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	IL6002075	A. BUILDING: ______ B. WING ______	C 06/21/2024

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CONTINENTAL NURSING & REHAB CENTER	**5336 NORTH WESTERN AVENUE CHICAGO, IL 60625**

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S 000	Initial Comments Complaint Investigation: 2484606/IL174239	S 000		
S9999	Final Observations Statement of Licensure Violations: ONE of TWO 300.610a) 300.690c) 300.1210b) 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 300.690 Incidents and Accidents 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	S9999		

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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 300.1210 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.

These requirements were not met as evidenced by:

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Based on interviews and records review, the facility failed to supervise one (R1) resident while on outside physician appointment of three residents reviewed for supervision. This failure resulted in R1 missing for approximately six hours. The Facility also failed to report to IDPH (Illinois Department of Public Health) when a resident (R1) was known to have gone missing while out of the facility for a physician appointment with a facility escort (V5).

Findings include:

R1's current face sheet documents R1 is a 63-year-old individual with medical diagnosis that include but not limited to: Wernicke's encephalopathy, unspecified dementia, unspecified severity, with other behavioral disturbance, other amnesia, other lack of coordination needs for assistance with personal care, cognitive communication deficit, dementia in other diseases classified elsewhere, moderate, with mood/ psychotic disturbance.
R1's MDS (minimum data set) section c-cognitive functions dated 4/20/2024 documents R1's BIMS (Brief Interview for Mental Status as 6/15, indicating R1 indicating R1 has severe cognitive impairment.
R1's MDS Section GG- Section GG - Functional Abilities and Goals document R1 needs substantial/maximal assistance with oral hygiene, shower/bathing self, lower/upper body dressing, putting on/off footwear, personal hygiene, rolling left and right, sit to lying, sit to stand, and R1 needs supervision or touching assistance with eating, walking 10, 50, 100 feet.

On 06/20/2024 at 2:44pm, V16 (Physician) stated

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R1 should not have been left alone while R1 was out of the facility for an outside physician appointment because R1 has diagnosis such as Wernicke's encephalopathy, Dementia which causes memory loss. V16 stated the only time R1 could have been left alone is when R1 was in the examination room with the physician and nurses. during R1's appointment.

On 5/18/2024 at 1:33pm, R1 was observed laying in his bed watching TV. R1 was able to answer some questions but was confused at times. R1 stated he has an appointment "Last week Monday, and they left me(R1) there, and I (R1) was scared." R1 stated he does not remember what the appointment was for does not remember where he went or how he got back to the facility on 6/10/2024. R1 was observed wearing a wander guard on his right-hand wrist.

On 06/18/2024 at 4:21pm, V1 (Administrator) stated R1 went out on appointment with (V5) Escort on 6/10/2024, R1 attended the appointment, and V5 was in the lobby of the hospital where R1 had an appointment and V5 had to use the rest room. V1 stated V5 asked the security guard to watch R1 while V5 used the washroom and when V5 come back from the washroom, V5 found R1 had walked off. V1 said V5 asked the security guard what happened, and the security guard told V5 that it was not the security guard's job to watch R1. V1 stated she found out R1 had disappeared at about 11:30am. V1 stated V5 then called V4(Memory Care Coordinator/Transportation Trainer) to let V4 know R1 had disappeared and V4 went to the hospital to help V5 look for R1. V1 stated the hospital is located about14 miles from the facility. V1 stated V4 notified the police and the security at the hospital so that they could assist in looking

