upper fields and clear lower fields. Patient (R3) has had a productive cough from time to time where she can clear her own airway by coughing. EMS asks if there's any suction equipment available if patient (R3) needs suctioning of her airway. Nurse claims there are no suctioning devices. Vitals are measured. Patient (R3) is maintaining adequate room air

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oxygen saturation. For several minutes, EMS examines the available equipment in an attempt to make something work. The preferred aerosol mask is attached to a 1-liter bottle of sterile water which, also has the necessary adapter to attach to the oxygen concentrator. Due to the large size of the bottle, it cannot fit on the concentrator. There are no smaller sterile water bottles available that will fit to the adaptor piece. The only other option is to use a simple mask which can also fit over the tracheostomy and provide supplemental oxygen. EMS explains to patient that supplemental oxygen, even if provided using improvised equipment might be what she needs to help ease of difficulty breathing and provide the comfort she seeks. Patient (R3) adamant (sic) refuses to let EMS try this and claims, "it doesn't work," and she "doesn't get enough air." EMS explains that if this is placed over her tracheostomy, it will work in providing oxygen as there is no reason it shouldn't work. Patient does not require supportive ventilation as she breathes with adequate rate and depth spontaneously. The simple mask would only increase the oxygen concentration entering her lungs as she breathes. EMS also adds that she is maintaining adequate oxygen saturation without any supplemental oxygen and current findings may be about her baseline with her history of COPD (chronic obstructive pulmonary disease). Despite these pleas, patient (R3) will not allow for use of the simple mask and demands that the aerosol mask be used. EMS explains that until the proper equipment can be provided, this demand cannot be met. Patient (R3) and family member who was in contact with the nursing home prior to EMS arrival request that patient (R3) be taken to (name of local hospital). Cot is prepared in hallway. Patient (R3) wheels self to hallway and she is able to stand and turn to cot, with minimal

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assistance .... Transport completed without incident."

R3's local hospital records dated 3/16/24 documents under Chief Complaint, "(R3) is a ...female who present with no symptoms from (name of facility). Patient (R3) was sent to (name of hospital) due to the nurse at that facility not being comfortable with tracheostomy care .... The following is a note from (name of hospital nurse) who spoke with V34 (Marketing Director) who is the director at (name of facility)."

"Received call from (V34), Director at (name of facility). (V34's facility title is Marketing Director) He offered deepest apologies to staff of (name of hospital) for confusion at his facility that resulted in patient being sent to this hospital. He stated, "the nurse on duty just wasn't comfortable with a trach patient. I don't know why. I have all the equipment here for patient. RN (Registered Nurse) that was uncomfortable is no longer an issue, and patient may return to (name of facility) at any time ...This RN verified with V34 that he would like this information put into note in patients' chart, verbal agreement given."

On 3/19/24 at 10:00 AM, R3 was in her room, lying in bed, with no obvious signs of distress. R3 was receiving oxygen via her tracheostomy. R3 stated she didn't really want to talk but was willing to answer a question. This surveyor asked R3 about the night she went to the hospital and R3 stated the facility staff couldn't figure out how to hook her oxygen up, so they sent her out. R3 stated she wasn't in distress and wasn't sure if the facility had the right equipment.

On 3/18/24 at 4:45 PM, V13 (LPN) stated the facility recently accepted a resident (R3) who had

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a tracheostomy. V13 stated R3 came to the facility with no supplies, and they had to send her out because they couldn't get R3 oxygenated with the supplies the facility had. V13 stated there was another nurse V25 (LPN) who wasn't comfortable providing care for someone with a tracheostomy. V13 stated V25 told administration and they didn't get her any training. V13 stated the facility didn't even have trach kits.

