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
	IL6003594	A. BUILDING: _____ B. WING _____	C 02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE CHICAGO NORTH	2451 WEST TOUHY AVENUE CHICAGO, IL 60645

(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 2480767/IL169220	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.690 b) 300.690 c) 300.1010 h) 300.1210 b) 300.1210 d)6) 300.1220 b)3) 300.3240 a) 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 a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident	S9999		

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S9999	Continued From page 1 or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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 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 Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		

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S9999	Continued From page 2 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	S9999		

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S9999	Continued From page 3 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to adequately supervise and failed to adequately report a significant incident to IDPH (Illinois Department of Public Health) and police department for 1 (R1) of 3 residents reviewed for elopement. This failure resulted in R1 leaving the facility unsupervised, sustaining a fall when he eloped from the facility, and R1 being taken to the hospital. R1 was diagnosed with a left foot fracture. The findings include: R1's health record documented admission date of 2/24/23, with diagnoses not limited to: Chronic respiratory failure with hypoxia, Chronic systolic (congestive) heart failure, Dysphagia, Encounter for attention to gastrostomy, Chronic obstructive pulmonary disease, Unspecified fracture of left calcaneus, subsequent encounter for fracture with routine healing, Ischemic cardiomyopathy, Unspecified abnormalities of gait and mobility, Other lack of coordination, Unspecified lack of coordination, Weakness, Acute kidney failure, Hypertensive heart disease with heart failure, Hypothyroidism, Gastro-esophageal reflux disease without esophagitis, Vitamin d deficiency, Encephalopathy, Anemia in other chronic diseases classified elsewhere, and Abnormal posture.	S9999		

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MDS (Minimum Data Set), dated 11/16/23, indicated R1's cognition was intact. R1 needed substantial/maximal assistance with eating, oral hygiene, upper body dressing; Total assistance/dependent with toileting hygiene, shower/bathe self, lower body dressing; Partial/moderate assistance with personal hygiene. MDS showed R1 was always incontinent of bladder and frequently incontinent of bowel.

Community survival skills, dated 11/16/23, documented: R1 does not appear to be capable of unsupervised outside pass privileges at this time. No care plan found for R1 supervised outside pass privileges.

R1's physician order sheet (POS) with no order for pass privileges.

Progress notes, dated 1/5/24, documented: R1 was out of the facility during med pass.

Progress notes, dated 1/6/23, documented:
- R1 has been admitted to hospital for observation.
- R1 readmitted from hospital via stretcher by two paramedics staff. R1 is Ax4 (alert x 4), he has non-displaced left foot fracture.

V21 (Nurse Practitioner/NP) progress notes, dated 1/9/24, documented:
- R1 seen today for a follow up visit for acute and chronic medical conditions/ER (Emergency Room) visit on 1/6/24. R1 states LLE (left lower extremity) pain d/t (due to) recent fracture, wants pain medicine.
- A&P (Assessment and Plan): Non-displaced LLE fx (fracture). Went out on pass but did not

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S9999	Continued From page 5 return. Found at hospital with this dx (diagnosis). PM&R (Physical Medicine and Rehabilitation) progress notes, dated 1/10/24, documented: - CC: S/P (status post) left calcaneal non-displaced fracture" - 1/6/24: R1 was out on pass, believes he lost his balance when trying to stand up, ultimately leading to ER evaluation due to left lower extremity pain. R1 was diagnosed with LLE non-displaced fracture of calcaneus. - R1 reporting mild to moderate pain in left foot heel. Pain is described as achy, intermittent. R1's MAR (Medication Administration Record) showed: - Haloperidol scheduled at 12:00pm on 1/5/24 was not signed or initialed. - Haloperidol scheduled at 6:00pm on 1/5/24, 12:00am and 6:00am on 1/6/24 were not given due to R1 not in the facility. - Atorvastatin, Lisinopril, Quetiapine Fumarate, Metoprolol Tartrate scheduled at 9:00pm on 1/5/24 were not given due to R1 not in the facility. - Protonix scheduled at 6:00am on 1/6/24 were not given due to R1 not in the facility. - Enteral feed order every 4 hours 150ml of water to be administered via hydration set with pump scheduled at 2:00pm on 1/5/24 was not signed or initialed, scheduled at 6:00pm, 10:00pm on 1/5/24, 2:00am and 6:00am on 1/6/24 were not given due to R1 not in the facility. - Enteral feeding: G-tube (Gastrostomy) - Jevity 1.5 at 75ml/hr (milliliter per hour) on at 6pm or until a total volume of 900ml infused scheduled at "evening" and "night: on 1/5/24 was not administered due to R1 not in the facility and scheduled "day" on 1/6/24 was not signed or initialed. Survey team interviewed V2 (Director of Nursing)	S9999		

