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
	IL6002950	A. BUILDING: ______ B. WING ______	C 07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVENS SENIOR LIVING	1790 SOUTH FAIRVIEW AVENUE DECATUR, IL 62521

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S 000	Initial Comments Complaint Investigation 2164437/IL135314	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.2900 d)2) 300.3100 d)2) 300.3240 a) 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 care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.2900/300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to supervise residents at risk for elopement, failed to maintain a functional door alarm/electronic monitoring system, and failed to implement additional safety precautions during the alarm system failure for fifteen (R1-R15) of fifteen residents reviewed for elopement on the sample list of 15. This failure resulted in R1, a resident with severe cognitive impairment, exiting the facility alone and undetected by staff on 6/28/21 at 5:34 am. R1 was found 0.9 miles from the facility walking on Route 48 (a three-lane highway) on 6/28/21 at 5:57 am. During the time of the elopement, R1 sustained a witnessed fall, which resulted in a two-centimeter laceration to R1's left eyebrow which required sutures. Findings Include:	S9999		

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S9999	Continued From page 2 The facility Elopement and Search Policy, dated February 2014, documents this policy is a "method for protecting residents who are at risk for elopement and for conducting an organized search for a resident who cannot be located. All nursing personnel are responsible for knowing the whereabouts of residents for which they are assigned. Residents are not permitted to leave the building alone unless a physician order is present. Residents who have been identified as cognitively impaired and who have been assessed as an elopement risk will be provided with an elopement prevention device (arm or ankle bracelet), or be placed in an area of the facility that has a door alarm device with audible sound, or on a secured/locked unit. All personnel are responsible for promptly reporting/replacing malfunctioning elopement prevention devices. Maintenance is responsible for fixing/replacing any exit doors that do not alarm. Appropriate security measures will be implemented to assure the resident is monitored to prevent reoccurrence of elopement." R1's Elopement Report, dated 6/28/21 by V8, RN (Registered Nurse), documents at 5:34 am, another hall called {station 2} and alerted staff there was a door alarm on station 4 sounding, and staff needed to check on R1. Staff immediately checked R1's room as well as the entire station 2 {where R1 resides}. Staff proceeded down to station 4 to check the door alarm that was sounding. A sweep of the facility campus, as well as the other halls were checked. R1 was seen approximately 5-10 minutes prior to receiving the call. At 5:57 am, V8 was notified R1 was with staff. When V9, CNA (Certified Nursing Assistant), found R1 outside of the building, R1 was ambulating. V9 called out R1's name, and R1 turned around, lost balance and fell to the	S9999		

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ground, at which time R1 hit R1's head on the ground causing a laceration to R1's left eyebrow area.

R1's Elopement Report, dated 6/28/21, includes a note from V1, Administrator, documents after interviewing staff and reviewing R1's medical record, R1 is alert with confusion. R1 wandered and walked down station 4 exiting outside door. Station 3 nurse (V10, Licensed Practical Nurse, LPN) heard the alarm sound when exiting another resident's room. Staff immediately went to station 4 exit door and had a head count performed, which was off by 1. Staff immediately went outside searching for R1. R1 was nowhere on facility grounds. Staff got in cars and found R1 walking on a "nearby road." Staff called R1's name which startled R1. When R1 turned to look, R1 fell. R1 was brought back to the facility. A head to toe assessment performed, to reveal a small cut to forehead, which was cleansed and bandaged. R1 was put on 1:1's and a staff member is "manning" station 4 {where the electronic monitoring monitor is located}.

R1's MDS (Minimum Data Set), dated 5/20/21, documents R1's BIMS (Brief Interview for Mental Status) Score as 5, which indicates severe cognitive impairment. This MDS also documents R1 requires supervision for ambulation, and "wanders". R1's Care Plan, dated 6/15/21, documents R1 has Dementia and has a behavior problem of "wandering and exit seeking", with an intervention to place an electronic monitoring bracelet on R1.

