STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007991	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CHICAGO HEIGHTS	120 WEST 26TH STREET SOUTH CHICAGO HEIGHT, IL 60411

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S 000	Initial Comments Complaint Investigation 2493699/IL173026 Facility Reported Incident of 5/4/24 IL172830	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 300.1210 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	S9999		

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S9999	Continued From page 1	S9999		

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:

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 are not met as evidenced by:

Based on interviews and records reviews the facility failed to prevent a cognitively impaired resident who requires supervision in the community that has a behavior of wandering from leaving the facility unauthorized without staff knowledge. This affected 1 of 3 (R6) residents reviewed for safety, supervision, and elopement. This failure resulted in R6 leaving through his bedroom window without staff knowledge.

Findings include:

R6's diagnosis, include but are not limited to Encephalopathy, Drug Induced Subacute

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S9999	Continued From page 2	S9999		

Dyskinesia, Malaise, Reduced Mobility, Adjustment Disorder, Type 2 Diabetes Mellitus, Seizures, and Hypertension. R6's Cognitive patterns assessment dated 3/1/24 indicates score of 8. Additionally, R6 displays fluctuating inattention and disorganized thinking.

Facility Reported Incident Form titled Initial Report states on 5/4/24 at 4:00PM "it was reported to the A. Admin that resident is missing from the facility by the social service staff, green protocol had been initiated and resident was not found in the facility."

A review of the Fire Department Run sheet dated 5/7/24, call received at 6:17AM, states R6 arrived ambulatory to the fire station stating he was experiencing double knee pain. Patient transported to the hospital.

On 5/7/24 at 2:21 PM R6 said he went to the church, he slept downstairs around the church, in a stairway at the church. R6 said he did not have medicine. R6 said he opened the window and left the facility. R6 said he left when his roommate was sleeping at 7:00 AM, as the sun was rising. R6 said the windows were not supposed to open like that.

On 5/9/24 at 10:35AM surveyor met with R6. R6 observed able to stand, turn, and ambulate without assistance. R6 difficult to understand, speech slurred, but some words understandable. R6 said "yes" he left and he "got a ride" and then went to the hospital because he was told to go there. R6 asked if he knows his address or the facility address, R6 said "no" to both.

On 5/9/24 at 11:41AM V5, Certified Nursing Assistant (CNA), said on 5/4/24 around 3:00PM

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S9999	Continued From page 3	S9999		

the nurse asked me if I had seen R6. V5 said the nurse asked me to look for R6. V5 said I left at 3:00PM and R6 was not found.

On 5/9/24 V7, Licensed Practical Nurse, said on 5/4/24 in the afternoon around 2:00 or 2:30PM I did not see R6 in his room. V7 said I raised alarm and asked the CNA about him. V7 said a code purple was initiated. V7 said I notified Social Service Department that I don't see R6. V7 said when I checked R6's room, there was no one in the room, his roommate was in the dining room. V7 said I didn't look at the window. V7 said when I went outside, I saw a footprint on the ground about 2 feet from the window. V7 said at baseline R6 is "very sneaky" and goes around the facility. V7 said R6 has periods of confusion at times, and he can be hard to redirect due to his confusion.

On 5/9/24 at 10:49AM V3, Social Worker, said, no one is a high risk of elopement in the building. V3 said I would know if they are at high risk for elopement. V3 said they have to make an attempt multiple times to exit to place them on high risk for elopement with a monitor. V3 said I was called in Saturday 5/4/24 and I was made aware R6 left. V3 said I came to the facility, and we did a room head count and we drove around the area looking for R6. V3 said R6's baseline behavior is confused, he talks slow, and he speaks loud. On follow up interview on 5/10/24 at 9:31AM V3 said a cognitive (BIMS) score of 8-12 is moderate cognitive impairment. (R6's score is 8). V3 said R6's behaviors include anger and tone changes, he will curse, is socially inappropriate, and uses inappropriate words. V3 said R6 wanders in the facility. At 10:59 V3 said I have to find out what score from the elopement assessment indicates the person is at risk.

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S9999	Continued From page 4 On 5/9/24 at 11:14AM V4, Social Services, said on 5/4/24 we were searching for R6. V4 said I became aware by the nurse at 3ish (3:00PM), I instantly checked R6's room and toilet, looking for him. V4 said I called a code purple immediately. V4 said when I looked in R6's room I saw the tv remote on the bed, his blankets on the bed, and all his personal possessions still there. V4 said R6 got out thru the window, but it was no longer open. V4 said R6 could open the window enough to get out. V4 said R6's window screen had returned to how it was supposed to be. V4 said R6 did not have an accomplice that I am aware of. V4 said we don't have any high risk elopement residents. V4 said R6's window led outside to the front of the facility. V4 said R6 went without medication while away. V4 said R6 was gone from Saturday 5/4/24 until Tuesday 5/7/24. V4 said according to GPS the hospital where R6 was located is about 6.7miles from here. On 5/9/24 at 12:38PM V6, Maintenance Director, said on Saturday, 5/4/24, I was called in and the Administrator asked me to help with the windows. V6 said I had some corner "L shaped" brackets here and used some regular screws. V6 said I have the screen for R6's former room in my office. V6 said the screen was on the mulch on the ground when I got here. V6 showed the surveyor the L shaped metal bracket screwed into the windowsill. On 5/10/24 at 12:35PM V6 said on Saturday 5/4/24, about 20 windows didn't have L brackets, none of the outside facing windows had them before I installed them. V6 said all the windows were resident rooms. V6 said the reason I put the bracket is to keep the window from opening "so wide," this is a safety mechanism. V6 said before Saturday the windows had nothing in place to	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CHICAGO HEIGHTS	120 WEST 26TH STREET SOUTH CHICAGO HEIGHT, IL 60411

