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S 000	Initial Comments Complaint #2472758/IL171690 Facility Reported Incident of 3/23/24/IL171513	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690b) 300.690c) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 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 b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident	S9999		

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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 300.1210 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 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

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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.

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 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.

These Requirements were not met evidenced by:

Based on interview and record review, the facility failed to ensure a resident with substance use

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disorder was safe for independent community access after being hit by a car the previous day while out in the community.

This failure resulted in R2 being found on the side of the road by a bystander and requiring hospitalization. Hospital records show R2 had fractures of the left fourth through 12th ribs, and an elevated blood alcohol level.

The facility also failed to notify the Department of R2 being found on the side of the road by a bystander while out on independent community pass and requiring hospitalization.
This applies to 1 of 3 residents (R2) reviewed for accidents in the sample of 6.

The findings include:

The EMR (Electronic Medical Record) shows R2 was admitted to the facility on September 30, 2022. R2 has multiple diagnoses including, mild osteopenia of the right lower leg, low back pain, chronic pain syndrome, multiple rib fractures of the left side, alcohol use, repeated falls, and multiple wedge compression fractures of the spine.

R2's MDS (Minimum Data Set) dated March 15, 2024 shows R2 is cognitively intact and requires supervision for all ADLs (Activities of Daily Living). R2 is always continent of bowel and bladder.

On April 15, 2024 at 9:51 AM, V3 (LPN) said, "When [R2] came back to the facility on March 23, 2024, he smelled like he was drinking. He did not come to me and tell me he was hit by a car. He told the therapist, who came to me. I notified [V4] (Physician). We called the paramedics, and [R2] signed a paper to refuse to go with them. He

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would not let us do X-rays either. They came and he refused. I worked a double shift on March 23, and was in the building from 7:00 AM to 11:30 PM. I returned the next day at 7:00 AM and was assigned to care for [R2] again. He came to me to get his medications before 9:00 AM, and he smelled of alcohol. He said he was going to leave the facility and go out in the community. It is not my call to keep him in the facility. At that time, I did not notify anyone. I did not call [V4] (Physician) to notify him [R2] wanted to go out or to check if it was okay since he was hit by a car the day before. I did not complete a community access assessment to determine if he was able to go out into the community without supervision. Later, I received a call from the hospital, and they told me they had [R2]. He was picked up from the street by emergency response."

On April 15, 2024 at 10:44 AM, V5 (Police Officer) said, "The driver of a vehicle hit [R2] on March 23, 2024, while he was in the crosswalk, approximately one half mile from the facility. The driver was making a turn at the stop sign and [R2] happened to be in her blind spot, and she hit him in his wheelchair. He was bleeding from his forehead. He fell out of the wheelchair onto the ground, and someone helped him get back into his wheelchair and sit until the fire department came. The street he was on is one of our busier streets. It is a four-lane road with a turn lane. We tried to get him to go to the hospital, but he refused."

On April 15, 2024 at 12:17 PM, V4 (Physician) said, "[R2] drinks every day. He went out on Saturday (March 23, 2024) and he was hit by a car. [V3] (LPN) must have assessed him to be safe in the community before he went out on Sunday (March 24, 2024). [R2] doesn't follow the

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rules. He still insists to go out. It was a possibility that he could have had supervision while out in the community on Sunday (March 24, 2024) but I was not contacted regarding that. I don't think he likes being supervised." V4 continued to say he was not contacted by V3 (LPN) for an order for R2's independent community pass on March 24, 2024.

On April 15, 2024 at 12:34 PM, V1 (Administrator) reviewed R2's care plan that was in place on March 23, and 24, 2024. V1 reviewed R2's care plan interventions which show that the resident is aware of the rules and regulations associated with accessing to the community and that the resident understands that access to the community is a privilege which may be revoked at any time due to engaging in prohibited activities and/or behaviors. V1 also reviewed the care plan intervention which shows to obtain a physician's order for outside pass privilege and inform if there have been any restrictions to the resident's community access placed by the physician.

After reviewing R2's care plan, V1 said, "I don't know the rules and regulations associated with accessing the community. I do not know what the prohibited activities are." V1 continued to say the facility does not have a list of rules or regulations for residents with independent community access.

On April 11, 2024 at 12:00 PM, R2 was self-propelling his wheelchair down the hallway towards his room. R2 had noticeable bruising around his right eye and faded bruising across the bridge of his nose and across his forehead. R2 had a scab on the top of his left hand. R2 said the hand injury and bruising were caused by injuries he sustained while out on pass in the

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community on March 23, 2024. R2 said he was out in the community in his wheelchair on March 23, 2024, when he was hit by a car. The car hit his wheelchair, causing his wheelchair to tip over. R2 said bystanders stopped and helped him get off the ground and back into his wheelchair before the police and paramedics arrived.

