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
	IL6005961	A. BUILDING: ______ B. WING ______	C 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD NURSING & REHAB CENTER	152 WILMA DRIVE MARYVILLE, IL 62062

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S 000	Initial Comments Complaint Investigation 2049518/IL129239 A partial extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210c) 300.1210d)6) 300.1220b)2)3) 300.3240a) 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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S9999	Continued From page 1 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: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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	S9999		

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needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure all facility doors were properly alarmed, provide adequate supervision and develop an elopement plan of care for a severely cognitively impaired resident with a risk of elopement (R4), and failed to ensure electronic wander management transmitter bracelets were in working order for seven of seven residents (R2, R4, R11, R12, R13, R14, R15) reviewed for elopement risk in the sample of 14. These failures resulted in R4, a severely cognitively impaired resident with the diagnosis of Dementia, eloping from the facility on to a two-lane interstate, and being found wandering aimlessly on a busy interstate by the police, 1.7 miles away from the facility. The facility was unaware of R4 missing, and the weather outside was 41 degrees Fahrenheit and sprinkling.

Findings include:

The facility's Elopement Policy and Procedure (no date) documents, "All residents must be assessed on admission for elopement risk. It is the policy of this facility to be aware of the

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location of each resident. Sensor door alarms will be kept in the 'ON' position at all times. At the time the resident is located assess the resident's condition and document in the medical records. Include: The condition of the resident prior to the incident (physical and mental). The condition of the resident when located including a head to toe assessment, clothing and condition of clothing. A complete description of search efforts. Details of the incident. Document time, place, and by whom located the resident. Document interventions implemented to assure resident safety."

The Wander Management Transmitters (wander guard bracelet) Manufacturer's User Guide dated 11/2018 documents, "Each transmitter is stamped with a warranty expiration date. The date indicates the date that (the manufacturer's) warranty on that transmitter expires. If the warranty period has expired, discard the transmitter immediately. Warning: Using a transmitter beyond the printed expiration date can result in system failure and/or elopement. Do not use the transmitter tester on a transmitter with an expiration date that has expired. Results may not be accurate. All steps are mandatory. The following testing is required for all transmitters in use on residents. Weekly testing: 1. Test the operation of transmitters using the transmitter tester. 2. Visually inspect transmitters for damage or loose parts. 3. Verify that the warranty expiration on the transmitter has not expired. If the warranty period has expired, discard and replace the transmitter immediately. 4. Your facility must keep records of test and transmitter inspection."

R4's Petition for Adjudication of Disability and Appointment of Guardian dated 8-30-19

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documents, "The petitioner believes that (R4) is disabled due to dementia, substantially limited orientation and excessively low mental status, as attested by the physician's report filed herein. That because of said incapacity, (R4) lacks sufficient understanding or capacity to make or communicate responsible decision concerning care of (R4's) person, estate, and financial affairs. (R4) refused to accept medical care and cannot care for himself. (V23/R4's Guardian) is that of an adult protective services case manager with the Visiting Nurses Association who believes (R4) is unable to care for or protect himself from injury."

R4's Face Sheet documents R4 is a 73-year old male that was admitted to the facility on 9-23-19 with the diagnosis of Dementia without behavioral disturbance.

R4's Physician Order Sheets dated 11-19-20 to 12-19-20 document R4 has the Diagnosis of Dementia without behavioral disturbance.

R4's Elopement Assessment, dated 9/23/19, identifies R4 as a risk for elopement, due to frequently approaching exit doors, attempting to leave without supervision and ambulating aimlessly.

R4's 7-7-2020 Plan of Care documents, "(R4) experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety). Goal: (R4) will not injure/harm self-secondary to wandering. Approaches: Equip (R4) with a device that alarms when (R4) wanders. Check for proper functioning of the device every shift. Maintain a calm environment and approach to the resident. When (R4) begins to wander, provide comfort measures for basic needs. (R4) is

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unable to verbally communicate due to aphasia. (R4) has a memory/recall problem due to Dementia. Goal: (R4) will not sustain serious injury due to memory/recall deficit. Approach: Ensure (R4's) areas are free of hazards. Re-direct (R4) when entering unsafe areas."

R4's Minimum Data Set assessment, dated 10/06/20, documents R4 has significant cognitive impairment, along with short term and long-term memory loss, and is able to ambulate independently.

