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
	IL6005177	A. BUILDING: ______ B. WING ______	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE LAKESHORE	7200 NORTH SHERIDAN ROAD 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
S 000	Initial Comments Complaint Investigation 2288649/IL152766	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)3) 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 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	S9999	Attachment A Statement of Licensure Violations	

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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.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to (a) ensure resident safety by allowing two residents(R4 and R5) to go out on a community pass without a medical provider authorization/order, (b) ensure safe return of one resident(R4) from a community pass that was unauthorized by medical provider. These failures resulted in R4 and R5 sustaining serious injuries requiring hospitalization and treatment.

Findings Include:

1. R4's Brief Interview for Mental Status (BIMS), dated May 24, 2022, documents R4's BIMS (Brief Interview for Mental Status as 13/15. R4's Activities of Daily Living (ADL) Assistance, dated May 25, 2022, documents R4 as requiring extensive assistance with transfer and bed mobility, and R4 needs limited assistance with walking.

Current POS(Physician Order Sheet) documents: R4 is an 82-year-old female admitted to the facility on 11/30/2021. R4 is 82-year-old female with diagnosis not limited to: Alzheimer's disease,

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S9999	Continued From page 2 unspecified, Chronic Obstructive Pulmonary Disease with (Acute) exacerbation, Bipolar disorder, Current episode mixed, Mild, anxiety Disorder, unspecified, Disorder, unspecified psychosis not due to a substance, or known physiological condition, unspecified hearing loss, bilateral. On 10/19/2022, staff allowed R4 to go out on a community pass, and R4 was returned to the facility at 9:30pm by Chicago Police. On 10/30/22 Social Worker(V6) provided R4 another community pass. R4's progress notes by V6 (SSD/Social Services Director), dated 10/20/2022 at 11:40, document R4's community pass was restricted for 14 days after R4 went on a community pass on 10/19/2022 and was brought back to the facility via CPD (Chicago Police Department). R4's SS-Community Survival Skills Assessment, dated 10/13/2022 and 10/20/2022, completed by V6 document R4 has the ability to adhere to pass privilege policies, e.g., respecting time parameters and curfews Social Services progress notes documents, "(R4) left facility on a restricted community pass (four hours only pass) on 10/30/2022. (R4) has failed to return the facility to date." On 11/16/2022, 10:30am, V1(Administrator) said based on the admitting diagnosis from the hospital, a resident is placed on dementia unit and an Interdisciplinary team-IDT does resident assessments. V1 said a resident pass privilege is based on Social Services assessments and based on assessment, a resident's pass level is	S9999		

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S9999	Continued From page 3 determined. V1 said documentation on resident assessments and residents progress notes should be completed on time. On 11/16/2022 at 10:42am, V6(Social Services Director) said when a resident is admitted to the facility, the resident is coded "red", which means the resident is restricted on observation for 14 days, and during this time, the resident cannot leave the facility on a community pass. V6 said after the resident is monitored for 14 days for behavior, medication compliance, cognition and if there were no issues with resident, the resident can then be given a yellow pass, which means the resident can leave the facility on a community pass for up to four hours. V6 stated if the resident displays good conduct for a month when the resident is on yellow, then they go to "green", which means resident can leave the facility for up to ten hours. V6 said, "If the resident is on red, they can still go out on a pass with an escort who is a family member and on file, or with a staff member." On 11/16/2022 at 10:42am, V6 said, "(R4) did not exhibit and behavioral problems and was fine and was not aggressive and took her(R4) medication. (R4) went out on a pass on the 10/19/2022, and (R4) was brought back by the police the same day because (R4) ran out of money and (R4) flagged down the police who escorted resident back to the facility." V6 stated she spoke to R4 who said R4 had run out of money, and told the police to bring R4 back. V6 stated R4 provided the name of the facility to the police and R4 was brought back to the facility. V6 stated she completed another community	S9999		

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S9999	Continued From page 4 assessment on R4 on 10/20/2022, and R4 was a "yellow". V6 said V6 congratulated R4 for calling the police, and since R4 was able to use the police to get back to the facility, V6 gave R4 a yellow pass, even though R4 had used all of her money in the community and was not able to get back to the facility. V6 stated, a yellow coded pass means the resident can be out only for 4 hours. On 11/16/2022 at 10:42am, V6 stated she did not consider the previous time R4 was gone for more than 4 hours from the facility, and R4 did not have money to get back to the facility. V6 said, "I did not know what time specifically (R4) had come back to the facility. We only look for the residents after 8pm, if they go on a pass and don't come back. I don't know when (R4) left the facility on a community pass, and I think (R4) came back after 7pm. (R4) was brought back to facility by the police." On 11/16/22 at 10:55am, V10(PCP/Primary Care Provider) said, "When (R4) left the facility on 10/30/2022, I did not know where (R4) was until 10 days later." V10 stated R4 was not supposed to leave the unit, but R4 was able to get out of the facility. V10 indicated she (V10) was not consulted by staff, and did not write an order for R4 community pass. Subsequently, R4 sustained a left jaw and nasal fracture, two aching wrists and R4 has unsteady gait per medical records from community hospital. R4's medical records from community ED(Emergency Department), dated 11/09/2022, document: R4 sustained a left jaw and nasal fracture, two aching wrists and R4 has unsteady gait per medical records from community hospital.	S9999		