On April 11, 2024 at 12:00 PM, R2 said he could not recall the events of March 24, 2024 that led to his hospitalization from March 24, 2024 to April 2, 2024.

On April 11, 2024 at 12:21 PM, V8 (NP) said, "Anyone who is under the influence of alcohol or intoxicated cannot make decisions to be safe."

On April 11, 2024 at 1:00 PM, V6 (SSD-Social Service Director) said, "[R2] does not understand the consequences of his actions because he has been drinking his whole life."

The Illinois Traffic Crash Report number 2024-00017709 shows R2 was struck by an automobile in a four-lane street on March 23, 2024 at 9:15 AM. V13 (Vehicle Driver) failed to yield the right of way to R2 in a crosswalk and struck R2.

The facility's resident sign out sheet dated March 24, 2024 shows R2 signed himself out of the facility at 9:14 AM.

Local fire department documentation dated March 24, 2024 shows EMS (Emergency Medical Services) was notified on March 24, 2024 at 1:27 PM and had contact with R2 on March 24, 2024 at 1:32 PM. The EMS provider documented: "[EMS Crew] dispatched for male with back pain from being struck by a vehicle 2 days ago. Upon

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arrival on scene [Local Police] stated that they were called for a check on the wellbeing. [Local Police] stated that patient wheelchair had gone off the sidewalk and he was already assisted back to the sidewalk by a passerby. [Local Police] stated that patient had refused any need for [Police] or EMS. Police stayed on scene to see if [R2] could make it back to [the Facility]. Police stated they called for EMS as patient was unable to navigate broken wheelchair back to [the Facility]. Patient stated that he had no medical complaints and refused to be seen at the hospital. EMS offered to get him back to [the Facility] via courtesy ambulance ride. Patient initially refused and then agreed as his wheelchair was broken. When EMS brought cot to patient, he complained of back pain from the accident. EMS advised that if he was still in pain to be seen at the ER. Patient kept refusing ER transport. After a few minutes of assisting patient to cot, patient agreed to be transported to [local hospital] ER due to his back pain as long as we brought his broken wheelchair with. BLS (Basic Life Support) assessment and care provided ...."

On March 25, 2024 at 3:28 AM, V7 (Hospital NP-Nurse Practitioner) documented R2 "Presented to the emergency department at [local hospital] on March 24, 2024 after bystanders found him on the side of the road inside of his wheelchair unable to get up and called 911. ...Patient is very poor historian and was unable to recall the events that took place for him being on the side of the road. ...A chest CT revealed fractures of the left fourth through 12th ribs. There is also bibasilar atelectasis predominantly in the left lower lobe with mild left effusion and hemarthrosis (bleeding) but no evidence of pneumothorax. He was seen the following morning on the medical unit. He was tremulous

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in upper and lower extremities. His speech was slurred. He had evidence of intoxication and possible early withdrawals of alcohol which is a chronic issue for him. He had multiple hospitalizations regarding injuries associated with alcoholism. ...On March 23, 2024 he was in his wheelchair when he was struck on his right side apparently by a driver who was using her phone at the time. He was knocked out of the wheelchair, landed on his left side which is where the injuries are present. Police were called to the scene, and he refused transport against medical advice and was given an incident report at that time with the exchange of driver information."

R2's blood alcohol level, collected at the local hospital on March 24, 2024 at 4:15 PM shows, "Abnormal: 337 mg/dl (milligrams/deciliter)." The report shows the normal/flag reference level is less than 10 mg/dl.

On March 24, 2024 at 1:19 PM, V3 (LPN) documented: "Resident alert and oriented, signed out the facility this AM at approximately 0914 (9:14 AM). [R2] was encouraged to be cautious while out of the facility since he was involved in an accident just yesterday to what [R2] responded in aggressive manner using profane language. He was noticed to have alcohol breath at the time. At approximately 1420 (2:20 PM) received a call from [local hospital] to notify of [R2] been brought to the ER by [local] paramedics as per ER nurse. [R2] was reported to be sleeping on the grass on the side of the street then found by [local police department] who contacted emergency staff and transported [R2] to the emergency room as reported by ER nurse. [R2] appears alcohol intoxicated on arrival to ER. PCP and POA made aware."

