Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001895	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW MANOR	3311 S. MICHIGAN AVE. CHICAGO, IL 60616

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S 000	Initial Comments Facility Reported Incident of 9/09/19, IL115677	S 000		
S9999	Final Observations Statement of Licensure Violations. 300.610 a) 300.1210 d)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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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that each resident receives adequate supervision and assistance to prevent accidents.

Based on observation, record review, and interview the facility failed to monitor and supervise a cognitively impaired resident by not screening residents who were leaving the facility for an outside activity and failed to ensure each resident returned to the facility after an outside activity.

As a result, a cognitively impaired resident (R3) with a known behavior of wandering exited out of the facility on 9/9/19. R3's whereabouts was unknown by the facility staff for 24 hours putting the resident at risk for possible harm. R3 was found on 9/11/19 by local police.

This deficient practice has the potential to affect 10 of 10 residents (R7-R16) who were identified as elopement risk.

Findings include:

The Face Sheet documents R3 is a 69 year old admitted to the facility on 11/04/10 with the diagnosis of the following (but not limited to): Major Depressive Disorder, Anxiety Disorder, Schizophrenia, and Schizoaffective Disorder. R3's Minimum Data Set (MDS) dated 6/12/19 documents that R3 has (mild) cognitive impairment. R3's Elopement Care plan dated 6/12/19 documents R3 is an elopement risk with current history of exit seeking behaviors. R3 has left her family while on pass. Interventions include assess for potential elopement/unauthorized departure risk, engage R3 in programs, provide clear directions as needed, give choices, set limits, redirect and engage R3 in discussion and

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conversation, and provide rounds/hourly room checks per facility protocol to monitor R3 to assist in minimizing chance of unauthorized leave.

The Community Survival Skill Assessment dated 6/12/19 documents R3 requires supervision while out in the community and is not a candidate for independent pass privileges. The Elopement Risk Review dated 6/12/19 documents R3 is at risk for elopement.

Progress Note dated 7/26/19 documents R3 pushed the window screen out of window in the dining area, staff immediately intervened, and R3 was placed on 1:1. Progress Note dated 9/09/19 documents staff did not see R3 upon doing their meal time rounds. Staff immediately searched the floor. Facility did a community search and R3 was not found.

9/13/19 incident report documents, R3 was reported missing from the facility around lunch time on 9/09/19. Facility initiated elopement policy, notified the police, notified family, and started investigation. R3 was located the next day about 5 blocks from the facility. R3 was returned to the facility by local police. Upon returning to the facility, the nurse did head to toe assessment and R3 denied pain. MD was notified and gave order to send to local hospital for medical and psychiatric evaluation. R3 returned to the facility on 9/11/19 and placed on 1:1 for close observation. Report documents R3 stated she left with activity on a fresh air walk and she left to go to the park. Report documents Conclusion: R3 may have sneaked out with the group of residents going out on a fresh air walk and she walked away from the group.

R3's Hospital Medical Record dated 9/10/19

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documents History of Present Illness: Patient had absconded from the nursing home where she resides for 24 hours. Patient reports having slept outside overnight. Chief Complaint: Patient was sent over with ambulance because she was gone from the nursing home for more than 24 hours.

On 9/11/19 at 10:48 AM, R3 stated she left the facility with the group and ran away from the group outing. R3 stated the group walked from this facility to 35th street. She stated that she ran away from the group. She went to the park on her own. She stated that she was not able to get back to facility from where she was. The local police found her at a bus stop and brought her back to the facility. R3 stated that she went to the local hospital and came back. R3 stated she is happy to be back. She doesn't plan on leaving the facility anymore. She is currently on 1:1 at the time of this interview.

On 9/11/19 at 10:00 AM, V9 (Activity aide) stated she made the group list which contained 16 residents (R3 was not included). List was made when residents were lining up to go out. Activity aide stated she keeps the resident list and keeps it for filing. Activity aide stated that she doesn't give list to the desk. Activity aide denies seeing R3 in this group.

On 9/11/19 at 10:02 AM, V10 (Activity aide) stated that she did not ask R3 to participate in the group. Activity aide denies seeing R3 lining up to be in this group. Activity aide stated she invited the residents on the floor activity aide is assigned to. Activity aide stated that she will make a list of residents when they line up for the group, keep a list for herself and will present another list to the front desk (receptionist and safety coordinator). Activity aide stated that she did not make the list

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for this outing.

On 9/11/19 at 12:41 PM, V12 (Safety Coordinator) was aware of the nature walk group. V12 stated she saw R3 lingering around that nature walk group, and that she had also observed R3 in the past participate in the nature walks. V12 stated that she saw R3 go out with nature walk group on 9/09/19, however, she did not observe the nature walk group return to the building. V12 stated she did not receive a list of residents that were present for the nature walk, and that the Activity Aides were responsible for writing down residents and tracking residents participating in the nature walk.

