STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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 Incident Report Investigation to Incident of 9/25/16/IL89066 A partial extended survey was conducted.	F 000		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility neglected to follow their operating policy on door alarms and potential elopement/missing persons for one (R1) of three residents reviewed for elopement in the sample of three. This failure resulted in R1, who is cognitively impaired and assessed as high risk for elopement, leaving the facility unnoticed at night only to be found a half mile from the facility at the intersection of a two lane highway. This failure resulted in an Immediate Jeopardy. While the immediacy was removed on 10/14/16, the facility remains out of compliance at severity level two. The facility is in the process of the folowing: monitoring R1 with staff - one on one, assisting R1 with placement to a secured dementia unit, screening all other residents at risk	F 224		10/27/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/28/2016

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for elopement then reassess and update care plans, an elopement binder with photos have been updated and placed on each unit, facility staff are being inserviced on the facility's elopement policy, facility have revised Elopement/ Alarm drill procedures, and initiating QAPI (Quality Assurance Performance Improvement) tool daily to assure compliance.

Findings Include:

The facility policy titled "Door Alarms" dated October 2015 directs facility staff to perform the following: "Respond immediately when alarm sounds by checking alarm panel for location of alarm and proceed to door. Investigate reason for alarm. Determine if all residents are safe and accounted for...."

The undated facility policy titled "Potential Elopement/Missing Person Protocol" directs staff to perform the following: "If a door alarm is activated and there is not visual line of sight as to who triggered the alarm, or anytime a resident is missing, a head count is required. Staff should announce "twenty-twenty" overhead to signal a head count to start.....staff should be checking the outside parameters of the building (front, back, left or right side of the building)..."

A facility Elopement Assessment dated 8/5/16 identifies R1 as being at High Risk for Elopement.

A facility Observation Report dated 8/5/16 documents that R1 is repeatedly attempting to elope, opening doors/setting off alarms of secured doors, resisting redirection from staff, verbalizing statements about leaving and wandering. The report documents that a door

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alarm band is applied to R1's wrist. The Minimum Data Set (MDS) dated 8/11/16 documents that R1 is severely cognitively impaired, has disorganized thinking and wanders on a daily basis. The MDS documents that with the above behaviors, R1 is at "significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)." This places R1 at higher risk for accidents.

A facility Incident Report dated 9/26/16 documents on 9/25/16 at approximately 9:22 pm a door alarm located on the north side of the facility and intersecting with the facility's D Wing and E Wing was sounding. The facility investigation documents that E8 and E10, Certified Nursing Assistants responded to the alarm. On arrival at the alarming door, resident R2 was standing near the door. According to the report R2 was redirected to E Wing and E8 and E10 returned to D Wing. The investigation report indicates neither CNA went outside of the building nor was a head count initiated to identify a potentially missing resident.

On 10/11/16 at 1:30 pm E1, Administrator stated that E8 and E10 responded to the door alarm but did not follow the facility policy on door alarms and potential elopements. E1 stated E8 and E10 did not open the door and go outside and check the grounds. E1 stated that E8 and E10 did not directly witness R2 set the alarm off.

On 10/11/16 at 3:05 pm, E6, Registered Nurse/E Wing confirmed that E6 had turned the alarm off when returning from break. E6 acknowledged that E6 did not go outside and check the grounds of the facility. E6 stated "I looked out the window, but I did not go outside and check."

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On 10/12/16 at 9:30 am E8, CNA confirms that E8 heard the door alarm going off and E8 and E10 responded and found R2 by the door. E8 stated that the door was closed and it was thought that R2 had just opened and closed the door, causing the alarm to sound. E8 stated that neither E8 or E10 opened the door and went outside to search the area. E8 stated "we just assumed it was (R2) setting the alarm off." E8 stated "We should have opened the door and checked outside. That's what our policy says."

