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S 000	Initial Comments Complaint Investigations: 24710538/IL183366- 24710539/IL183370- 24710435/IL183308-	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210d)3)6) 300.1220b)3) 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. 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	S9999		

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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:

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.

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

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modified in keeping with the care needed as indicated by the resident's condition.

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.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a resident identified with confusion, poor safety awareness, ambulatory, and had verbalization of wanting to exit the facility, was provided supervision to prevent elopement from the facility. The facility also failed to ensure the door on the ground floor leads to courtyard and main street was in good repair and had a working alarm system to alert facility staff of a resident attempting to exit the facility. This failure resulted in R1 eloping from the facility without being witnessed by facility staff during the early hours on December 29, 2024. This applies to 1 of 7 residents (R1) reviewed for risk of elopement in the sample of 7.

R1 was found standing on the sidewalk of a local street near an intersection with 4 traffic lanes, which was approximately 183 feet from the entrance of the facility by a bystander, who alerted the police on December 29, 2024, at

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5:14AM. The local police and fire department found R1 wet, with no shoes and wearing only a pair of socks and pajamas. R1 had skin injury due to a fall occurred during the elopement. The weather showed at time of occurrence was 46 degrees Fahrenheit and raining. R1 was taken to the nearby hospital by paramedics. The hospital record dated December 29, 2024, showed R1 was diagnosed with cold exposure, small bump to left side of head with dried blood and laceration. The hospital's ED (Emergency Department) report dated December 29,2024 showed "(R1) arrives to ED via EMS (Emergency Medical Serves) after being found outside by police across street from the facility."

The findings include:

The EMR (Electronic Medical Record) shows R1 was originally admitted to the facility on October 4, 2024. R1, an 81-year old with multiple diagnoses including adrenal insufficiency, type 2 diabetes mellitus, laryngeal cancer with status post laryngectomy and tracheostomy, coronary artery disease with status post x4 (coronary artery bypass graft on 2020), hypertension, gangrenous cholecystitis with status post insertion of irrigation drain, and insertion of gastrostomy tube (on October 2024), clostridium difficile infection, hard of hearing, unsteadiness on feet, lack of coordination, major depressive disorder, adult failure to thrive and spinal stenosis.

R1's MDS (Minimum Data Set) dated November 25, 2024 shows R1 had moderate cognitive impairment with BIMS (Brief Interview Mental Status) score of 9/15.

On December 31, 2024 at 11:00 A.M., together with V3 (Assistant Director of Nursing), the

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facility's nine exit doors were checked. Two doors on the ground floor which lead to courtyard and main street were not in good repair. The first door by TV lounge/ground floor was observed with a non-functioning alarm. This door leads towards the courtyard and main street. This door would not close shut, and door remained a few inches ajar. There was a panel alarm next to this door. The alarm did not sound off when opening and closing this door. The door and the alarm were not in working condition. V3 said the door should always be closed, and alarm should sound when opening or closing the door for the staff to be alerted and checked to ensure no resident/s was outside unsupervised. V3 said the alarm should continue sounding off without staff reactivating the code of the alarm. V3 added, both the door and alarm were not in working condition and no alarm had sound off when the door was open. V4 (Director of Maintenance) came to the TV lounge door with surveyor and V3 present. V4 said the door and alarm were non-working condition, and the alarm panel was not sensing the alarm by the mother board above the door. V4 said the alarm should sound off when the door opens and closes for the staff to be alerted. V4 said since the door was not latching and not totally closing, the alarm will not sound off. V4 said, "This door (TV lounge) was not locked for quiet sometime now, and anyone can come and go, especially those who smoke." V4 said he cannot remember when the TV lounge door/alarm was last checked to ensure its functionality. V4 said he was informed on December 31, 2024 sometime in the morning that R1 eloped from the TV lounge door. V4 said he will call V18 (Regional Head for the Maintenance) to help fix the non-functioning alarm and door. V4 said he checks the doors and alarms randomly but does not document what doors were last checked since it was done in

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random.

Observation continued by touring the facility with V3. The defective TV lounge door leads to an open courtyard and to a main street. There was a pathway in the courtyard that went steep down and then inclined. Upon walking this walkway, caution and foot brakes were needed to avoid stumbling or falling. From the pathway, there was the access to the main street. There was an intersection between main street with four lanes of traffic from north and south direction of the facility. The second door by the library room on the ground floor also leads to the courtyard and to the main street. The alarm was not sounding and was not in good repair. V1 (Administrator) came and explained the alarm by the door in the library room was not functional and said the library door was locked at nighttime around 8:00 P.M. There was no documentation/log the library door was locked every 8:00 P.M.

