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
	IL6000186	A. BUILDING: ______ B. WING ______	C 12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR NURSING & REHAB CENTER	4900 NORTH BERNARD CHICAGO, IL 60625

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S 000	Initial Comments Complaint Investigations: -2087888/IL127462-no deficiency cited. -2088056/IL127639-no deficiency cited. -2088205/IL127802-no defeciency cited. Facility Reported Incident of 08/11/2020-IL127036.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210d)3) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
01/07/21

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the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

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.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not evidenced by:

Based on observation, interview and record review, the facility failed to monitor a cognitively impaired resident with known exit seeking behavior; failed to develop, update and

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implement individualized care plan interventions; failed to implement their "Policy and Procedure Regarding Missing Residents and Elopement" by failing to complete elopement risk assessments as per policy for one of three residents (R1) reviewed for incidents and accidents. These failures resulted in R1 leaving the third floor, gaining access to and falling from the facility's elevated smoking patio (six feet, four inches from ledge of deck to ground below) and sustaining a fractured foot.

Findings include:

R1 is a 57 year old re-admitted to the facility on 01/18/2020 with diagnoses including but not limited to Dementia with Behavioral Disturbances, Schizophrenia, Unspecified Mood (Affective) Disorder, Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms; Anxiety Disorder, and Restlessness and Agitation.

R1's Annual MDS (Minimum Data Set) of 08/10/2020 shows the following: Resident's cognition is moderately impaired; demonstrates behavioral symptoms not directed towards others that place R1 at risk for physical illness or injury and wandering that places R1 at significant risk of getting to a potentially dangerous place.

Elopement Risk Review of 02/21/2020: Resident doesn't have a history of elopement, however resident has started exit seeking. She will be placed on elopement protocol program and monitored for relocation. She removes (electronic monitoring device). Score: 16
Elopement Risk Review of 08/11/2020: On (electronic monitoring device), room assigned near the nursing station to monitor resident from leaving the floor. Score: 24.

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On 12/10/2020 at 10:40 AM, V3 (ADON-Assistant Director of Nursing) said, (regarding Elopement Risk Review scores)"I don't fill them out so I don't know." They then said, "if it's less than 10 it's low risk, greater than 10 high risk for elopement. When you complete the assessment in (electronic medical record) the computer generates a score. No additional information regarding range of scores was provided.

Facility's Incident Report Final submitted 08/15/20 for incident of 08/11/2020 notes, "This AM resident went out through the alarmed door and exited the patio by sliding down the side of the patio wall landing on (R1's) feet then buttocks. Resident was sent to the hospital post fall, returned with a fracture of the left foot calcaneus (broken heel bone) and fractures of the second through fourth proximal metatarsals (broken bones of foot) with a splint in place.

On 11/29/2020 at 1:30 PM, surveyor toured the facility's elevated smoking patio with V9 (Maintenance Director). V9 measured the distance from patio ledge to ground below. The distance on the north side is 74 inches.

On 12/02/2020 at 3:19 PM and 12/11/2020 at 1:39 PM, V2 (DON-Director of Nursing) said, "I looked at the tape after the incident. I saw the elevator door open, someone got off and (R1) got on. I don't know if it was a resident or staff member that got off (the elevator) or if the person was male or female. I would like to think that if it were a staff member they would have redirected her."
"She did not have a sitter until she came back from the hospital. She is now on the 1st Floor (across from Nurses' Station) and has a sitter

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24/7. She was moved from the 2nd Floor to the 3rd Floor when it (2nd Floor) became a Covid Unit."
"At the time of the incident, she probably did have a wander guard. I can't be sure. Social Service did not tell me it had been discontinued."

On 12/08/2020 at 2:25 PM, V23 (CNA-Certified Nursing Assistant) said, "I heard the alarm and the overhead announcement, "Patio door open please check." I went to check, I thought it was a smoker trying to get out to the patio to smoke. I didn't see anyone in the Dining Room. I approached the door. I saw R1 on the other side of the rail. I saw her jump from the patio ledge to the ground below. She landed on her feet. She still tried to run. I called a Code 99 (Elopement)."