On 10/12/16 at 9:55 am E7, CNA stated that CNAs E9 and E11 stated they had seen a resident of the facility outside down the road as they were coming on for third shift. E7 stated E9 reported the sighting to D Wing and E8 and E7 went out the front door and met E11 coming in and E11 stated that E11 thought R1 was down by the car wash. E7 stated "we (E7, E8) jumped in (E11's) car and went down to the car wash and there was (R1). (R1) was confused, wearing a tee-shirt, jeans and carrying a hospital gown. (R1) stated (R1) was going to (local village in opposite direction). We brought (R1) back to the facility." E7 stated the time was approximately 9:50 pm. (28 minutes after the door alarm sounded) and that the weather was cool that night.

On 10/12/16 at 11:30 am, E5 Licensed Practical Nurse D Wing stated that E5 did not go investigate the sounding door alarm. E5 stated "I just took what they (E8 and E10) said about (R2) setting the door alarm off." E5 stated that at approximately 9:45 pm, E9, CNA for third shift came to D wing and reported that E9 saw R1 walking down the road. E5 stated the overhead code "twenty-twenty" for a head count was called

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at this time (23 minutes after the door alarm had sounded).

On 10/12/16 at 12:45 pm, E9 stated E9 was traveling west on the main road that runs in front of the facility coming to work. E9 stated that about half way between the facility and the local car wash, E9 saw R1 walking on the shoulder of the road heading east and there were cars moving in both directions on the highway. E9 stated it was reported to D Wing and a head count was called at this time, approximately 9:45 to 9:50 pm(approximately 23 to 28 minutes after the door alarm sounded).

On 10/12/16 at 2:15 pm, E8 acknowledged that R1 was found at the car wash in a tee shirt, jeans and house slippers. E8 stated that E8, E7 and E11 brought R1 back to the facility around "9:50ish" pm.

On 10/12/16 at 4:10 pm the route that R1 would have traveled had uneven sidewalks and an adjacent field of six feet tall corn that is approximately five acres in size and not yet harvested. Immediately adjacent to the sidewalk is a major two lane, heavily traveled highway.

On 10/12/16 at 1:05 pm, Z1 Primary Care Physician for R1 stated that R1 is not safe outside alone. Z1 stated that it was dangerous for R1 to be out unsupervised. Z1 stated "there are a lot of things that could happen to (R1) that are not good for (R1's) health and safety." Z1 acknowledged that R1 was not safe to independently negotiate traffic, walk alone in the dark or navigate independently.

On 10-14-16 an Immediate Jeopardy was

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identified. The immediate jeopardy situation began on 9/25/16 when the facility failed to properly respond to a sounding door alarm and not following the facility's Door Alarm and Potential Elopement policies, resulting in R1 leaving the building unnoticed. R1's health, safety and life were in danger. R1 could have been struck by a motor vehicle, wandered into an adjacent corn field and not have immediately been found. E1 Administrator was notified of the Immediate Jeopardy on 10/14/16 at 11:10am.

The surveyor was able to confirm through record review and interview that the facility took the following actions to remove the immediacy:

1. R1 was returned to the facility with no injury or harm and has not eloped from the facility since 9-25-16.

2. On 9-25-16, facility assured that no other resident eloped from the facility. Facility conducted a head count to assure all residents were in the facility.

3. R1 has been placed under closer monitoring as of 9-25-16.

4. The facility is assisting R1 with placement to a secured dementia unit.

5. All other residents screened to be at risk for elopement, have been reassessed and care plans have been updated - completed on 9-28-16, by social services.

6. An elopement binder with resident photos have been updated and placed on each unit. Staff have reeducated on location of the binder

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F 224	Continued From page 6 on 9-26-16, by social services. 7. Facility staff have been in-serviced on Elopement Policy as of 9-26-16, by administrator. 8. Facility have revised Elopement/ Alarm Drill procedures as of 9-26-16 by the administrator. 9. QAPI tool initiated daily to assure compliance as of 10-14-16. Results will be reviewed at the QAPI Meeting.	F 224		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		10/27/16

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Based on record review and interview, the facility failed to revise and update the Care Plan of R1, identifying R1 as being assessed at high risk for elopement and failing to implement targeted interventions to prevent R1 from exiting the facility unsupervised. R1 is one of three residents reviewed for Elopement in the sample of three.

