STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009757	A. BUILDING: _____ B. WING _____	C 01/12/2024

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PAVILION OF SOUTH SHORE	7750 SOUTH SHORE DRIVE CHICAGO, IL 60649

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S 000	Initial Comments Complaint Survey: 23810387/IL167736	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.690b) 300.690c) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local	S9999		

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law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

These Requirements were not met as evidenced by:

Based on interviews and record review the facility staff failed to report an elopement and unusual occurance (unscheduled hospitalization) to the Illinois Department of Public Health for 1 (R2) of 3 residents reviewed for reporting. R2 eloped from the facility, was located with the assistance of the local police department , taken to local the hospital and recieved treatment for hypothermia. The facility also failed to follow the facility policies for reporting an accident, incident or unusual occurrence. This deficient practice was evidenced by the following:

Findings Include:

On 12/10/23 R2 was observed to be missing from the facility-by-facility staff. R2 was not found after a facility and community search was conducted by the facility. Per facility documentation the Chicago Police department was notified and participated in the community search. R2 was later identified at the Hospital after arriving via EMS (Emergency Medical Services) and admitted

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with a diagnosis of hypothermia.
R2 was admitted to the facility on 11/07/23 with diagnosis not limited to Dysarthria Following Cerebral Infarction, Dysphagia Following Cerebral Infarction, Essential (Primary) Hypertension, Personal History of Transient Ischemic Attack, Cerebral Atherosclerosis, Psychoactive Substance Abuse, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Cerebral Infarction Due To Thrombosis of Left Anterior Cerebral Artery, Cerebral Infarction Due To Thrombosis of Right Posterior Cerebral Artery, Cerebral Infarction Due To Unspecified Occlusion or Stenosis of Right Middle Cerebral Artery, Unsteadiness on Feet and Weakness. MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 7 indicating severe cognitive impairment.

Progress note dated 12/10/23 16:15 document: Nurses Note Text: Resident noted not to be present in facility. Staff notified and conducted a facility wide search.

Progress note dated 12/10/23 17:40 document: Nurses Note Text: Writer called police (911) as staff participated in a community search.

Progress not dated 12/10/23 17:45 document in part: Nurses Note Text: V6 (R2 Family Member) notified of resident being out of facility and that staff was doing a community search and police notified.

Progress note dated 12/10/23 17:50 document in part: Nurses Note Text: Area hospitals called, and resident is not in any hospital at this time.

Progress note dated 12/10/23 19:45 document in part: Nurses Note Text: Resident later identified at

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Hospital. Resident arrived via EMS.

Hospital records dated 12/10/23 document in part: dated and time of arrival 12/10/23 at 1840. Discharge Summary: at the time of admission: #Acute encephalopathy with accidental hypothermia, #Acute ventricular fibrillation cardiac arrest status post CPR (Cardiopulmonary Resuscitation) with ROSC (Return to Spontaneous Circulation), #Acute circulatory shock, #Acute on chronic heart failure with reduced EF (Low Ejection Fraction), #Multiple bilateral rib fractures due to CPR likely, #Acute respiratory failure and #Sepsis due to aspiration pneumonia. Patient was initially brought to the ED by EMS after he was found wandering outside, confused with minimal clothing. There was a report for a missing person from a nursing home/assisted living facility which was confirmed to be our patient.

On 01/02/24 at 2:15 PM V3 (Director of Nursing) stated "R2 did not have a reportable for the elopement."

On 01/02/24 at 03:18 PM V1 (Administrator) stated "this incident was not reported to IDPH (Illinois Department of Public Health) to my knowledge. It was not reported because R2 was found. Usually, it would be the Director of Nursing in conjunction with the administrator that is responsible for reporting it."

On 01/03/24 at 12:18 PM V21 (Vice President of Operations) stated "when we identified the noncompliance for the elopement the binder is to show that we are in compliance prior to (referring to me the surveyor) entering the building on yesterday 01/02/23. We talked about the root cause analysis, and we took the steps to remedy

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the issue of a resident leaving the building. The elopement should have been reported to the state. I was not aware that it was not reported. I am just merely a consultant. It was a past noncompliance (the elopement that happened that day) for immediate jeopardy."