R4's Illinois State Police Incident Brief Report #11-20-00032017 dated 10-27-20 at 10:09 AM documents, "(R4) found walking southbound on Interstate 55 (I55). Call (local nursing homes) to see if they had anyone walk away from the nursing homes. 10:23 AM (R4) returned to (the facility) nursing home."

R4's Final Investigation of Abuse Allegation dated 11-3-20 and signed by V1 (Administrator) documents, "On 10-27-20 (R4) possibly exited the smoke door on 200 hall at approximately 9:50 AM. The weather was 50 degrees and sprinkling. (R4) was last saw by a certified nursing assistant ten minutes (9:40 AM) before exiting the facility. At 10:29 AM received a call from state police. At 10:35 AM (R4) was returned to facility."

R4's Progress Notes dated 10-27-20 to 12-19-20 do not include any documentation of R4's elopement on 10-27-20 or any documentation of an assessment and/or condition of R4 before leaving the facility or upon return to the facility.

A website Accuweather.com states the local weather near the facility on 10-27-20 reached a high of 41 degrees Fahrenheit.

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R4's Care Plan last updated/revised 10-13-20 does not include an elopement plan of care with approaches to prevent (R4) from eloping.

On 12-19-20 at 9:45 AM, R4 was sitting on the edge of his bed. R4 had a wander guard bracelet on his right ankle. R4's wander guard bracelet had a stamp on it that the bracelet expired on 12-27-19. At this same time, V24 (Licensed Practical Nurse/LPN) also read the bracelet expiration and stated that R4's wander guard bracelet expired on 12-27-19. R4 was confused to time and place. R4's room was two doors down from the East Side 200 hallway exit door.

On 12-18-20 at 2:30 PM, V17 (State Police Telecommunicator Specialist) stated, "I got a call on 10-27-20 at 10:10 AM that a male gentleman (R4) was wandering out on the interstate near the weigh house on Illinois Interstate 55 (I55) and Illinois Route 159. That interstate is very busy and has two eastbound and two westbound lanes. This interstate weigh house is 1.7 miles away from the nursing home by roadway. I immediately sent (V17/Illinois State Police Trooper) to pick (R4) up. (V17) found (R4) walking up the exit ramp to the weigh house around 10:15 AM. (V17) called the nursing home and found out that (R4) was missing. The nursing home was unaware that (R4) was missing. (V17) took (R4) back to the nursing home."

On 12-18-20 at 2:40 PM V19 (Community Witness) stated, "On 10-27-20 around 9:45 AM I was heading on Interstate I55 towards St. Louis, Missouri. I saw a black gentleman on the shoulder of the interstate. It was cold out, sprinkling, and he had no hat, gloves, or coat on.

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He looked homeless. When I saw him, it was about one mile from the nursing home. It was not safe to pull over when I saw him, so I drove a couple miles down the road and pulled over. I called the police to let them know that I saw a gentleman wandering around on the interstate that looked lost and looked like he could have had Dementia. The police took over from there."

On 12-19-20 at 9:55 AM, V4 (LPN) stated, "I am not sure who checks the wander guard bracelets for expiration, or to see if the bracelets are working."

On 12-19-20 at 10:40 AM, V1 (Administrator) stated, "The police called me on 10-27-20 and said that (R4) was on the interstate. The police brought (R4) back to the building. (V29/Activity Aide) was the last person that saw (R4) in the building prior to (R4's) elopement. I thought (R4) could have left through the front door. We (the facility) had contractors in the building that were bringing supplies through the front door. I thought possibly the front door could have had the door alarm disabled. (R4) could have pushed on an exit door for 15 seconds and then left the door once it opened. I could not get any staff to admit that a door alarm was alarming. I asked (R4) what door he left out of and he pointed to the 200-hall door. I just went with what (R4) told me. I know (R4) is confused. I never could figured out for sure how (R4) eloped. (R4) had a wander guard bracelet on prior to elopement. I was not aware that (R4's) wander guard bracelet was expired. I am not aware of any staff checking the wander guard expiration dates. I did not think to check (R4's) wander guard bracelet for expiration. I put (R4) on 15-minute visual checks for 48 hours after the elopement. We (the facility) did not implement any further elopement

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interventions besides the 15-minute visual checks for 48 hours."