On December 31,2024 at 12:00 Noon, R1 was sitting in a regular chair in his room. R1 had a tracheotomy that was capped. R1 speaks with slow raspy voice. R1 was noted to be hard of hearing. During this time, V16 (R1's spouse) was at bedside. V16 said, "I was called by the staff here (R1) had left the facility without them knowing it. They said he exited by the door from the TV lounge. They told me he was found by the police and their staff across the facility's main street. I know it, that TV lounge door was always unlocked, people go in and out to smoke. That door/TV lounge was close to my husband's room. I went to the hospital at once when the staff called me around 5:20 A.M. on December 29,2024. When I went to the hospital with my daughter, and saw him (R1), he was only wearing cotton pajama, socks no shoes, no jacket and the

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weather was cold, was raining and was still dark. I asked him what happened, and he said, "I want to go home"; then when I asked him again what he was doing outside the facility he said, "I do not know." I was told he fell while he left the facility. Look at this, (V16, pointing skin injuries) he got a cut on the right eyebrow, left side of forehead, and bruises on knees and ankles. He was so impulsive, weak and does not know where to go especially when he needs to go to bathroom. Since that TV lounge door was always unlock and no alarm, he left without staff knowing it. (R1) had been saying he wanted to go home. I told him to get stronger, there was a nurse who heard this conversation, and this was like a month ago. I don't remember the name of the nurse." R1 said "I don't know" and responded he does not remember being out of the facility and was alone during the early morning of December 29, 2024. V16 assisted R1 to the bathroom with a walker device. R1's gait was observed to be unsteady. V16 said R1 was weak, and at facility for therapy. V16 said R1 is confused at times and had said his desire to go home but does not know how to get home.

On January 2, 2024 at 10:30 A.M., together with V2 (Director of Nursing), the facility's video surveillance was reviewed for the date of December 28,2024 at 11:00 P.M. going to 5:12 A.M. of December 29, 2024. The video surveillance showed R1 came out of his room at 4:05 A.M. V7 (LPN/Licensed Practical nurse) started to look for R1 at 4:53 A.M. Several staff: V8 (CNA-Certified Nurse Assistant), V10 (RN/Registered Nurse), V5 (CNA) went out the main entrance at 5:12 A.M. and all came back to the facility. V2 said, "They must have found (R1) was why they all were back to the facility and R1 was taken to the hospital by paramedics. The

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video surveillance showed no staff went inside R1's room to check from 11:00 P.M. of December 28, 2024 through 4:53 A.M. of December 29, 2024.

On December 31,2024, multiple interviews were held with the staff worked on December 28-29, 2024, from 11:00 P.M. though 7:00 A.M and assigned to R1.

On December 31, 2024, at 2:08 P.M., V6 (CNA) said she took care of R1 the evening shift (3-11 P.M.) on December 28, 2024. V6 said R1 was restless, confused, impulsive and was not aware of his safety. V6 said during the evening shift on December 28, 2024, the shift prior to R1's elopement, R1 had exhibited and repeatedly verbalized wanting to go home. V6 said R1 was cued, reoriented and was assisted to go back to bed. V6 said few moments later, R1 was verbalizing again he wanted to go home. V6 said she continued to work for the next shift which was the night shift. V6 said she was on the same unit where R1 resides, but it was V5 (CNA) who was assigned to R1. V6 said R1's room was next to the TV Lounge Room that had the defective door, and the alarm was not sounding off. V6 said, "The door by the TV lounge has been like that, not locking, no alarm sounding off and people including residents go in and out to smoke. We sit by the lounge area whenever we get a chance, but taking care of residents especially early morning was busiest time. Nobody was supervising or monitoring that unlocked, no alarm door and we do not know if any residents go out without us knowing. (R1) must have exited that door. There was no other door he can leave the facility being undetected."

V5 (CNA) said at 2:17PM on December 31, 2024,

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the TV lounge door was unlocked, without an alarm and no supervision from staff. V5 stated the TV lounge lacks supervision when staff is providing care to residents. V5 said R1 must have exited the malfunctioning door/alarm since no one had heard any alarm sounding off. V5 said R1kept saying he wanted to go home. V5 said she saw R1 at 3:30 A.M. prior to elopement.

Review of the facility's video surveillance indicated staff was not seen checking R1 from 11:00PM December 28, 2024, until he was noted missing on December 29, 2024, by V7 (LPN-Nurse) at 4:53AM. V7 said when she went out of the facility to look for R1 at around 5:12 A.M., she saw R1 standing by the sidewalk across the street from the facility. V7 stated R1 had passed by the main street. V7 said a bystander had called the police. V7 said R1 was wet, was wearing pajamas and socks, weather was cold, and it was still dark at the time R1 was found.

On December 31, 2024, at 4:20 P.M., V10 (RN/night supervisor) said she was called by V7 when R1 had eloped from the facility on December 29, 2024, early morning. V10 said R1 was found across the street from the facility. V10 said R1 was taken by the paramedics when found.