On 01/04/23 at 09:43 AM V3 (Director of Nursing) stated "On 12/10/23 it was at about 02:50 PM when staff were doing their last rounds and noticed R2 was not there. They checked the floor and called the supervisor then called a code purple (to say a resident is missing). They called me and I came. I gave the police sergeant a description of R2 when the sergeant came to see what was going. The sergeant said I think I saw your guy, but I can't be for sure, but I saw the red shirt. The sergeant said let me call my squad and send them over to the hospital to see if that is your man. The squad went over there and radioed back to confirm that was R2. I called V6 and told her R2 was located at the hospital. The sergeant said R2 was found on 83rd and South Shore. I don't know the exact location, some passer byes called 911, that is what the sergeant said. I was writing things down as they happened, and my documentation is for the time stamp as things happened. It was approximate 3.5 - 4 hours that R2 was missing. In my book it was cold outside the day that R2 was missing. R2 only had a tee shirt, sweatpants, socks, and shoes on but no coat. In the morning on 12/10/23 it was 34 degrees, and, in the evening, it was 32 degrees outside. It was cold that is what possibly caused the hypothermia. In the hast of all this not reporting this to the state was just an oversight on my part. I called the hospital, and they told me R2 was on a ventilator, R2 was cold, and they were treating R2 for hypothermia. When I called V6 (R2 Family Member), she also told me R2 was on

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a vent and in ICU (Intensive Care unit)."

On 01/09/24 09:59 AM V42 (Assistant Director of Nursing) stated "If a resident elopes, we need to notify the Director of Nursing and Administrator immediately, do a search, call the family, call 911 and report it to the State Agency. I am not sure if the cameras at the reception desk record. I am not sure if the alarms were working on the exit doors."

On 01/09/24 at 02:10 PM surveyor asked V3 (Director of Nursing) the Policy and procedure for reporting an accident, incident, or elopement. V3 responded "in general as soon as I know it, I report the information. When I am notified of injuries, elopement, or abuse, I work with the administrator for abuse coordination. Abuse should be reported within 2 hours. For the other stuff it is within 24 hours. After the initial report I finish the full investigation. Then I formulate the final reportable of the findings." The surveyor asked V3 why the elopement was not reported to the state. V3 responded "a couple of days had past, the nurse consultant asked me if I had reported the elopement to the state. In my mind I knew I hadn't reported it, the time frame had past, and I was more so not thinking about the reportable case. I was focused on R2 and communicating with R2's family. I was just a little traumatized myself. I don't have a real reason why I did not report the elopement. I was in serviced on reporting some days ago. I did a formal in service before that they had verbally talked to me."

On 01/09/24 the facility presented a document titled "Record of Inservice Education Offering" dated 01/05/24 and 01/08/24 documenting in part: Topic: Reporting Incident to State Agency

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including V1 (Administrator), V2 (Business Office Manager/Assistant Administrator), V3 (Director of Nursing) and V42 (Assistant Director of Nursing) in attendance.

Policy:

Titled "Unusual Occurrence Reporting" revised 11/13 document in part: As required by federals and state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees, or visitors. Policy Interpretation and Implementation: 2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations as soon as possible but within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. 3. A written report detailing the incident and action taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within (24) hours of reporting the event or as required by federal and state regulations.

Titled "Reporting and Response" revised 05/15 document in part: The administrator or designee will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The Illinois Department of Public Health must be notified of any accident/incident/unusual occurrence that results in physical harm or injury (i.e., hospital or emergency room treatment that involves more than diagnostic evaluation as soon as possible within 24 hours of the occurrence. A narrative

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summary of the reportable occurrence will be sent to the department within five (5) working days of the occurrence. Final Investigation Report. The investigator will report the conclusions of the investigation in writing to the administrator or designee and to other state officials including IDPH within five working days of the reported incident. The administrator or designee is then responsible for forwarding a final written report of the investigation and any corrective action taken to the Department of Public Health as soon as possible but within five working days of the reported incident.

Titled "Accidents and Incidents: Supervision, Investigation and Reporting revised 05/15 document in part: Completion of Accident /Incident/Unusual Occurrence Report: 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 5. The Nurse and/or the department director or supervisor shall complete an Incident/Accident/Unusual Occurrence form as soon as possible at the time of the occurrence an submit the original to the Director of Nursing Services within 24 hours of the incident or accident.

(NO VIOLATION)

Licensure Viol;ations 2 of 2

300.1210b)
300.1210d)6

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care

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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:

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 met as evidenced by:

Based on interview and record review the facility failed to adequately supervise 1 of 3 residents (R2) reviewed for elopement. This failure resulted in R2 leaving the facility unsupervised through an exit door. R2 was found hours later by the police, taken to the hospital by EMS (Emergency Medical Services), and admitted with a diagnosis of hypothermia.