On 6/28/21 at 10:45 am, R1 was not in R1's room. V4, CNA (Certified Nursing Assistant), assigned to station 2, where resident resides, stated V4 was unsure where R1 is; R1 wanders

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all over, "you might want to check on station 3, that is where he was just moved from." On 6/28/21 at 10:48 am, R1 was observed ambulating in station 3, without 1:1 supervision as there were no staff in the area. R1 had a bandage over R1's left eyebrow area. R1 stated R1 hit R1's head on R1's truck yesterday, and that is why R1 had the bandage covering R1's left eye. R1 did not recall eloping from the facility or getting into a car with a staff member.

On 6/28/21 at 11:10 am, V8, RN (Registered Nurse), stated R1 "is normally up all night pacing the halls. Around 5:20 this morning, (R1) was at the nurses station. (R1) was pacing as usual. At 5:34 am, I (V8) got a call from someone on station 3, not sure who, that called and stated the door alarms were sounding on station 4, and that we (facility staff on station 2) needed to make sure (R1) was here. I (V8) had everyone start to do head checks and I (V8) went to station 4. The exit {door} on station 4 was the door that was sounding. I (V8) announced over the speaker to do a head count and I (V8) went outside and walked around the facility to see if I (V8) could find (R1). (R1) was not in the facility nor outside so myself (V8), (V9 CNA (Certified Nursing Assistant)), and (V10 LPN (Licensed Practical Nurse)) got in our cars and drove around looking for (R1)." V8 stated at 5:57 am, V9 called V8 to report V9 had located R1 on Route 48. V9 also reported to V8 when V9 called R1's name, R1 turned around and fell, receiving a laceration to R1's left eyebrow. V8 stated R1 is confused and oriented to R1's name only.

R1's Progress Notes, dated 6/28/21, documents R1 is picking at the wound closure strips that had been applied to R1's left eyebrow, as a result of the fall that happened after R1 eloped from the

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facility, and they are no longer keeping the laceration closed. R1 was sent to the hospital and returned with six sutures in place.

The facility undated Listing of Residents at Risk for Elopement documents R1-R15 are at risk and utilize an Electronic Monitoring Device.

A facility Work Order #4038, dated 3/25/21, documents the monitors for the electronic monitoring system are not working. An Email Communication provide by the facility, from V11, Electronic Monitoring Contractor, dated 6/28/21, documents on 5/4/21, a new "Black Box Transmitter" was installed at the facility and an additional six receivers were ordered. On 6/28/21 at 11:24 am, V3 stated the receivers that were ordered "are what will make the station monitors work with the new black box communicator. Until then, even with the new black box {on station 4}, the monitors on the stations don't work." At this time, V3 also confirmed that the facility electronic monitoring system has not been fully functional since 3/25/21.

On 6/28/21 at 11:02 am, V3, Maintenance Director, stated the facility recently got a "new main alarm communicator box" for the electronic monitoring system due to the previous one no longer working, but the new communicator box does not communicate with the other alarm boxes on the different Stations {parts of the building} like the previous one did. V3 stated the only way to know if an alarm for the electronic monitoring system is alarming {to show the door has opened}, is if you are on that station and can hear it, or if you are on station 4 looking at the alarm communicator, since the monitors on the other stations aren't working.

