STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145043	A. BUILDING _____ B. WING _____	C 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL CARE CENTER-KANKAKEE	**900 WEST RIVER PLACE KANKAKEE, IL 60901**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1671558/IL84230	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide supervision of one confused resident with Dementia and failed to provide monitoring/supervision of an unlocked door . These failures resulted in one resident (R1) leaving the building without facility knowledge and walking to a four lane highway where he fell, sustaining bruises and an abrasion. This applies to one resident (R1) out of three reviewed for safety/elopement. Findings include: R1 is an 84 year old male admitted to the facility 9/10/15 with numerous medical diagnoses including malignant neuroleptic syndrome and Dementia. R1's Admission Nursing Assessment documents the following: moderately impaired cognitive skills for daily decision-making; R1 has poor decision-making and requires cues and supervision. Under the section entitled "Exit-seeking," this documentation states R1 has	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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a history of wandering. R1 was also noted to have a history of falls and urinary incontinence. Under section entitled "activity," assessment states R1 walks occasionally during the day for very short distances, with or without assistance, but spends most of each shift in bed. Admission (9/26/15) MDS (Minimum Data Set) BIMs score (Brief Interview for Mental Status) was scored as 12 (out of 15) indicating some cognitive impairment. Section G of R1's admission MDS reflects for ambulation off the unit, R1 was scored as a 3/3, indicating R1 required extensive assistance of 2 for moving to and returning from off-unit locations. R1 was assessed as being independent with walking in his room and requiring supervision walking in the corridor (1/1). R1's MDS indicates R1 used both a walker and a wheel chair.

R1's incident report dated 9/30/15 and timed at 6:30 PM states the facility received a telephone call from the local police stating they had found a resident several blocks away. He had been injured and the police were taking him to the hospital. This incident report documents notification of R1's family and attending physician.

On 3/29/16 at 12:45 PM, E2 (DON) stated (with E1, Administrator present) on 9/30/15, just after dinner, R1 (who had periods of confusion) walked out of the facility. E2 stated R1 just decided to leave and the facility investigation determined he had most likely walked out of the main entrance of the facility. According to E2, although he had a documented history of wandering and periods of confusion, R1 had not exhibited exit-seeking behavior since admission. At the time of the occurrence, the main entrance was not being monitored by staff or by cameras. E2 stated

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although the facility did not have a certified Dementia unit at the time, they did accept residents with a Dementia diagnosis who had other diagnoses which required treatment, and those residents were in rooms scattered throughout the building. They were not contained in any locked unit. According to E2, staff were not aware R1 had left the building until the local police called the facility to notify them of finding R1 several blocks away. A nurse got the phone call and gave the phone to a supervisor and then a Code Green was called, which is the facility's protocol for a missing resident. A search was done and it was identified R1 was missing. The police and ambulance brought R1 to the facility for identification, and then took R1 to the hospital for evaluation. According to E2, R1 sustained an abrasion to his nose, but no serious injury, and he returned to the facility that same evening. E2 stated their investigation had established R1 was last seen leaving the main dining room at 6:15 pm. They received the phone call from the police dispatch at 6:27 PM. On 3/30/16, E2 stated although they have staff assigned to monitor in the dining room, those staff would be monitoring for safety and to ensure residents who needed help received it and to monitor intake. They would not be expected to follow any resident leaving the dining room. R1 ate in the main dining room which is located the closest of all the dining rooms to the main lobby/entrance. This dining room is used for residents who are more independent and could eat on their own, or with just supervision or minimal help.

The Police Case Report summary dated 9/30/15 indicates a time of 18:27 (6:27 PM) and documents a missing male adult from a nursing home. Narrative police documentation indicates

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F 323	Continued From page 3 at the above-referenced date and time, an officer was dispatched to Kennedy Dr. for a welfare check. A witness at the scene stated she had observed a confused older male adult, who was later identified as R1. R1 was determined to reside at the facility and had walked away. Facility staff had been notified and R1 was transported to the hospital as he was noted to be bleeding from the nose. On 3/29/16 at 3:20 PM, E5 (LPN) stated R1 was quiet and had Dementia. E5 stated she had seen him ambulating and using a wheel chair. E5 stated she hadn't cared for him but had seen him in passing. She denied him being a behavior problem and had no knowledge of him having any exit-seeking behavior. On the day of the incident, she received a call from the police who said they had found a person on Kennedy Drive and they were questioning whether he was a resident at the facility. E5 stated she gave the telephone to E4, a supervisor. E5 confirmed at that time, no one was monitoring the front door and it was unlocked until sometime in the evening. On 3/29/16 at 2:30 PM, E4 (RN/ADON) stated she had just become ADON at the time of R1's elopement from the facility. E4 recalled seeing R1 use a walker and responding to questions verbally. E4 stated he did have some confusion, but it was not readily apparent; you had to speak with him for a while before you realized he was confused, because with superficial conversation, he was verbally appropriate. She did not recall R1 being a behavior problem. E4 confirmed Dementia residents were scattered throughout the building. E5 originally got the call from the police and then she gave E4 the phone. The dispatcher told her someone had called into the	F 323		

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police saying a resident had been hurt at the end of the block. E5 notified both E2 and the former Administrator. E5 recalled a Code Green being called and a search was done and it was determined R1 was missing. E5 stated she believed after his evening meal on that day in question, R1 just got up and walked out. At that time, there was no one monitoring the main entrance and no door bell at the main entrance.