Findings Include:

On 12/10/23 R2 was observed to be missing from the facility-by-facility staff. R2 was not found after a facility and community search was conducted by the facility. Per facility documentation the Chicago Police department was notified and

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participated in the community search. R2 was later identified at the Hospital after arriving via EMS (Emergency Medical Services) and admitted with a diagnosis of hypothermia.
R2 was admitted to the facility on 11/07/23 with diagnosis not limited to Dysarthria Following Cerebral Infarction, Dysphagia Following Cerebral Infarction, Essential (Primary) Hypertension, Personal History of Transient Ischemic Attack, Cerebral Atherosclerosis, Psychoactive Substance Abuse, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Cerebral Infarction Due To Thrombosis of Left Anterior Cerebral Artery, Cerebral Infarction Due To Thrombosis of Right Posterior Cerebral Artery, Cerebral Infarction Due To Unspecified Occlusion or Stenosis of Right Middle Cerebral Artery, Unsteadiness on Feet and Weakness. R2 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 7 indicating severe cognitive impairment.

R2's Care plan documents in part: have been assessed to be at risk for elopement. R2 may be confused at times and express the desire to leave/go home and also R2 is a recent admit in the last 30 days. R2 may become agitated and combative with redirection attempts.

On 01/03/24 at 12:59 PM V22 (Social Service Director) stated "I did R2 assessment. R2 was not adjusting to placement here and this was new to R2. R2 told me I want to go home. R2 went in his roommate stuff one time. R2 told me that he had never been to a place like this before. By the paper R2 was considered an elopement risk but never went to the elevator and never packed his things. R2 triggered as an elopement risk because of the questions."

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Narrative of Investigation dated 12/10/23 documents: on Sunday December 10th at approximately 4:15 PM, it was noted R2 was missing from the facility. The resident was last seen at 2:55 PM in his room by nurse aids rounding. The resident was in bed most of the day and did not exhibit any wandering behaviors during the shift. Resident has diagnosis of cerebral infarction, dysphasia, hypertension, hemiplegia left side. Resident has a BIMS score of 7 (assessed on 11/13/23). The facility immediately started a community search contacted the police, POA (Power of Attorney) and resident's physician. The police located the resident at 7:30 PM and brought him (R2) to the hospital where he was admitted with a diagnosis of hypothermia. Investigation started including staff interviews. It was determined the resident left the second floor and went to the basement back door and exited the facility at approximately 3 PM. The door alarmed but staff did not respond to the alarm immediately and the alarm disengaged after 10 minutes. The resident was assessed as an elopement risk on 11/23/23 by social service and care plan in place. The root cause: 1. The back door alarmed, and staff did not respond.

R2's Progress note dated 12/10/23 16:15 documents: Nurses Note Text: Resident noted not to be present in facility. Staff notified and conducted a facility wide search.

R2's Progress note dated 12/10/23 17:40 documents: Nurses Note Text: Writer called police (911) as staff participated in a community search.

R2's Progress not dated 12/10/23 17:45 documents in part: Nurses Note Text: V6 (R2

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Family Member) notified of resident being out of facility and that staff was doing community search and police notified.

R2's Progress note dated 12/10/23 17:50 documents in part: Nurses Note Text: Area hospitals called, and resident is not in any hospital at this time.

R2's Progress note dated 12/10/23 19:45 documents in part: Nurses Note Text: Resident later identified at Hospital. Resident arrived via EMS.

R2's Progress note dated 12/14/23 16:14 documents in part: Nurses Note Text: Writer called V6 (R2 Family Member). Per V6, R2 has been extubated but is still in ICU (Intensive Care Unit).

Interview statement written by V9 (Registered Nurse) documents in part: At 02:55 PM writer was alerted by CNA (Certified Nurse Assistant) of resident (R2) not being in the room upon CNA last rounds before the end of the shift. Writer did not hear the alarm go off.

Investigation statement dated 12/13/23 written by V16 (Licensed Practical Nurse) documents in part: I did not hear any alarms going off on the second floor during my shift.

Interview statement written by V23 (Licensed Practical Nurse) documents in part: 12/10/23 at 02:30 second-floor staff started buzzing around and making notice that one of their residents was missing. Floor count was done, and we searched all over the building looking for resident. At 3:00 PM supervisors were continuously looking for resident. Back hallway alarm, we did not notice

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alarm going off. At 3:30 PM resident was not found as I left building.

Document titled On-Line Communications dated 12/11/23 documents in part: work was completed for back door facing driveway with alarm and keypad entry and push button exit.

A missing person report was filed with CPD (Chicago Police Department) on 12/10/23.

