STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S 000	Initial Comments Complaint Investigation 2195821/IL137023 2195734/IL136918	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 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 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.	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 1 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: 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. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to monitor and supervise three residents (R1, R11, and R12) that were at high risk for elopement for four residents reviewed for elopement in a total sample of sixteen. This failure resulted in R12 eloping from the facility during smoke break on 5/31/21 and was found deceased on 6/8/21. Findings Include: R12 R12's diagnosis: type 1 diabetes mellitus with hyperglycemia, patient's noncompliance with medication regimen, and bipolar episode with psychotic features. R12 was admitted to the facility on 5/26/21. The Admission Hospital Records dated 5/5/21 documents R12 is an elopement risk due to R12 attempting to run away from the hospital on this day. The Discharge Records document R12 has type one diabetes with poor compliance with insulin. R12 needs a more structured setting for	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 2 managing the diabetes. A Nursing note dated 5/31/21 documents R12 fled facility on foot, wearing all white, including a white baseball cap. Code was enacted, and staff search the area to no avail. Non-emergency police were informed as well as R12's guardian. The Police Report dated 6/8/21 documents police assisted in a wellness check of R12 when R12's family member could not get an answer at the door of R12's apartment. When the police officer entered the apartment, R12 was noted on a mattress and deceased. R12's body was stiff and had what appeared to be dry brown vomit coming out of R12's mouth. The Police Report dated 6/11/21 documents officers were at the morgue on 6/10/21 during an autopsy in a death investigation for R12. R12's blood sugar was tested and was 1500 (normal blood sugar range is 60-100 mg/dL). The doctor performing the autopsy told the office that R12 had lethal levels of blood glucose and vitreous glucose. Vitreous glucose means the glucose level is greater than 200 mg/dL. Because glucose levels decline rapidly after death, a postmortem vitreous glucose level greater than 200 mg/dL is indicative of diabetes mellitus, diabetic ketoacidosis (a serious complication of diabetes that causes a build-up of acids in the blood when blood sugar levels are too high), or nonketotic hyperosmolar coma (coma resulting in person with a very high blood glucose level). On 8/17/21 at 12:07PM, V7 (Nurse) stated, "That day (R12) was talking on the phone with his mom and yelling. I heard him say he wanted to go home. (R12) seemed to calm down. I didn't hear anything else from him. Then I heard he left out the gate during smoke break. I didn't think he was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 3 an elopement risk. If they have a prior elopement, then that makes them an elopement risk automatically. I was never told anything about him eloping." On 8/17/21 at 3:55PM, V3 (DON) stated, "I was called and told (R12) left during smoke break. They told me (R12) left out the gate. The nurses go over the admission paperwork and then myself and the admissions department will go over it again the next day. I don't remember him having an elopement history." On 8/18/21 at 10:35AM, V14 (family member) stated, "I was called around 4PM that day and was told by the nurse that he eloped. He had called me an hour or two before on his cell phone. I was concerned when I was talking to him because he was starting to yell and argue over little things with me again. I called the place back to talk to the nurse to tell them I thought he might need a high level of care because of how he was acting when I was on the phone with him, but I never got answer. It was later they called to tell me he left, and they tried to look for him, but they couldn't find him. He called me a couple days later saying he had made it to Chicago near 95th by the train and was taking the train home. I know he was staying at a Dunking Donuts and they would give him all the day old donuts and juice. Without insulin, I'm sure that was not good for his diabetes at all. We are in Carbondale. He told me he was going to stay with a friend for a while, but he wouldn't tell me exactly where. I tried telling him to come home because he needed his insulin. He would get upset when I would mention it and kept telling me he could do it on his own. I just kept encouraging him to at least go to the pharmacy and get his insulin. I heard from him a couple days later and he said he broke into his	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 4 old apartment and had his insulin. This was on Saturday (June 5, 2021). He asked us to bring him somethings and we did and left it there for him. The next day we got a text from him saying he was feeling good and had a sore throat. We told him to go to the hospital because all the clinics were closed. We didn't hear from him that day and thought he went or must have felt better. We called again on Monday to see how he was and had no answer on his phone. My husband called again on Tuesday and it went straight