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	IL6003644	A. BUILDING: _____ B. WING _____	C 11/27/2018

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NILES NSG & REHAB CTR	9777 GREENWOOD NILES, IL 60714

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S 000	Initial Comments Complaint Investigation #1897549/IL00107436	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 were not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain the functionality of the alarm system by staff immediately disarming the emergency alarm that alerts all staff of an elopement. This failure resulted in the facility failing to maintain resident safety by not alerting staff of elopement and preventing the elopement of a newly admitted resident. The facility further failed to immediately act to search for the resident who wandered off unsupervised resulting in the resident (R1) sustaining multiple injuries and fractures then emergently transferred to the hospital ER for treatment. This failure affects one (R1) of four residents reviewed for dementia with wandering behaviors in a sample of four residents. Findings include: R1 is a 90 year old admitted on 11/17/18 with diagnoses Dementia, Low back and shoulder pain, Age-related Osteoporosis, and recurrent Depressive Disorders. Nursing progress notes dated 11/17/18 written by V5 (RN-Registered Nurse) states, "Patient is new admitted from other nursing home to here at 1 PM with son. Pt is not used any assist devices. Steady and balanced gait. Alert and Oriented x	S9999		

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2-3 forgetful. Korean speaks better, Diagnosis: low back pain , Right shoulder pain, Cervicalgia, spondylolisthsis lumbar region, osteoporosis without fracture, Dementia, Depression. Dining room at 1st main. vitals taken. Called attending doctor and left message. Continence on both B/B. Faxed hard script for Oxycodone and Fentanyl patch to pharmacy. Assist pt at time. Endorse to next nurse. Will give PPD at evening shift.

Nursing progress notes written over eight hours later by V3 (RN) at 9:33 PM states,"Incident note: Resident left building exit setting off facility alarms. Search was conducted. Police notified. Medical director notified. Son is aware. Resident currently at hospital as he sustained a fall in the community."

Interview with V9 (weekend receptionist) on 11/21/18 at 1:23 PM states, "I was with V8 (CNA-Certified Nurse's Aide) at the reception desk. V8 was looking at his schedule which is posted at my desk. We were monitoring (R1). I saw the resident come back in the building from the yard. It was cold and he was wearing only a sweater and sweat pants. He went back inside from the backyard entrance. All of a sudden he disappeared from the security camera around 5:50 PM. It was dark outside already. The emergency alarm rings in the front at my desk. I told V8 to go look for him. 3-5 minutes pass and I got a bad feeling so I called V3 (Weekend Nursing Supervisor) and told her we might have a resident that left the building. I decided to call a code purple (missing resident). We continued to monitor the situation and we had called every floor.

Asked if the emergency alarms go off on the floors, V9 stated, "No just at my desk. I turned

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them off right away because V8 was standing there and I just told him to go out back and look."

Asked what he was supposed to do when the emergency alarms go off, V9 stated, "I'm supposed to call a code green, It's when a resident escapes. I know I didn't but I thought he (R1) might have just gone back upstairs."

Asked if a code green was ever called so that staff would immediately come down to search outside, V9 stated, "Well they started later after doing the code purple and about six CNA's'. came down to look for him on the main level."

Asked when the staff went outside to conduct the search, V9 stated, "I guess it was 30-40 minutes later. V9 went outside this time and walked around the building but didn't see R1 but by then we got a call from the hospital saying (R1) was there."

Facility's undated policy titled "Resident elopement and missing resident policy" states, "It is the policy of this facility that personnel who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken. Procedure: In the event of resident elopement, every reasonable effort will be made to return the resident to the unit. The following will be implemented: A. Code Green will be announced with the exit door that the resident has used. (This also includes all instances of an exit door alarm that goes off and there is nobody seen exiting through that exit door.) B. Staff must respond to the code and go to the exit location that was announced. If a resident is found and redirected back inside, then Code Green will be canceled by announcing

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"Code Green all Clear", If there was no resident upon searching outside, then proceed to C: Do head count and make sure all residents on your floor are accounted for. D. When all residents are accounted for, Code, Green will be canceled.

Missing Resident Procedure: Code Purple is initiated on the overhead paging system to alert staff of a missing resident. Contact administrator or designee and Director of Nursing or designee immediately. Initiate coordinated, organized search of the facility grounds, maintain on to two people on each unit to attend to resident's needs during the search. If the resident is not located after the building and the grounds have been searched, call in other department heads, the responsible party or POA, physician, and the police and expand the search to the local neighborhood. Search the facility and the grounds again.

Interview with V8 at 11/21/18 at 11:15 AM states, "He's a new resident (R1). I came around 3 PM when my shift starts and went to the dining room around 5 PM and served the food tray to (R1) I was assigned to. I saw him in the day room up to 5:50 PM. I took all the meal trays and cart to the kitchen door. I redirected (R1) to the elevator then I went to the reception desk and checked my schedule. At that time (R1) came back to the reception area. Then he went outside the patio doors to the yard and V9 saw him on camera."

