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S 000	Initial Comments Complaint Investigation: 2492804/IL171746 2491193/IL169740	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

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

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.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

This REQUIREMENT is not met as evidenced by:

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Based on interview and record review, the facility failed to monitor and supervise a resident with cognitive impairment, identified as high fall risk with a history of falls and decreased safety awareness. This affected one of three residents (R4) reviewed for falls and supervision. This failure resulted in R4 having two unwitnessed falls which resulted in a small subdural hematoma and a hematoma to right side of forehead.

R4's diagnosis includes Vascular Dementia and Altered Mental Status. Brief interview for mental status dated 4/11/24 documents a score of five which indicates severe cognitive impairment. Fall risk assessment dated 3/1/24 documents: at risk for falls. Care plan dated 2/9/24 documents: R4 had an activity of daily living (ADL) self-care/mobility performance (functional abilities) deficits that may fluctuate with activity throughout the day related to activity intolerance, impaired balance, limited mobility/range of motion, shortness of breath and impaired cognition. Interventions documents: R4 requires substantial/maximal assistance with chair/bed to chair transfer, lying to sitting on side of bed and toilet transfer. Fall occurrence dated 11/16/23 documents: R4 had an unwitnessed fall in resident's room. Upon rounding staff, observed R4 lying on the floor on her right side next to her bed and wheelchair. R4 statement documents: she was trying to get into her wheelchair and her legs got weak, she fell to the floor and hit her head. New injury: hematoma to right side of forehead (bleeding under the skin).

On 6/7/24 at 11:03AM, R7 (R4's roommate) who was assessed to be alerted and oriented to

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person, place, and time, said R4 went to the bathroom without staff assistance and fell. R7 said, she asked R4 to wait for staff but R4 did not. R4 is forgetful.

On 6/7/24 at 12:23PM, V5 (Nurse) said, R4 needs assistance with transfers. R4 has episodes of confusion and requires reminders.

On 6/7/24 at 12:48PM, V6 (Nurse) said, R4 was able to make her needs known. R4 required one-person physical assist with transfers and ambulation. R4 is forgetful and needs reminders.

On 6/7/24 at 1:42PM, V2 (Director of Nursing/DON) said, R4 self-transferred from bed to wheelchair. R4 went to the bathroom. R4 loss her balance. R4 fell onto the floor. R4 required assistance with toileting. R4 will attempt to toilet self. R4 has intermittent confusion.

On 6/12/24 at 11:15AM, R4 who was assessed to be alert to name and situation, said she went to the bathroom by herself, fell and hit her head. R4 could not recall what she hit her head on. R4 was apologetic and said, she was sorry she could not remember. R4 said, she forgets a lot. R4 was asked if she could use the call light, R4 replied, no she forgets. R4 said, she can call 911 but doesn't have a phone.

On 6/12/24 at 12:55PM, V34 (Director of Rehab) said, R4's cognition is not consistent. R4 can follow step by step instructions when given prompts. R4 requires redirections. R4 was on physical therapy before she fell.

R4's care plan initiated on 09/16/2019 documents: At risk for falls and injury related to falls. Risk factors: requires assistance with ADLs,

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possible medications side effects, urinary incontinence, weakness, impaired cognition, not used to being dependent to staff. Intervention: assess for altered cognition, decline in safety awareness, assist with ADL's. Anticipate and meet the resident's needs, assist with toileting upon awakening, before and after meals, during rounds, before bedtime as needed (PRN), ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed.

Physical therapy evaluation and plan of treatment dated 3/7/2024 documents: R4 readmitted and presents with a continued functional decline in all areas of mobility placing R4 at risk for further decline and a high risk for falls. Precaution: history of falls. Indoor Mobility (ambulation): needed some help. Functional cognition: needed some help, has patient fallen in past year: yes, does patient feel unsteady when walking: yes, does patient worry about falling: yes, reason for therapy: R4 presents with balance deficits, decreased safety awareness, safety awareness deficits, strength impairments and tremors. Assessment summary: follows one -step directions usually with prompts/cues. Diagnosis: lack of coordination and unsteadiness on feet.

Nursing note dated 3/30/2024 documents: Called doctor about R4's unwitnessed fall. No new orders. Provide schedules toileting assistance. Call light in reach.

Nurse Practitioner note dated 4/1/2024 documents: per nurse on duty. Dementia: alert and orient times 1-2: forgetful. History of fall. Fall/safety precaution: 1:1 transfer assistance. Urge R4 to call for assistance when transferring.