On 3/19/24 at 3:39 PM, V25 (LPN) stated she provided care to R3 for 2-3 hours on the day she admitted to the facility (3/15/24). V25 stated R3 got to the facility and stayed in the dining room, since she arrived around dinner time. V25 stated an unknown staff member let V25 know R3 was having trouble breathing and wanted some oxygen. V25 stated she started searching the supply room to try to find everything they needed. V25 stated, "It was kind of a fail." V25 stated she kept going into the dining room to ensure R3 was ok and because R3 was scared. V25 stated R3's oxygen saturations fell into the upper 80's. V25 stated she didn't feel like R3 was in any danger but at the same time R3 was scared and kept saying, "I can't breathe." V25 stated the other nurses working that day assisted her and then R3 had her call V26 (Family Member). V25 stated V26 came to the facility and asked her what she wanted him to do since he didn't have the needed equipment at his house either. V25 stated V26 thought to call the hospital R3 had discharged from, and he drove to the hospital in a neighboring town and got supplies. V25 stated R3 did have a simple mask on over her trach with normal oxygen tubing. V25 stated R3 told her it wasn't going to work but that was what we had to work with. V25 stated R3 did calm down some after V26 arrived at the facility. V25 stated she was sent to the hospital after V25's shift ended.

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V25 stated she didn't have the supplies needed to apply oxygen when R3 arrived at the facility.

On 3/21/24 at 9:37 AM, V39 (CNA/Certified Nursing Assistant) stated when R3 got to the facility she wanted to sit in the dining room. V39 stated she walked past the dining room around 4:00 PM and R3 said she was having problems breathing. V39 stated R3 was really panicky and couldn't catch her breath. V39 stated she told the nurse, and they went to look for the equipment needed for the trach. V39 stated they didn't have the equipment so a family member of R3's went to the hospital and got what they needed. V39 stated she left around 6:00 PM or switched halls so she didn't have anymore contact with R3.

On 3/19/24 at 3:59 PM, V26 (Family Member) stated he got a call from the facility that they were going to send R3 to the hospital because they didn't have the equipment they needed. V26 stated he went to the facility and spoke with V25 who said they didn't have the equipment and probably wouldn't be able to get it since it was the weekend. V25 stated he called the hospital R3 discharged from and then drove to the neighboring town and got the equipment. V26 stated R3 was fine when he left the facility and then they sent her to the hospital later.

On 3/19/24 at 10:20 PM, V13 (LPN) stated V25 was the nurse on shift when R3 arrived at the facility and then V13 came on shift and got report from V25. V13 stated she was the nurse who sent R3 to the hospital. V13 stated she called R3's physician but had to leave a voicemail and explained in the voicemail they didn't have the equipment they needed to provide oxygen for R3 and R3 had requested they send her to the hospital because she was having trouble

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breathing. V13 stated R3's oxygen saturation was at 90% when she checked it and at 93% when the EMS arrived. V13 stated all the equipment V26 brought to the facility worked but the bottle was too long to attach to the concentrator. V26 stated the bottle of sterile water wasn't fitting into the compartment on the concentrator so they couldn't attach it. V13 stated they had two other bottles that also didn't work. V13 stated EMS attempted to get it to work and another nurse attempted to get it to work but it wasn't fitting on the concentrator. V13 stated R3 had a non-rebreather mask over her trach but said that wasn't working for her. V13 stated she sent V2 (DON/Director of Nursing) a text message that R3 was requesting to be sent to the hospital and explained the sterile water didn't fit into the concentrator, that R3 had oxygen on, was getting a little air, but was saying she was having trouble breathing, and her oxygen saturation was at 90%. V13 stated V2 sent a message back to send R3 to the hospital. V13 stated the messages were not in the computer system but they were on WhatsApp, the communication app the facility staff were using.

On 3/21/24 at 10:37 AM, V37 (Paramedic) stated he transported R3 from the facility to the hospital on 3/15/24. V37 stated he got called to the facility for a resident who was short of breath, and they were having difficulty managing the resident with a tracheostomy. V37 stated when he arrived and got to the main nurse's station he was met by the resident (R3) flagging him down. V37 stated R3 stated she was having some shortness of breath, but the main problem was she was having issues with the concentrator. V37 stated R3 took them to her room and nurse (unknown) told them they were trying to get R3 hooked up to oxygen. V37 stated there were three main pieces. V37 stated