On 3/29/16 at 3:00 PM, E3 (CNA) stated she recalls R1, who she described as quiet. He stayed in his room and did not exhibit behaviors. She stated she saw R1 several times throughout the shift, and he was visiting with his family earlier in the evening shift. E3 stated that she comes on duty at 2:00 PM. E3 recalled his family taking R1 to the main dining room and leaving around 4:00 or 4:30 PM. E3 stated that she was assigned to another dining room, so she did not see him during the evening meal and did not see him leave the dining room.

On 3/30/16 E1 stated on 9/30/15 she was working at the facility as a PRN (as needed) Director of Care Delivery and was considered part of management. She did not do direct care. On 9/30/15 she stated she overheard a phone call taken by a nurse seeming to question if a resident was missing. E1 stated she notified E2 about the phone call along with other Corporate staff and they took over the investigation. E1 stated she recalls seeing R1 brought into the facility by the ambulance on a stretcher. R1 was identified and was noted to have an abrasion to his nose and facility staff felt he should go to the hospital for evaluation, which was done. E1 stated she spoke to R1 when the ambulance brought R1 to the facility for identification and she

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asked him why he left. He said he was trying to go to a particular place but she could not recall where he said he was trying to go. She asked R1 how he had scraped his nose and he said that he didn't know.

Hospital emergency room records dated 9/30/15 for R1 document an abrasion to R1's nose. His primary diagnosis was fall and Dementia. The examining physician notes R1 was "disoriented but history of dementia." R1 was returned to the facility that same evening.

On 3:30/16 at 10:15 AM, E1 (with 2 - Property Management Consultant present) stated at the time of this occurrence, all doors except the front door were locked and alarmed. The front door automatically locked at 7:00 pm, but was unlocked during the day. There were no cameras in place then. E1 also stated the facility was owned by a different owner at the time of this incident, and after R1's elopement, the previous owner instituted a person to monitor the front door, both by contracting with an outside agency and utilizing staff. This continued through 1/4/16. On 1/5/16, new ownership took over and from 1/5/16 to 1/7/16, a doorbell was in place at the front door and staff had to physically go to the door to key in a certain code to allow entry and exit at that door. This continued until 1/27/16, when a light duty person was utilized to physically sit at the entrance to allow entry and exit to/from the building. Cameras and monitors were since installed in the building and this was completed by 2/25/16, per documentation provided by E1 from the facility's contracted vendor. Currently, the building has five cameras installed and monitors allowing for visualization. All doors are locked and alarmed and the entrance used by

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employees has a keypad that the employees must enter a code to gain access or exit. The front door is always locked and someone wishing to enter must ring a doorbell; either reception or nursing staff can look at a monitor to visualize who is at the door and grant access by hitting a button which will allow access; the same applies when someone exits the building - you must be buzzed out.

Hospital emergency room records dated 9/30/15 for R1 document an abrasion to R1's nose. His primary diagnosis was fall and Dementia. Examining physician notes R1 was "disoriented but history of dementia". R1 was returned to the facility that same evening. 10/1/15 nursing note timed at 3:02 am reflects a body assessment done on R1, reflected an abrasion of R1's nose and a small abrasion over his left eyebrow as well as numerous areas of bruising to the back of his left hand. R1 denied pain. A body alarm was placed on R1.

R1's care plan contains focus areas identified on various dates. On 9/29/15, the facility identified the focus areas as follows: activity interests; cognitive loss as evidenced by confusion related to Dementia (interventions included identifying self when speaking to resident, inviting R1 to participate in activities, providing cueing and prompting as needed, using simple words, cues and statements and using R1's name). Despite R1's history of wandering identified on admission, the facility failed to identify wandering as a focus area for R1 until 9/30/15, the date of his elopement. This care plan states it was created on 10/1/15, after R1's elopement. There was no increased supervision put in place for R1 despite his diagnosis of dementia, his confusion and

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F 323	Continued From page 7 history of wandering until after his elopement. On 9/30/15 the facility initiated a care plan for R1 being at risk for behavior symptoms related to dementia; this care plan was created on 10/5/15. Progress notes dated 9/23/15 through 10/7/15 provide numerous diagnoses for R1 including unspecified Dementia with behavioral disturbance. 9/29/15 nursing note timed at 10:25 PM notes R1 alert and oriented x 1 (oriented to person only). 9/23/15 nursing note timed at 9:54 PM states R1 is alert with confusion. Nursing note from 9/26/15 at 7:33 PM indicates R1 is alert and oriented x 1. Nursing note from 9/28/15 at 10:44 PM again indicates that R1 is alert and oriented x1, and he is able to make his needs known to staff, but only if asked. On 3/30/16 E2 stated she saw the admission assessment which noted a history of wandering. She stated she spoke to the admission nurse who could not recall where she obtained that information, but thought it was possibly in a report from the hospital when R1 was first admitted. In the hospital, R1 had been so confused he required a sitter because he was getting up and falling, but this was felt to be a result of a specific medication which had been stopped and the confusion improved somewhat. However, nursing notes as referenced above reflect some level of continued confusion for R1.	F 323		