On 12/03/2020 at 1:58 PM and 12/12/2020 at 11:28 AM, V21 (CNA) said, R1 was trying to leave that night. She was up all night, pacing. One time she made it into the stairwell and got down a flight of stairs between the 2nd and 3rd floors. Each time she tried to leave the unit it was by stairwell. The nurse (V16) knew about it (attempts to leave unit). I went to follow her (R1), I could see V16 coming towards me to help me get R1."
-"She (V16) just told me that I had to watch her because she was trying to leave. I would re-direct her when she tried to leave."
"Sometimes she had a sitter. She didn't that night. I don't know if she had one scheduled (for that shift when incident occurred). Clearly she needed one. When everyone was in the room with that resident there wasn't anyone to watch her. There aren't enough CNAs."

On 12/03/2020 at 1:23 PM, V20 (CNA) said, "I don't really know how she got to the patio door. She's usually supposed to have a sitter. She

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didn't have one that night. If there's no sitter, you (staff) have to take the place of the sitter. It's a problem when you have to care for other patients. V21 (CNA) and V22 (CNA) took her away from the elevator (during the shift). I saw her not so long before the code (Code 99-Elopement) was called, standing in the doorway of her room. I don't know if she had a (electronic monitoring device)."

On 12/03/2020 at 12:44 PM, V19 (RN-Registered Nurse) said, "We suspect she got off the floor on the elevator. When we start our rounds, it's difficult to maintain close monitoring. We have to pass meds, turn and reposition residents. I don't know what happened. If someone was there (at Nurses' Station) we could have stopped her. I took care of her when she was on the 2nd Floor. She was very anxious, pacing. She tried too many times to get off the unit using the elevator."

On 12/03/2020 at 12:07 PM V16 (RN-Registered Nurse) said, she was the nurse assigned to resident at time of incident. "I heard one of the staff paging the code from the desk (3rd Floor Nurses Station). I was in a room helping staff (CNAs V21 and V22) with a resident. I went down to the first floor. When I got down to the first floor, I saw other staff wheeling (in wheel chair) R1 back into the building. Prior to the incident she would just walk back and forth on the unit. She never tried to leave by elevator or stairwell. I never heard of any elopement behavior. Some interventions that were in place at the time of the incident were redirection, close monitoring. She did not have a (electronic monitoring device) at the time of the incident."
On 12/12/2020 at 2:05, V16 said, when asked for clarification, "Maybe you should ask the DON about it (the incident), she's the one that

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investigated it. I don't remember that anymore, I only remember what's in the incident report. That night she didn't need a sitter. She was sleeping most of the night."
"It was roughly between five and six is what I remember (when code was paged). We're usually passing our meds around that time."
"I overheard that when she was on the 2nd Floor she needed a sitter. I was thinking about why she was moved from the 2nd Floor to the 3rd Floor. It was because of Covid. The 3rd Floor has a higher acuity level than the 2nd Floor. The 2nd Floor is the "behavior" floor."

On 12/02/2020 at 4:08 PM, V17 (Former Social Service Aide) said, "R1 had an (electronic monitoring device). She had a history of taking it off. She paced by the elevator a lot, trying to elope." When asked by this writer if resident ever got off the unit, V17 replied, "Plenty of times. She got out of the building a few times. Twice she got to the bottom of the ramp outside (in front of facility's main entrance). We were able to bring her back inside. She got off the unit three times down to the 1st Floor."

On 12/03/20 at 3:58 PM and 12/12/2020 at 10:20 AM, V24 (R1's Family Member) said, "She is a flight risk. She's always running, trying to escape from the unit. She wants to be with her family. She was able to go down the elevator from the 3rd Floor to the 1st Floor through the door on the smoking patio and jumped over the railing. A staff member actually saw her jump off the patio. I got a call from the nurse (V16) around 8:30 AM (day of incident) and was told that she fell while trying to elope two times; she injured her foot but was otherwise okay."
"She did try to leave the facility before the incident. Sometimes the nurses called me. They

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would say, "she tried to get on the elevator but we stopped her." She had a sitter off and on as far back as 2018. Some days she was okay and didn't need one."

