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
	IL6001895	A. BUILDING: ____ B. WING ____	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW MANOR	3311 S. MICHIGAN AVE. CHICAGO, IL 60616

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S 000	Initial Comments Complaint Investigations: 2387559/IL164241 - 300.610a); 300.1010h); 300.1210b); 300.1210d)1)2)3); 300.2210 8) 2388512/IL165416 - 300.610a); 300.690a); 300.1210b); 300.1210c); 300.1210d)6); 300.2900d)2); 300.2940a)1)2); 300.2940f) Investigation of Facility Reported Incident of 8/22/23 -IL164354 - 300.3240d); 300.3240f) Investigation of Facility Reported Incident of 9/6/23 -IL164616 - 300.610a); 300.690a); 300.1210b); 300.1210c); 300.1210d)6); 300.2900d)2); 300.2940a)1)2); 300.2940f)	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)6) 300.2900d)2) 300.2940a)1)2) 300.2940f) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 300.690 Incidents and Accidents
a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains

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S9999	Continued From page 2 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. Section 300.2900 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. (B) Section 300.2940 Electrical Systems a) General Requirements 1) All material including equipment, conductors, controls, and signaling devices shall be installed to provide a complete electrical system with the necessary characteristics and capacity to supply the electrical facilities required by these standards. All materials shall be listed as complying with the applicable standards of Underwriters' Laboratories, Inc. or other similarly established standards. 2) All electrical installations and systems shall be tested to show that the equipment is installed and operates as planned or specified and be in accordance with these standards. f) Door Alarm System Each exterior door shall be equipped with a signal that will alert 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. These requirement were NOT MET as evidenced	S9999		

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by:

A.) Based on interview and record review the facility failed to supervise (R6), a cognitively impaired resident who is at a high risk for elopement from the facility. The facility failed to ensure the elopement/unauthorized departure list was accurate, failed to ensure staff were aware of the elopement/unauthorized departure resident list, failed to document hourly rounds and implement care plan interventions to prevent elopement. The facility also failed to ensure that all staff were aware of code pink protocol, failed to implement code pink protocol and the facility failed to conduct and document elopement incident report investigations for one of six residents (R6) reviewed for elopement. These failures resulted in R6 eloping from the facility on 10/1/23, returning on 10/10/23 and eloping again on 10/11/23. R6's whereabouts remain unknown.

On 10/11/23 at 4:15am the south side door alarm was sounding as per progress notes. A call was made to the front desk and CNA (Certified Nursing Assistant) stated that it was this resident (R6) that was missing. Resident (R6) remains out of the facility.

Findings include:

R6 is schizophrenic and in constant paranoia with delusional disorder and has U.S. (United States) Marshall involvement for threatening a Judge in the past.

R6's diagnoses include schizoaffective disorder, bipolar disorder, unspecified psychosis, generalized muscle weakness and unsteadiness on feet.

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R6's (10/2/23) BIMS (Brief Interview Mental Status) summary score is blank; however, the assessment affirms inattention and disorganized thinking are continuously present. Cognitive skills for daily decision making are moderately impaired (decisions poor; cues/supervision required).

R6's (7/21/23) functional assessment states setup help is required for walking and/or locomotion.

R6's (7/15/23) community survival risk assessment affirms resident is not sufficiently oriented/coherent affording him/her the potential for independent pass privileges. Resident is unable to refrain from self-harm or socially inappropriate behaviors while in the community. Resident is unable to behave with respect while in the community and there have been problems/concerns with behavior/conduct. Resident lacks knowledge of potentially dangerous situations while out in the community such as walking alone after dark, accepting rides from strangers, and carrying valuable items where they are easily seen.
Summary/Conclusion: Resident needs a structured/supervised living arrangement.

R6's (10/1/23) elopement risk assessment affirms history of unauthorized departure from a health care setting and/or verbalizes a serious intent to leave the facility and/or has a history of elopement/ unauthorized departure. Resident has the physical ability to leave the building. Resident becomes easily agitated, confused and/or disoriented or shows poor judgment. Engages in "theme" behavior (i.e., has belief that he/she has specific responsibilities in another setting, such as going to work, returning home to care for children, driving to church, preparing

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dinner, etc). Based on score of assessment (total score: 8), resident is at Risk for Elopement/Unauthorized Departure and will be placed on the elopement risk list/program. Additional note: Resident has history for risk of unauthorized departure at this time. [a score of 4 or higher indicates risk for unauthorized departure/elopement risk and appropriate interdisciplinary interventions].

R6's progress notes state (10/1/23) it was reported to staff that resident left the building unauthorized. Staff members searched the building and surrounding but couldn't find him. Writer informed charge nurse, PRSD (Psychiatric Rehabilitation Service Director), and manager on duty. Police were called and a report was filed. (10/3/23) Hospital ER (Emergency Room) Nurse called. [a Code Pink/Elopement announcement was not documented]. Resident walked into ER (Emergency Room) yesterday but did not volunteer his residency information until a few minutes ago. (10/10/23) Readmit note: 5:30pm, resident received. Monitoring continued. (10/11/23) 4:15am, writer was going downstairs to take a break. When writer reached the 1st floor, the alarm on the south side door was sounding. Receptionist and writer ran towards the sounding alarm. Writer asked vendor who was filling the vending machine did someone run out of the door that was sounding. The vendor responded yes. Writer and receptionist ran towards the parking lot and alley to see if we could see the resident. Then the vendor stated that resident ran towards the front of the building. Staff members ran to their cars to search for resident. PRSA was asked to secure building and watch the front desk. Head count was immediately done on each floor. Call was made to front desk and CNA stated that it was this resident (R6) that was

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missing. Staff called nearby hospitals, visited train/bus station, eateries, and gas stations searching. Resident wasn't located by staff. All responsible parties were made aware. Police were informed.

