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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145431 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Loft Rehabilitation & Nursing | | STREET ADDRESS, CITY, STATE, ZIP CODE 700 North Main Street Eureka, IL 61530 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682</p> <p>Based on observation, interview, and record review the facility failed to ensure all facility door alarms sounded loud enough for immediate staff response, immediately search the premises for a resident once a door alarm was heard sounding and provide adequate supervision to a cognitively impaired resident with a history of exit seeking for one of three residents (R1) reviewed for elopement risk in the sample of five. These failures resulted in R1, a severely cognitively impaired resident with the diagnosis of Dementia, exiting the facility without staff knowledge or supervision on 9-10-24, walking over 1635 feet down a hill, falling by a tree that was located approximately 25 feet from a main street, causing R1 to sustain two fractures to the end of the forearm (at the wrist), excruciating pain, abrasions to the chin and right arm, and hospitalization for treatment.</p> <p>Findings include:</p> <p>These failures resulted in an Immediate Jeopardy.</p> <p>While the immediacy was removed on 9-19-24, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>The facility's Elopements and Wandering Residents policy dated 5-6-24 documents, Policy: The facility ensures that resident who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering and elopement risk. Definition: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. Policy explanation and compliance guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risk, and monitoring of effectiveness and modifying interventions when necessary. 4. Monitoring and managing residents at risk for elopement or unsafe wandering. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary team. b. The interdisciplinary team will evaluate the unique factors to contributing the risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the residents' behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff.</p> <p>R1's Admission Record documents R1 is a [AGE] year-old that was admitted to the facility on [DATE] with the diagnoses of Parkinsonism, Dementia, Neurocognitive Disorder with Lewy Bodies, Altered Mental Status, Depression, Muscle Weakness Unsteadiness on Feet, Lack of Coordination, Hallucinations, and a History of Falling.</p> <p>R1's current Order Summary Report documents, Order date 1-31-24: (electronic monitoring bracelet) check for function and placement daily.</p> <p>R1's current Care Plan documents, Focus 2-2-24: I (R1) wander with no rational purpose, seemingly oblivious to my needs or safety throughout the healthcare center. Goal: I will wander safely within the facility by next review. Interventions: I wear an (electronic monitoring bracelet) to my left wrist. Please check it works routinely to ensure my safety. I am at risk for falling due to lack of coordination, limited mobility, forgetting my limits, the diagnosis of Parkinsonism, and due to psychotropic medication use.</p> <p>R1's Fall assessment dated [DATE] documents R1 was at a high risk for falls.</p> <p>R1's MDS (Minimum Data Set) assessment dated [DATE] documents R1 is severely cognitively impaired.</p> <p>R1's Elopement Risk assessment dated [DATE] documents R1 was a high risk for elopement, was fully ambulatory, wanders aimlessly, and has two or more diseases (Dementia, any type of mental illness).</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>R1's Social Service Note dated 2-2-24 at 1:26 PM and signed by V10 (Social Services) documents, (R1) admits for long term care. (R1) did reside with (V6/R1's Family member) but due to (R1's) progression of Dementia, (V6) is unable to care for (R1) at home safely. (R1) at times is able to answer conversations appropriately (and) other times seems to not understand or articulate answer that goes with conversation at hand. (R1) is in the memory unit. (R1) also has displayed exit seeking behaviors generally toward afternoon and nights. (R1) does have an (electronic monitoring device bracelet) for safety measures as (R1) is new to her environment and does have episodes of active wandering and exit seeking behavior.