to voicemail, so we knew something was wrong. My husband went over there and knocked on the door, but he did answer. He called the police and go the landlord to come open the door. When they went into his apartment, he was deceased. We had to send his body to the coroner for testing and the coroner called me to tell me the final report was still pending but R12's blood sugar was 1500. When the police searched his house, he did have insulin and the supplies in the fridge, but I don't know if he took any of it like he was supposed to. I called and spoke with a nurse a day after he was admitted and told them he tried to escape from the hospital, and he needed to be watched closely. I told the staff he was a high elopement risk and he still got out." On 8/18/21 at 11:13AM, V15 (PRSC) stated, "We are supposed to do an L formation outside. All the staff members get in the shape of an L so we can see all sides. I don't remember him being an elopement risk. We have a binder of people that are elopement risks that we update when there is an elopement. I don't know how often it is updated. No, we don't take this outside with us." On 8/18/21 at 12:52PM, V16 (Mental Health Technician) stated, "When a resident is an elopement risk, you have them sit near you or	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 5 away from the gate. I don't remember this resident but if he got out, he probably just opened the gate. The gates aren't locked and when it's two staff members trying to watch thirty or more people things can happen. I don't think there is a certain formation we can make to watch. You just pick a spot where you can see as many people as possible." On 8/19/21 at 11:58AM, V17 (Primary Physician) stated, "If you don't take your insulin, you can go in diabetic ketoacidosis because your sugars will be so high. It is not a good thing to do. If it is left untreated, you will go into a diabetic coma and can die." On 8/20/21 at 11:10AM, V19 (Psychiatrist) stated, "We get residents all the time that attempt to elope. Some are successful in eloping and others just talk about leaving all the time. Then there are residents who don't show behaviors initially then start to show signs after a few days. If someone was an elopement risk, I would expect an extra person be with that resident if they are outside the building." The Elopement/Unauthorized Leave Risk review dated 5/26/21 documents R12 is not at risk for to elope at this time and placement on the Elopement Risk Protocol is not indicated. The question on the form "Is there a prior history of wandering/elopement and/or does the resident verbalize a strong desire to leave?" is documented as "no". The Community Survival Skills Assessment dated 5/29/21 documents R12 does not appear capable of unsupervised outside pass privileges as this time. Per facility policy and due to COVID, R12 is not eligible for independent pass privileges at this	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 6 time. The Elopement/ Unauthorized Leave Risk review dated 5/31/21 documents R12 is at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. The Care Plan dated 5/31/21 documents R12 is an elopement risk/wanderer related to exit seeking, history of attempts to leave the facility unattended, impaired safety awareness, and R12 wanders aimlessly. R12 has type 1 diabetes mellitus and is insulin dependent. The Minimum Date Set (MDS) Section E dated 5/31/21 documents R12 does have a behavior of experiencing delusions. R1 R1's diagnosis: schizophrenia, bipolar disorder and chronic viral hepatitis C. R1 admitted to the facility on 7/30/21. The Admission Hospital Records dated 7/14/21 document R1 was hospitalized for safety and stabilization after escaping from nursing home multiple times. Intake reports document R1 was found in the cellar of a house after being heard talking to self. A Social Service Note dated 7/30/21 documents per the hospital records, R1 escaped from the previous facility several times and will be placed on elopement risk protocol. A Social Service note dated 8/7/21 documents R1 was previously at another facility and left unauthorized from there six times in eight months. A Nursing note dated 8/9/21 documents R1 left	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 7 the facility unauthorized during smoke break and was brought back in by staff. 72-hour behavior monitoring initiated. A Social Service note dated 8/11/21 documents R1 left unauthorized during smoke break and was picked up by staff down the street. R1 requested to go to the hospital and reported will attempt to leave again in not sent. R1 continues to be on elopement risk protocol. During the smoke break on 8/16/21 at 1:15PM, 67 residents were outside with four staff members, on 8/17/21 at the 3:15PM, 54 residents were outside with five staff members, and on 8/18/21 at 11:15AM, 71 residents were outside with four staff members. R1 sat on a bench or on the ground each smoke break. Staff was not within close proximity of R1 for the entirety of the smoke break. There was no closer monitoring noted for elopement risk residents. On 8/17/21 at 11:24AM, V5 (PRSC) stated, "She eloped from the previous facility and the police brought her to the hospital. Her family had her transferred here because they were concerned about her escaping the other facility so many times. She walked out the gate both times. When I did her assessment, I put