Findings include:

The September 2016 facility Face Sheet includes the following diagnoses for R1: Dementia, Transient Ischemic Deafness, Blepharochalasis of the left eye (inflammation of the eye lid with skin drop over the eye) and Cardiac Pacemaker.

On 8/5/16, R1 was assessed by the facility as being at high risk for elopement. On 8/5/16 an Observation Report documents that a door alarm band was placed on R1's right wrist.

R1's Care Plan dated 9/24/16 did not include documentation of a problem statement for R1 being at high risk for elopement, nor did the Care Plan have targeted interventions/approaches to prevent R1 from leaving the facility alone and unsupervised.

The following Nursing Notes document R1's repeated attempts to exit the building: 8/5/16, 8/10/16, 8/15/16 and 8/16/16.

On 9/25/16 at 9:22 pm, a facility Incident Report documents that R1 exited the facility's D/E Wing door, setting off the door alarm. Two Certified Nursing Assistants (E8 and E10) responded to the alarm and found R2 nearby. According to the report E8 and E10 redirected R2 and did not go outside of the door and investigate. The alarm

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F 279	Continued From page 8 was turned off by E6, Registered Nurse. On 10/11/16 at 1:30 pm, E1 Administrator stated the facility had video of R1 going out the D/E Wing door at 9:22 pm. On 10/12/16 at 12:45 pm, E9, Certified Nursing Assistant (CNA) stated that E9 had reported seeing R1 on 9/25/16 at about 9:45 or 9:50 pm to the Licensed Practical Nurse on D wing. E9 stated R1 was half way between the facility and local car wash. E9 stated R1's room was checked and it was empty. E9 stated two other CNAs left the building to go get R1. On 10/12/16, E7, CNA stated that E8, E11 and E7 (all CNAs) retrieved R1 from the car wash and returned R1 to the facility at about 9:50 pm. On 10/11/16 at 2:30 pm, E4 Social Service Director, the employee responsible for revising/updating behavior Care Plans for the facility, acknowledged that R1's Care Plan did not include a problem statement of "Potential Elopement". E4 acknowledged there were no targeted interventions for R1's exit seeking behaviors and being at high risk for elopement. E4 stated awareness of R1's previous attempts to exit the facility. E4 stated, "I just didn't get the Care Plan updated."	F 279		
F 323 SS=J	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.	F 323		10/27/16

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to supervise (R1) who is assessed as being at high risk for elopement. This failure resulted in R1 leaving the building unnoticed at night. R1 who is severely cognitively impaired was found near an intersection of a two lane highway one half mile from the facility. This facility failure had the potential to cause serious injury or death to R1. R1 is one of three residents reviewed for supervision in the sample of three.

These failures resulted in an Immediate Jeopardy.

While the immediacy was removed on 10/14/16, the facility remains out of compliance at severity level two. The facility is in the process of the folowing: monitoring R1 with staff - one on one, assisting R1 with placement to a secured dementia unit, screening all other residents at risk for elopement then reassess and update care plans, an elopement binder with photos have been updated and placed on each unit, facility staff are being inserviced on the facility's elopement policy, facility have revised Elopement/ Alarm drill procedures, and initiating QAPI (Quality Assurance Performance Improvement) tool daily to assure compliance.

Findings Include:

The facility Face Sheet dated September 2016 for R1 includes the following diagnoses: Dementia,

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Transient Ischemic Deafness, Cardiac Pacemaker and Blepharochalasis left eye (inflammation of the eyelid with drooping of skin over the eye).

The facility Elopement Assessment dated 8/5/16 identifies R1 as being at High Risk for Elopement. R1's Plan of Care dated 9/23/16 does not include a problem statement or targeted interventions for R1's known exit seeking behaviors.

A facility Observation Report dated 8/5/16 documents that R1 is repeatedly attempting to elope, opening doors/setting off alarms of secured doors, resisting redirection from staff, verbalizing statements about leaving and wandering. The report documents that a door alarm band is applied to R1's wrist at this time.