On 10/12/23 at 2:28pm, surveyor inquired about R6. V1 (Administrator) stated, he (R6) took off again yesterday (10/11/23)." Surveyor inquired if R6 eloped prior to 10/11/23. V1 responded, "We've caught up with him (R6) before (about a week ago) and he was hospitalized but then he left again on the 11th. We've (staff) had contact with his (R6) father (V15) in Ohio. He (V15) said (R6) has got a long history of this and severe mental illness. He (R6) claims to have a 14-year-old wife in prison and a fake administrator." Surveyor inquired if R6 was found. V1 replied, "No, we called the police yesterday and the staff went out looking for him (R6) yesterday morning (10/11/23)." Surveyor inquired if staff were aware when R6 left the facility (10/11/23). V1 stated, "There was an alarm on the door, the vending machine people were here and saw him hit the door. The alarm went off, they (staff) called a code pink and staff went out immediately to catch him (R6), they were not able to." Surveyor inquired if staff searched "immediately" (when the door alarmed) why was R6 not found? V1 responded, "If the nurse is on the 5th or the 6th floor by the time, they get out the door, I'm just saying it wasn't like someone was there waiting for him." Surveyor inquired which door did R6 exit? V1 replied, "There's a side door fire exit (and pointed towards the south end of the building). When the alarm went off, they (staff) went and checked it, the vending machine man said he saw somebody go out the door." Surveyor inquired if staff was at the front entrance when R6 eloped? V1 stated, "Yes, but

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there's no visual to this door." Surveyor inquired what floor R6 resided on. V1 responded, "He was moved from the 6th floor onto the 2nd because he didn't want to be on that floor." Surveyor inquired what the facility is doing now to find R6. V1 replied, "When he came back (from the hospital) we did everything we could to see. He's not confused, he's not disoriented he's just mentally ill." Surveyor inquired if R6 stated that he did not want to be in the facility. V1 stated, "Yes, I believe he told the hospital he didn't want to come here. He didn't want to be in the nursing home. The last I heard he wants to be in Texas with his emancipated bride." Surveyor inquired (again) what the facility is doing now to find R6. V1 responded, "We've notified the family we've notified the hospitals. The police took a report, they took a face sheet (R6's face sheet excludes a photo)." R6's elopement incident reports/investigations were requested at this time however not received during this survey.

On 10/16/23 at 10:36am, surveyor inquired about R6's cognitive and functional status. V2 (DON/Director of Nursing) stated, "With me he's (R6) been alert and oriented times 3 to 4. He's (R6) under supervision, that is why most people are in the nursing home. He walks around he doesn't use any type of assistive device." Surveyor relayed that R6's (10/2/23) cognitive assessment is incongruent with said statement. V2 responded, "I don't know if he goes off chain sometimes which may be possible, or he don't know what he's saying but he don't do that with me." Surveyor inquired about R6's recent elopement(s). V2 replied, "The first one I can't really remember but they said he left unauthorized and checked himself into the hospital. When he (R6) came back, we (facility) admitted him to the 2nd floor. I know he (R6) left

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last week; he told the nurse he was going downstairs to the vending machine. They (staff) heard the door alarm and went to look for him (R6) and they went driving around and to the hospitals nearby. They (staff) called the hospitals to see if he (R6) is there." Surveyor inquired about interventions implemented to prevent R6's elopement. V2 stated, "The intervention that we have in place is that most of the exits have the alarms and we do the rounds per CNA (Certified Nursing Assistant) and per Nurse or psychosocial department if they are here at that time." Surveyor inquired if "rounds" are documented by nursing staff. V2 responded, "Well, not per se but I know per psychosocial they have a round sheet. Per the nursing department we (staff) have the duty to walk around and do that. It depends on the situation; I can check but the rounds sheet most of the time goes into the PCC (electronic medical record)." Surveyor inquired about R6's current location. V2 replied, "Right now, I'm not sure." Surveyor inquired if it is safe for R6 to be in the community alone if the care plan states he's at risk for abuse due to behaviors. V2 stated, "If I look at the care plan saying he's (R6) at risk for abuse, I can assume he's not."

On 10/16/23 at 11:14am, V2 (DON) presented R6's (10/1/23) unauthorized departure/elopement risk assessment, post behavior observations and 72-hour follow-up information however the requested (10/1/23 & 10/11/23) elopement incident reports and investigations were excluded.

On 10/16/23 at 11:39am, surveyor inquired if R6's elopement(s) were investigated V2 (DON) responded, "I know that she (V1/Administrator) did ask questions and speak with staff the were there that night and did some interviews"

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[documented staff interviews regarding R6's elopements were also not received during this survey]. surveyor inquired about the facility policy/procedures for elopement. V2 (DON) stated, "If somebody leaves unauthorized, we (staff) go out in the community and look for that person. We (staff) do a head count first to see that the resident is in fact missing. We (staff) let the administrator know that a person is missing, and she (V1) will call the police. The physician and family will be notified and then we'll call the hospital to see if the resident is there" [calling a Code Pink/Elopement was excluded]. [Documenting an incident report and conducting an investigation were excluded].

On 10/16/23 at 1:20pm, surveyor inquired about R6's (10/11/23) elopement. V5 (RN/Registered Nurse) affirmed he worked 11pm-7am (on 6th floor) and stated, "We (staff) rushed to the area where the alarm is sounding and looked around to see what is going on. The front desk called code pink, that's somebody is trying to get out the door. We (staff) looked outside, conduct immediate head count, and found out that all the floors are complete except the 2nd floor where he (R6) was the one missing. He (R6) was not found."