</p> <p>R1's Local Police Department Incident #24-EUREKA-03436 dated 9-10-24 at 4:55 PM and signed by V3 (Local Police Officer) documents, On 9-10-24 at approximately 4:55 PM, I (V3) was on routine patrol around the (facility campus) and I was flagged down by (V4/Chief Executive Officer Assisted Living) in regard to a missing resident (R1). I advised (V4) that I was not notified of any missing person and advised that I was just driving through, but that I would help locate (R1). (V4) advised (R1) has been reported missing from the memory care facility within (the facility) about 15 minutes prior to (V4) flagging me down. Several staff members were on foot looking for the missing female. While searching the area, (V1/Administrator) flagged me down and advised that the missing resident (R1) had been located in the front of the building. I was advised that (R1) was walking and fell down the steep hill and has several injuries. It appeared that (R1) had a broken left wrist, a laceration on her right elbow, a laceration on her chin, had bit her tongue which was causing her mouth to bleed, and was complaining of back pain. It should be noted that (R1) told nearby staff that she was trying to escape from the building on purpose. (R1) said she was waiting on everyone to leave for the day, and she was planning her escape out the doors, which (R1) was successful at and had been missing for about 15 minutes before it was noticed that (R1) was gone from the facility.</p> <p>R1's Health Status Note dated 9-10-24 at 5:09 PM and signed by V5 (Agency LPN/Licensed Practical Nurse) documents, (R1) noted outside in front of facility laying on her backside. Upon assessment (R1) has a swollen left wrist and an abrasion to her chin area. (R1) c/o (complains of) pain and states she is unable to stand with assistance. When asked what occurred prior to fall (R1) states that she was on her way to her appointment, when she lost her balance and fell , landing on her back. AMT (Advanced Medical Transport) contacted for transportation to ER (emergency room). (V6/R1's Family Member) also notified of (R1's) fall and elopement. Staff waiting along with (R1) until AMT is here for transport. Will continue to monitor.</p> <p>R1's Health Status Note dated 9-10-24 at 5:22 PM and signed by V5 (Agency LPN) documents, AMT present to transport (R1) to (local hospital) for evaluation and possible treatment. All appropriate parties notified. Bed hold sent with (R1). Will continue to monitor.</p> <p>R1's Health Status Note dated 9-10-24 at 5:55 PM and signed by V8 (LPN) documents (V8) was reported that elopement of (R1) outside of the parking lot. (V8) went to observe (R1) laying on the ground. (R1) was on her back side with open areas on her elbow and knee. (V8) also noticed that (R1's) left wrist was swollen. EMT (Emergency Medical Transport) were called and (V6/R1's Family Member) and (V7/R1's Physician) notified. (V8) went to check doors to see how (R1) escaped. (V8) noticed that hall six fire exit door alarm was going off. (V8) came back upstairs and noted that no sound of alarm or light (was) going off at the nurse's station. (V8) notified staff to call maintenance man to come assess the alarm system.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>R1's Emergency Department Note dated 9-11-24 documents, Chief Complaint: (R1) left the (facility) and was found lying down after rolling down/sliding down a hill. EMS (Emergency Medical Service) reports deformity to the left wrist. (R1) complained a 10/10 pain and EMS provided 50 mcg (micrograms) of Fentanyl, four mg (milligrams) of Zofran, and splint the left wrist. (R1) has dementia. (R1) states she was going out to get her car when she began to stumble and slid down a hill and hit a tree. Has pain in her left wrist but denies further pain. Abrasion to midline chin noted. Clinical Impressions: Closed fracture of distal end of left ulna and left radius (end of forearm bones at the wrist).</p> <p>R1's X Ray Report of the Left Wrist dated 9-11-24 documents, Impression: Acute distal forearm fractures with associated soft tissue swelling.</p> <p>R1's Health Status Note dated 9-11-24 at 4:35 AM and signed by V9 (LPN) documents, (R1) arrived back to facility at approximately 3:30 this am via transport from (V6). (R1) has an ulnar (forearm) fracture as well as a radial (wrist) fracture. (R1) also has an abrasion of the face. (R1) has a referral made with (Orthopedics). (V6) will keep us updated on exact date of appointment. (R1) currently in room in bed resting.