Hospital records dated 12/10/23 documents in part: date and time of arrival 12/10/23 at 1840. Discharge Summary: at the time of admission: #Acute encephalopathy with accidental hypothermia, #Acute ventricular fibrillation cardiac arrest status post CPR (Cardiopulmonary Resuscitation) with ROSC (Return to Spontaneous Circulation), #Acute circulatory shock, #Acute on chronic heart failure with reduced EF (Low Ejection Fraction), #Multiple bilateral rib fractures due to CPR likely, #Acute respiratory failure and #Sepsis due to aspiration pneumonia. Patient was initially brought to the ED (Emergency Department) by EMS after he was found wandering outside, confused with minimal clothing. There was a report for a missing person from a nursing home/assisted living facility which was confirmed to be our patient. Presentation is concerning for early onset vascular dementia and accidental hypothermia. While in the ED, patient decompensated into V-fib (Ventricular fibrillation) cardiac arrest. Noted in detailed cardiac arrest while in the emergency department. Patient is status post CPR requiring shock x 3 with successful return of spontaneous circulation. S/p (status post) hypothermic protocol. CTA Computed Tomography Angiography) chest abdomen and pelvis on admission showed multiple bilateral rib fractures. Echo ejection

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fraction is 35% and akinesis of the mid anteroseptal, mid inferoseptal, apical anterior, septal, apical inferior, and apical lateral walls and the apex. CTA head and neck (12/14) with bilateral pleural effusion and bilateral lung infiltrates or pulmonary edema s/p cardiac cath. Patient initially seen on admission hypothermic with leukocytosis and lactic acid of 7.7. CTA chest showed large areas of consolidation in the lower lobes may be aspiration. Clinical history: SP cardiac arrest, on vent. 59-year-old male who presented unresponsive and subsequently had a cardiac arrest. Chief Complaint Patient presents with * Altered Mental Status The pt is a 59 y/o (year old) male that presents to the ED with a chief complaint unresponsiveness. The pt (patient) was found by CPD (Chicago Police Department) on the curb. On arrival, pt had no coat and was 32.4C. ED (Emergency department) Triage Vitals Group Temp 12/10/23 1903 (!) 89.6 °F (32 °C). Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Cardiac failure and respiratory failure.

During interview on 01/09/24 at 01:06 PM V46 (Primary Physician) stated "I am aware of R2's elopement. It was a cold day and R2 went to the hospital with hypothermia." When asked by the surveyor how long it would take for a person to get hypothermia V46 stated "I don't know because I don't know what R2 was wearing or R2 comorbidities." When asked by the surveyor if a person gets hypothermia can they go into cardiac arrest. V46 responded "If a person gets hypothermia that could send them into cardiac arrest, that I do know."

On 01/02/24 at 01:44 PM Per telephone interview V6 (R2 Family Member) stated "V3 (Director of

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Nursing) called me at home and said I want to inform you that R2 left the facility. It was almost 06:00 PM. V3 said that R2 left out through the employee entrance. V6 never told me what time R2 left out. It was cold outside. I called some family members, and they went looking for R2. The police found R2 sitting on the curb. They found out that R2 was so cold that he coded when I was on my way to the hospital. It took the hospital 10 minutes to get R2 back. They said R2 had a heart attack because his body was 32 degrees, and his body did not know how to react. R2 was in the hospital for 2 weeks."

During interview on 01/04/23 at 09:43 AM V3 (Director of Nursing) stated "On 12/10/23 it was at about 02:50 when staff were doing their last rounds and noticed R2 was not there. They checked the floor and called the supervisor then called a code purple (to say a resident is missing). They called me and I came. They checked the floor and did a head count. When I came everything was in motion. I called 911 to report R2 missing then I called V6 (R2 Family Member) to let her know. V6 said that she was coming and came to the building. When she came to the building, I was waiting for the police to come. V6 called some family members and V6 left. When V6 was leaving the police pulled up, I gave them a description of R2 when the sergeant came to see what was going. The sergeant said I think I saw your guy, but I can't be for sure, but I saw the red shirt. The sergeant said let me call my squad and send them over to the hospital to see if that is your man. The squad went over there and radioed back to confirm that was R2. I called V6 and told her R2 was located at the hospital. The sergeant said R2 was found on 83rd and south shore. I don't know the exact locating some passer byes called 911 that is what the

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sergeant said. I was writing things down as they happened, and my documentation is for the time stamp as things happened. It was approximate 3.5 - 4 hours that R2 was missing. In my book it was cold outside the day that R2 was missing. R2 only had a tee shirt, sweatpants, socks, and shoes on but no coat. In the morning on 12/10/23 it was 34 degrees, and, in the evening, it was 32 degrees outside. It was cold that is what possibly caused the hypothermia. In the hast of all this not reporting this to the state was just an oversight on my part. I called the hospital, and they told me R2 was on a ventilator, R2 was cold, and they were treating R2 for hypothermia. When I called V6 she also told me R2 was on a vent and in ICU (Intensive Care unit). The alarms were low. R5 told the staff that your man (R2) went out the back door. The cameras do not record. R2 would lay in the bed and sleep all day. R2 had one aggressive moment with staff, and I had psych to see R2."