Asked what it was like outside, V8 stated, "It was cold out and already dark outside."

Asked what R1 was wearing V8 stated, " He was wearing a T-shirt and pants so he went back inside the other door. I went to check and R1 wasn't there. I didn't hear the emergency alarm.

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S9999	Continued From page 5 There is no alarm here (at security door) just at the desk. I then went upstairs and told my nurse and another CNA that I was going outside to look. I searched for 10-15 minutes probably starting around 6:30 PM." Asked to show surveyor the security door (R1) exited from, V8 walked out to the patio and back inside the back of the building and to the security door in question. On the security door read a sign saying "door alarmed". V8 opened the door but no alarm rang. Asked about this, V8 stated, "I don't know sir, I think it just rings in the front (reception)." Interview with V5 (RN) on 11/21/18 at 11:30 AM states, "I admitted (R1) around 1:00 PM. I went with V6 (RN) because I don't speak Korean. I did a head-to-toe assessment and I checked his gait and he walked by himself with a steady gait. He seemed aware and I did an elopement assessment and he was ok. He was pretty much calm." Asked if she heard any alarm go off when R1 triggered the security door, V5 stated, "No." Asked if she went outside to do a search, V5 stated, "I didn't go". Asked if she was responsible for supervising R1, V5 stated, "Yes, he was my resident." On 11/21/18 at 11:45 AM, V1 (Administrator) was asked to show surveyor where R1 exited the building, V1 showed the back exit doors and opened the door for the surveyor. A loud shrieking alarm and flashing strobe lights went off and numerous staff came down the back of the stairs.	S9999		

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Asked why the same alarm did not go off during V8's demonstration earlier, V1 stated, "Receptionist must have turned them off."

Interview with V6 (RN) on 11/21/18 at 12:11 PM states, "I helped assess (R1). He was alert, spoke Korean and he knew who he was. He had diagnosis of dementia but he was not on our locked unit.

Asked if she helped search for R1 outside, V6 stated, "No. There was no alarm but I did a head count on the floor and we couldn't find him."

Interview with V1 (Administrator) on 11/26/18 states, "We immediately suspended V9 pending the investigation of this incident and he has now resigned his post. (V9) worked only weekends and was PRN (as needed) basis. This should not have happened. We have installed new alarms and now they ring at all security doors so the receptionist cannot just turn off the emergency alarm." V1 added, "We've been conducting regular tests and in-services but I see we still need some more work."

Interview with V12 (Physician) on 11/26/18 at 12:30 PM states, "I got paged that day but I was told of a new admission but that he was already in the ER. I found this out late in the evening probably around 9 or 10, I'm not sure. Sometimes it is hard for me to hear my pager when I am in the hospital you know."

Asked to comment about the elopement, V12 stated, "This should not happen but family is usually with resident when they are new and should have stayed with resident."

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S9999	Continued From page 7 Asked to clarify statement as to who should stay with the resident, V12 stated, "This happens a lot (elopements). I see it everywhere." Asked how a 90 year old could leave a facility unnoticed, V12 stated, "I don't know, you have to ask administration. He cannot walk fast so I don't know how it happened." Hospital radiology reports 11/17/18 shows, "Findings: Right prefrontal hematoma without underlying calvarial fracture. Minimally displaced left lateral orbital wall fracture. Minimally displaced left inferior orbital floor/rim fracture and left zygomatic arch fracture. Minimally displaced left anterolateral maxillary sinus wall fracture. Fracture of the medial left maxillary sinus wall. Mild bilateral periorbital hematomas. Right prefrontal scalp; hematoma without underlying calvarial fracture." Hospital consultation reports dated 11/21/18 shows, "Consultation: obtained from the medical record. Patient does not follow commands. (R1) is a 90 year old male with dementia who presented as a trauma after he was found wandering the streets with cutaneous manifestations of facial trauma. He lives in a nursing home and per report he left unsupervised. He was transferred due to concerns for unwitnessed fall and signs of facial trauma. He was evaluated in the ED. CT of the face revealed multiple facial fracture for which Plastic Surgery is consulted for definitive management. Ophthalmology is also at the bedside at the time of my evaluation. CT of Head: Extensive intracranial atherosclerosis and moderate intracranial small vessel ischemic disease. Mild to moderate bifrontal temporal volume loss. Large right	S9999		

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S9999	Continued From page 8 prefrontal scalp hematoma without underlying calvarial fracture. Left inferior orbital floor/rim fracture. Minimally displaced fracture anterolateral left maxillary wall. All fractures non-operative. While argument may be made for reducing the left zygomatic fracture, given patient's age, I would not recommend any intervention. Appreciate ophthalmology evaluation of the globes bilaterally. Plan of care relayed to Surgery Service. Plastic surgery to sign off. Eye consult: Patient has history of trauma to left side of head with orbital floor fracture being followed by plastics. He is not able to open either eye because of lid swelling." (A)	S9999		