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there was a one-piece vent circuit that wasn't usable, just an extension and a Venturi or aerosol mask. V37 stated this mask was appropriate for R3 to get oxygen. V37 stated on the end of that where it would connect to the concentrator there was a "bubbler" on. V37 stated it was like a one-liter bottle and it was too long to fit with the way the connections were. V37 stated it physically would not fit on the machine. V37 stated the third piece was a simple mask. V37 stated this is a mask you would normally use on your nose/mouth. V37 stated the facility nurse was going to use it and put it over the trach so R3 could get oxygen since the aerosol mask was not an option. V37 stated they tried different "bubblers," but they wouldn't fit on the aerosol mask. V37 stated R3 adamantly refused the simple mask. V37 stated as far as he knew they didn't have any other equipment options at the facility. V37 stated he had never seen a trach resident at the facility in the six years he has been a paramedic for that area. V37 stated the nurses were very uncomfortable with the trach and unfamiliar with the equipment. V37 stated the nursing staff had already tried everything he did but didn't seem very comfortable or knowledgeable with tracheostomy care. V37 stated there was also no suction equipment in the room. V37 stated R3 had some rhonchi. V37 stated he asked the nurse if R3 needed suctioning at all and the nurse said she didn't have any suctioning there. V37 stated as soon as they got to the hospital with R3 she coughed up a decent size mucus plug and needed suctioning. V37 stated if R3 hadn't been taken to the hospital it would have been an issue.

On 3/19/24 at 10:37 AM, V27 (RN/Registered Nurse) stated she was not working the night R3 admitted to the facility. V27 stated she was

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working on the day R3 returned to the facility from the hospital and told V2 (DON/Director of Nursing) she wasn't comfortable with trach care. V27 stated V2 told her R3 was pretty independent with the trach and if she needed anything to call her. V27 stated another nurse who was familiar with trach's showed her how to suction because she had an order to suction and didn't know how to do it. V27 stated, "We should have been trained before she (R3) got here, and we weren't at all." V27 stated this is the first trach patient she has ever provided care to.

On 3/20/24 at 9:38 AM, V34 (Marketing Director) stated when there is a potential resident he gets the referrals from the hospital, puts the information in the system and then they look at things such as payor source and background checks. V34 stated they will at times do a bedside evaluation and talk to the resident and/or family. V34 stated he was familiar with R3, and they had accepted her because V1 (Administrator) knows her well. V34 stated everyone else (other facilities) denied her. V34 stated he looked in the computer system around 5:00 PM (this time does not match the time of the other interviews) and saw they had sent R3 back to the hospital. V34 stated V5 (MDS Coordinator) told him R3 was in the dining room and her oxygen saturations were in the 90's, she was very anxious, so they sent her out. V34 stated he called the hospital to let them know they could accept her back. This surveyor reviewed the hospital record documenting V34's conversation with the hospital. V34 stated a nurse at the facility who was uncomfortable with the care was saying they didn't have supplies and because of that he said we would make sure we had the supplies at bedside. V34 stated they never had a problem caring for a resident with a tracheostomy before.

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V34 stated it had been a couple of years since they had a resident with a trach. When asked if he talked with staff prior to accepting R3 to see if they needed training prior to the admission, V34 stated he didn't. V34 stated he thought it would be clinical who would do that. When asked if he would know the equipment needed for a resident with a trach, V34 stated that would be a clinical question.

On 3/20/24 at 9:54 AM, V5 (MDS Coordinator) stated she was a little bit familiar with R3. When asked what the admission process was, V5 stated V34 gets a referral and then lets the team know the referral is there then a member of the nursing team reviews it and says if the person is appropriate for the facility. V5 stated she didn't remember who reviewed R3's information. V5 stated they had residents with a trach before but wouldn't or couldn't say how long ago just said, "It is not a very frequent thing." V5 stated they did have a training on trach care about a year ago. V5 stated if they have a resident with a unique need, they will do an in-service with staff prior to the admission. V5 stated she wasn't at the facility when R3 admitted but she knew they had supplies and she told V2 (DON) where to look for them. V5 stated she remembered R3's referral because the report had been called over from the hospital one day and then they held R3 at the hospital for an extra day. V5 stated when the hospital called report, they said R3 was independent with trach care, was mainly on room air, and only used oxygen as needed. V5 stated she knew V2 had set up another in-service for trach care. V5 stated if she had been working, she would have reached out to a manager and asked to be shown what to do and "to my knowledge that didn't happen."