On 10/16/23 at 2:55pm, surveyor inquired about the elopement risk list/program. V6 (PRSD) presented an undated "unauthorized departure's list" (which includes R6) and stated these are the people (residents) that we know might walk out of the building, go to their family, or go to the hospital and come back. It means to the staff that they (staff) need to keep an eye on them (residents) and that they (residents) may leave without doctor's permission." Surveyor inquired about R6. V6 responded, he (R6) is kind of a guy

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that is always delusional and is alert and oriented times 4. He (R6) likes to write and is always trying to write a letter to a government official or somebody in Texas. Most of it is about court cases most of it doesn't make any sense. The last one he (R6) wrote to me (V6) was something about a defense case judge, the defense organization was just I can't make any sense of it. He (R6) does not believe he has a mental illness and is looking for a judge to see that. He (R6) believes the food is poison and the doctor needs to send him to the hospital and then he wants to go on a hunger strike. Sometimes he (R6) will call 911 and say someone needs help and was having an attack but nobody was. Sometimes he (R6) believes what he believes. He (R6) has schizoaffective disorder, he has schizophrenia, bipolar disorder and unspecified psychosis." Surveyor inquired what was implemented for R6 (post 10/1/23 elopement). V6 replied, "We put him on this list (referring to "unauthorized departures" list) and updated the care plan. [the unauthorized departures list states R6 is "low" risk - which is incongruent with the 10/1/23 elopement risk assessment]. We're (staff) supposed to monitor him (R6) to make sure that such things (referring to elopement) are not repeated. The second time (referring to 10/11/23 elopement), he (R6) came back in the evening, and I (V6) was gone at that time. So, he (R6) didn't give the facility opportunity to put things in place [R6 eloped 10/1/23 therefore 10 days prior to - second elopement]. He (R6) was supposed to be sleeping at that time, I know they (staff) were doing rounds and putting it in the POC (Plan of Care) it's in the system (referring to electronic medical records). The CNA's are supposed to be marking rounds every hour. They (staff) need to know where he (R6) is, and they need to know what he is doing."

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On 10/16/23 at 3:52pm, surveyor inquired if R6 was monitored by staff (on 10/11/23). V2 (DON) presented R6's behavior monitoring and interventions report and stated, "This is for behavior monitoring and if the person is present its marked here (referring to behavior monitoring/ interventions report). On 10/11/23 at 6:59am, R6's behavior monitoring report is marked "wandering" however progress notes affirm R6 left the building at 4:15am (2.75 hours prior), and there are no additional entries documented - prior to elopement. Surveyor inquired if R6's monitoring was documented (on 10/11/23). V2 responded, "When he (R6) came back on the 11th, he was marked wandering around the floor and then the next time he was already out (referring to elopement). It says he (R6) was wandering around (referring to 6:59am entry). Wait, I think this has the incorrect date because he wasn't here at that time."

On 10/17/23 at 11:03am, surveyor inquired how staff know which residents are at risk for elopement. V4 (LPN/Licensed Practical Nurse) stated, "Usually there would be something by the nurses station saying this person is an elopement risk and usually staff would be informed." Surveyor inquired about R6's elopements. V4 responded, "I didn't know about the previous elopement but the night of the 10th going into the 11th (10/11/23), I was there working on 5th floor. At 4:15am, I was going downstairs to smoke. As soon as I hit the first floor, I heard the alarm go off. I didn't want to go outside by myself because it was like 4am so I went and got the receptionist (referring to V7). We (V4 & V7) went out in the parking lot and the alley to look. I asked the vendor that was there, did you see what he had on? He (vendor) said, no and said he (resident)

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went the other way. A code pink was called to find out who it was and what he (resident) had on. After that, we (staff) figured out that it was (R6). We (V4 & V7) went in our cars looking for him because we didn't see him. I checked the gas station, and the bus station was checked. I called the hospitals, they said he (R6) wasn't there." Surveyor inquired about R6's cognitive status. V4 replied, "He'll come to 5th floor wanting paper and says it's because he don't want to sue me. I think he's alert times 3." Surveyor inquired if R6 is delusional. V4 stated, "Yes he is delusional. He thinks he's from this big corporation and has access to all these lawyers." Surveyor inquired if V4 was aware that R6 was at risk for elopement. V4 replied, "I didn't know nothing about the 1st time" and affirmed she was unaware. Surveyor inquired if the 1st floor alarms can be heard on the units. V4 affirmed, they cannot.

On 10/17/23 at 1:27pm, surveyor inquired about staff requirements for resident elopement. V7 (Receptionist/PRSA-Psychiatric Rehabilitation Services Aide) stated, "For my department, I (V7) do the security of the staff and the facility residents. If anything, happen they (staff) will call for the PRSA and I will redirect them (residents). When they (residents) elope, then call for help, call for head count, search around and find the person. I (V7) call for head count and then go outside for the resident. There's a pager on the front desk that go to all the floors. I call code pink that somebody left unauthorized. When we (staff) say code pink, we do emergency head count on all the floors." Surveyor inquired about R6's (10/11/23) elopement. V7 responded, "I was at the front desk, it was past 4am. (V4) came down for a break, we (V4/V7) heard the alarm. My colleague (V8/PRSA) was not there, he came to us (V4/V7) at the front desk. I (V7) told him