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On March 23, 2024 at 3:35 PM, V3 (LPN-Licensed Practical Nurse) documented: "Resident alert and oriented reported to have been involved on an accident where he was hit by a car at a near intersection, resident refused to provide any information to this writer but states to therapist,, "I was hit by a car while I was crossing the street." PCP (Primary Care Physician) and administration informed of the occurrence. MD gave order to send [R2] to the ER for evaluation and treatment. [Ambulance Company] was contacted to transport resident to nearest ER. EMTs (Emergency Medical Technicians) arrived at approximately 3:25 PM but resident refused to be transported at the time and signed a refusal of care form provided by ambulance service. PCP and POA (Power of Attorney) made aware of incident and refusal of care by [R2]. He was up in his wheelchair. He complains of discomfort to left side rib cage. No skin discoloration or any swelling noted to area."
The facility's initial and final Report to IDPH (Illinois Department of Public Health) regarding R2 is dated March 29, 2024. The report shows the date of the incident as March 23, 2024.

On April 15, 2024 at approximately 3:30 PM, V1 (Administrator) said the facility should report all incidents and accidents to IDPH within 24 hours. V1 continued to say the facility delayed sending the report regarding R2 to IDPH for five days because the facility did not become aware R2 had sustained rib fractures until March 29, 2024.

Facility documentation by V3 (LPN) dated March 24, 2024 at 5:59 PM shows the facility was aware of R2's hospitalization and rib fractures on March 24, 2024 when V3 (LPN) documented the following: "This writer contacted [local hospital] ER to inquire about the condition of [R2]. As per

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ER nurse resident will be admitted with diagnosis of rib fracture, hypokalemia, and hypoxia. PCP, management and POA made aware of [R2's] admission to the hospital for inpatient care."

The facility does not have documentation to show R2 has a physician's order to consume alcohol.

The facility does not have documentation to show R2 was reassessed to be safe in the community without supervision on March 24, 2024, after being hit by a car on March 23, 2024.

The facility's Elopement Risk and Community Survival Skills Assessment shows nine community survival skills assessment questions with yes or no answers. The assessment continues to show: "Community Survival Skills - If one or more is marked "NO" then resident is at risk in community and a supervised pass is indicated."

R2's quarterly Elopement Risk and Community Survival Skills Assessment, completed by V12 (ADON-Assistant Director of Nursing) on January 26, 2024 shows two of the nine community survival skill questions were answered no.

Based on the Elopement Risk and Community Survival Skills Assessment completed on January 26, 2024, R2 did not meet the criteria for independent pass privileges. V12 (ADON) selected, "Appears to be capable of outside independent pass privileges at this time. A care plan for outside pass privileges including risk factors for non-compliance for adhering to pass policies and parameters is indicated."

The facility does not have documentation to show why R2 received independent pass privileges

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when he did not meet the criteria for independent pass privileges.

The facility does not have documentation to show R2 had another Elopement Risk and Community Survival Skills Assessment completed between January 26, 2024 and March 24, 2024.

As of March 24, 2024, the facility did not have documentation to show R2 had a physician's order to leave the facility without supervision.

On March 3, 2024 at 5:20 PM, V9 (RN-Registered Nurse) documented, "Resident's behavior/mood noted at this shift. Resident's behavior noted as was socially inappropriate. ...Resident was observed to have alcohol in his possession which rolled out from his jacket, and he appears to be drunk ..."

On January 30, 2024 at 11:00 PM, V3 (LPN) documented, "Resident continues to be noted to have strong alcohol breath this evening. He was noticed to be loud while speaking to peers, residents, and staff.

On January 25, 2024 at 10:41 AM, V3 (LPN) documented, "Resident was witnessed to have alcohol breath and behaving erratically, using profane language towards staff."

On January 24, 2024 at 4:09 PM, V10 (RN) documented, "Resident alert and oriented, appears intoxicated at this time. Resident has a strong smell of alcohol. Resident asking for alcohol test but this resident knows how to make the result of alcohol test negative. Alcohol serum was ordered STAT by PCP, narcotic medications discontinued."

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S9999	Continued From page 12 On January 24, 2024 at 3:42 PM, V3 (LPN) documented, "Resident alert and oriented was noticed to be verbally aggressive and disruptive after he was made aware PRN (as needed) Norco can't be administered due to apparent alcohol intoxication. [R2] appears to have strong alcohol breath and was noticed to have erratic movements and slurred speech while interacting with staff, very argumentative when questioned as to whatever he is been drinking or not. Verbal education provided in regards of opioids and alcohol interaction to what [R2] responded on a very offensive way towards staff providing education. PCP made aware of behavior and suspects alcohol intoxication. MD gave an order for alcohol serum tomorrow and d/c (discontinue) order for PRN Norco. [R2] had an encounter with MD in which PCP made [R2] known of Norco been d/c." On January 24, 2024 at 2:00 PM, V4 (Physician) documented, "Plan: Alcohol intoxication. He claims he does not drink. Last time tricked on alcohol saliva test. Will do blood test. Now he is refusing blood test." On January 23, 2024 at 1:09 PM, V3 (LPN) documented, "Resident alert and oriented appears to be argumentative with staff and peer. Resident is demanding to have PRN Norco, but unable to state the origin of his pain. [R2] was made aware his last administration was less than 6 hours ago and he must wait until his next scheduled time, but he will be able to get PRN Tylenol or ibuprofen. [R2] was also noticed to have strong alcohol smell during assessment, but resident denied having drank alcohol. This nurse provided verbal education in regards of risks of mixing opioids and alcohol to what [R2] responded on an aggressive manner, using	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005847	A. BUILDING: ______ B. WING ______	C 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