On 1/2/24 The facility provided surveyor with a binder containing in service documentation:

Record of In-Service Education Offering dated 12/11/23, 12/12/23, 12/13/23 documents in part: Summary of Presentation: 1. Code Purple for missing persons/Elopement. 2. Follow protocol of checking census/people on each floor and then search facility and grounds. 3. Notify Supervisor, Manager on Duty, or DON (Director of Nursing). If/when resident returns to facility staff must monitor 1:1.

Record of In-Service Education Offering dated 12/16/23 and 12/17/23 documents in part: Summary of Presentation: Code Purple for Elopement/missing person. Elopement Book Front Desk - 1st floor - 2nd floor - 3rd floor -

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Therapy Office. Follow protocol check census, do rounds on floors and throughout the building. Notify Manager on Duty, DON, nursing supervisor. 1:1 monitoring if/when patient returns.

Surveyor did not observe any documentation of the event being reported to Illinois Department of Public Health (IDPH). In servicing documentation also did not include reporting procedures to IDPH.

On 01/02/24 at 2:15 PM V3 (Director of Nursing) stated "R2 did not have a reportable for the elopement. We called a code and attempt to look for the resident, if we don't locate the resident, we call the family and search the facility. We also notify the police for a missing person at the beginning, the staff notify the administrator and director of nursing."

On 01/02/24 at 03:18 PM V1 (Administrator) stated "this incident was not reported to IDPH (Illinois Department of Public Health) to my knowledge. It was not reported because R2 was found. Usually, it would be the Director of Nursing in conjunction
with the administrator that is responsible for reporting it. My expectations are to make sure the staff immediately check the surrounding area, listen to cues if alarm doors go off, check doors, check surroundings and report to the Director of Nursing who would report to me. I am aware R2 was admitted to the hospital with hypothermia. We do not have any video footage. R2 left the facility through the exit door at the basement level. That door is not typically used. That was the only alarm door that went off. The alarm is one of the things we changed. Staff have to put in a code to disarm the alarm. We changed all of the alarms and we put in what ever did not happen is

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happening now. We did not have codes on each of the floors prior to this incident. I was not here when the incident happened. There are drills in the binder and in services."

On 01/03/24 at 12:18 PM V21 (Vice President of Operations) stated "when we identified the noncompliance for the elopement the binder is to show that we are in compliance prior to (referring to me the surveyor) entering the building on yesterday 01/02/23. We talked about the root cause analysis, and we took the steps to remedy the issue of a resident leaving the building. I was not here at the time of the elopement. I was made aware sometime on the evening that it occurred. I did not come to the building, and I don't remember when I came to the building. I consulted with V1 (Administrator) and V3 (Director of Nursing) over the phone. The elopement should have been reported to the state. I was not aware that it was not reported. I am just merely a consultant. It was a past noncompliance (the elopement that happened that day) for immediate jeopardy. That is what a past noncompliance is and we have a form in the binder" (referring to document titled "Elopement PNC documenting in part: Item, Action, Person, Target date and Progress). V21 stated "PNC stands for Past noncompliance. We did it at the time of the incident. We fixed the noncompliance prior to anyone asking us to fix it. The binder was put together as a team. The alarm was working, and it was not obviously that loud at the time of the elopement. We enhanced the alarm system based on the events that occurred."

On 01/02/24 at 01:10 PM V9 (Registered Nurse) stated "I was R2's nurse. I did my rounds between 02:00 PM - 02:30 PM and R2 was in his room sleeping. At 02:55 PM I ask the aide to do

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the rounds and V12 (Certified Nurse Assistant) said that R2 was not in his room. When V12 told me, we all started looking for R2 in the building and outside. We did not find R2, and we had to alert management. When we started looking for R2 the whole building was alerted. I did not do any documentation. I had to call my Director of Nursing and she said that she would take care of it. My shift was over, and I had to leave for the day. This happened on 12/10/23. They found R2 but I don't know specifically where he was found. V35 (Licensed Practical Nurse) relieved me." When surveyor asked V9 was R2 an elopement risk V9 responded "Not that I know of."