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S9999	Continued From page 13 (V8) to make the pager for code pink and head count. [V7 was at the front desk and heard the alarm however did not immediately call a code pink/elopement]. We (V4/V7) ran out where the alarm was going off. The door was close to the parking lot, we checked around the parking lot and didn't see anybody. So, I (V7) ran towards street 35 (35th street) to see if anyone was there and turned back. When I turned back another nurse (V5) came too and we (V4, V5, V7) drove around looking for him (resident)." Surveyor inquired how V7 knew who to look for. V7 replied, "Most times we (staff) are familiar with most of the residents, so I know who I am looking for. We (Staff) didn't find anybody. When we (staff) turned back (to the facility), I asked my colleague (V8) who was gone? He (V8) said that it was (R6)." Surveyor inquired if R6 has a history of eloping. V7 stated, "Yes he has done that earlier." Surveyor inquired why R6 was on the 1st floor at 4am? V7 was unsure. Surveyor inquired how staff are aware of which residents are at risk for elopement. V7 responded, "Nobody knows when they are going to run out unless they have that type of behavior." Surveyor inquired how resident elopement risk is communicated to staff. V7 replied, "The CNA's maybe, they (residents) have certain behaviors, or they (residents) complain or something, worried about something that how maybe they (CNA's) know that they (residents) have history of that behavior." Surveyor inquired how staff are aware that residents are at risk to elope. V7 stated, "Like I said, if they (staff) had anything they would communicate to us (PRSA) that this person (resident) is an elopement risk." [Resident elopement risk assessment and/or Unauthorized Departure's List were excluded]. On 10/17/23 at 2:28pm, surveyor inquired how staff are made aware that residents are at risk for	S9999		

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elopement. V8 (PRSA) stated, "Usually the nurse will maybe contact you at the desk and call the other front desk and let you know. As far as I know" [Resident elopement risk assessment and/or Unauthorized Departure's List were excluded]. Surveyor inquired about R6's (10/11/23) elopement. V8 responded, "I was making the rounds, there were two of us (PRSA's) on that night. I (V8) was coming back from the north end of the building, and I heard the alarm go off. So, when I (V8) heard the alarm go off, I went straight to the front desk [V8 did not immediately check the door which was alarming]. I (V8) told my other guy (V7/PRSA) I was going to call a code pink. They (V4/V7) were running to the door that was alarming. So, I (V8) paged for the building to every floor that somebody eloped and make a head count so we could know who it was. The floors started giving me the report and said were complete here, our floor is okay and that. We (staff) didn't know until that morning exactly who the person was. It was about 6:30am or 7am, something like that because not all the floors brought in the report" [roughly 2.25 hours after the alarm sounded]. Surveyor inquired how long it should take staff to count the residents (which were likely asleep at 4:15am). V8 replied, "I don't know exactly but depending on how many people are on the floor it shouldn't take that long, like 30 minutes at the most." On 10/17/23 at 2:28pm, surveyor inquired if an incident report is documented for resident elopement. V8 (PRSA) stated, "Not that I know of."

On 10/17/23 at 3:46pm, surveyor inquired how staff are aware of which residents are at risk for elopement. V9 (Charge Nurse) stated. "If there is documentation of what he has done before then you would be able to know that this man is at risk

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S9999	Continued From page 15 for elopement. We (staff) read the communication. We (staff) go to the behavior notes you will be able to know who is at risk of what" [Resident elopement risk assessment and/or Unauthorized Departure's List were excluded]. Surveyor inquired about the facility elopement protocol. V9 responded, "The protocol is that if a resident eloped, the moment they eloped the administrator would be called, the DON will be called then you would call the police to see if they can help recover him and the family would be notified. [Code pink and head count were excluded]. Surveyor inquired about R6's (10/11/23) elopement. V9 replied "I came in 11:00 at night, I (V9) did my rounds he was in bed. I went to the communication (referring to progress notes) so I will know what is going on because he was on 6th floor before (changed rooms/floors). I (V9) learned he (R6) came back from the hospital, that's when I know the reason he was there (residing on 2nd floor). (R6) passed me, I said where are you going? and he said going to vending machine. The CNA was cleaning one of the residents, I (V9) said wait and let the CNA go with you and he (R6) said OK. I (V9) take my cart (medication cart) and keep on working, the next thing I heard was the beeping of alarm. Nobody knew what was going on, then the announcement came over the phone. I (V9) can't remember the time. I (V9) always start passing my medication at like 5:30 in the morning [roughly 1.25 hours after R6 eloped]. When I (V9) heard that somebody eloped, we (staff) have to start checking our rooms every floor. It was then that we (staff) discovered that this man (R6) is not here. Surveyor inquired if V9 knew why R6 was hospitalized (prior to 10/10/23 readmission). V9 stated, "No." Surveyor relayed that R1 had eloped from the facility (10/1/23) and was hospitalized. V9 responded, "I didn't know. I didn't	S9999		

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know that he eloped and that's why he went to the hospital." V9 (Charge Nurse) affirmed she was assigned to R6 on 10/11/23 when the elopement occurred. Surveyor inquired if an incident report was documented (10/11/23) post R6's elopement. V9 stated, "I (V9) documented in the (electronic medical records) and referred to R6's (10/11/23) progress notes. I called the police came, they interview me and give me the report and the number. Maybe I didn't do an incident report."