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S9999	Continued From page 6 on 1/28/24 and stated that nurses should document in the Medication Administration Record (MAR) to reflect that the medications were administered. V2 stated that if it's not signed or not documented in the MAR, that means the medications were not given and nurses should document the reason why they were not given and inform the physician. Hospital records documented in part: - Admission date: 1/5/24. Admission type: Emergency. Discharge date: 1/6/24 - Encounter information: 1/5/24 at 9:17pm. - Chief complaint: Foot pain - Reason for admission: Closed displaced fracture of body left calcaneus, initial encounter (Primary). Closed non-displaced fracture of left calcaneus, unspecified portion of calcaneus, initial encounter. - ED (Emergency Department) notes dated 1/6/24 at 12:38am: R1 presents for evaluation of left foot injury. States he was just walking on the street tripped and fell and now with pain to the left heel. Painful bearing weight. - X-ray of left foot dated 1/5/24: Acute nondisplaced calcaneal fracture. On 1/29/24, no care plan found for R1 supervised outside pass privileges and elopement. Facility reported incident (FINAL), dated 1/11/24, documented: On 1/5/24, R1 reported to his nurse that he would be going outside of the building to the smoking area where he would socialize with other residents. While outside, he attempted to stand, without assistance, lost his balance, twisted his ankle and experienced a fall. Shortly after the fall, he reported pain to this left ankle and was transported to hospital for evaluation. He was determined to have a left foot	S9999		

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non-displaced calcaneal fracture. On return to facility, a fall risk assessment was completed, and interventions were updated based on the assessment of the root cause of the event.

On 1/28/24 at 10:59am, R1 was lying in bed, alert and oriented to person, time, place, and situation. R1 stated about 2 weeks ago, he left the facility in his wheelchair by himself, and went to the store without telling anybody. R1 stated he left his wheelchair by the bus stop about a block away from the facility and walked to the store by himself. R1 stated he tripped and fell by the store's driveway (parking lot). R1 stated somebody saw him and called the ambulance and he was brought to the hospital. R1 stated he broke his left foot.

On 1/26/24 at 12:58pm R1 observed sitting in a wheelchair. R1 stated he tripped and fell in the driveway/parking lot by the store, picked up by emergency services/ambulance, and they brought to the hospital. R1 stated he had a broken left foot. R1 stated no surgery was done in the hospital. He cannot put weight on his left foot. R1 stated he left the facility around 2 or 3pm in his wheelchair by himself, without informing the staff. R1 stated around 4pm - 5pm, he went to the store by himself and fell.

On 1/26/24 at 1:41pm, V5 (Registered Nurse / RN) stated, "On 1/5/24, (R1) did not go out on pass. (R1) went to smoke and left the building without informing the staff. Around 1:30 pm, (R1) was at the front desk and was not seen after that time." V5 stated he was working double that day, but for the 3-11 shift, he was assigned to 4th floor. V5 stated V8 (Licensed Practical Nurse/LPN) was assigned on 2nd floor and called him asking where R1was at because they could

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not find him. V5 stated, "Staff looked outside and could not find (R1). DON (Director of Nursing) was informed. One of the CNAs (Certified Nursing Assitants) coming to work for 3-11 shift, saw the wheelchair with facility's name by the bus stop."

On 1/26/24 at 1:56pm, V7 (Certified Nursing Assistant/CNA) stated, "(R1) goes outside patio to smoke regularly, but would come back after smoking." V7 stated she was working double shift at the time R1 left the facility without informing staff. V7 stated she heard an overhead page saying "code green", meaning elopement or resident was missing. V7 stated, "All staff was looking for (R1) but couldn't find him. (V23, CNA) saw R1 by the bus stop while she was driving to facility to work for 3-11 shift. Some staff went back to bus stop to look for (R1), but he was not seen." V7 stated staff saw R1's wheelchair with facility's name. Staff informed managers.