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for R1. V1 stated she(V1) received a call from the police at approximately 3pm on 6/10/2024 letting her know R1 was located 10 miles away from the hospital where R1 had gone for him appointment escorted by V5.
V1 stated V5 should have gone to the bathroom while R1 was in his appointment, because it would have been safer because R1 was in the hands of medical personnel. V1 said V5 was given a write up and a suspension for leaving R1 with the security guard, who was not responsible for R1. V1 stated R1 needed an escort because he is not capable of taking care of himself and it is the responsibility of the facility to make sure R1 was safe during his outing to the appointment. V1 further stated during the period R1 was lost, he could have gotten hurt, lost, and not found, and there could have been many other negative outcomes related to R1 getting lost. V1 stated her expectation was that V5 should have always remained with R1 during the outing to the appointment. V1 said V5 was suspended for three days for leaving R1 alone and R1 getting lost after walking away alone from the hospital.
V1(Administrator) stated she did not report to IDPH (Illinois Department of Public Health) that R1 went missing while on outside facility appointment escorted by V5(Escort) because V6(Nurse consultant) told V1 there was no need to report to IDPH since R1 was found and brought back to the facility after approximately six hours unharmed. V1 said V5 was suspended for three days for leaving R1 alone and R1 getting lost after walking away alone from the hospital.

On 06/20/2024 at 12:05pm, V5 (Escort) stated on 6/10/2024, V5 escorted R1 to an outside physician appointment and left the facility about 9:30am via taxi, and the appointment was completed at about 11:45am. V5 stated there was

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S9999	Continued From page 5 a security guard by washroom and there was a seat, so V5 asked the security guard to keep an eye on R1 as V5 went to the restroom. V5 stated the security guard agreed, so V5 went to the bathroom, and when V5 come back from the bathroom, V5 did not see R1. V5 asked the security guard where R1 was, the security guard told V5 that it was not his job to watch R1. V5 stated V5 called facility front desk and spoke to V17 (Transportation) who was at the reception and informed V17 that R1 was lost, and to let V1 and V2 know. V5 stated V17 called V5 back and stated V4(Memory Care Coordinator/Transportation Trainer) would go to the hospital and assist V5 in looking for R1, and other management staff were also on the way. V5 stated the hospital security cameras showed R1 had walked outside the facility through the main door and was heading on the East side of the building. V5 stated she does not know the exact time R1 was found, but it was after 4:00pm. V5 stated she is not supposed to leave a resident without supervision, but V5 stated she had to go to the bathroom really badly, so she(V5) asked the security guard to watch R1. V5 stated the security guard was not responsible for R1, but she (V5) couldn't "pee" (sic) on herself, therefore V5 left R1 with the security guard. V5 stated she had been told never to leave a resident while escorting the resident to an appointment, but V5 stated she could not pee (sic) on herself, so she asked the hospital security guard to watch R1. V5 stated she was trained/in-services on safety and how to take care of the resident while out on escort about three months ago. V5 stated R1 could been hit by a car, R1 might not have been found, or R1 could have consumed something he is not supposed to, which could have affected R1 heath.	S9999		

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S9999	Continued From page 6 On 06/20/2024 at 11:26am, V2 (Director of Nursing-DON) stated R1 went to an outside appointment with V5 (Escort) because he has dementia and confusion and R1 needs supervision because of his mental status. V2 stated she received a call from V4 who informed V2 that V5 had told her that R1 had wandered away from V5. V2 stated she informed V1 and V1 told all management staff to go to the hospital where R1 had the appointment and start looking for R1. V2 stated she went to the hospital and was driving around the building trying to see if she could locate R1. V2 further stated that V7(Housekeeping supervisor) informed V2 that the campus/hospital security had looked at the cameras and R1 was observed on the cameras walking out the exit doors. V2 stated she kept driving around looking for R1 until she received a call from one of the facility's search team (V2 cannot remember who) informing V2 that R1 had been located at R1's old address. V2 stated she drove to the police station to see R1 and stay with R1 and brought R1 something to eat. V2 stated V2 and R1 waited for transportation from the facility. together to come pick R1 up. V2 stated R1 told V2 that (R1) was going home and told V2 that he took the bus. V2 stated R1's family no longer lives in address R1 went to. V2 stated V5 was supposed to always stay with R1 because R1 is confused and the purpose of V5 accompanying R1 to outside appointment was to watch R1 and keep him safe. V2 stated R1 could have been lost and not found, R1 could have been hurt by someone, or R1 could have walked into traffic and got hit by a car. V2 stated so many bad things could have happened to R1 when R1 was left unaccompanied. On 05/20/2024 at 10:40am, V4 (Memory Care	S9999		