On 10/18/23 at 11:17am, surveyor inquired how staff are aware of which residents are at risk for elopement. V10 (CNA) stated, "It's from the report in the system (electronic medical records) it will say the risk." Surveyor inquired if the facility has a list of elopement risk residents. V10 responded, "No we don't, everything is on tablet." Surveyor inquired about R6's (10/11/23) elopement. V10 affirmed he was assigned to R6 that day and replied, "He (R6) was pacing back and forth like he used to do. I think he ran away from the 6th floor (on prior date) and came back on the 2nd floor. That night (10/11/23) he (R6) was pacing back and forth, and we (staff) are not allowed to restrict residents from moving. I (V10) was like why are we not doing at a certain day or night why we are not doing that (restricting residents). He (R6) was allowed to move about the building, you (staff) can't stop them (residents) that is one of the issues there (facility). I (V10) think that when he (R6) went to the elevator, he (R6) said to the Nurse (V9) I'm going down to get a pop. He (R6) got on the elevator; we (staff) cannot stop him. I (V10) was alone with the Nurse (V9), it was only 2 staff on the floor that night. There was a call that somebody ran out of the building from the front desk, we have to do a head count. After I (V10) counted, I told the

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S9999	Continued From page 17 Nurse (V9) that (R6) was not there. I can't say for sure what time." Surveyor inquired why staff allowed R6 to leave the unit (unattended). V10 stated, "I (V10) am a CNA I look for residents on the floor, I am not security. I (V10) am not allowed to force them (residents) to the floor. When they (residents) go downstairs it is the security that is responsible, it is no longer the Nurse and the CNA because I (V10) cannot be on the 1st floor and the 2nd floor at the same time. When they (residents) go down, the security should ask them where they are going." R6's care plan includes (8/29/23) resident has history of self-harmful or suicidal ideation and/or behavior. This appears to be manifested by a disturbed impulse to punish oneself or another person, a disturbed need for attention, admitting to having thoughts of self-harm. (9/1/23) Resident is at risk for abuse as evidenced by behavior that might be characterized as provoking, antagonizing, disrespectful, socially inappropriate. History/current behavior of physical abuse or threatening physical aggression towards others. (10/1/23) resident has history or current behavior of unauthorized departure from the facility. Resident left the building unauthorized. Interventions: monitor for any sign/symptoms or preparation for unauthorized departure. Provide safety checks as appropriate. (10/11/23) Resident is at risk for elopement related to: BIMS score of 10 or less (cognitive impairment). Resident becomes easily agitated, confused and/or disoriented or shows profound poor judgment, cognitive deficits. Resident verbalizes a serious intent to leave the facility. Interventions: rounds/hourly room checks per facility protocol to monitor resident to assist in minimizing chance of unauthorized leave.	S9999		

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On 10/18/23 at 12:04pm, surveyor inquired what R6 was wearing prior to leaving the unit (10/11/23). V9 (Charge Nurse) stated, "I did see like a black jacket that he put on and he had shoes on."

Evidence shows that on 10/11/23, R6's "safety checks" were not documented "hourly". Staff was aware that R6 has history of elopement, was pacing back & forth, wearing shoes and a jacket at approximately 4:15am (preparation for departure) prior to leaving the unit. Staff also observed R6 enter the elevator however interventions were not implemented to prevent departure from the facility.

On 10/26/23 at approximately 12:12pm, surveyor inquired about potential harm to a resident with delusions that elopes from the facility. V22 (Medical Director) stated, "Death and murder what else can I say. If he (resident) has a psych history somebody should have picked him (resident) up by now."

On 10/18/23 at 12:24pm, V4 (LPN) activated the south side (front) exit door alarm (as requested) and walked outside the door with surveyor. The alarm was turned off at 12:25pm (within 1 minute) nobody came to the door/exit to inquire who had opened the door and/or left the building. At 12:41pm, V4 stated, "This is a disaster. You know ain't nobody coming to get us, right? This is bad."

On 10/18/23 at 12:44pm (20 minutes after the door alarmed) surveyor entered the building and asked why nobody inquired who went outside when the alarm went off. V11 (Receptionist) stated, "I called the code pink when the door alarm, they (staff) called and told me it was (V4) at the door then I called the code green."

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Surveyor inquired about the elopement protocol. V11 responded, "Once I hear the alarm, I call the code pink and whenever they bring someone in, I will call the code green all clear." Surveyor inquired about video surveillance (at the reception desk) to see the south side (front) exit door. V11 replied, "What video? I (V11) have no cameras here."

On 10/18/23 at 12:56pm, surveyor relayed concerns with the door alarm being shut off (within 1 minute) and staff not responding as warranted. V2 (DON) stated, "The receptionist (V11) is at fault, she (V11) said codepink and immediately called code green so nobody was coming. I know she called code pink and cleared it immediately." Surveyor inquired if the 1st floor door alarm can be heard on all the units. V2 responded, "I know that the 6th, 5th and 4th floor you can't. Even the 3rd floor you can't hear it sometime" and affirmed you may be able to hear it on 2nd floor.

On 10/18/23 at 1:02pm, surveyor instructed V2 (DON) to activate the south side (front) door alarm again (via phone) while surveyor was on 2nd floor (at the Nurse's station) far from the stairwell. Surveyor inquired if staff could hear the alarm. V12 (LPN) stated, "I didn't hear an alarm." A "code pink" was called at this time, surveyor inquired what's code pink? V11 responded, "I don't know for certain."

On 10/18/23 at 1:06pm, surveyor inquired if a (3rd floor) staff V13 (LPN) could hear the alarm (which was still sounding). V13 stated, "No."

On 11/2/23 at 2:08pm, surveyor inquired what code pink means. V26 (PRSD) stated, "code pink is for a resident ran out, elopement." Surveyor

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inquired if an elopement risk list was posted on 2nd floor. V26 stated, "I'm not so vast to the building here cause we're just here for a short-term basis the only person that can give that to you would be (V6)." V2 (DON) responded, "We have a list of the code (posted on the med room door). We don't have a list of the people who are at risk."

The (undated) LPN Job Description states provide licensed nursing care to residents on assigned unit in accordance with current federal, state, and local standards, guidelines, and regulations. Monitor the activities delegated to the CNA's and assist them as necessary.

The (undated) CNA Job Description states report changes in the resident's condition to the Nurse as soon as practical. Report all accidents and incidents you observe on the shift that occur.