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S9999	Continued From page 5 Fall IDT (Intra Disciplinary Team) note dated 4/1/24 documents: R4 was transferring from the toilet to the wheelchair, while reaching (for) the wheelchair to sit (down) she slid down, she denies hitting her head. IDT fall committee meeting note dated 4/1/24 documents: root cause-attempting to transfer without assistance. New interventions and/or changes suggested by the IDT at this time: continue to encourage to ask for assistance. Hospital paperwork dated 4/2/2024 documents: R4 was seen for confusion as well as falls. R4 also had a CT of head which showed a small subdural hematoma (pool of blood between the brain and it outermost covering.) Fall prevention program dated 11/28/12 documents: to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate intervention to provide necessary supervision and assistive devices are utilized as necessary. Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and as addressed on the plan of care. "A" Statement of Licensure Violations II of II: 300.610a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.2210b)2)	S9999		

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S9999	Continued From page 6 300.3100d)2) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and	S9999		

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determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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

Section 300.2210 Maintenance
b) Each facility shall:

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

Section 300.3100 General Building Requirements
d) Doors and Windows

2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to monitor and prevent one resident with a diagnosis of Alzheimer's disease with a history of exit seeking behaviors and wandering from eloping from the facility. This affected one of three residents (R1) reviewed for supervision.

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This failure resulted in R1 exiting the facility unauthorized and being found outside by emergency services a mile away from the facility in a yard confused with only a t-shirt and shorts in the month of January.

Findings Include:

R1 was admitted to the facility on 1/16/24 with a diagnosis of Alzheimer's disease, type II diabetes, chronic obstructive pulmonary disease, hypertension, heart disease, post-traumatic stress disorder, delirium, delusional disorders, and cocaine use. Resident brief interview for mental status sated 1/19/24 documents a score of 2/15 which indicates severe cognitive impairment.

R1's referral paperwork dated 1/15/24 documents: Sitter discontinued 1/10/24. Patient at doorway when approached room today. Easily redirected. Per nurse wandered x1 last night. Patient requires 24/7 supervision for safety precautions.

R1's initial elopement risk dated 1/16/24 documents: at risk for elopement and should be placed on the elopement risk protocol.

R1's social service progress note dated 1/17/24 documents: social service spoke to Nurse Practitioner while visiting resident. Stated recommends for resident to be in a locked Alzheimer unit due to inability to redirect resident.

R1's physician progress notes dated 1/22/24 documents under history: Resident with vascular dementia, post-traumatic stress disorder, delusional disorder, and previous cocaine use. He has been very delusional, confused, and

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aggressive. He is attempting to elope to meet his girlfriend and engage in previous activities.

R1's police report dated 1/29/24 call received at 12:22PM from local citizen for well-being check. Address documented on the police report and where R1 was located is approximately one mile from nursing facility. (According to goggle maps, approximately a 25-minute walk from the facility) Under notes: Male in t-shirt and shorts sitting by garage/seems lost. Cold exposure. Subject transferred to local hospital.

R1's ambulance report dated 1/29/24 documents under impression: confusion/delirium; under complaint Patient confused and slow to answer questions; under mental status; Patient is alert but slow at answering questions, patient unable to tell crew address, president, time or what he is doing outside in the cold. Under narrative: dispatched to above location for the male patient who seems confused. On arrival crew found patient standing outside with bystanders at his side. Bystanders stated they found this man wandering their yard and have no clue who he is. Bystanders stated patient looks like he's freezing and unsure how long he has been outside. Crew asked patient what was going on. Patient was alert but slow at answering questions. Patient could not give crew his home address or phone number and had no idea how he got to his location. Patient stated he left his house and just started walking and ended up here. Patient had no complaints besides being cold and just looking to go back home but patient could not tell crew or police his address. Patient had no phone or wallet to call family or get further information.

R1's hospital record dated 1/24/24 at 1:05PM documents under chief complainant: Altered

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mental status. Patient was found outside in a t-shirt and shorts and unable to identify himself. Patient is confused and unable to provide any history. Resident physician spoke with nursing home who reported that they have been looking for patient. Under history: Patient was brought in by emergency medical services when found wondering in someone's yard. Patient eloped today and was unable to be stopped by staff.

According to Accuweather (weather application), weather in Oak Lawn on 1/29/24 was a low of 31 degrees and high of 40 degrees.