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S9999	Continued From page 7 Coordinator/Transportation Trainer) said residents who have low cognitive abilities with diagnosis of diseases such as Dementia , Alzheimer's, residents at risk for elopement, residents who wander and residents who are on yellow and red community pass need an escort when leaving the facility so that the escort can assist the residents and keep them safe while out of the facility. V4 stated the escort cannot leave the resident alone, and if the escort needs to use the restroom, the escort can only leave the resident when the resident is in the care of doctors/nursers during the appointment. V4 stated the escort cannot leave a resident with a security guard at a community hospital because it is not the responsibility of the security guard at an outside facility to watch facility residents. V4 said she would not expect an escort to leave a resident with an outside security guard because that is neglect. V4 stated she was off on 6/10/2024 when R1 was left with a security guard by V5 (Escort) during an outside appointment. V4 sated she received a call from the facility front desk letting her know V5 just called the facility stating R1 was not in V5's view at a community hospital. V4 stated she called V1(Administrator) and V2 (Director of Nursing-DON) and told them that V5 did not know where R1 was. V4 stated she was off duty and was eight minutes away from the community hospital, so she went to the hospital to help V5 look for R1. V4 stated when she got the hospital, she called 911 to report R1 was missing. On 06/20/2024 at 12:32pm, V8 (Director of Social Services) said R1 disappeared during R1's outside the facility medical appointment. V8 said she heard V5 (Escort) had gone to the bathroom and left R1 with the hospital security guard, and when V5 come back, R1 was gone. V8 stated it is	S9999		

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not the responsibility of the hospital security guard to keep R1 safe because R1 is not the hospital's resident. V8 further stated it would have been different if V5 had left R1 with someone providing care for the R1 such as the doctors, nurses, Certified Nursing Assistants -CNAs or anyone who was involved with R1's appointment at that time, because that person would have been responsible for R1's safety. V8 stated if a person has memory loss, diagnosis such as Dementia, Alzheimer's, extreme behaviors such and promiscuous related to mental health issues, they will need an escort while going out of the facility for outside services. V8 stated social services does the Community Survival Assessment to determine the eligibility for community access and assess if the resident is independent, supervision or is restricted for community pass privileges, even when going to appointments. V8 stated the Community Survival Assessment is completed quarterly, and if a resident is on supervision or restricted pass, they cannot leave the facility without being accompanied by a family member of a staff member for safety and to ensure the resident is provided with the support they need such as monitoring their baseline and making sure the resident can function while out in the community. V8 stated R1 should not have been left alone because of his diagnosis. V8 stated R1 could have wondered into traffic and got hurt, could have been harmed or harmed someone else. V8 stated it was not acceptable for V5 to leave R1 alone unattended while outside the facility.

On 06/20/2024 at 2:09pm, V9 (Psychiatric Rehabilitation Services Coordinator) said she has worked with R1 for a short period of time and completed R1's Community Survival Skills Assessment after R1 had disappeared at the

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hospital during his appointment on 6/10/2024. V9 stated R1 wears a wander guard because R1 had diagnosis of dementia, Wernicke's encephalopathy, depression and, and R1 is confused at sometimes to time and place and is often looking for his family. V9 stated R1 should be supervised at all times when out in the community because R1 can get lost, and R1 if R1 walks around the block he would not know where he is, and R1 can wander to unsafe areas. V9 further stated that R1 is not aware he lives in a long-term care facility and does not remember the address of the facility and does not know he(R1) is in a long-term care facility. V9 stated R1 is on a yellow pass, which means R1 cannot leave the building alone because R1 always needs supervision. V9 stated the community survival skills assessments documents the resident's recommendation for being in the community and notifies the nursing staff the level of care a resident need while out in the community.