The (3/2021) elopement policy states "elopement "means the unplanned, unauthorized leaving of the facility by a resident who is unable to understand the risks of leaving the facility. Residents should be evaluated for elopement risk on admission and throughout their stay by the interdisciplinary care planning team. [Preventive measures for elopement are excluded].

The elopement vs. unauthorized/unplanned discharge policy (revised 11/1/19) states an elopement attempt/exit seeking incident is defined as a resident who is not alert, oriented to at least two, has a legal guardian or active power of attorney and/or is an immediate threat to him/herself or others and attempt to flee the facility is successful. For an elopement: any resident who leaves under the following conditions and is not redirected back to the facility

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will be considered an elopement, and all elopement procedures will be followed: resident is not considered to be alert and/or oriented x2. Resident has a legal guardian or active power of attorney and leaves without their permission. Resident is assessed to be a high risk for elopement. . An investigation shall be coordinated by the facility administrator, director of nursing or manager/supervisor on duty.

B.) Based on interview and record review facility failed document quarterly fall risk assessments, failed to review and revise care plans quarterly with appropriate fall prevention interventions, and failed to provide supervision to prevent falls. These failures affect one of four residents (R5) reviewed for falls on the sample list of six.

These failure resulted in R5 falling, sustaining facial swelling/bruising, and a nasal fracture.

Findings include:

R5's diagnoses include hypertensive heart disease, cataract, insomnia, generalized anxiety disorder, schizophrenia, and psychosis.

R5's (7/19/23) functional assessment affirms supervision is required for locomotion on/off unit.

The (9/6/23) incident report states it was reported to this writer (V25/Registered Nurse) that resident (R5) just had a fall on the staircase. Resident (R5) was noted with blood to her face, swollen nose, and right side of face. Bruises to her (R5) face and a little bit of confusion. Resident (R5) was unable to give details of the reason for the fall. She (R5) stated that she tripped and fell on the staircase while walking to her floor. No witnesses found.

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R5's (7/19/23) BIMS (Brief Interview Mental Status) determined a score of 15 (cognitively intact).

On 10/23/23 at 11:55am, surveyor inquired about the (9/6/23) fall. R5 stated, "My head I hit, it doesn't hurt no more." R5 appeared to have a small bump on the bridge of the nose, surveyor inquired if R5 injured her nose during the fall. R5 responded, "A little bit, not too much. Just a little bit." Surveyor inquired if R5 sustained a nasal fracture. R5 replied, "I could have if I fell harder."

The (9/6/23) Initial Facility Reported Incident states resident (R5) was sent to the hospital for evaluation. Resident (R5) returned to the facility with nasal fracture.

The (9/6/23) Final Facility Reported Incident states it may be concluded that resident (R5) had an unwitnessed fall from tripping on stairways.

R5's (10/19/20) fall risk assessment determined a score of 40 (moderate risk). [R5's electronic medical record affirms there were no additional fall risk assessments documented until 9/6/23 -post fall].

R5's (7/21/22) care plan states resident is at risk for falls due to medication side effects. Interventions: be sure call light is within reach and encourage resident to use it for assistance as needed. Resident needs a safe environment free from spills/clutter, and glare-free light [supervision is excluded].

On 10/31/23 at 1:36pm, surveyor inquired about R5's ability to ambulate. V24 (Assistant Director of Nursing) stated, "She (R5) can walk, might not

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be steady but she (R5) can walk." Surveyor inquired about concerns with R5's fall care plan. V24 responded, "I see 07/21/2022, we have a target date for the review July 11, 2023" (expired 3.5 months ago).

On 10/31/23 at 3:17pm, surveyor inquired about R5's functional/cognitive status. V25 (Registered Nurse) stated, "(R5) is somebody that goes around moves around a lot. She (R5) has mental diagnosis because sometimes she may be confused because she has something going on in her head. When she (R5) goes into someone's room and is looking for something she will say like my mom was there" and affirmed R5 is delusional. Surveyor inquired about R5's (9/6/23) incident. V25 responded, "I remember that the CNA (Certified Nursing Assistant) walked up to me and said that (R5) was found on the stairs and said that she (R5) fell. She (R5) wasn't making sense with her words; I had to call the administrator and call 911. I wasn't sure if she (R5) hit her head or anything. She (R5) was stable with vitals but just was confused." Surveyor inquired which residents are at risk for falls. V25 replied, "Everybody is at risk for fall. I am at risk for fall, anybody might fall. The greatest risk are those (residents) who are not balanced. Those (residents) who are at greatest risk, I need to monitor closely. I told everybody (staff/residents) I don't want them (residents) to use the stairs they're (residents) supposed to use the elevator."

On 10/26/23 at approximately 12:05pm, surveyor inquired about potential harm to a resident that falls on the stairs. V22 (Medical Director) stated, "Head injury what else can I say, that's probably the worst thing that could happen or breaking the bone."

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The (3/2021) fall program policy states all residents will be evaluated for falls; on admission/readmission, at least quarterly after admission, change in condition, after a fall. Upon completion of the fall evaluation, if the resident is identified at risk for falls; the following may occur: a care plan is developed or updated, new fall interventions are reviewed with the resident and/or responsible party and applicable staff.
(A)

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300.3240d)
300.3240f)

Section 300.3240 Abuse and Neglect

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements were NOT MET as evidenced by:

Based upon observation, interview and record

Illinois Department of Public Health

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review the facility failed to investigate alleged abuse and failed to report abuse to the State Survey Agency within regulatory requirements for two of six residents (R3, R4) in the sample. The facility also failed to find suitable placement for R4 (perpetrator) to ensure safety of (R3), staff and/or other residents post verbal and/or physical aggression.

Findings include:

R4's diagnoses include schizoaffective disorder, bipolar type, disorganized schizophrenia, and psychosis.