On 01/10/24 at 12:15 PM Per telephone interview V51 (Nurse Manager) stated "I was there when R2 exited the facility. I was sitting at my desk on the desk 4th floor and got a call from V16 (Licensed Practical Nurse) that they could not find one of the residents, it was about 02:43 PM close to 03:00 PM. I called the Director of Nursing and began searching the facility. They had already begun searching for R2. Staff were driving the neighborhood in search of R2. I did not here any alarms. V9 (Registered Nurse) said the last time that she saw R2 in his room was at 02:15 PM. The certified nurse assistants were not sure the last time that they saw R2, but it was earlier that day. I am not sure who discovered R2 was not in his room. We did not find R2 in the building or neighborhood. We called hospitals and the police were notified by the director of nursing. The protocol if a resident is missing is to notify department heads, notify the director of nursing, search every room, make sure they check that all of their residents are accounted for, search the facility top to bottom and outside the facility. I received the in service for code purple, which is made over the intercom, take a census, look for

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the residents on the floor and notify department heads. If the resident is found we call an all clear, do 1:1 supervision and notify the doctor. There is an elopement book on each floor with the resident picture and care plan. I have been involved in the drills when I hear the alarm, I go into action like everybody else."

On 01/02/24 at 02:30 PM V11 (Certified Nurse Assistant) stated "I was already gone when R2 left the facility. I was here that day, but I left early. Before I left between 9 AM and 10 AM R2 was here. R2 wandered the floor but not to leave the facility. R2's gait was steady enough to walk without a walker. I believe R2 was an elopement risk but not 100% sure. On that day they would only have had 2 certified nurse assistants because I went home."

On 01/02/24 at 03:43 PM V28 (Environmental Service Director) stated "I did not see when R2 left. The other staff looked for R2. I looked for R2 in the car. V28 walked with the surveyor to the north end of the basement then V28 stated "this is the fire exit door. The delivery door is by the vending machines where we receive deliveries and take out the garbage. There is an emergency exit by the elevator. The alarm went off at the northwest door for 15 seconds. The southeast door is near the parking lot. I believe that R2 came all the way to the basement. The staff went room to room looking for R2."

On 01/02/24 at 03:51 PM V29 (Maintenance Director) stated "I was not here when R2 left the building. They called me and I came in. The exit door alarms go off and stays on until you enter a code. The alarm sounds at every nurse station." V29 walked to the first floor and north end of the facility basement. V29 opened the northwest exit

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door to demonstrate how the alarm is activated.

On 01/02/24 at 04:21 PM Per telephone interview V12 (Certified Nurse Assistant) stated "I was there when R2 left the facility. I was doing my rounds at 02:55 PM and I did not see R2. I let the nurse know and they called a code purple. I was doing patient care about 02:30 PM. R2 was in the room and was able to walk. I saw R2 walking around earlier during the shift. It was two Certified Nurse Assistant and two nurses on the floor. Sometimes we may have more CNA' (Certified Nurse Assistants), sometimes there are call offs and we have to work with what we have. We looked for R2. I did not know R2 was an elopement risk. They call a code purple and search the facility. I did not hear any alarms going off because I had the door closed doing patient care."

On 01/02/24 at 05:44 PM per telephone interview V13 (Certified Nurse Assistant) stated "I was there on 12/10/23 and there were 2 CNA's (Certified Nurse Assistant) on the floor because V11 (Certified Nurse Assistant) went home. I was asked to work the second floor because I usually work on the third floor. After doing last rounds we discovered that R2 was missing, and we let the nurse know. We searched everywhere. I drove the neighborhood and did not see R2. I did not hear any alarms because I was in a resident room with the door closed providing care. There is no way that we can supervise residents when we are giving patient care. They never found R2, and it was cold outside."
Eight camera screens were observed behind the receptionist desk. The camera screen listed as C-4 was not operating. On 01/03/23 at 08:40 AM V30 (Office Manager) stated "I don't work on the weekends and was not here when R2 eloped.

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V48 (Weekend Receptionist) works on the weekends. The gate on the west parking lot is always locked and we don't ever use it.". V30 Stated "that camera has been broken for a while. The camera with Camera C-1 is for the northwest of the building. The two cameras with Camera C-2 one is for the front door and the other is for the third floor. The two cameras with Camera C-3 one is for the first floor and the other is for the third floor."

