STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000244	A. BUILDING: _____ B. WING _____	C 06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHAB & NURSING OF NORMAL	510 BROADWAY NORMAL, IL 61761

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S 000	Initial Comments Investigaion of Facility Reported Incident of 05-31-2024/IL174333	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)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 administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 1	S9999		

care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Based on interview and record review the facility failed to ensure a severely cognitively impaired resident (R1) did not exit the facility unnoticed (elopement). The facility failed to reassess and develop a plan of care for a resident with a known

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S9999	Continued From page 2	S9999		

history of exit seeking behaviors, wandering, and supervision needs during emergency procedures. These failures affect one (R1) resident reviewed for elopement on a sample list of three residents. These failures resulted in R1 exiting the facility in the late afternoon on 5/31/24, unsupervised, being found 17 hours later in a grassy area next to a creek. R1 had potential for serious injury and/or death due to poor safety awareness in negotiating city streets/traffic and environmental hazards including crossing four lanes of traffic to arrive at a nearby creek with dense brush, rugged terrain in the dark.

Findings include:

The facility's Elopement and Wandering Resident's Policy dated 2/1/2020 documents that the facility ensures that resident who exhibit wandering behavior and /or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.

The facility's final report to the State Agency documents that on 5/31/24 at approximately 5:04PM a fire alarm drill was initiated. When the fire alarm was silenced, an exit door was heard alarming and R1 was found to be missing from the facility. Staff initiated a search for R1 both on the interior and exterior of the facility without success.

An undated timeline provided by the facility documents that on 5/31/24 at 5:39PM, V1 Administrator called 911 to notify the authorities of a missing resident. The undated timeline provided by the facility further documents that R1 was

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S9999	Continued From page 3	S9999		

missing from the facility from 5/31/24 at approximately 5:10PM until 6/1/24 at 10:04AM (17 hours) when law enforcement found R1 and took him to a local hospital for evaluation and treatment.

R1's Brief Interview for Mental Status dated 4/28/24 documents R1 as severely cognitively impaired. R1's Minimum Data Set dated 3/5/24 documents R1 as independent with mobility. R1's elopement assessment dated 3/26/24 documents R1 as high risk for elopement. R1's progress notes dated 3/26/24, 4/17/24, 4/21/24 document exit seeking behaviors requiring redirection, including exiting the building and walking around the facility to his bedroom window. R1's care plan with reviewed date of 2/26/24 does not address R1's wandering behaviors or high risk of elopement.

R1's Order Summary Report dated 6/17/24 documents the following diagnoses: dementia, transient cerebral ischemic attack, type 2 diabetes, dehydration, chronic kidney disease, Picks disease, malnutrition.

A map provided by the facility documented where R1 was found on 6/18/24 at 10:00AM. On 6/18/24 at 10:08AM when walking from the facility to the location, it was approximately three blocks from the facility, across a four-lane street, behind a fraternity building in a low lying, brushy, grassy area next to a creek without any barricade. Additionally, this area had a metal fire pit littered with empty cans and trash.

On 6/17/24 at 9:15AM, V1 Administrator stated on 5/31/24, R1 was out of the building overnight for 17 hours and was found 3 blocks away from the facility. V1 further stated that he believed that

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S9999	Continued From page 4	S9999		

R1 eloped from the facility via the therapy room doors on the Uptown West Hall, near where R1 resided in (room number) because R1 was last seen on camera at 5:06PM near the therapy room. V1 Administrator also stated that R1 thought that his wife lived in the apartments that are visible from the therapy room. On 6/17/24 at 9:15AM, V1 Administrator stated R1 had a personal alarm but that the personal exit alarms only work on the front door.

On 6/17/24 at 1:00PM, V7 Registered Nurse (RN) stated on the evening of the elopement, R1 was hovering around the exit doors that day and that several staff tried to redirect R1. At approximately 5:00PM, V7 RN saw V1 Administrator redirect R1 toward the Uptown West Hallway, near the nurse's station, approximately 6 feet from the therapy room. At the time of the fire alarm, there were no nurses at the nurse's station on the Uptown West Hallway. V7 RN then stated she seen R1 attempt to exit the facility four or five times at least from various doors throughout the facility.

On 6/17/24 at 9:50AM, V3 Licensed Practical Nurse stated seen R1 wandering and looking out the doors frequently. V3 said that R1 would try to leave the facility to go to where he thought his wife lived across the street.

On 6/17/24 at 10:10AM, V5 Registered Nurse stated R1 had a history of wandering throughout the facility and out the front door.

On 6/17/24 at 10:25AM, V6 Administrative Assistant stated she would often see R1 looking out the front door.

On 6/18/24 at 11:55AM, V18 Maintenance

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S9999	Continued From page 5 Director stated that the only door alarming after the fire alarm was silenced was the therapy room exit door, one of ten exit doors in the facility. On 6/18/24 at 3:53 PM, V19 Regional Nurse Consultant stated he was not the one that found R1 that third shift found R1 but R1 was found alone in a grassy area, wet as it had rained that previous night and that R1 had defecated himself and indicated he was hungry. V19 stated he could not understand how R1 was able to leave facility and get to area found on own as he would have to cross a heavily traffic area. (B)	S9999		