On 12-19-20 at 11:30 AM, V21 (Social Service Director) stated, "(R4) has a care plan for wandering only. (R4's) care plan has not been updated since (R4's) elopement on 10-27-20. (R4) does not have a care plan addressing (R4's) elopement and does not have new interventions to prevent (R4) from eloping." (V22/Restorative Nurse) was doing the wander guard bracelet checks prior to me. The wander guard bracelet checks are supposed to be done monthly. I have not done any of the wander guard bracelet checks yet. (R4) is very confused and would not be safe to walk along an interstate or anywhere outside of the facility. (R4) has poor safety awareness."

On 12-19-20 at 10:00 AM, V25 (CNA/Certified Nursing Assistant) stated, "I do not know if (R4) has a wander guard bracelet on or not. (R4) goes to the exit doors frequently and writes down numbers from the interstate. (R4) wanders around the facility almost the entire day. (R4) is very confused and would not be safe to be outside alone or next to an interstate. (R4) would definitely get lost. I do not know what residents are at risk for elopement."

On 12-19-20 at 10:20 AM, V26 (Restorative CNA) stated, "I am not sure which residents wear a wander guard bracelet. I do not know who checks the wander guards or who keeps the wander guard check log. (R4) is absolutely confused and would not be safe to leave the building."

On 12-19-20 at 10:30 AM, V26 (Restorative CNA) stated, "I was working on 10-27-20 and gave (R4)

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some ice early in the morning. (V1) called and asked me if I had saw (R4). We (facility staff) did a room search and could not find (R4). I am not sure how (R4) got out of the building. My co-worker (V25) was on a break at the time that (R4) would have left the facility. (R4) is not safe to be outside by himself. (R4) is very confused and has Alzheimer's (disease). I never check the residents' wander guard bracelets. I am not sure what residents wear wander guard bracelets. I don't feel like any of the residents in the facility are at a high risk for elopement. I am not aware of any interventions implemented after (R4) left the building. I just try to re-direct (R4)."

On 12-19-20 at 10:40 AM, V28 (LPN) stated, "I am not sure which residents wear wander guard bracelets."

2. R2's Elopement Risk Assessment dated 10-29-20 documents, "(R2) is at risk for elopement. (R2) is severely cognitively impaired and has a history of leaving the facility. (R2) has the diagnoses of Dementia and Alzheimer's Disease. Intervention: Equip (R2) with a device that alarms when (R2) wanders (wander guard)."

R2's Behavior Care Plan dated 8-31-20 documents, "(R2) experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety). Goal: (R2) will wander safely within specified boundaries. Approach: Equip (R2) with a device that alarms when wandering."

On 12-19-20 at 10:40 AM, R2 was wandering aimlessly up and down the west hallway. R2's wander guard bracelet was on her right ankle and the bracelet was stamped with an expiration dated 1-13-19. At this same time, V28 (LPN) verified that R2's wander guard bracelet was

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expired on 1-13-19.

3. R11's Elopement Risk Assessment dated 10-29-20 documents, "(R11) is at risk for elopement. (R11) is moderately impaired-decisions poor. (R11) has had elopement attempts in the past that were unsuccessful, wanders with no rational purpose, and attempts to open doors. (R11) has the diagnoses of Dementia and Schizophrenia. Intervention: Equip (R11) with a device that alarms when (R11) wanders (wander guard)."

R11's Care plan dated 10/29/2020 documents, "Category: Behavioral Symptoms(R11) is at risk for elopement due to an alteration in safety awareness due to the diagnoses of Schizophrenia and Dementia. Long Term Goal: (R11) will not exit the facility unattended through the next review. Provide me with a Wander Guard. Check for placement and functioning every shift and as needed."

On 12-19-20 at 10:45 AM, R11 was lying in his bed. R11's wander guard bracelet was on his right ankle and the bracelet was stamped with an expiration dated 5-19-20. At this same time, V28 verified that R11's wander guard bracelet was expired on 5-19-20.

4. R12's Care Plan dated 10/29/2020 documents, "Behavioral Symptoms: (R12) is at risk for elopement due to an alteration in safety awareness due to anxiety and impaired memory. Long Term Goal: (R12) will not exit the facility unattended through the next review. Provide (R12) with a wander guard. Check fot placement and functioning every shift and as needed."