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S9999	Continued From page 13	S9999		

profane language. PCP made aware of behavior."

On January 22, 2024 at 7:15 PM, V3 (LPN) documented, "Resident was noticed to have strong alcohol breath, with slurred speech and loud voice, he was noticed to be argumental with peer residents and staff. Resident approached this nurse to request PRN Norco. This nurse verbally educated [R2] on risks of taking opioid medications while alcohol intoxicated, to which [R2] replied, "My doctor knows and its okay just give it to me." [R2] was made aware of order been written to hold medication if suspected to be intoxicated. [R2] became angry and started using foul language towards staff."

On January 18, 2024 at 11:59 AM, V3 (LPN) documented, "Resident was noticed to have alcohol breath, slurred speech, and also appears argumental with peer residents and staff."

On January 18, 2024 at 7:30 PM, V9 (RN) documented, "Resident appears to be intoxicated, smells like alcohol with slurry speech and talking loudly in the hallway. Insisting to get his Norco pill. Explained to him that writer is unable to give medication for his own safety. Displayed an angry attitude and verbalized, "I will call [V4] (Physician), I want to get out of this place."

On January 8, 2024 at 11:30 PM, V3 (LPN) documented, "Resident was noticed to have alcohol breath and slurred speech. No medication due at this time."

On January 3, 2024 at 2:57 PM, V3 (LPN) documented, "Resident was noticed to be highly alcohol intoxicated, strong alcohol breath during

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	IL6005847	A. BUILDING: ______ B. WING ______	C 04/22/2024

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S9999	Continued From page 14	S9999		

lunch meal. [R2] was encouraged to stop drinking as is unsafe and he has history of injuries related to alcohol intoxication. Resident denied feeling intoxicated and left the site."

On January 3, 2024 at 6:57 PM, V10 (RN) documented, "Resident noted to be alcohol intoxicated and has strong alcohol breath before dinner time. Female CNA approached writer that the resident tried to grab her in the dining room. Staff CNA redirected the resident and went away, encouraged to stop drinking as is unsafe and he has history of injuries related to alcohol intoxication. Resident denied feeling intoxicated and got agitated and left."

On January 2, 2024 at 11:24 PM, V3 (LPN) documented, "Resident was noticed to have strong alcohol breath and acting oddly using profane language to address staff, slurred speech, PCP made aware."

R2's care plan for community access, initiated on August 23, 2023, and in effect on March 23 and 24, 2024 shows: "Community Access - Independent. Goals: [R2] will be agreeable to access the community under facility policy governing community pass privileges, through next review." Interventions initiated August 23, 2023 show: "Explain that receiving and maintaining an on-going pass privilege will be contingent upon compliance with my care/treatment plan. Make sure that I am aware of the rules and regulations associated with accessing to the community and that I understand that access to the community is a privilege which may be revoked at any time due to engaging in prohibited activities and/or behaviors. Obtain a physician's order for outside pass privilege and inform if there have been any restrictions to my

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S9999	Continued From page 15 community access placed by my physician." The facility's policy entitled Community Pass Guidelines, revised "11-17-17" shows: "Purpose: To define the facility and the resident's responsibility when a resident leaves the facility with the consent of the facility. Guidelines: The resident has the right to community access with the consent of the facility and the residents' cooperation with the standards described within. If the resident refuses to adhere to the standards, he or she may be restricted from independent pass privileges. 1. A Community Skills Assessment will be completed by Social Services upon Admission, Quarterly, or as appropriate with changes in cognitive or functional ability. If appropriate, the resident will be given independent community access. 2. The Resident/Representative will be provided with medications and instructions for the duration of the visit. 3. Residents returning from passes that are suspected to be under the influence of alcohol, or illegal drugs will agree to drug testing and/or treatment programming. 4. Residents returning from passes that have resulted in injuries caused by falls, or bruising of unknown origin may have the Overnight Community Passes restricted until the facility reassess the resident's safety in the community." (B)	S9999		