</p> <p>On 9-13-24 at 2:00 PM V23 (Maintenance Director) used a measuring wheel to measure and determine the distance from the door of where R1 exited the building on 9-10-24 to where R1 was found lying on the ground by the tree. There were two routes R1 could have taken. V23 measured both routes with one route measuring 1635 feet from the exit door to the right, through the parking lot, and down a hill to the tree. The other route measured 2475 feet from the exit door to the left and around the building to the bottom of the tree. The tree where R1 was located was approximately 25 feet from the main street in (City facility is located).</p> <p>On 9-13-24 at 3:15 PM R1 was lying in bed at a local hospital. R1 had a four-centimeter scabbed abrasion to the chin, seven-centimeter-long dark purple bruise to the right elbow, and a few small abrasions to the right lower arm. R1's left forearm was in a removable casting splint. R1 was confused to time and place.</p> <p>On 9-13-24 at 6:15 AM V1 (Administrator) stated, On 9-10-24 around 4:47 PM, (V11/Housekeeping Supervisor) heard an (electronic monitoring device) alarm going off at the north door of the basement level. (V11) was trying to shut the alarm off and could not get the alarm to shut off. (V11) grabbed me to help. We initially looked around outside and did not see any residents. (V22/Human Resource Director) called a 'code yellow' over the intercom and we did a head count in the facility and noticed (R1) was missing. (V11) and I went outside and searched the entire perimeter of the facility. Other staff helped look for (R1) and (V12/CNA/Certified Nursing Assistant) found (R1) down by the road, on the ground by a tree. It appeared (R1) had fractures her wrist and was sent to the emergency room. After the incident I watched the cameras and saw (R1) go to the elevator and go downstairs at approximately 4:20 PM. I saw (R1) go down the hallway and around to the back. There are no cameras in the back hallway to see what (R1) did after that. Since the (electronic monitoring device) alarm was sounding we determined (R1) had exited out of the north door. That door has a delayed egress of 15 seconds but there is no alarm hooked up to sound when the door opens except for the (electronic monitoring device) alarm.</p> <p>On 9-13-24 at 6:30 AM V14 (CNA) stated, (R1) says frequently that she wants to go home. (R1) forgets her walker and we must remind her to use it.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 9-13-24 at 6:40 AM V18 (CNA) stated, (R1) is not safe to go outside unattended and forgets to use her walker.</p> <p>On 9-13-24 at 8:00 AM V20 (Activity Director) stated, (R1) tries to exit seek and gets confused. (R1) goes to the lobby doors and tries to go out.</p> <p>On 9-13-24 at 8:10 AM V11 (Housekeeping Director) stated, I heard an alarm that sounded muted like a phone alarm going off (on 9-10-24). It was around 4:45 PM. I had to look around to find where the alarm was sounding off. I found the north basement door (electronic monitoring device) alarm sounding at the north door in the basement. (R5) was standing down by the door, so I thought (R5) had sounded the alarm. I tried to shut the alarm off and could not get the alarm to shut off. I found (V1) and had (V1) go down with me to try to shut the alarm off. In the meantime, two CNAs (V12 and V21) came down and were looking for (R1) to give (R1) a shower. (V1) then said maybe (R1) had set off the alarm. (V1) and I went outside to look for (R1) and a 'code yellow' was sounded over the intercom. (V1) and I searched the entire perimeter and could not find (R1). A little while longer (V12) found (R1) on the ground, down the bottom of a hill, by a tree, that was by the road. (R1) had walked a long way without her walker and had fallen. (R1) had to be sent to the emergency room . The tree is close to the road.</p> <p>On 9-13-24 at 10:00 AM V12 (CNA) stated, I was working on 9-10-24 from 2:00 PM to 10:00 PM. Sometime before supper (V21) was looking for (R1) to give (R1) a shower and could not locate her. Me and (V21) searched all the hallways and resident rooms and could not find (R1). We went downstairs and looked for (R1) and could not find her. That is when I found (V11) by the back door. I got (V13/MDS/Minimum Data Set Coordinator) to help look for (R1). I have been a CNA for a long time and thought I needed to search by the road first. I found (R1) down a hill, lying by a tree on her back with her left leg crossed over her right leg. (R1) had blood on her chin, had bit her tongue, had abrasions to her arms, and her left wrist looked deformed. I got help from (V1 and V13) and 911 was called.