On 9/11/19 at 12:16 PM, V13 (Receptionist) stated she saw R3 lingering with the group that was going out on nature walk. Receptionist stated that she did not receive a list of residents going out on nature walk. Receptionist stated that she has seen R3 go out on nature walk in the past because it is supervised by staff.

On 9/11/19 at 10:04 AM, V1 (Administrator) stated (prior to the incident) the facility is monitoring elopement risk residents by hourly safety checks. The Safety Coordinator and Psychiatric Rehabilitative Service Aides (PRSAS) are responsible for filling out the safety checks. R3 verified last safety check documented was on the patio smoking at 11:00 AM. While rounding on the 2nd floor around 2:00 PM, V1 stated he was informed that staff could not locate R3. V1 instructed the receptionist call a code green for R3. The staff initiated a room to room search of the entire building. V1 stated R3 likes to go to other floors to socialize. Because R3 was not located within the building, V1 instructed staff to search the local vicinity. Police were notified, and

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missing person report was filed. R3's family, MD (medical doctor), and state agency were notified. The facility began its initial investigation. V1 interviewed staff and created a time line. On 9/10/19 at 5:00 PM, V1 learned R3 was found by local police department and brought back to the facility. The police called the facility stating R3 was found at local bus top near local university and they were bringing her back to the facility. Once R3 arrived, nursing staff did head to toe assessment, notified MD and family, and R3 was sent to local hospital for evaluation. R3 returned to the facility after hospital evaluation.

On 9/10/19 at 12:27 PM, V6 (Psychiatric Rehabilitative Service Coordinator/PRSC) stated she arrives at facility around 10:00 AM. PRSC stated she did not see R3 at all on 9/09/19. Staff told PRSC that R3 was noted missing around 11:40 AM. PRSC assisted staff in finding R3. Facility did room to room search on all 6 floors and resident was not found. R3 has a behavior which she hides throughout the facility. R3 is very social with peers and family who resides at the facility. No other residents or staff was aware of R3's whereabouts. R3 is on moderate supervision. R3 is allowed to leave the floor by elevator. Resident is on the elopement sheet and has hourly checks.

On 9/11/19 at 12:38 PM, V4 (Psychiatric Rehabilitative Service Director/PRSD) stated R3 is alert and oriented x 2-3. R3 is able to make her needs known. R3 is an elopement risk and is not appropriate for independent pass privileges. R3 has history of elopement. R3 requires supervision and is monitored every hour. R3 is allowed to go on nature walk pass because staff member is going with the residents.

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On 9/10/19 at 12:15 PM, V14 (Licensed Practical Nurse/LPN) stated she first saw R3 on 9/09/19 around 7:30 AM during initial nursing rounds. R3 was getting dressed at that time. LPN saw R3 during breakfast meal in the dining room around 8:00 AM. R3 received her 9:00 AM medications as scheduled. R3 came to LPN asking for her nutritional supplement that was provided around 11:00 AM. V14 stated R3 was not noticed during the 11:40 AM lunch meal time. Staff started looking for R3 around 11:40 AM. LPN went from floor to floor to search for resident so she can eat lunch. LPN stated R3 did not come down for her smoke break after lunch. The facility initiated a head count. R3 was not found. LPN stated that she never saw R3 with exit seeking behavior nor had R3 has ever discussed any plans to leave the facility under V14's care. R3 is known to hide throughout the facility (behind a door and under a bed). R3 has a behavior of hiding. Resident does not use personal electronic monitoring. R3 did not give LPN any reason to believe that she would be leaving that day.

On 9/10/19 at 12:04 PM, V15 (Certified Nurse Aide/CNA) stated she was assigned to R3 on 9/09/19. CNA first saw R3 on the initial CNA rounding. CNA served R3 her breakfast in the 2nd floor dining room. R3 went down to smoke around 9:00 AM while CNA was giving resident care. CNA did not see R3 report for lunch. CNA informed nurse that she did not see R3 report to lunch during lunch service. The facility searched the floor and the entire building. Resident was not found. R3 never told CNA that she wanted to leave or has any plan to leave. CNA has not seen R3 with any exit seeking behavior or attempts to leave.

On 9/10/10 at 12:00 PM, Surveyor asked for

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S9999	Continued From page 7 Outside Activity Protocol and PRSD and Activities Director stated there was no protocol. On 9/12/19 at 9:45 AM, V1 (Administrator) stated the facility did a head to toe assessment for R3 and sent out to local hospital for evaluation. R3 remains on 1:1 supervision with CNA. She was reassessed for elopement risk and care plan is updated. R3 will be on 1:1 for 72 hours. R3 is not allowed for group outings however, she can go out with family or with 1:1 staff supervision. V1 stated when going out on nature walk group, the activity aides must be accountable for the residents. The activity aides should present the resident list to the security coordinator upon leaving and returning the facility. The security coordinator must verify that all residents are present when leaving and returning. All resident with elopement risk will be reassessed for any intent of leaving the facility. V1 will provide staff education on supervision and monitoring of residents in general. V1 created an activity tracking sheet for outside activities. The receptionist and security coordinator are responsible for signing resident in/out. (B)	S9999		