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S9999	Continued From page 6 On 6/28/21 at 12:55 pm, V8, RN, stated "the monitors on the walls should be on and then when a resident who is an elopement risk gets close to them or tries to open the door, the monitor will tell us which door is alarming and which resident caused it to go off." V8 stated the monitors have not been working for "awhile." "Had the monitors been working, I (V8) would have known immediately this morning that the door was sounding and I (V8) could have responded but I (V8) couldn't hear the door {alarm} on station 4, from here on station 2 (across the building). Station 4 is currently closed so no staff {are} down there. The only way station 3 heard it this morning is because it was quiet at 5:30 am." V8 stated nothing new had been implemented by the facility for resident safety while the electronic monitoring system wasn't functioning correctly. On 6/28/21 at 1:10 pm, V12, LPN, stated the electronic monitoring system has "not worked in months. You can only hear the alarms on your station." V12 also stated, "it wasn't until after this morning's elopement {by R1}, that they {facility} initiated every hour check sheets for us to fill out on the resident location" for those residents who are at risk for elopement." On 6/28/21 at 1:25 pm, there was no staff on station 4 monitoring the electronic monitoring system monitor. On 6/28/21 at 1:30 pm, V13, QA (Quality Assurance) Nurse, stated the electronic monitoring system monitors were not working and haven't worked since 3/25/21, and no other interventions were put into place for resident safety. On 6/28/21 at 1:32 pm, V1, Administrator, confirmed the electronic monitoring system had not been fully functional since March 2021 due to waiting on parts to make the electronic monitoring	S9999		

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system monitors work.

On 6/28/21 at 1:38 pm, V2, DON (Director of Nursing), stated V2 had been off work from February - May 2021, but upon V2's return, V2 was made aware that the electronic monitoring systems monitors did not work and that the facility was waiting on parts for it. V2 explained the audible alarm at the door itself still worked but that the monitors on the floor (hallways and stations) didn't work expect for on station 4, so unless you were in close proximity to the actually door that had been alarmed, staff would not be able to hear the alarm sounding. V2 stated no new safety measures were put into place while the monitors were down. V2 stated V2 had been made aware the morning of 6/28/21 that R1 had eloped from the facility, and made it to "the roadway (Route 48)" but was unsure of the exact location R1 was found.

On 6/28/21 at 1:42 pm, V14, SSD (Social Service Director), stated when R1 first came to the facility, R1 would wander around, but not try to exit, but this past week, R1 has been exit seeking, and trying to get out. V14 confirmed the electronic monitoring system has not been fully functional since March 2021 and stated no other systems were put into effect at that time for resident safety and monitoring of residents at risk for elopement.

On 6/28/21 at 2:22 pm, there was no staff on station 4 monitoring the electronic monitoring system monitor.

On 6/28/21 at 2:32 pm, V9, CNA, stated V9 was at station 2 when V9 was alerted that a door alarm was sounding so staff needed to make sure all of our residents were in their rooms. V9 stated V9 could not hear an alarm sounding.

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"When we realized R1 was not in R1's room, (V8, RN) immediately announced overheard that a head count needed to happen. Some people stayed inside looking, while others went outside looking on the property and others left in their cars." V9 stated V9 left in V9's car. "I rode around, and rode around, and finally saw (R1). (R1) was walking down the main road." V9 stated R1 was walking south and "was by a stoplight and there were cars driving past {R1} and nobody even stopped until I (V9) yelled (R1's) name and (R1) fell. I (V9) pulled over to the side of the road and then a car stopped to help, but I (V9) told them {people in the car} that I (V9) didn't need their help." V9 stated R1 received a laceration above R1's left eye during the fall. V9 was unable to state exactly where R1 was located due to not knowing the names of the road, so at 3:17 pm, observations were completed with V9 on R1's whereabouts, which was at the intersection of Route 48 and Rock Springs Road, 0.9 miles from the facility. This location is a busy, three lane state highway with a railroad running parallel to the road, and a speed limit of 40 MPH (miles per hour). In order to get to get to this location on foot, R1 would have had to either walked on the road from the nursing facility, or walked through the properties of the surrounding the nursing facility which is located in a densely wooded neighborhood, which V9 confirmed.

On 6/29/21 at 8:45 am, there was no staff on station 4 monitoring the electronic monitoring system monitor. On 6/29/21 at 9:10 am, V3, Maintenance Director, stated the parts to make the hall and station monitors work came in and V3 installed them during the afternoon of 6/28/21, but that the electronic monitoring system monitors are "still not working."

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