The Minimum Data Set dated 8/11/16 documents that R1 is severely cognitively impaired, has disorganized thinking and wanders on a daily basis, placing R1 at significant risk of elopement and accidents.

R1's Nursing Notes document the following:

"On 8/5/16 at 4:35 am Resident attempts to leave the building...."

"On 8/10/16 at 12:45 am Resident attempts to leave the building on "E" section...."

"On 8/15/16 at 1:30 am Resident attempts to leave the building..."

"On 8/16/16 at 1:00 am Resident attempts to leave the building..."

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"On 9/25/16 at 10:12 pm Resident found walking down the road by a CNA (Certified Nursing Assistant) coming to work."

A facility Incident Report dated 9/26/16 documents on 9/25/16 at approximately 9:22 pm a door alarm located on the north side of the facility and intersects with the facility's D Wing and E Wing was sounding. The facility investigation documents two Certified Nursing Assistants E8 and E10 responding to the alarm. On arrival at the door, resident R2 was standing near the door. According to the report R2 was redirected to E Wing and E8 and E10 returned to D Wing. The facility's investigation indicated that neither CNA went outside of the building nor was a head count initiated to identify a potential missing resident.

On 10/11/16 at 1:30 pm E1, Administrator stated that E8 and E10 responded to the door alarm and assumed that R2, who is also assessed as high risk for elopement had set the alarm off. E1 acknowledged that E8 and E10 did not go outside the door and look to see if there was a resident out of the facility. E1 stated "They did not follow facility policy."

On 10/11/16 at 2:00 pm Z2, family of R1 stated that when R1 lived at home, prior to admission R1 had left her house in pajamas and no shoes at 4:00 am. Z2 stated R1 is not safe alone. Z2 stated this incident had been communicated to E4, Social Services on R1's admit to the facility.

On 10/11/16 at 2:30 pm, E4 Social Services Director stated that Z2 had informed E4 on R1's admit that R1 had gotten out of Z2's house. E4 acknowledged that R1 was assessed by E4 and

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scored as being at high risk for elopement. E4 stated the problem statement for potential elopement and targeted interventions for elopement had not been added to R1's Plan of Care.

On 10/11/16 at 3:05 pm, E6, Registered Nurse/E Wing stated that at approximately 9:30 pm on 9/25/16, E6 was returning from break and the D/E wing door's alarm was sounding. E6 stated it was told to E6 that R2 had set the alarm off and E6 went to the door and used E6's key to shut the alarm off. E6 stated she did not open the door and go outside. E6 stated "I looked out the window but I should have went outside and looked."

On 10/12/16 at 9:30 am E8, CNA stated that E8 heard the door alarm going off and E8 and E10 responded and found R2 by the door. E8 stated that the door was closed and it was thought that R2 had just opened and closed the door, causing the alarm to sound. E8 stated that neither E8 or E10 opened the door and went outside to search the area. E8 stated "we just assumed it was (R2) setting the alarm off." E8 stated the alarm sounded for about ten more minutes and then E6, E Wing Registered Nurse came and shut the alarm off. E8 stated "We should have opened the door and checked outside. That's what our policy says."

On 10/12/16 at 9:55 am E7, CNA stated that CNAs E9 and E11 stated they had seen a resident of the facility as they were coming on for third shift. E7 stated E9 reported the sighting to D Wing. E8 and E7 went out the front door and met E11 coming in and E11 stated that E11 thought R1 was down by the car wash. E7 stated "we (E7,

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	145926	A. BUILDING _____ B. WING _____	C 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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E8) jumped in (E11's) car and went down to the car wash and there was (R1). (R1) was confused, wearing a tee-shirt, jeans and carrying a hospital gown. (R1) stated (R1) was going to (local village in opposite direction). We brought (R1) back to the facility." E7 stated R1 did not appear to have any injuries. R1 had a door alarm band on R1's right wrist. The weather was cool.

On 10/12/16 at 11:30 am, E5 Licensed Practical Nurse D Wing stated that E5 did not go investigate the sounding door alarm. E5 stated "I just took what they (E8 and E10) said about (R2) setting the door alarm off." E5 stated that at approximately 9:45 pm, E9, CNA for third shift came to D wing and reported that E9 saw R1 walking down the road. E5 stated the overhead code "twenty-twenty" for a head count was called.

