Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008965	A. BUILDING: _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOME OF SPRINGFIELD	3306 SOUTH 6TH STREET ROAD SPRINGFIELD, IL 62703

(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
S 000	Initial Comments Complaint 1945590/ IL114438	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210 d) 6) Section 300.1210 General Requirements for Nursing and Personal Care 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 are not met as evidenced by: Based on observation, interview, and record review, the facility failed to reset the alarm on the emergency exit door in a dementia unit, resulting in R1 exiting the facility without staff knowledge and wandering outside onto facility grounds. R1 is one of three residents reviewed for elopement in the sample of five. Findings include: The facility's Final Report- Elopement 7/27/19, documents R1 attempted to exit the dementia	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

unit through the emergency exit on 7/27/19 at 1:24pm, and that the emergency door alarm sounded when R1 attempted to exit the unit. The report documents "The exit doors must be reset with a key to silence the alarms. ((V3, Registered Nurse (RN)), thought that she had 'reset' the door, but in error, had turned the door alarm off." The report documents that "At 5:05pm, a CNA (Certified Nursing Assistant) reported to staff there was a man wandering around the outside of the facility."

On 8/6/19 at 9:30am, V1, Administrator, provided video surveillance photographs documenting R1 exiting the dementia care unit on 7/27/19 at 4:46pm and re-entering the facility at 5:11pm. V1 stated V3(RN) failed to reset the emergency door alarm after R1's attempted exit at 1:24pm. V1 stated R1 sustained no injuries during the incident. V1 stated the facility has installed fencing outside the emergency doors, rekeyed the emergency doors, and inserviced nurses on how to reset the alarms.

On 8/6/19 at 12:00pm, V3, RN, stated (R1) tried to exit through the emergency door on 7/27/19 at 1:24pm, and "I thought I had reset the door alarm with a key, but when I got to work the next day, I found out I had not done so. I was never shown how to use the key to reset the alarm."

On 8/6/19 from 8:45am-9:15am the emergency door alarms on both dementia units were on and flashing. Black wrought iron fencing was present outside the emergency doors and encompassing a small area of grounds preventing residents from eloping onto facility grounds and into the community. Each fence has a gate which provides egress and is opened by releasing it on the side of the fence away from the resident.

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S9999	Continued From page 2 Surrounding the facility grounds are residential neighborhoods and streets. The National Weather Service reports the 7/27/19 maximum temperature as 89 degrees Fahrenheit at 3:24pm for Springfield, Illinois (retrieved 8/7/19 from https://w2.weather.gov/climate/index.php?wfo=ilx) . R1's "Wander 4" assessment dated 5/7/19 documents R1 is high risk to wander, cognitively impaired with poor decision making skills, ambulatory, has a history of wandering, has medical diagnosis of dementia/cognitive impairment, has attempted to leave the facility, but hasn't left grounds, and has expressed the desire to leave, packed their belongings to go home, or stayed near an exit." R1's current Service Plan documents "Resident is an elopement risk/wander as evidenced by history of elopement from prior admissions." R1's Progress Notes document R1 attempted to elope via the emergency door on the dementia unit, multiple times daily, on the following dates: 5/12/19, 5/15/19, 6/10/19, 7/4/19, 7/13/19, 7/15/19, 7/20/19, 7/26/19, 7/27/19. (B)	S9999		