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On 11/16/2022 11:36am, V1(Administrator) said, "When residents go out, the residents sign out by receptionist, and sign back in upon entry. If a resident did not come back to the facility, the receptionist would notify Social Services staff that the resident does not come back.After staff is notified, the staff should notify the resident's physician, family member, Director of Nursing and the Administrator ,and possibly the police will be notified."

On 11/16/2022 11:36am,V1 stated she started working at the facility on 11/10/2022. V1 stated she met with the previous Administrator, who told V1 that R4 was in a hospital, and at the hospital, R4 had told hospital staff R4 had left "Against Medical Advice-AMA." Per surveyor documentation review, there is no evidence R4 left facility AMA.

V1 stated if a resident does not come back at the time their pass privileges they should return, the facility should start looking for the resident, the facility should follow facility policies. V1 stated resident community pass privileges should have a physician order. V1 said "Our goal is to keep residents safe."

On 11/16/2022 at 12:11pm, V2(Director of Nursing -DON) said R4 was going out to the community on a pass and comes back. V2 said Social Services do community assessments and assign residents pass privileges depending on the assessment. V2 said that on 10/19/2022, R4 went out on a pass to the community. V2 said V2 does not know what time R4 left the facility, but R4 come back to the facility at 9:32pm, brought back by the police. V2 said If a resident is gone out on a pass for longer than the pass privilege

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allows, Nursing staff is supposed to call V2 or V1 (Administrator), and notify resident family who is the emergency contact number, and then call police. V2 said, "I have no idea how long (R4) was supposed to go out on a pass for." V2 said R4 came back within R4 time frame to come back, but V2 does not know what time R4 left, and what time R4 was supposed to come back to the facility. V2 said that the pass privilege / facility policy determines who is safe to go into the community safely on a pass, and who needs an escort to be safe going out into the community. V2 said there are residents who don't get pass privileges because they are not safe to go to the community alone, or without an escort.

On 11/16/2022 at 1:40pm, V12(Nurse) said on 10/19/2022 when V12 started her evening shift of 3-11pm, she did not see R4 in the unit. V12 said V12 did not know exactly what time she called the receptionist to ask about R4's whereabouts. V12 stated she was told
R4 was out on a community pass. V12 said, "This was after 6pm." V12 stated she documented at 9:28pm that R4 was brought in by police.

On 11/16/2022 at 2:29pm, V6(Social Services) stated she does not know the whereabouts of R4, and does not know if R4 is at the hospital.

Progress note(written by V6) on 10/20/22 at 11:40am, documents: "(R4) was on a restricted pass." V6 said, "The progress note should not be in (R4's) progress notes, it should have been error-ed out."

On 11/16/2022 at 2:29pm, V6 said V6 makes discretionary decisions on resident's community pass privileges. V6 said "Yes, a doctor order is

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needed for a community pass." V6 was unable to show a doctor's order in R4's physician order sheet for R4's community pass. V6 said V6 should follow facility policies.

On 11/16/2022 at 2:45pm, V14(Family member of R4) said, "I don't know where (R4) is. The Social Worker from a hospital called me last week and told me (R4) is in the hospital and the Social Worker is trying to place (R4) somewhere else, but I don't know where the Social Worker was calling me from." V14 said the police had put out a missing person flier, and that is how the hospital knew R4 is was a missing person. The Social Worker from the hospital called V14 to let V14 know R4 was at the hospital. V14 said, "I don't know where (R4) is and I have not seen (R4) since (R4) left the facility."

On 11/16/2022 at 2:55pm, surveyor called V10(Nurse Practitioner) regarding R4. V10 said, "(R4) plays a very good game and (R4) is good at masking (R4's) delusions, but after talking to (R4) for a while, you would know (R4) is very delusional. (R4) is very confused at times and has strange beliefs. V10 said, "(R4) said (R4) can have (R4's) teeth made out of (R4's) hip bone, by getting (R4's) hip bone and mashing it to make teeth, which shows (R4) has very poor insight." V10 stated because R4 has dementia, R4 is at brisk for serious harm if R4 is not supervised. R4 was on the 3rd floor, which is for dementia residents, and even though R4 is not on the complete locked unit on the 3rd floor, R4 was still in the dementia unit for safety.