Progress Notes as follows, document multiple attempts made by R1 to leave the unit. PRN (as needed) medications are given for behavior. No documentation is found noting notification of Psychiatrist.
-02/24/2020, 4:05 PM: "Pt agitated walking around trying to leave facility unable to redirect. Pt needs constant redirection and monitoring (electronic monitoring device) in place. Needs constant monitoring place on 1:1.
-02/25/2020 7:17 AM: At 11:45 PM resident came to Nurses' Station. Walked back and forth. Is anxious. Wants staff to take off her (electronic monitoring device). Needs constant redirection.
-05/31/2020, 2:29 PM: "Resident very agitated, voicing wanting to leave and running without direction on unit, and attempting to leave via elevator or stairs. Haldol IM as ordered. Resident became calmer and stopped ranting."
-06/09/2020, 10:10 AM: "Suddenly became agitated, trying to open stairway door. Unable to re-direct."
-06/11/2020, 3:23 PM: "Resident was observed running in the hallway trying to go down the stairwell. She was pacing the floor. This is baseline. 1:1 counseling and provided a sitter for her room. Resident responding to internal stimuli AEB (as evidenced by) talking to herself. "
-06/13/2020, 10:30 AM: "Very anxious, restless, trying to open stairway, door unable to redirect."
-06/19/2020, 3:21 AM: "Res confused, became agitated, trying to use stairway to go out, unable to redirect."
-07/15/2020, 10:40 AM: "Attempts to get in elevator on occasion."

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-07/27/2020, 9:30 AM: "Res became agitated, trying to use stairway to go down, unable to redirect."

On 11.29.2020, the facility presented a pre-filled care plan for "wandering, pacing or roaming" dated 08/10/2020 (annual care plan). 12/03/2020 at 4:49 PM V18 (SSD-Social Service Director) said when resident's annual review is completed, a new care plan is made, old care plans are removed and filed in Medical Records. No previous care plans related to R1's "wandering, pacing, or roaming" behavior addressing R1's previous attempts to leave the unit were provided after multiple requests.

On 12/11/2020 at 10:32 AM, V25 (Medical Records) said, "These are her (R1's) old care plans."
43 care plans from 06.2017 -05.2019 were noted. No care plans were found in R1's medical record (Hard Copy); no "wandering, pacing, or roaming" were in Medical Records

On 12/03/2020 at 4:49 PM and 12/09/2020 at 4:22 PM, V18 (SSD) said, "She paces a lot and is an elopement risk. To my knowledge she never got out of the facility before the incident (08/11/2020). She was on the 2nd Floor and transferred to the 3rd Floor. She never tried to get off the 2nd Floor, she did get off the 3rd Floor. She was trying to get to the 2nd Floor because that was her "home." Prior to the incident, I don't believe she had a sitter because she wasn't an elopement risk like that, she never tried to run. She had a wander guard but she cut it off. So we put it on her ankle. The last time I saw her was in October, she didn't have a (electronic monitoring device) at that time but she did have an (electronic monitoring device) at the time of the

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incident (08.11.2020).
"Social Service is responsible for initiating/updating the care plan. It should be updated after each incident, quarterly and annually. Interventions could include 1:1 monitoring/sitter, electronic monitoring device)/check for placement of (electronic monitoring device), redirection."
"Typically I try to get to elopement risk assessments within 72 hours of admission. They are done annually, quarterly, and with a significant change (any improvement or decline of physical or mental health)."
"It really surprised us, we never saw her do anything like that (leave unit)." This writer informed V18 that there is documentation in R1's medical record (Progress Notes, Elopement Risk Review) and staff statements regarding R1's known exit seeking behavior prior to the incident. V18 said, "I was never told she had exit seeking behavior. It would have made a difference (with interventions). We would have monitored her more closely, maybe a sitter before the incident. I think we should have monitored her more closely."

Policy and Procedure Regarding Missing Residents and Elopement (undated) notes:
-Policy Statement-"It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs. All residents assessed to be at risk of elopement will have this issue addressed in their plan of care."
Procedure for the Prevention of Missing Residents
1. "All residents shall be assessed for behaviors that place them at risk of elopement utilizing an elopement risk assessment upon admission, quarterly, annually and upon significant change of

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S9999	Continued From page 10 condition." An assessment dated 02/21/2020, was completed 34 days after R1 was readmitted on 01/18/2020; no admission or quarterly assessments were found. On 12/10/2020 at 2:40 PM, V3 (ADON) said, (regarding "Policy and Procedure Regarding Missing Residents and Elopement") "if that's all you have that's the only policy and procedure we have in place. I can reach out to the DON and my nurse consultant to see if there is an "Elopement Program Protocol" or any other elopement protocol." No additional documentation was provided. (A)	S9999		