On 01/03/24 at 08:48 AM V2 (Business Office Manager/Assistant Administrator) stated "the alarm system has been upgraded. We watch the parking lot, hallway, and main entrance. The cameras are recording over what was on there."

On 01/03/24 at 09:12 AM V18 (Certified Nurse Assistant) stated "I work on the 3rd floor. I saw the second-floor nurse then the supervisor said to check all the rooms. I did not hear the alarm go off. It was towards 03:00 pm."

On 01/03/24 at 09:15 AM V17 (Certified Nurse Assistant) stated "When R2 eloped, it was on a Sunday. I worked on the third floor when we heard the code purple, we had to start searching all the rooms. I did not hear the alarm go off. The nurses from the second floor were on the third floor to start searching the floor. It was after lunch, and it was supposed to be three Certified Nurse Assistants on that floor. V13 (Certified Nurse Assistant) was looking for R2 also but we did not find R2. I looked in the basement, laundry and did not find R2. When someone go out of the exit doors the alarm sound. On the third floor there was no alarm. Most of the residents know how to stop the alarm."

On 01/03/24 at 09:32 AM V9 (Registered Nurse)

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stated "I did not hear the alarm because that would have alerted me that something was going on. I am aware that R2 ended up in the hospital with hypothermia. The last time I saw R2 he had a tee shirt, pajama bottoms and socks on. R2 gait was a little wobbly but R2 did not use any assistive devices. I did my last rounds around 02:00 PM - 2:30 PM and R2 was sleeping. It is possible R2 left the facility after I did my rounds. I never saw R2 walk the stairs. R2 gait is not bad enough for him not to be able to walk the stairs. On the door at the end of the hallway there is no code, it is a little alarm that is audible enough and sometimes it is heard at the nurse station. Once the door closes the alarm goes off."

On 01/03/24 at 09:43 AM R7 stated "we (R7) and (R2) were watching the bears game on Sunday 12/10/23 and R2 walked out of the back door. It was about half time around 02:00 when R2 left. I saw R2 wander in other people rooms and R2 tried to leave before. They have alarms on all the doors. I heard the alarm 2-3 minutes, but it goes off. As soon as they change the door code the staff do it in the open and the residents see the code anyway."

On 01/03/24 09:57 AM R5 stated "R2 would come out of his room and go down the back stairs. The alarm would alarm when you open the door but when the door closes the alarm go off. I was watching the bears game on Sunday 12/10/23 and it was about 15 minutes before the shift got ready to change. R2 timed that just right. R2 is the only one that did that. R2 would wander the floor and go in other resident rooms. I did not hear any other alarm."

On 01/03/24 at 10:05 AM V16 (Licensed Practical Nurse) stated "I was working the day that R2

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eloped. They did the elopement code purple and staff started searching the building. R2 nurse said R2 is not in the room, and we started searching the floor to make sure R2 did not go into another resident room. I did not hear any alarms go off. If I hear an alarm, I will get up and check."

On 01/03/24 at 10:18 AM V14 (Licensed Practical Nurse) stated "I was here when R2 eloped, but I was on break and was in my car. I did not know what was going on. When I came back in from my break, they were searching the building. I never saw R2. I leave at 3:00 PM and I did not hear alarms going off."

On 01/03/24 at 10:31 AM V15 (Certified Nurse Assistant) stated "I was here when R2 eloped, and I was on the 1st floor. The staff were looking for R2 but could not find him. During the search the front door alarm was going off because everyone was going in and out looking for R2. Alarms go off all day."

On 01/03/24 at 02:10 PM per telephone interview V23 (Licensed Practical Nurse) stated "The staff from the second floor came down to the first floor and started about 02:30 PM checking all around the building. At 02:45 PM the supervisor came down continued to search. At 03:00 PM R2 had not been located. They continued to look for R2, the shift changed at 3pm and I left at 03:30 PM. I am not sure if the alarm went off. The staff was running all around and it was almost time for the shift to be over. They searched all around the building. I did help them search in the basement and outside. R2 may have gone out of that Northwest door. We are supposed to hear the alarm if someone went out of the door."

On 01/03/24 02:29 PM Per telephone interview

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(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 24	S9999		

V25 (Certified Nurse Assistant) stated "I work on the first floor. When R2 eloped, we searched the facility. I did not hear any alarms. Someone from the second floor came and said someone was missing and we started searching together.