E5 stated on 10/12/16 at 11:30 "R1 gets very aggressive between 4:00 pm and 8:00 pm wanting to leave the facility and that's why we give R1's medication of Xanax and Melatonin at 4:00 pm instead of bedtime. We are all aware that R1 tries to leave."

On 10/12/16 at 12:45 pm, E9 stated E9 was traveling west on the main road that runs in front of facility while coming to work (night shift). E9 stated that about half way between the facility and the local car wash, E9 saw R1 walking on the shoulder of the road heading east. E9 stated "I thought I recognized (R1's) shirt and I just got this sinking feeling in my gut." E9 stated E9 went to D Wing and asked if R1 was in bed. E9 stated that staff checked R1's room and R1 was not in R1's room. E9 stated a "twenty-twenty" was called overhead at this time, approximately 9:45 to 9:50 pm. E9 stated "two CNAs went and got (R1) at

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the car wash and brought (R1) back." E9 stated there were cars on the road going both ways when E9 saw R1 on the shoulder of the road.

On 10/12/16 at 2:15 pm, E8 acknowledged that R1 was found at the car wash in a tee shirt, jeans and house slippers. E8 stated that E8, E7 and E11 brought R1 back to the facility around "9:50ish" pm.

On 10/12/16 at 1:05 pm, Z1 Primary Care Physician for R1 stated that R1 is not safe outside alone. Z1 stated that it was dangerous for R1 to be out unsupervised. Z1 stated "there are a lot of things that could happen to (R1) that are not good for (R1's) health and safety." Z2 acknowledged that R1 was not safe to independently negotiate traffic, walk alone in the dark or navigate independently.

On 10/12/16 at 4:10 pm the route that R1 would have likely traveled had uneven sidewalks and an adjacent field of six feet tall corn that is approximately five acres in size, not yet harvested. Immediately adjacent to the sidewalk is a major two lane, heavily traveled highway.

The facility policy titled "Door Alarms" dated October 2015 directs facility staff to perform the following: "Respond immediately when alarm sounds by checking alarm panel for location of alarm and proceed to door. Investigate reason for alarm. Determine if all residents are safe and accounted for...."

The undated facility policy titled "Potential Elopement/Missing Person Protocol" directs staff to perform the following: "If a door alarm is activated and there is not visual line of sight as to

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who triggered the alarm, or anytime a resident is missing, a head count is required. Staff should announce "twenty-twenty" overhead to signal a head count to start.....staff should be checking the outside parameters of the building (front, back, left or right side of the building..."

On 10-14-16 an Immediate Jeopardy was identified. The immediate jeopardy situation began on 9/25/16 when the facility failed to supervise R1 who had known exit seeking behaviors, resulting in R1 exiting the facility unnoticed. This created a potentially dangerous situation for R1. E1 Administrator was notified of the Immediate Jeopardy on 10/14/16 at 11:10am.

The surveyor confirmed through record review, observation, and interview that the facility took the following actions to remove the immediacy:

1. R1 was returned to the facility with no injury or harm and has not eloped from the facility since 9-25-16.

2. On 9-25-16, facility assured that no other resident eloped from the facility. Facility conducted a head count to assure all residents were in the facility.

3. R1 has been placed under closer monitoring as of 9-25-16.

4. The facility is assisting R1 with placement to a secured dementia unit.

5. All other residents screened to be at risk for elopement, have been reassessed and care plans have been updated - completed on 9-28-16, by social services.

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F 323	Continued From page 16 6. An elopement binder with resident photos have been updated and placed on each unit. Staff have reeducated on location of the binder on 9-26-16, by social services. 7. Facility staff have been in-serviced on Elopement Policy as of 9-26-16, by the administrator. 8. Facility have revised Elopement/ Alarm Drill procedures as of 9-26-16 by administrator. 9. QAPI tool initiated daily to assure compliance as of 10-14-16. Results will be reviewed at the QAPI Meeting.	F 323		