On December 31, 2024, at 1:50 P.M., V8 (CNA) said the TV lounge was not latching, and no alarm was sounding off. V8 said she did not hear alarm when R1 had eloped from facility.

On December 31, 2024 at 2:37 P.M., V11 (PT/Physical Therapist/Director of Rehabilitation) said R1 was receiving skilled therapy for deconditioning since R1 was weak. V11 said R1

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needed his walker device with staff supervision for safe ambulation. V11 said R1 is with bouts of confusion with poor safety awareness.

On January 2,2025 at 1:00 P.M., V13 (CNA), V15 (CNA) and V14 (LPN) said doors have access to outside to the facility going to street should be locked and always alarmed. They said there was no recent training to monitor the doors/alarms. V19 (CNA) said the TV lounge door has always been unlatched, was not closing properly and alarm was not sounding when the door was fully open nor when the door was closed. V19 said residents go in and out to unlock/unalarmed door to smoke.

On January 2,2025 at 12:30 P.M., V17 (R1's family member) said they thought R1 left the building through the door by the ground floor and TV room. V17 added they never heard an alarm. V17 said R1 wanted to return home but he needed to recover and was weak. V17 was upset R1 was able to exit the building and was found outside wearing only socks and pajamas. V17 stated R1 can be confused and does not know his own safety.

On January 2,2025 at 2:06 P.M., V18 (Regional head of Maintenance department) said the TV lounge door exit to the courtyard and to the main street was not in working order. V18 said the sensor board above the door was short circuited, and it does not give signal to the alarm panel. V18 said he was only informed by the V1 regarding the malfunction doors and alarms on December 31, 2024 at around 1:30 P.M. V18 explained the pathway route where R1 exited had a steep pathway sloped down to at least 20-degree angle and inclined after to another 20-degree angle.

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S9999	Continued From page 10 The care plan dated December 29,2024 showed non-specific interventions regarding supervision and monitoring of R1's elopement risk. Review of the facility's policy dated December 2007 for "Elopement" showed there were no preventative measures to prevent elopement, no process for monitoring alarm doors to prevent elopement there was no procedure identify and address assessment of residents for elopement risk. (A) Statement of Licensure Violations 2 of 2): 300.1810l) 300.1810m) 300.1810n) Section 300.1810 Resident Record Requirements l) All Cook County facilities with Colbert Class Members shall submit to the Colbert Lead Defendant Agency, or successor Colbert Lead Defendant Agency, monthly, an accurate census of all Medicaid-eligible residents, the previous month's voluntary and involuntary discharges conducted under Section 300.3300, including any voluntary and involuntary discharges scheduled to be conducted within 48 hours after the end of the reporting month. This monthly census must be submitted on the form prescribed by the Colbert Lead Defendant Agency using secure (encrypted) email, no later than the fifth business day of each month.	S9999		

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m) All Cook County facilities with Colbert Class Members shall provide educational materials and information to all Colbert Class Members voluntarily or involuntarily discharging from the facility at the time of completing the discharge paperwork, informing them of their rights and services under the Colbert Consent Decree, as prescribed by the Colbert Lead Defendant Agency. All Cook County facilities shall provide written verification of educational materials and information given to the Colbert Class Members, as requested by a Colbert Defendant Agency.

n) All Cook County facilities shall notify any agency providing transition services to a Colbert Class Member of such Class Member ' s discharge at least 48 hours prior to the discharge taking place.

This REQUIREMENT was not met as evidenced by:

Based on interview and record review, the facility failed to report and submit required data of Colbert Consent Decree Dementia Reviews for Medicaid eligible residents residing in the facility. This applies to 2 of 4 residents (R4 and R9) reviewed for Colbert William Decree.

The findings include:

On December 31,2024 at 2:45 P.M., V1 (Administrator) said that the facility was cited regarding Colbert William Decree last October 22,2024. V1 said she tried to comply by reaching out directions but to no avail. V1 added that she had reached out to Envision to teach a class but to no luck. V1 said she had received email from IDPH on November 22, 2024 that facility has 2 missing residents that were not reported as

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S9999	Continued From page 12 required by the decree. However, V1 said she was not provided the names of these 2 residents. V1said that the last time request was made for residents' information was December 31, 2024, which were all information for 3 residents, were entered into the system. V1 added that she has questions to fulfill the requirements, but there was no no assistance. V1 said that R4, R6, and R8's required information was submitted but were denied. During the interview with V1, V1 placed a call to V27 (Director of Admissions). V27 said she tried to follow the requirements but the task requires ample time and directions and that she needed help to be in complaiance. Review of the datasheet website for Colbert Decree showed that facility did not comply with required submission of information for 2 residents (R4 and R9). (C)	S9999		