| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigations:#2180161/IL00130046 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.1220b)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>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.<br>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:<br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b)The DON shall supervise and oversee the nursing services of the facility, including:<br>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) | S9999 | | |

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These requirements were not met evidenced by:

Based on interviews, observations, and record review, the facility failed to provide interventions and supervision to reduce the risk of one resident (R2) leaving the facility. This failure resulted in R2 leaving the facility unsupervised multiple times without developing new interventions to prevent further elopements. In addition, the facility failed to prevent R2 from being punched in the face, and suffering a facial laceration and acute comminuted nasal bone fracture. This failure affected 1 (R2) of 3 residents reviewed.

Findings include:

R2 is a 73 - year old military veteran residing in the facility. R2 said he served 3 tours in Vietnam. R2's diagnosis include Altered Mental Status, Restlessness, Agitation, Mood Disorder, Anemia, Depressive Disorder, Bipolar Disorder, Epilepsy, Anxiety, Alcohol Abuse, Tremor, Extra Pyramidal, Movement Disorders, and Rheumatoid Arthritis. R2 was transferred to the hospital for evaluation on 1/20/21 and had not returned on 1/22/21.

During an interview on 1/19/21 at 10:45AM V9, Social Service Director, said an elopement assessment is completed when a resident is admitted, quarterly, and following an incident. A resident at risk is monitored more closely, but this is not documented anywhere.

During an interview on 1/19/21 at 1:25PM V15,

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Activity Director, said the patio door is always unlocked. V15 said residents at risk for elopement are watched while smoking. R2 is a smoker and he is supervised while smoking. V15 said R2 is at risk for elopement. R2 has jumped the fence at least once, might have been twice.

During an interview on 1/19/21 at 1:46PM V21, Registered Nurse (RN), said she did not see R2 had left the facility. Once she was alerted, she began a search, all staff was searching all over the facility for R2. V21 said during the search R2 was suddenly in front of me. He denied going anywhere, but I saw him pouring vodka in a cup. Following this incident, we were not given new instructions to provide care to R2. V21 said she tries to watch R2 to prevent from leaving, but she does not stop her tasks. V21 said she tries to watch R2 from the windows when he is on the patio. V21 said after the activity monitor leaves in the evening all the residents go to the patio, if we call them to come in they won't. V21 said there is a potential that R2 is outside on the patio unsupervised.

On 1/19/21 at 2:00PM V13, Licensed Practical Nurse (LPN), was at the 2nd floor nurses station, watching the phone with earbuds on. Surveyor was unable to get V13's attention to request assistance. R2 was not in his room.

During an interview on 1/19/21 at 2:20PM R2 said in December I climbed the fence to get tobacco and vodka. Staff just told me to go to my room when I returned. No one is in the patio that evening. I go behind the fence grab the rail, pull myself up, and put my foot on the other rail and push myself up and over.

During an interview on 1/19/21 at 2:34PM V9 said

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R2 should have had an elopement risk assessment completed after he eloped in July 2020. V9 said at the time she spoke with the former administrator and R2 was not able to be moved to the secured 3rd floor, because no rooms were available. V9 said R2 does not necessarily need to be on a locked floor, he needs to be supervised. V9 said on 12/4/20 R2 said he didn't climb the fence to get out. There were no cameras in the area at the time. V9 said the Certified Nursing Assistants (CNA) are supposed to monitor the smoking patio after activity and behaviors monitors leave. V9 said the door to the patio remains unlocked at all times.

During an interview on 1/19/21 at 2:54PM V14, Director of Nursing (DON), said I was first made aware of R2's risk for elopement in December of 2020. V14 said R2 goes outside unsupervised. V14 said since R2's elopement in December increased cameras were placed in the area. V14 was unable to provide a date when the cameras were placed.

During a phone interview on 1/20/21 at 9:28AM V31, R2's family, (listed as Power of Attorney) said they should have it so he (R2) can't get out to buy alcohol. They never give me an answer when I ask what changes are in place. V31 said R2 has an escape route he uses.

During an interview on 1/20/21 at 9:55AM V6, Certified Nursing Assistant, the surveyor asked V6 what is a Code Pink. V6 said I have to ask. V6 told the surveyor the rooms she is assigned to for care. V6 said R2's room is assigned to the CNAs on the other side of the unit. V6 did not follow up with surveyor regarding a code pink.

During an interview on 1/20/20 at 10:00AM R2

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said I went to the liquor store at 8PM last night. I didn't ask anyone. The stores is about 4-5 blocks away. I took a bus, it was dark out. No one saw me leave. I climbed the fence.

Surveyor spoke with V17, CNA, on 1/20/20 at 10:04AM. V17 said R2 is not her assigned resident. V18, CNA, said R2 is not my assigned resident. V18 said there are 2 CNAs, myself and V17, on this side and V18 said we have a trainee but he is not assigned any rooms.

During an interview at the nurses' station on 1/20/21 at 10:07AM V11, Registered Nurse (RN), was asked by surveyor what a Code Pink is. V11 said hang on I have to check. V11 left the nurses' station and went into a locked room behind the station. V11 observed searching in a bag she grabbed. At 10:09 V11 said Pink is elopement.