On 1/26/24 at 2:10pm, V8 (Licensed Practical Nurse/LPN) said he has been working in the facility for almost 3 years, and regularly works on the 2nd floor for 3-11 shift. V8 stated on the day that R1 was missing, he did his rounds before shift started, and R1 was not in his room, but he knows usually would stay on the 1st floor talking to fellow residents or smoking, and would come back to the unit before dinnertime. V8 stated he heard an overhead page "Code Green", meaning elopement or resident was missing. V8 stated staff was looking for R1 but could not find him. V8 stated, "The whole 3-11 shift (R1) was missing. The facility called the closest hospitals in the area and staff was looking for him in the neighborhood, because it was a cold night, but (R1) was not found." V8 stated V9 (Social Service) informed R1's family and R1's doctor.

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S9999	Continued From page 9 V8 stated he did not call R1's doctor. V8 stated he did not know the whereabouts of R1 for the whole 3-11 shift, and scheduled medications were not given. On 1/26/24 at 2:22pm, V4 (Social Service Director/SSD) said she was not able to recall the exact date, but maybe about 2 weeks ago, Social Service received a call from the receptionist saying R1 wanted to go to the store. V4 stated the receptionist was informed R1 could not go by himself to the store, and R1 needed supervision to go to the community. V4 stated R1 was missing in the facility or could not be seen in the building. Reviewed R1's EHR (electronic health record) with V4, and V4 stated the assessment for community pass indicated R1 needed to be supervised. Care plan reviewed, none found. On 1/26/24 at 2:39pm, V9 (Social Service/SS staff) stated, "The purpose of the community pass assessment is to make sure that a resident is aware of his surrounding and safe/appropriate to go out in the community. (R1) needed supervision with community pass." V9 stated she was unable to recall an exact date, but about 2 weeks ago, they received a call from the receptionist asking if R1 could go out to the community independently, and receptionist was informed R1 could not go out of the facility by himself. V9 stated around 3pm-4pm, code green was activated. "All staff were looking for (R1) and administration called the hospital, but could not find (R1). V9 stated she informed R1's family. V9 stated around 6pm, she left the facility; R1 was still not found. On 1/26/24 at 3:17pm, V2 (Director of Nursing/DON) said, "(R1) needs supervision to go out on pass. If a resident needed supervision	S9999		

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for community pass, a care plan should be in place. For any individualized assessment with identified concerns, the resident should have a care plan to address and to guide staff on how to care for the resident." V2 stated she was off on 1/5/24, but she was notified R1 left the building without permission. V2 checked R1's EHR (electronic health record) remotely, and it indicated R1 was cognitively intact, and not a risk for elopement. V2 stated she was worried because it was very cold that day. V2 stated, "The same day, maybe close to 11pm, I called hospital and was informed by hospital staff that (R1) was being evaluated in the emergency room. On 1/6/24, (R1) came back to the facility with diagnoses of left foot fracture. I sent the initial and final report of the injury - left foot fracture-- to State Agency/IDPH (Illinois Department of Public Health)." V2 stated she could not remember if she informed the nurse on duty at that time, but she informed the Administrator (V1) and corporate. V2 stated V1 (Administrator) spoke with the hospital nurse as well.

On 1/26/24 at 4:00pm, V11 (Receptionist) said she usually comes to work at 2:45pm, and R1 was not in the facility at that time. V11 stated she would know, because R1 would always stay on the first floor. V11 stated one resident told her that he did not see R1, his smoking buddy. V11 called the 2nd floor nurse (V8), and V8 stated V8 did not see R1. V11 stated she called the 7-3 shift nurse (V5), who was working double on that day, but was assigned to 4th floor for 3-11 shift, and said he last saw R1 after lunch time. V11 stated she then activated the "code green", meaning elopement/missing resident. V11 stated, "All staff was looking for (R1). (V23, Certified Nursing Assistant/CNA) was asking for

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whom the code green was for, and was informed that (R1) was missing." V11 stated V23 said on her drive to work, she saw R1 in his wheelchair by the bus stop, about a block away from the facility. V23 went to check the bus stop, saw the facility wheelchair, but did not see R1. V11 stated there were 3 other CNAs (V3, V13, and V19) that went to the bus stop, saw the wheelchair which was brought back to the facility, but R1 was not found.