V10 said, "When (R4) left the facility on 10/30/2022, I did not know where (R4) was until 10 days later." R4 was not supposed to leave the unit, but R4 was able to get out of the facility. V10

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S9999	Continued From page 8 said review of the video system at the facility showed R4 left the facility on 10/30/2022 at 9:00 am. V10 said V10 got the information on when R4 left from the Social Worker (V6) and the previous Administrator. V10 said R4 should never have left the facility on 10/30/2022 because recently, on 10/19/2022, R4 left the facility on a restricted community pass and R4 got confused while out in the community and police had to bring R4 back to the facility. On 11/16/2022 at 2:55pm, V10 said, "After (R4) did not return to the facility on 10/30/22, facility made a police report. On 11/9/2022, (R4) was reported to have been taken at a nearby hospital by EMS (Emergency Medical Services) on 11/092022. (R4) was domiciled when EMS found (R4), and (R4) has been domiciled since (R4) left the facility." V10 said per hospital records, R4 fell and broke R4's Maxillary bone and sprained bilateral wrists. V10 said R4 was also very dehydrated when R4 was taken to the emergency department of a nearby hospital after R4 was found sleeping on a bus stop bench. On 11/16/2022 at 4:06PM, V26(Licensed Practical Nurse-LPN) said, "(R4) would go out on a community pass about 3 times a week and (R4) would come back between 7-8pm, and if (R4) was not in at this time, that is when a supervisor would be notified." V26 said V26 did not know how many hours R4 was supposed to be out in the community as long as R4 come back between 7-8pm. Review of physician orders do not document Community pass privileges for R4. 2. POS(Physician Order Sheet) dated 9/05/22, documents R5 is 69-year-old male, with	S9999		

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Diagnosis not limited to: Parkinson's Disease, Type II DM, Dementia-unspecified), lack of coordination, abnormal gait and mobility, Schizophrenia and Bipolar Disorder) was allowed to go out on community pass without community skills assessment and without doctor's order. According to resident's (R5) medical records, R5 fell while out on a pass and sustained fracture of right pubis and fracture of right femur.

R5's Brief Interview for Mental Status (BIMS), dated 9/16/22, documents: R5 has a BIMS score of 13/15, and R5's Activities of Daily Living (ADL) Assistance, dated 9/22/22, documents R5 needs extensive assistance with ADLs.

R5's SS/Social Services-Community Survival Skills Assessment, dated 10/12/2022, document R5 is not eligible for community pass at this time. No previous Community Assessment Pass is documented. Elopement /Authorized leave assessment, dated 10/12/2022, is on file for R5.

Review of Physician Orders do not document Community pass privileges for R5.

On 11/15/2022 at 12:33pm, R5 was observed in R5's room speaking to R5's roommate. R5 was laying in bed with R5's wheelchair nearby. R5 said R5 can walk a little distance without wheelchair. R5 said on 9/15/2022, R5 went with R5's brother to the gas station near the facility to buy chips. R5 said R5's wheelchair got caught on something and R5 fell and broke R5 hip, leg, and R5 had to be transported to the hospital where R5 said R5 had surgery. R5 said before R5's fall on 8/15/2022, R5 used to go to the beach during the summer, and R5 said at that time, R5 was never restricted from going out to the facility.

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S9999	Continued From page 10 On 11/15/2022at 12:46pm, V10 (Nurse Practitioner) said R5 went out to a nearby gas station, and while there, fell and landed on right side and broke the head femur head, superior and inferior acetabular (socket" of the "ball-and-socket" hip joint). V10 said R5 has slight dementia and should not have been out there by himself (R5). V10 said R5 was assessed by Social Services. V10 said Social Services assess residents for pass privileges. V10 said R5 should have had an escort when R5 left the building on a pass so that if anything was to happen to R5, the escort could have helped R5, because R5 does not have the ability to correct the problem. V10 said R5 thinks R5 has more capabilities to take care of R5 than R5 has. V10 said if R5 had an escort the day R5 fell, the fall could have absolutely been prevented. V10 said, "I have seen (R5) go out by himself after the fall." On 11/15/2022 at 1:08pm, V11 (Licensed Nurse Practitioner-LPN), said R5's cognition is a 3, meaning R5 is oriented to person, place and time, but sometimes R5 can be confused. V11 said R5 knows how to ask for help. V11 said R5 should not have been going out by himself because R5 has Parkinson's disease and should have an escort to keep R5 safe when R5 is out and about. V11 said an escort while R5 is out and about in the community can help R5 maneuver R5's wheelchair. V11 said R5 is a fall risk because of R5's medical diagnosis and should have an escort to keep R5 safe when R5 is going on the ramp in and out of the facility without staff supervision. Facility Policy titled Community Pass Guidelines, dated 11/28/2022, documents -The resident has the right to community access	S9999		

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S9999	Continued From page 11 with the consent of the facility, physician's orders and the residents' cooperation with the standards described -Decisions regarding pass privileges, including, independent privileges or being accompanied by a responsible individual are determined by physician orders and social services assessments (A)	S9999		