During an interview on 1/20/21 at 10:30AM V14, Director of Nursing, looked at her schedule and reported 3 CNAs are working on R2's floor. V14 spoke with V6 over the phone who said she is not assigned to R2. V14 then spoke with V18 who said she is not assigned to R2. V14 then spoke with V17 and said you are assigned to R2. V14 said to V17 you are to know where R2 is at all times.

During an interview on 1/20/21 at 10:38AM V16, Dietary Manager, said I don't know what a code pink is. V16 left the office and returned with his name tag. The tag has a list of codes on it. V16 said pink is not on the list. V17 witnessed this observation.

During a phone interview on 1/20/21 at 11:05AM V28, outside facility Social Worker, said R2 is a high risk for elopement and the facility is not

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| S9999 | Continued From page 6<br>taking precautions. V28 said R2 has a history of elopement.<br><br>During an interview with V9, Social Services Director, on 1/20/21 at 11:26 AM, she said we need the gate fixed. V9 said nothing else is in place to prevent R2 from climbing the fence. V9 said currently groups are on hold and R2 has not been able to attend his behavior group.<br><br>During a phone interview with V13, on 1/20/21 at 12:38PM, V13 said she was notified on 1/19/21 that R2 had gone over the gate. This was my first notification he was out of the facility. V13 said she had seen R2 between 5:15PM and 6:00PM. R2 was assigned to V30, CNA. V13 said rounding should be done every 30 minutes to 1 hour. V13 said residents at high risk for elopement should have rounds every 15-30 minutes. V13 said when R2 returned 2 bottles of brandy were confiscated. V13 said one bottle was open and he maybe drank 6-7 ounces of the brandy.<br><br>During a phone interview with V30, CNA, on 1:13PM V30 said he was notified R2 was outside on 1/19/20 around 9:00PM. I was instructed to go get him. V30 said this is not the first time R2 has gotten out. V30 said he last saw R2 around 4:30PM or 5:00PM. V30 said we don't know when he was last seen before leaving. V30 said R2 may have gone out for a smoke around 7:00PM. V30 said he went at least 3 hours without seeing R2. V30 said I don't do rounds on R2 every 15 or 30 minutes.<br><br>During an interview on 1/20/21 at 2:00PM V25, Doctor, said they call me about R2 eloping the facility. They called me on 1/19/21 and said R2 was drunk. V25 said they could put him on a locked floor, report to his psyche, or put some | S9999 | | |

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kind of device on him to alert the staff when he leaves. V25 said over the last 2-3 weeks he has gotten worse. He is not safe to be climbing fences and going out unsupervised. V25 said R2 ambulates with a cane and has tremors. V25 said they need to monitor, if nobody checks on him ... [did not complete sentence or statement].V25 said when the nurse is busy R2 leaves. I know they check on him daily.

On 1/20/21 V1, Administrator, said she is not able to find a history of the date the surveillance cameras were worked on.

On 1/20/21 at 3:00PM V14, DON, brought surveyor 2 clear, glass, bottles of Brandy that were confiscated from R2 on 1/19/21. Both bottles were 375ml and one bottle was open with approximately 1/3 liquid gone.

During an interview on 1/21/21 at 11:56AM V14 said elopement is when someone is missing from the facility and is unable to be located. V14 said R2 is not an elopement because he has a mission. We would prefer he not leave to get alcohol. V14 said a resident needs an order from the physician to leave the facility. V14 said a resident is an elopement if he does not return. Even if the police return the resident it is not an elopement because he has returned. I expect staff to follow procedures and nurses to follow physician orders.

During an interview on 1/22/21 at 9:52AM outside at the fence V8, Housekeeping Supervisor - serving as temporary maintenance director, said the smoke tent could be moved to block the access to the gate. V8 said he was told by a previous administrator to remove the grill on the patio because the residents used it to jump gate.

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| S9999 | Continued From page 8<br>V8 said this week he has not been informed of any residents climbing the fence.<br><br>During an interview on 1/22/21 at 10:24 AM V3, Minimum Data Set Nurse, said risk assessments are done quarterly by each department.<br><br>During a phone interview on 1/22/21 at 10:31AM V32, Registered Nurse, said she told "them" how R2 gets out of the fence. V32 did not clarify who she told. V32 said she worked on 12/5/20 when R2 reported another resident hit him in the face. V32 said no staff was in the basement when R2 was hit. V32 said rounds on R2 are done hourly. R2 has continuous movement and goes to the basement at night. V32 said R2 goes by himself anywhere. V32 said a code yellow is elopement or fighting, she was unable to report what a code pink is.<br><br>During an interview on 1/22/21 at 11:00AM R9 said she was drinking coffee with R2 in the basement when R2 was hit. R9 said she saw when R2's was punched, but she did not know who the other guy was. R9 said R2 and another resident were fighting over the vending machine. R9 said there was no staff in the basement when this happened. R9 said the staff was made aware when they returned to the unit.<br><br>During an interview on 1/22/21 at 11:23AM V14 said R2 had increased behaviors in December. V14 said I don't know if a medication review was conducted on R2.<br><br>During an interview on 1/22/21 at 11:26AM V34, Psyche Nurse Practitioner, said when he is notified of a psyche emergency (such as behaviors) he would either order an as needed medication be given or to send the resident for | S9999 | | |