On 1/28/24 at 9:30 am, V3 (Certified Nursing Assistant/CNA) said about 2 weeks ago, unable to remember the exact date, she heard an announcement/overhead page for "code green", meaning elopement or missing resident around 4pm before dinner time. V3 stated V5 (Registered Nurse/RN) said R1 was seen by V23 (CNA) on her drive to work for 3-11 shift at the bus stop about a block away from the facility. V3 stated she (V13, CNA) and V19 (CNA) went to the bus stop, saw R1's wheelchair, and took it back to the facility. V3 stated they were looking for R1 in the neighborhood area, including the store, but R1 was not found. V3 stated they were told R1 went out to get a cigarette. V3 stated she never heard the whereabouts of R1 for the whole 3-11 shift.

On 1/28/24 at 10:59am, R1 was lying in bed, alert and oriented to person, time, place, and situation. R1 stated about 2 weeks ago, he left the facility in his wheelchair by himself, and went to the store without telling anybody. R1 stated he left his wheelchair by the bus stop about a block away from the facility and walked to the store by himself. He tripped and fell by the store's driveway/parking lot. R1 stated somebody saw him and called emergency services/ambulance and he was brought to the hospital. R1 stated he

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S9999	Continued From page 12 broke his left foot. On 1/28/24 at 11:07am, V13 (CNA) said on 1/5/24, she was working double on the 4th floor, and heard one of the residents was missing. V13 stated the receptionist told her R1 was missing between 3pm - 4pm. V13 stated V23 (CNA) saw R1 by the bus stop about a block away from the facility. V3 stated she and V19 (CNA) went out to the bus stop, and R1's wheelchair was found, but R1 was not there. V13 stated they went to the neighborhood to look for R1, but to no avail. V13 stated after almost an hour of looking for R1, they went back to the facility and brought R1's wheelchair with them. V13 stated =they informed V9 (Social Service) that R1 was not found. On 1/28/24 at 3:09pm V19 (CNA) said, "About 2 weeks ago, around 3-4pm, I heard an overhead announcement "code green" (Elopement / missing resident). One resident was missing and (V23, CNA) had commented that (R1) was seen at the bus stop." V19 stated she and 2 other CNAs (V3 and V13) went to the bus stop, before 5pm, and saw the wheelchair, but R1 was not there. V19 stated they looked in the neighborhood for almost an hour, but R1 was not found. V19 stated R1's wheelchair was brought back to the facility, and they informed the nurse R1 was not found. On 1/28/24 at 3:59pm, V22 (R1's attending physician) was interviewed via phone, and stated V22 was not aware R1 was missing on 1/5/24. V22 stated, "If the nurse documented that (V21, Nurse Practitioner/NP) was made aware, then it could be. Documentation is proof that (V21) or (V22) was informed about the incident, and if there was no documentation then it was not done. The facility can determine if the resident is safe to	S9999		

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	IL6003594	A. BUILDING: _____ B. WING _____	C 02/02/2024

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go out on pass by himself; if the assessment of (R1) indicated that (R1) needed supervision, then (R1) should have supervision to go out of the facility. The facility should have closely monitored and supervised (R1) so he can't leave the facility by himself, as it is not safe according to the assessment done by the facility." V22 stated R1 should have not gone out of the facility unsupervised. V22 stated, "If there was a left foot fracture, as confirmed by the hospital, it could be a result that (R1) went out of the facility unsupervised."

On 1/29/24 at 10:08am, V21 (R1's Nurse Practitioner) was interviewed via phone, and V21 stated she was not informed R1 was missing on 1/5/24. V21 stated she saw R1 in the facility after hospitalization, and knew R1 went out on pass, fell, and had a left foot fracture. V21 stated if the assessment showed R1 needed supervision, then R1 should have somebody with him when out of the facility for safety. V21 stated if R1 left his wheelchair and walked to the store by himself, then it was not safe for him. V21 stated the left foot fracture from a fall in the community could have been prevented if R1 went out with supervision.

On 1/29/24 at 10:19am, V20 (Director of Human Resource/HR) stated V24 (former receptionist) was let go about a month ago due to attendance issues and overall performance. V20 verified V24's last day of work was on 1/12/24.

On 1/29/24 at 11:31am, V24 (Former Receptionist) was interviewed via phone, and V24 stated she was "let go" the second week of this month. V24 stated V1 told her that she was not able to provide information that they needed, and family were complaining that information

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regarding residents were not provided correctly. V24 stated a week prior to her termination, she saw one resident leaving the facility, but came back after. V24 stated the following day, she was called by V1, and V1 told her one resident left the facility on her shift and was missing.