On 6/7/24 at 12:28PM, V6 (Nurse) who was identified as the nurse assigned to R1 on 1/29/24 at time of elopement. V6 said that was her first time working with R1. V6 said she wasn't familiar with R1, and staff reported R1 was combative, but they did not report he was at risk for elopement. V6 said R1 was with her most of morning following her as she did her morning medication pass between 800-1030AM. V6 said she last observed R1 sitting at the nursing station but unable to recall what time that occurred. V6 said she noticed R1 was gone right before lunch. V6 said she asked the staff and walked the facility and was unable to find the resident. V6 said she called the code and staff began looking for R1. V6 said she did recall hearing any alarms at time of incident.

On 6/11/24 at 9:24AM, V13 (Social service director) was asked about her documentation on 1/17/24 in relation to R1 needed a locked unit. V13 said the facility is not considered a locked unit but the all the doors have alarms. V13 said they were attempting to find R1 another facility. V13 was asked what interventions were in place for R1 being at risk for elopement. V13 said

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making sure staff is aware R1 has a bracelet in place to trigger alarm doors upon attempting to exit. V13 was unaware of monitoring or rounding on the resident and said that would be a nursing intervention. V13 was unable to provide any documentation of the monitoring of R1's location, wandering behavior, and attempts diversional interventions in behavior log.

On 6/11/24 at 10:41AM, V2 (DON) said R1 was asked about interventions R1 had in place for being on elopement risk prior to elopement. V2 said R1 had a bracelet in place to trigger alarm doors upon attempting to exit. V2 said she was unaware of the interventions (monitoring location every 15/30/60 and documenting wander behavior and identify patterns of wandering) and would not be the responsibility of nursing staff to document that information and unsure who would be responsible. V2 unable to provide any documentation of monitoring location, wandering behavior or patterns of wandering.

On 6/11/24 at 11:58am, V25 (Front Desk) said V6 (nurse) called a code pink and reported R1 was missing. V25 said she received a call from local hospital if the facility was missing any residents and gave R1's description which matched and reported he would be returning to the facility. V25 said she did not hear any alarm day of elopement and said there is no system that alerts her when any door alarms. V25 said you cannot hear all the door alarms from each exit door.

On 6/11/24 at 9:54AM, V10 (Certified Nursing Assistant/CNA) who was working on 1/29/24, said she did not hear any alarms that day.

On 6/11/24 at 1:17pm, V27 (CNA) said staff told her R1 was missing around lunch time. V27 said

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she does not recall hearing any alarms. V27 said sometimes it's hard to hear the door alarms if you are in a room or another hallway.

On 6/7/24 at 1:19PM, V8 (Maintenance Director) reviewed door check list tool log and said doors are checked daily. V8 was unable to locate the door checklist for the week of January 28th-January 31st. V8 said the northwest door by the oxygen room has a device that alarms when a resident wearing a bracelet is close to the doors attempting to exit. The door also has an alarm that is activated when the door is pushed with a 15 second delay prior to the door opening. The second door that leads outside does not have any alarm. On 6/11/24 5:05PM, V8 said there were no changes to the door after R1's elopement.

R1's care plan for elopement documents: R1 deemed to be at risk for elopement as evidence by assessment and reassessment elopement review of risk/wanderer, unable to find what I am seeking, pacing, or roaming repeatedly. Responds poorly to staff redirection, impaired cognition. Risk factors Alzheimer's disease, delusion, on wander guard date initiated 1/23/24 revision 3/8/24. Disguise exits, cover doorknobs and tape floor distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; identify patterns of wandering, intervene as appropriate; monitor for fatigue; monitor location every 15/30/60 min (no time was documented) document wandering behavior and attempts diversional interventions in behavior log; wander alert right wrist initiated on 1/23/24 revised 3/8/24.

Facility code pink policy reviewed 11/25/18 documents under should an employee discover that a resident is missing from the facility, they

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE OAK LAWN	9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453

(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 13 should: report missing person to nursing supervisor; review orders to determine if resident out on pass; alert staff by announcing code pink; inform staff the name and picture of resident that is missing if available; make a thorough search of the building and premises; notify administrator and director of nursing immediately if resident not found after search; administrator and director of nursing will evaluate the situation develop a plan of action based on individual resident; the following steps should occur: Nurse should notify the attending physician; notify resident legal guardian; notify the police department; provide search team with resident information; increase search by more extensive search of surrounding area, remain in contact with hospitals; complete incident report and notify the state agency according to reporting guidelines, document appropriate notifications in the medical record. Facility elopement device policy revised 9-13-19 documents: The elopement alert exit door device will be inspected for proper working daily by maintenance and manger on duty. "A"	S9999		