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| S9999 | Continued From page 9<br>evaluation.<br><br>During an interview on 1/22/21 at 12:13PM V2, Assistant Director of Nursing, said if R2 had been seen by V34 there would have been a note.<br><br>On 1/19/21 an Elopement Risk List updated 10/1/20 was provided to the surveyor. R2's name is not on the list. Note R2 has been outside the smoking patio 4 times since this list was updated.<br><br>Review of R2's Order Summary Report active as of 1/20/21 notes may have community access with supervision only.<br><br>The 12/28/20 Elopement Risk Review was completed by V14 and the following questions are documented Yes:<br>Is there a history (prior to admission) of wandering/elopement and/or does the resident verbalize a strong desire to leave?<br>Is there a diagnosis of dementia and/or severe mental illness?<br>Reported episodes of elopement and or attempts to elope?<br>Signs of compromised decisional capacity and impaired judgement and/or physical status limitation that would place the resident at risk in the community?<br>Has the resident's representative requested that the resident be monitored on the Elopement Protocol?<br>Verbalizes a serious/strong intent to leave the facility in the absence of an appropriate discharge plan?<br>Has the physical ability to leave the building?<br>Elopement Risk Decision: the resident presently appears to be at risk to elope and should be placed on the Elopement Risk Protocol. | S9999 | | |

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| S9999 | Continued From page 10<br><br>Review of R2's Progress Notes state on 12/4/20 around 8:15PM R2 left the building without permission.<br><br>Review of R2's Progress Notes from 12/5/20 state at 1:30AM resident reported to the nurse that a co-resident hit him on the face in the basement. R2 noted with bleeding from his face. At 6:22AM Emergency Room notified the facility R2 will be returning to the facility.<br><br>Review of R2's Progress Notes on 12/17/20 state R2 on the street across from the facility. According to the note R2 said he jumped over the fence at the patio to get out to buy cigarettes.<br><br>Review of R2's Progress Notes on 12/24/20 state staff was conducting a search and saw police drop off R2. Police reported to nurse R2 slid through the space between the iron fence and the wall.<br><br>Review of R2's Progress Notes on 1/19/21 state R2 was observed climbing the gate returning to the facility. R2 noted with 2 bottles of prohibited items.<br><br>Review of R2's Progress Note dated 11/6/20 is the most recent Psychiatrist Note. R2 had 3 episodes in December of getting out of the facility.<br><br>R2's care plan initiated on 12/31/20 notes he is an elopement risk/wanderer. History of attempts to leave facility unattended. Intervention dated 12/31/20 states distract resident from wandering by offering pleasant diversion, structured activities, food, conversation, television, book. Resident prefers: [no further text]. No other interventions are listed. R2 has a care plan | S9999 | | |

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stating he has impaired cognition. R2's history of "active alcohol" use is identified on his care plan. R2's care plan identifies smoking as a focus. Interventions do not include supervision while smoking.

Review of R2's Emergency Room History and Physical from 12/5/20 note R2 presents after being punched in the face by another resident. Admits to alcohol use tonight, stating he drank half a pint of vodka. Diagnosis listed are facial laceration and closed head injury. Review of R2's hospital records dated 12/5/20 note R2 with facial trauma after being punched in the face. Has obvious nasal deformity with facial bone tenderness over the right maxilla.

Review of R2's hospital records dated 12/5/20 note R2 underwent a laceration repair to the right infraorbital. R2 received 4 sutures to the laceration.

Review of R2's CT report from 12/5/20 note acute comminuted nasal bone fracture with associated soft tissue swelling.

On 1/22/21 surveyor requested a smoking assessment for R2. The facility provided a SS Lookback Summary dated 4/3/20. The lookback summary does not address safety, supervision, or resident's ability to hold smoking devices. This summary states the resident is a smoker.

On 1/22/21 surveyor was provided a list of "Resident Smokers" R2's name is not listed. Shortly after a second list was provided to the surveyor of Current Smokers 1/22/21. Current list notes Bed hold residents that smoke, includes R2.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6003453 | A. BUILDING: _____ B. WING _____ | 01/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APERION CARE WEST RIDGE | 6450 NORTH RIDGE BLVD CHICAGO, IL 60626 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 12<br><br>Surveyor requested reports of investigation R2's elopements on 1/20/21. V14 said she was unable to give surveyors copies and surveyor requested she review the investigations with surveyor. V14 did not provide review.<br><br>Per the facility Smoking Safety policy dated 11/28/12 A Smoking Safety Assessment will be completed upon admission, quarterly, and with significant change.<br><br>Per the facility Code Pink - Missing Resident Elopement policy review date 11/15/20 notes: Upon return of the resident to the facility, the DON or charge nurse should: Complete a new Elopement Risk Assessment and update plan of care as appropriate.<br><br>" A" | S9999 | | |