On 1/29/24At 11:43am, V23 (CNA) said she passed the bus stop about 1-2 blocks away from the facility, saw a person with a hoodie in a wheelchair, but was unable to identify who he was. V23 stated she arrived in the facility around 3:07pm to work for 3-11 shift. V23 stated after her rounds on the 2nd floor, she heard a "code green", meaning elopement or missing resident. V23 stated she went to the receptionist, and was informed R1 was missing. V23 stated she informed the receptionist she saw a man in his wheelchair by the bus stop, and she thought it was R1. V23 stated around 3:30pm, she drove to the bus stop and saw facility's wheelchair, but R1 was not found. V23 stated she also looked in the neighborhood, but not able to find R1. V23 stated she arrived the facility, met the Administrator, and informed V1 she was not able to find R1.

On 1/29/24 at 12:11pm, V4 (Social Service Director/SSD) said, "Elopement protocol such as "code green" was activated, locked down the unit and did a head count, searched residents in the building, premisea, neighborhood, and called hospitals when (R1) was missing on 1/5/24, except police were not informed. Documentation was not done because we were advised by corporate not to do so." V4 stated she left the facility around 6:45pm, with no information about R1's whereabouts. V4 stated she heard the following morning R1 was found in the hospital with a left foot fracture. V4 stated she verified

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S9999	Continued From page 15 again Monday (1/9/24) what to do, and was advised by corporate not to document. On 1/29/24 at 12:55pm, V1 (Administrator) stated from his recollection R1 was alert and oriented x 3, went outside to the front of the facility, and V1 was informed later in the evening, about 3-4pm R1 was missing and did not receive the medications. V1 stated staff was looking in the building, but R1 was not seen. V1 stated they searched the premises but did not find R1. V1 stated the facility called the family, and was informed they did not take R1 out on pass. V1 stated one of the staff informed them R1 was seen by the bus stop at the corner of the facility. V1 stated staff went back to the bus stop, but did not find R1, and brought back the wheelchair to the facility. V1 stated he called the hospitals, but did not find R1. V1 stated later that night, he called another hospital and was informed R1 was there. V1 stated he informed V2 (Director of Nursing/DON) R1 was found in the hospital ,and maybe 11-7 shift nurse was informed that R1 was in the hospital. V1 stated documentation was not completed correctly. V1 stated that police were not informed, if it was considered an elopement. On 1/29/24 at 1:24pm, V2 (Director of Nursing/DON) stated staff is expected to follow policy for elopement. V2 stated R1's doctor was informed on the 6th, but was not informed on the 5th when R1 was out of the facility without permission. V2 stated if it was considered an elopement, then it should have been reported to the State Agency or IDPH (Illinois department of public health). V2 stated she reported the injury of the left foot fracture to IDPH. V2 stated that possibly, the incident /accident and left foot fracture could have been prevented if R1 went to the community supervised.	S9999		

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Facility's missing resident/elopement policy, dated 11/15/18, documented:
- Alert staff by announcing "Code Green" over the paging system.
- The Administrator and Director of Nursing (DON) will evaluate the situation and develop a plan of action based on the individual resident.
- The following steps should occur:
  > A nurse should notify the attending physician.
  > Notify the sheriff and / or police department and file a missing person report.
  > Complete incident report and notify the state agency according to reporting guidelines.
  > Document appropriate notations in the medical record.

Facility's Community pass guidelines, dated 11/25/19, documented:
- Purpose: to define the facility and the resident's responsibility when a resident leaves the facility whin the consent/order obtained by the facility's PCP. Many individuals admitted to the facility have a history of psychosocial problems, mental illness, physical ailments, substance abuse and poor impulse control. As a result, certain residents may not be fully capable of negotiating safely in the community independently.

Facility's Incident and Accident policy, dated 4/7/2019, documented:
- An incident/accident report will be completed for:
  > All serious accidents or incidents of residents.
  > All unusual occurrences.
  > All unexpected events that occur that cause actual or potential harm to a resident.

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S9999	Continued From page 17 > Leaving premises without authorization. - The DON must notify the following if an actual injury occurs: > The IDPH within 24hours of the occurrrence. > A narrative summary of teh incdient is to be sent to the IDPH wihtin five working days. > Public health is to be notified for the following: any incident or accident which has, or is likely to have, a significant effect on health, safety, or welfare of a resident. (B)	S9999		