R4's (10/6/23) BIMS (Brief Interview Mental Status) determined a score of 15 (cognitively intact).

R4's (8/22/23) care plan states resident is at risk for abuse/neglect as evidenced by having behaviors that may be categorized as antagonizing, provoking, socially inappropriate. Monitor resident behavior to prevent disposition to abuse. Resident was physically aggressive (8/22/23) towards a co-peer.

R4's progress note states (8/22/23) it was reported that resident was physically aggressive towards co-peer by scratching co-peer on the face during an argument over a cigarette. Incident was reported to charge nurse and resident was ordered to be transferred to the hospital for psych (Psychological) evaluation. Resident is on close monitoring awaiting ambulance. (8/29/23) Received resident from the hospital.

R3's (8/22/23) progress notes state resident reported to Nurse another resident hit her in the

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eye 2-3 days ago. Sister stated it happened Saturday (8/19/23) when I came to visit.

The (8/22/23) incident report states resident (R3) reported another resident (R4) hit her in the eye because she (R3) did not give him (R4) a cigarette. Left eye discolored, slight swelling noted. Resident (R3) stated I would not give him (R4) a cigarette and he hit me (R3). [No witnesses found].

R3's (8/2/23) care plan states resident is at risk for abuse/neglect. (8/22/23) Resident was involved in physical altercation with a co-peer over a cigarette.

R3's diagnoses include schizoaffective disorder, anxiety disorder, bipolar disorder.

R3's (8/1/23) BIMS determined a score of 15.

On 10/23/23 at 11:50am, surveyor inquired about the (8/19/23) physical altercation (with R4) R3 stated, "We were just smoking cigarettes that's all." Surveyor inquired why a physical altercation occurred with R4. R3 responded, "He was just hustling for a dollar and wanted a cigarette."

The IDPH (Preliminary) Incident Report Form states date of incident: 8/22/23 however the incident occurred 2-3 days prior - per progress note. Resident (R3) was noted to have a small amount of bruising near her left eye. (R3) stated, resident (R4) hit her. Type of Incident: alleged abuse. Type of Injury: hematoma. Final report to follow within 5 working days of occurrence.

On (8/22/23) IDPH was notified of the (8/19/23) incident involving R3 & R4 however a final report was not received.

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On 10/26/23 at 2:34pm, surveyor inquired about the regulatory requirements for abuse V1 (Administrator) stated, "Any time a resident indicates a physical abuse occurred we report it as abuse to IDPH within 2 hours and then the final within 5 days. The definition of abuse is according to the resident not us (staff) so if the resident feels unsafe, or there's any injury an investigation is started." Surveyor inquired about R3's abuse allegation (reported 8/22/23) V1 responded, "(R3) came to the staff and they (staff) noticed that she (R3) had a discoloration by the eye. When they (staff) asked her (R3) what happened she (R3) said she was hit. She (R3) was checked for any kind of injuries; the police were called and (R3, R4) were spoken to. It turns out there was a misunderstanding, (R3) talks very loud and is aggressive they were arguing over cigarette. What they (R3, R4) said happened, it (incident) didn't happen at that time (8/22/23) it happened I think like 2 days earlier." Surveyor inquired when R3's physical abuse allegation was reported to IDPH. V1 replied, "The initial was on 8/22, I have to go pull it out of my email on the final." Surveyor inquired if an investigation was conducted regarding R3's abuse allegation. V2 stated, "We went through with the staff, and I talked to (R3, R4)." [The facility provided no documentation - as requested - to affirm that an investigation was conducted]. Surveyor inquired when R3's reported abuse occurred. V1 stated, "The date I was told, it happened the 22nd because that's when we were made aware of it" which is incongruent with prior statement "2 days earlier" and R3's (8/22/23) progress notes.

On 10/26/23 at 2:46pm, surveyor inquired about R3's abuse allegation (reported 8/22/23) involving

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R4. V23 (Licensed Practical Nurse) stated, "I believe she (R3) had told us (staff) that he (R4) had hit her (R3). I (V23) didn't see it, that's what she (R3) stated to me. I notified all the responsible parties, the family, the DON (Director of Nursing), the administrator, and social service. We (staff) made sure that they (R3 & R4) didn't come in contact with each other anymore." Surveyor inquired if R3 and R4 reside on the same unit V23 responded, "Yes, he's (R4) in a private room." Surveyor inquired how R3 is currently being protected from R4 if they reside on the same unit. V23 replied, "She (R3) is monitored the whole time" however R3 was previously observed by surveyor alone/unsupervised in her room. Surveyor inquired if R3 incurred an injury on or about 8/22/23 V23 stated, "I think she had a minor scratch or a bruise or something I'm not sure."

On 10/26/23 at t 3:21pm, V1 stated, "I don't believe I sent the final on that" [referring to the 8/19/23 incident].

R4's (7/12/23) care plan states resident has been identified as an offender of a felony offense, and has been assessed as a potential Moderate Risk towards other residents, staff and visitors. The nature of the offense was sexual assault. Interventions:screening for indication of aggression and harmful behaviors. R4's care plan affirms the following incidents occurred post (8/29/23) return from the hospital/psych evaluation: (9/26/23) Resident was verbally aggressive towards staff unprovoked. (10/7/23) Resident was verbally aggressive towards a co-peer. (10/7/23) Resident was physically aggressive towards a co-peer.