On 06/20/2024 at 2:52pm, V17 (transportation) stated on 6/10/2024 at 11:45am, V5 (Escort) called V17 while V17 was at the reception filling in for the receptionist and V5 stated she (V5) did not know where R1 had gone to after R1's appointment at the hospital. V17 stated V5 told V17 that she (V5) had asked the security guard at the hospital to watch R1 as V5 went to the bathroom, but when V5 come back, R1 was not there. V17 stated she called V2 and V4 and let them know that V5 had called V17 stating R1 was missing. V17 stated she volunteered to go assist in looking for R1 and V17 called the hospital while en-route to the hospital and spoke to a nurse (No Name) who stated they would notify the campus police that R1 was missing from the hospital. V17 stated after a while the nurse called V17 back

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and stated the campus/hospital security were looking for R1. V17 stated she drove around the hospital looking for R1 and could not find him, therefore V17 come back to the facility and found all the department heads in a meeting discussing R1 missing, and there after the department heads left to go look for R1 at the hospital. V17 stated approximately 5:55pm V17 was informed R1 had been found, but she does not remember who informed her. V17 stated when transporting a resident to appointments, the resident cannot be left alone because they can wonder off, they can get hurt, and when R1 was lost, there was a lot of construction going on in the hospital and R1 could have fallen in one of the open holes and got hurt. V17 stated R1 has a wander guard for a safety, but it only works when R1 is in the facility, and the wander guard does not work outside of the facility. V17 stated for residents with memory loss, the staff must always keep them within eyesight for safety, especially while outside the facility.

On 6/20/2024 at 1:09pm, V10(Human Resource Manager) stated if a staff member is written up, the department head writes up the staff member, the write up is taken to Human Resources-HR and V10 puts it on the staff member's HR file. Surveyor and V10 reviewed V5's HR file and V5 had one write up dated 6/10/2024, and V5 was suspended for 3 days because V5 left a R1 unattenuated while at an outside facility appointment as V5 went to the restroom and when V5 come back, R1 was not there.

On 06/18/2024 at 5:29pm V9(Nurse Consultant) said R1's disappearance is not a reportable because R1 did not suffer any injuries.

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On 06/18/2024 at 3:41pm, V9 stated the facility does not report elopement or a resident missing unless there is a major injury associated with the incident. V9 further stated only major injuries and abuse are reported according to the facility protocol.

No facility reported incident report to IDPH was provided. No policy was provided.
V5's disciplinary Action form dated 6/10/2024 documents"
-V5 accompanied R1 on escort appointment and left R1 unattended.
-V5 was suspended for three days -06/13/24, 6/14/24 and 6/16/24.

R1's nursing progress notes dated 06/10/2024 documents:
-R1 went to R1's regular appointment at a nearby hospital and was accompanied by an escort (V5).
-R1 wandered off his scheduled doctor's appointment.

R1's facility summary dated 6/10/2024 documents:
-R1 left facility with V5 for appointment at a community hospital at 9:30am
-V5 asked the hospital security guard to watch R1 and V5 went to the bathroom. At 11:30am, V5 come out of the bathroom and R1 had walked off. The hospital security guard told V1 that he (Security guard) was not responsible for R1.
-At 3:30pm, police called the facility and stated R1 was found 10 miles from the hospital.
-At 5:30pm, V2 picked up R1 from the police station and took R1 back to the facility.

R1's Physician order Sheet (POS) documents:
10/31/2022 -Wander guard- Check for placement and functioning every day and night shift

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL NURSING & REHAB CENTER	**5336 NORTH WESTERN AVENUE CHICAGO, IL 60625**

(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
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3/6/2024-Appointment on the June 10th Monday 9.30am {arrived by 9.15 am} (liver center)
6/22/2023-Yellow Pass-May have community pass with supervision.

Policy titled Physician Visits for Medical Specialties Outside of the facility dated 06/16/12 documents:
-The scheduler makes transportation and escort arrangements as necessary.

Policy titled Missing Resident/Elopement dated 4/5/2023 documents:
-It is the policy of the facility to provide a safe and secure environment for all residents.
Purpose:
-To ensure the safety and security of all residents
-to educate and maintain staff awareness of the importance of resident safety and security.

R1's Community Survival Skills Assessment dated 6/10/2024 and 9/27/2023 documents:
-R1 is currently assessed as appropriate for YELLOW PASS privileges d/t (due to) dx (Diagnosis) of dementia and medical dx.
-R1 incapable of caring for self independently in the community and requires accompaniment at all times.

(B)