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(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 36	S9999		

On 3/20/24 at 10:05 AM, V2 (DON) stated she started working at the facility on 1/29/24 and took the DON position on 2/2/24. V2 stated they were originally told by the hospital R3 was not on oxygen. V2 stated R3 got to the facility and was short of breath. V2 stated the nurse attempted to put a mask on R3 and she didn't like the mask the facility had. V2 stated R3 got very anxious and wanted to go to the hospital. V2 stated she said to send her if she wasn't comfortable. V2 stated she wasn't familiar with where everything was located at the facility. V2 stated they didn't tell her the type of mask R3 had on. V2 stated she spoke with other managers (V5 and V18), and they said they had everything at the facility. When asked if she had any conversation with the nursing staff about it, V2 stated when R3 came back to the facility, we made sure the hospital sent specifically what she wanted with her so, R3 could be comfortable coming back. V2 stated they spoke with the nurse working the night R3 was admitted and told her where the equipment was located, and they also have extra supplies in the shed outside. This surveyor confirmed with V2 they had all the equipment for oxygen including, sterile water, tubing, and mask on 3/15/24 when R3 admitted to the facility and V2 stated, "Yes." When asked if there was ever any conversation with the nursing staff about needing training on trach care, V2 state, "At the expense of sounding rude or heartless they are nurses in long term care, and trach's do come but after this incident I did reach out to get training set up again."

On 3/20/24 at 4:07 PM, when asked about staff being trained on tracheostomy care, V1 (Administrator) stated, "they are licensed nurses to do their capabilities within their work ethics and if they aren't comfortable, they can come get us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006878	A. BUILDING: _____ B. WING _____	C 04/02/2024

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to get training provided. We have it anytime they need from (name of online training program), it is a real person and any of us would be happy to go down and help them." V1 stated she was on the phone with nursing staff and verified all the equipment was there and was on the phone with the hospital. V1 stated she also had the manager on duty, V36 (Laundry/Housekeeping Manager) in R3's room going over all the items with her. V1 stated, "No one was uncomfortable, everyone was fine, and everyone had the equipment." V1 stated they had a venturi mask and R3 refused to use it and that is why they went to the hospital to get her a different mask. V1 stated we had venturi masks at the facility.

On 3/25/24 at 10:10 AM, when asked if she assisted nursing staff with finding supplies for R3's trach care, V36 (Laundry/Housekeeping Supervisor) stated when R3 came back from the hospital (3/16/24) she spoke with V1 (Administrator) on the phone to verify they had everything they needed to meet R3's needs.

On 3/20/24 at 1:00 PM, V32 (Physician) stated she wasn't familiar with R3 since she had just admitted to the facility. V32 stated she was not R3's physician prior to her admission to the facility. This surveyor explained the scenario to V32 and asked if there was any potential negative outcome for R3, V32 stated there is a lot of potential negative outcome. V32 stated it could have devastating consequences if the facility doesn't have the necessary equipment for the trach. This surveyor then asked V32 if she had ever seen nurses who had not worked with trach's before and if so, would they need to be trained prior to caring for a resident with a trach, V32 stated it is very reasonable for a nurse who hasn't cared for a trach to need to be trained on

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S9999	Continued From page 38 how to do it. The facility Inservice Education Record dated 6/7/23 documents the subject of the training as "trach orders" and has a list of who attended. V13 (LPN), V25 (LPN), and V27 (RN) are not documented as attending the meeting. The training attached to this meeting documents staff was trained on how to set up tracheostomy orders in the electronic health record system. The facility annual training calendar does not include training on tracheostomies. The facility undated Tracheostomy Care procedures documents, "The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas." The procedure documents under General Guidelines "7. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times." This procedure does not address the specific equipment needed to supply oxygen. (A)	S9999		