On 10/31/31 at 9:32am, surveyor inquired about

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R4's behaviors V2 (Director of Nursing) stated "Honestly he (R4) is not a resident that I know that has behaviors." Surveyor responded that the care plan affirms R4 was verbally and/or physically aggressive towards staff/residents, in addition to being an identified offender and inquired how residents are being protected from R4 V2 responded "We (staff) try to monitor the floors and try to monitor him (R4) although we don't do the 1:1. We (staff) monitor him (R4) to make sure there is no foul play going on. Nursing wise we monitor the floor, the psychosocial team will also be monitoring." Surveyor relayed concerns that R3 and R4 are both residing on 4th floor and inquired why they were not separated V2 replied "When there's an altercation, I know that is what is supposed to happen that is supposed to be the protocol to keep them away from each other."

The (3/2021) abuse policy states in part when an allegation of abuse has been made the administrator, or designee shall notify Department of Public Health's regional office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse has been reported to the administrator and is being investigated. The report shall include the following information: date of the alleged event. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, will be sent to the Department of Public Health. Residents who allegedly abuse another resident shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety as well as the safety of other residents and employees of the facility. The facility shall take all steps necessary to ensure the safety of residents including, but not

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limited to, the separation of residents.
(B)

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300.610a)
300.1010h)
300.1210b)
300.1210d)1)2)3)
300.2210b)8)

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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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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, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.2210 Maintenance
b) Each facility shall:
8) The building and grounds shall be kept free of any possible infestations of insects and rodents by eliminating sites of breeding and harborage inside and outside the building;

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eliminating sites of entry into the building with screens of not less than 16 mesh screen to the inch and repair of any breaks in construction. (B)

These regulations were NOT met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a resident remained free from bug bites, failed to notify the physician of a change in condition, failed to assess pain every shift, failed to ensure medications to relieve inflammation and/or pain were prescribed and failed to administer medication to treat bed bug bites as ordered. These failures affect one of six residents (R2) reviewed for bed bugs/insect infestation on the sample list of six.

These failures resulted in R2 sustaining multiple bed bug bites to R2's hands, wrists, forearms, neck, and legs causing pain, difficulty sleeping, increased anxiety and worsened PTSD (Post Traumatic Stress Disorder).

Findings include:

R2's diagnoses include generalized anxiety disorder, major depressive disorder, suicidal ideation, and chronic post-traumatic stress disorder.

R2's (7/20/23) BIMS (Brief Interview Mental Status) determined a score of 15 (cognitively intact).

On 10/23/23 at 11:28am, R2 stated, "I get bit up by bed bugs every night, every single night since I've been here (6 months)." R2's bed had tiny brown smears observed all over the fitted sheet.

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R2 responded, that's bed bug poop (tiny brown smears). See all the bumps on me, that's from getting bit. I told the social workers about it. I've also told the DON (Director of Nursing) and the Administrator they all know this is going on. A lot of small red raised bumps were subsequently observed on R2's neck, hands, wrists, forearms, and legs. R2 stated, "I was abused (prior to admission) and have PTSD (Post Traumatic Stress Disorder) because of it. My PTSD has gotten worse because now I have nightmares about bugs and the pain sometimes make me paranoid and causes my anxiety to spike. I also have difficulty sleeping because I keep getting bit."

On 10/23/23 at 11:45am, R2 came into the hallway and stated, "I found a few bed bugs in my room, I have one right here" a live bedbug was subsequently observed in R2's hand. Surveyor inquired about the red bumps on R2's neck, hands, and arms. V19 (Licensed Practical Nurse) replied, "They do look like bug bites."

R2's (9/14/23) progress notes state patient complained of itching states he was bitten by bug. Will continue to evaluate and treat medical conditions accordingly. There is no additional documentation regarding R2's multiple bug bites and/or physician notification - until after the facility was asked about the bites on 10/23/23.

On 10/23/23 at 12:08pm, surveyor inquired about the facility protocol for bedbugs in the facility. V1 (Administrator) stated, in part "The residents are showered and checked for bites. If they react to the bites the residents are given Hydrocortisone."

R2's physician order sheets document, Hydrocortisone cream 1% was prescribed twice

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S9999	Continued From page 34 daily (9/14/23) which expired 10/6/23 (17 days prior). On (10/24/23) Permethrin Cream 5% was prescribed one time for raised areas (start date: 10/24/23). Pain medication was excluded. R2's (October 2023) MAR (Medication Administration Record) includes (4/12/23) pain scale (every shift) however actual pain levels were excluded. Permethrin Cream administration was not documented (the entry is blank). On 10/26/23 at 10:32am, surveyor inquired if R2's (October 2023) pain assessments were documented. V2 (Director of Nursing) reviewed R2's MAR and stated, "It's supposed to be every shift, its' not being done every time on the afternoon shift there's a bunch of holes (referring to blank entries)." Surveyor inquired if actual pain scores were documented on R2's (October 2023) MAR. V2 responded, "I don't see any number." Surveyor inquired if R2 received Permethrin cream on 10/24/23 as ordered. V2 replied, "There's a space on the 24th and 25th. The order was put in on the 24th, if we (staff) put it (order) in it (Permethrin) should be delivered before midnight and given on the 25th" then affirmed Permethrin was not documented as administered on either date. On 10/26/23 at 12:01pm, surveyor inquired about potential harm to a resident who sustains multiple bedbug bites. V22 (Medical Director) stated, "If they (resident) scratch too much, they could get an infection." Surveyor inquired what Permethrin cream is prescribed for. V22 responded, "It kills the bed bugs." The (3/2021) change in condition policy states in part change in condition is defined as: an incident that involves the resident which results in injury	S9999		

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S9999	Continued From page 35 and requires physician intervention. A need to alter treatment. Procedure: call physician at the time the change occurs. The (10/24/22) pain management policy states a pain assessment is completed every shift. A pain evaluation is also completed on change in condition, increased complaints of pain. Nursing will inform the physician about current pain medications and the need for potential supplemental pain medications if appropriate. (B)	S9999		