</p> <p>On 9-13-24 at 10:20 AM V13 (MDS Coordinator) stated, On 9-10-24 (V12) asked for my help to find (R1). I went outside to help find (R1). (R1) was found lying on her back by a tree and her left wrist was swollen. (R1) was sent to the emergency room and had a broken wrist. Earlier that day (R1) had asked for a code to try to leave through the front door. (R1) was always saying she wanted to go home. (R1) came to this facility for more security because she had eloped from another facility prior to her admission here. (R1) is not safe to be outside unattended by staff.</p> <p>On 9-14-24 at 10:10 AM V6 (R1's Family Member) stated, I was called on 9-10-24 and was told (R1) was being sent to the hospital because she had got out of the building and had fell . (R1) had broken her wrist in two places and had abrasions on her legs, arms, and chin. I had put (R1) in the nursing home because (R1) needed more supervision and her dementia was worsening. I put (R1) in a nursing home and (R1) had got outside of that nursing home unattended, so that nursing home decided (R1) needed more supervision. So, back in January (R1) was transferred to this facility. (R1) cannot be outside without supervision. (R1) does not even know where she is at or what town she is in.</p> <p>The Immediate Jeopardy started on 9-10-24 at 4:20 PM when R1 left the facility without knowledge or supervision of staff and eloped over 1635 feet down a hill, falling by a tree that was located approximately 25 feet from a main street, causing R1 to sustain two fractures to the end of the forearm (at the wrist), excruciating pain, abrasions to the chin and right arm, and hospitalization for treatment.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 9-17-24 at 9:45 AM, V1 (Administrator) was notified of the Immediate Jeopardy.</p> <p>On 9-19-24 this surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> On 9/10/2024 and 9/12/2024 V1 (Administrator) in-serviced all staff in the facility regarding policies and procedures on elopement and wandering residents, prompt response to door alarms, utilization of facility protocol internal alert code alerts code yellow for elopement wandering residents, head count, and notifications. All staff not in the facility were in-serviced prior to their next scheduled shift. On 9/12/2024 V24 (Social Service Director/SSD) and V13 (MDS Coordinator) conducted an audit to ensure all current residents at high risk for wandering and elopement had a care plan in place and interventions in place to ensure their safety. On 9/12/2024 V1 and V25 (Vice President of Clinical Services) ensured the communication book was updated with all residents at high risk of wandering. On 9/11/2024 V25 completed new elopement assessments for all residents. V23 is continuing audits of door function daily for six weeks. V1 is continuing to audit the communication book daily for 6 weeks to ensure the elopement procedure is fully implemented. On 9/11/2024 V25 provided in-service to the Interdisciplinary Team (IDT) regarding assessing all residents quarterly who wander/exit seek and with any changes in behavior. IDT continues to review the 24/72-hour notes to assess for changes in behavior and possible completion of a current wandering risk assessment. On 9/10/2024 V6 (R1's Family Member) and V7 (R1's Physician) were notified of R1's elopement with injuries and an order was given to send R1 to the emergency department for evaluation and treatment. On 9/19/2024 at 11:45 AM a tour was done, and all exit doors were checked for enunciators. The front entrance door and the basement service doors were not alarmed with an enunciator as stated by the abatement plan. V1 revised the abatement plan to include applying an enunciator to the basement service doors on 9/19/24 by V26 (Corporate [NAME] President of Plant Operations) and assuring the front entrance door was double alarmed. On 9/19/24 at 1:46 PM the basement service door was alarmed with an enunciator and the front entrance door was double alarmed. <p>Abatement completion date: 9-19-24</p> | | |