On 01/03/24 at 02:42 PM V26 (Certified Nurse Assistant) stated "I was at the facility when R2 eloped. R2 was not a resident from my floor, I work the first floor. R2 had on a red shirt. R2 was found and was taken to the hospital due to it being cold outside. It happened at the middle of the shift change. I looked on my floor and I told them I did not know what the person looked like. They did not have a book with residents that were elopement risk at the desk. They talked about designing one after the fact. I am not going to lie. I did not hear any alarm prior to them calling a code purple."

On 01/03/24 at 02:52 PM Per telephone interview V27 (Licensed Practical Nurse) stated "I got there when they were looking for R2. Everyone was searching the rooms and outside. To my understanding it had to be right before I got there. I got there a little before 3 pm and they were already checking. I don't remember a book with a list of residents at risk for elopement being at the nurse stations if it was, I am not aware. R2 wanders and would go through any doors he came across; other resident rooms and we would redirect R2 to his room. There were no alarms going off when I came in. I heard from R5 that R2 went out the back door of the hall."

On 01/03/24 at 03:34 PM V35 (Licensed Practical Nurse) stated "I work the pm shift. When I came in on 12/10/23 they could not account for R2. They checked in every room and outside. R2 was always in his room, confused and able to

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	IL6009757	A. BUILDING: _____ B. WING _____	C 01/12/2024

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ambulate without assistance. I assisted in the search for R2."

On 01/03/24 at 03:45 PM V32 (Licensed Practical Nurse) stated "I worked that evening when R2 eloped. When I came in the search was over. One day R2 left the second floor and came to the first floor down the back stairs, and I call the nurse to come get R2. I did not know there was a book with a list of the residents at risk for elopement there on the first floor."

On 01/04/24 11:32 AM V29 (Maintenance Director) stated "the northwest door has an alarm that go to the nurse station and is faint, but you can hear it. The alarm to the northwest door was not that loud initially. Originally it goes off and you shut it off but after 15 minutes it goes off on its own. When I came in on 12/10/23 it was between 5-6 o'clock pm."

On 01/04/24 at 12:56 PM per telephone interview V20 (On-Line Communications Low Voltage Technician) stated "on 12/11/23 the facility requested to have alarms installed at the doors. We installed a door alarm to the northwest door. I am not sure if an alarm was there. We quoted an annunciator that will ring at the nurse station when the alarm goes off."

On 01/09/24 at 11:52 AM V29 (Maintenance Director) stated "the alarms were working but the old was not as loud. The old alarm is still there, and you can still hear it. If you open the door, both the old and new alarms are alarming at each nurse station."

Policy:

Titled "Elopements" revised 11/16 document in

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part: Policy Statement; Staff shall investigate and report all cases of missing residents. Policy Interpretation and Implementation: 4. If an employee discovers that a resident is missing from the facility, he/she shall: b. If the resident was not authorized to leave, initiate a search of the building(s) and premises. c. If the resident is not located, notify the administrator and the Director of Nursing Services, the resident's legal representative, the Attending Physician, law enforcement officials and Emergency Management, Rescue Squads. 6. Procedures for Prevention of Missing Residents. a. 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 condition. b. Any resident identified to be at risk of elopement will be placed on a resident "AT Risk List" which shall be posted at each nurse station and at the reception area. The "At Risk List" will be updated whenever a new resident safety concerns are identified. Residents with identified elopement risk will be documented in the resident plan of care. c. Pictures of the residents that are at risk of elopement will be posted at the reception area. d. unless otherwise identified in the plan of care, any resident at risk of elopement shall be accompanied by a responsible individual while outside the facility. e. Should an alarm on one of the exits to the outside of the facility sound, staff will immediately respond to determine the cause of the alarm. 7. For the Response to missing Resident, In the event a resident is discovered missing, the following procedure shall be followed. b. Should a search of the inside and outside of the facility prove to be unsuccessful in locating the resident, the immediate vicinity surrounding the facility shall be searched with interview of any potential witnesses conducted.

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S9999	Continued From page 27 Titled "Accidents and Incidents: Supervision, Investigation and Reporting revised 05/15 document in part: The facility provides an environment that is free from accident hazards over which the facility has control. The facility provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes identifying hazard and risk, evaluating, and analyzing hazard and risk, implementing interventions to reduce hazard and risk, monitoring for the effectiveness, and modifying interventions when necessary. Adequate Supervision is defined by the type and frequency of supervision, based on the individual residents assessed needs and identified hazards in the resident environment. Supervision: Monitoring there is sufficient staff based on residents' needs. Such needs could include behaviors such as unsafe wandering, elopement risk, limited cognitive abilities, limited safety awareness, impaired physical functioning, balance, or gait. (A)	S9999		