R12's Elopement Risk Assessment dated

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S9999	Continued From page 11 10-29-20 documents, "(R12) is at risk for elopement. (R12) is severely cognitively impaired. (R12) has had elopement attempts in the past that were unsuccessful, wanders with no rational purpose, and attempts to open doors. (R12) has the diagnoses of Anxiety and Schizophrenia. Intervention: Equip (R12) with a device that alarms when (R12) wanders (wander guard)." On 12-19-20 at 10:15 AM, R12 was lying in her bed. R12's wander guard bracelet was on her left ankle and the bracelet was stamped with an expiration dated 11-25-20. At this same time, V27 (CNA) verified that R12's wander guard bracelet was expired on 11-25-20. 5. R13's Care Plan dated 10/28/2020 documents, "Category: Behavioral Symptoms. (R13) is at risk for elopement due to alteration in safety awareness due to impaired cognition from the diagnosis of Schizophrenia. Long Term Goal Target Date: (R13) will not exit the facility unattended through the next review. Provide me with a wander guard. Check for placement and functioning as needed." R13's Elopement Risk Assessment dated 10-28-20 is blank/incomplete. On 12-19-20 at 10:05 AM, R13 was ambulating on the east hallway. R13's wander guard bracelet was on his right wrist and the bracelet was stamped with an expiration dated 01-13-19. At this same time V24 verified that R13's wander guard was expired on 01-13-19. 6. R14's Care Plan dated 10-28-20 documents, "(R14) is at risk for elopement due to alteration in safety awareness due to the diagnosis of	S9999		

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Schizophrenia. Long Term Goal: (R14) will not exit the facility unattended through the next review. Approach: Provide (R14) with a wander guard. Check placement and functioning every shift and as needed."

R14's Elopement Risk Assessment dated 10-28-20 documents, "(R14) is at risk for elopement. (R14) is moderately impaired-decisions poor. (R14) has had elopement attempts in the past that were unsuccessful. (R14) has the diagnoses of Depression and Schizophrenia. Intervention: Equip (R14) with a device that alarms when (R14) wanders (wander guard)."

On 12-19-20 at 9:55 AM, R14 was sitting in a chair directly beside the east hallway exit door. R14's wander guard bracelet was on her left ankle and the bracelet was stamped with an expiration dated 9-29-19. At this same time V24 verified that R14's wander guard was expired on 9-29-19.

7. R15's Care Plan dated 10-28-20 documents, "(R15 is at risk for elopement due to an alteration in safety awareness due to diagnoses of CVA (Cerebral Vascular Accident), Bipolar Disease, and Traumatic Brain Injury. Long Term Goal: (R15) will not exit the facility unattended through the next review. Approach: Provide (R15) with a wander Guard. Check for placement and functioning every shift and as needed."

R15's Elopement Risk Assessment dated 10-28-20 documents, "(R15) is at risk for elopement. (R15) is moderately impaired-decisions poor. (R15) has had elopement attempts in the past that were unsuccessful, verbalizes statements about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: ____ B. WING ____	C 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD NURSING & REHAB CENTER	152 WILMA DRIVE MARYVILLE, IL 62062

(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 13 leaving, and is verbally abusive. (R15) has the diagnoses of CVA and Schizophrenia. Intervention: Equip (R15) with a device that alarms when (R15) wanders (wander guard)." On 12-19-20 at 10:00 AM, R15 was ambulating at the end of the east hallway. R15's wander guard bracelet was on his left ankle and the bracelet was stamped with an expiration dated 9-29-19. At this same time V24 verified that R15's wander guard was expired on 9-29-19. On 12-19-20 at 10:40 AM, V1 (Administrator) stated, "(V21, Social Service Director) takes care of the elopement assessments and the wander guard checks. I am not sure what all (V21) checks with the wander guard. (V22/Restorative Nurse) was doing the wander checks and logs prior to (V21). I cannot find any logs of the wander guard checks ever being done." On 12-20-20 at 10:55 AM, V30 (CNA) stated, "I do not check the wander guards for expiration dates, and I do not check wander guards to make sure they are working." On 12-20-20 at 3:15 PM V22 (Restorative Nurse) stated, "The Restorative Aide (V26) has a log to check the resident's wander guards. (V26) was to check the wander guards daily with a transmitter to make sure the wander guards are working. I never checked the wander guard bracelets. That was (V26's) responsibility, not mine. I was never told that I was responsible to check the wander guard bracelets." On 12-20-20 at 3:25 PM V26 stated, "I have been the restorative aide for a few months. I have never checked the wander guard bracelets or filled out the log. It would have been nice if (V22)	S9999		

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
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S9999	Continued From page 14 would have told me that I was responsible for checking the wander guard bracelets." (A)	S9999		