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S9999	Continued From page 5	S9999		

prevent them from opening "so wide," 49-50 inches. V6 said I do rounds everyday, I check windows, make sure they are not wide open. V6 said I never noticed them to be open so wide. V6 said they should not have them wide open, to prevent this issue from happening again. V6 said I have always checked the windows and I would close them to prevent someone from getting out. V6 said in the past I had seen windows open so wide. V6 said the installed brackets allow the window to open roughly 3-4 inches. V6 said I never mentioned to anyone if I saw a window open wide. V6 said the windows are not new. V6 said I work Monday thru Friday and I check the windows Monday thru Friday. V6 said no one is here over the weekend to do my rounds. V6 said I would hope staff would check the windows. V6 said I don't remember if R6's window was open when I came in Saturday 5/4/24.

On 5/10/24 at 10:13AM V2, Director of Nursing, said on 5/4/24 I was notified that code purple was called for R6. V2 said I was not able to come in, but I had phone calls to figure out what was going. V2 said when R6 was found the hospital called and said he was found. V2 said from the phone calls, it was determined that V5 was the last person to see R6 around 1:30PM. V2 said I am not aware what R6 was doing or where he was last seen. V2 said it was determined that R6 got out by the window in his room, because the screen was out. V2 said I would say no for community pass for R6. V2 said R6 gets frustrated and impatient with communication, he is aphasic. V2 said R6's attention span is not focused, his attention and patience is short. V2 said R6 has a psyche background, his thought process can be unorganized. V2 said when R6 returned he look tired. V2 said R6 said he went out the window. V2 said I would describe R6 as a

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S9999	Continued From page 6	S9999		

wanderer, he is not typically in one place, you have to look for him. V2 said R6 needs supervision while out of the facility.

On 5/10/24 at 11:09AM V12, Assistant Administrator, said I got a call at home around 3ish, that they could not find R6. V12 said I came in to assist with the search. V12 said we could not find R6 in the building or neighborhood. V12 said I looked at the camera footage for the front door and back doors and he was not seen. V12 said there is no front door outside camera. V12 said R6 was last in the facility around 1:30PM. V12 said the CNA reported she last saw R6 at 1:30PM while changing the roommate. V12 said when I came to the facility, we saw the screen in the mulch, and we thought R6 went out the window. V12 said R2 can open the window. V12 said we were notified R6 arrived to the hospital in an ambulance. V12 said when he returned, R6 told me he went to the fire department and was taken to the hospital and that he was tired. V12 said I did not speak with the fire department. V12 said I am not sure which fire department he presented at. V12 said I don't think R6 knows the phone number to the facility. V12 said R2 could not be unsupervised in the community.

On 5/10/24 at 11:40AM V1, Administrator, asked for the surveyor to follow her to show me something. V1 escorted the surveyor to R6's room at the time of elopement. V1 said I asked V6 to remove the L bracket so I can show you how R6 got out the window. V1 opened the window fully (as measured before) and climbed one foot on the adjacent bed, stepped onto the window ledge, and jumped down onto the raised landscaped area with mud and mulch. V1 said and V12 found this screen (V6 was replacing the window screen) right here. The surveyor noted

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S9999	Continued From page 7 the screen frame is bent. On 5/14/24 at 12:46PM V13, Doctor, said if R6's pass states R6 needs supervision while in the community, then R6 should not be in the community unsupervised. R6's Order Summary Report documents may go out on pass with medication with family. R6's progress notes dated 5/4/24 states in part, R6 not in room. Dining room and surrounding areas checked. Social Services immediately notified. R6's progress noted dated 5/7/24 at 10:45AM R6 returned from hospital. R6 Behavior assessment dated 3/1/24 documents delusions and wandering occurs 1 to 3 days during the assessment period. R6's Elopement Evaluation dated 2/29/24 notes a score of 3. Evaluation includes, the resident has demonstrated or presents with the physical ability to leave the building no. On 5/7/24 R6's score is 19. R6 exhibited elopement behavior has evidence by leaving the facility unauthorized. R6's Community Survival Skills Evaluation dated 2/29/24 states R6 needs supervision to access the community. R6's care plan initiated 4/2/24 states, R6 displays poor boundaries with staff and co-peers as evidenced by his wandering tendencies. R6 has poor perception of personal space. R6 is socially inappropriate towards peers and staff.	S9999		

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S9999	Continued From page 8 Interventions include: Encourage resident to participate in groups/activities/events throughout the facility. Redirect resident appropriately when seen displaying inappropriate boundaries. Staff to be consistent with setting limits in order to maintain boundaries. R6's care plan initiated 5/7/24 states R6 had an "unauthorized departure from the facility." Interventions include R6 applauded on all progress made towards goal. R6 will be reeducated on supervision policy. Facility provided hospital records dated 5/7/24 at 6:30AM note R6 reason for visit is knee pain. Medications given Ketorolac. (A)	S9999		