her at high risk. We tell the staff verbally when there is a new admission that is a high risk. There is also a list at the nurse's station and in the offices. I don't know how often that is updated. The staff should be passing on in report who is high risk if they are new." On 8/17/21 at 2:05PM, V10 (Nurse) stated, "I was her nurse the first time she left. I don't think she was on the elopement list then. I wasn't told she was a high risk. I didn't know she left the other	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 8 facility that many times." On 8/17/21 at 2:54PM, V11 (CNA) stated, "She just walked out the gate that I know. That was her second time leaving. I was standing by the gates by the basketball gates, so I didn't see her leave. At that time, she was an elopement risk so whoever was on that side should have been watching her." On 8/17/21 at 3:07PM, V12 (Activity Aide) stated, "This time she just walked out the gate. It isn't locked and she jumped over the other fence. I was passing out cigarettes and saw her leave. There was one or two other people out there I think but I can't remember. No one was standing by that side she left one. I don't know of any list of elopement risk. I just know who to watch for and if people are looking suspicious you watch them. I have another resident that I trust stand over by the gate now. I couldn't watch everyone and pass out the cigarettes at the same time." On 8/17/21 at 3:20PM, V18 (Mental Health Technician) stated, "I was outside, and I was standing over by the area where I can see both sides. This was on the East side. I didn't see her leave. I just saw her bag going over the fence. The girl (V11) said she opened the gate and then jumped the other fence. I ran through the building and left outside through the West side doors and caught up to her. We just get report from the shift before us on who to watch. I think I was told to watch her. It was my first day alone so I was watching everyone, and she must have just left when I was watching someone else." On 8/17/21 at 3:55PM, V3 (DON) stated, "She made attempts to leave on both sides. The West side area was closed down and all residents go to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 9 the East side now so staff can watch them all in one area. We have elopement risk list at each nurse's station. She is an elopement risk now. Signs of elopement are pacing, checking the doors, voicing they want to leave, and attempts of leaving the facility without staff being aware. She wasn't on the list when she was first admitted. She was put on after the first elopement. I believe her family called admissions to let them know she eloped from the previous facility. The elopement risk list is updated quarterly or when there is a new elopement." The Elopement/ Unauthorized Leave Risk review dated 7/30/21, 8/9/21, and 8/11/21 document R1 is at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. The Care Plan dated 7/30/21 documents R1 is an elopement risk related to history of elopement at previous facility. On 8/9/21 and 8/11/21, R1 left the facility unauthorized during smoke break. The Community Survival Skills Assessment dated 7/31/21 documents R1 does not appear capable of unsupervised outside pass privileges as this time. R1 is not appropriate for outside pass privileges based on reported history of socially inappropriate behavior and unauthorized leave from other nursing home. The MDS Section E dated 8/10/21 documents R1 does have a behavior of experiencing delusions. R11 R11's diagnosis: schizoaffective disorder, psychotic disorder, and type 2 diabetes. R11 admitted to the facility on 2/17/21.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 10 A Code Pink was called at approximately 2:43PM on 8/20/21 in the central wing. R11 was accompanied by staff returning to the building around 2:45PM. It was reported R11 exited the facility during an activity. V20 (Activity Aide) was running a music activity and had about twelve residents inside and seven or eight residents outside. R11 opened the gate and left. The video was replayed by V2 (Assistant Administrator). The video showed R11 open the gate and walk on the path to the west side of the building. Staff found R11 about three minutes after R11 exited the gate. R11 was brought back to R11's room. R11 was agitated at this time and refused to talk with surveyor. On 8/20/21 at 3:05PM, V20 stated, "I was doing an activity by myself. I had about 12 residents inside and maybe seven or eight outside. I kept going back-and-forth from inside to outside to keep checking on everyone. I was inside and one resident came in and tapped me on the shoulder and told me R11 left out the gate. I called the code pink and asked for the other residents to come inside. R11 was found on the employee smoke patio and R11 had walked over to the west side door. No, she's not an elopement risk we were doing a music therapy where I play music and I just kind of let the residents do whatever they want. Some play basketball and some play cards and others just sit there and listen to the music. I don't take more than 20 residents for an activity by myself. Normally I have a mental health tech with me but I know some of them are training today and their schedules are a little different because we just hired a bunch of new people, so it was just me today doing the activity." A Social Service Note dated 6/10/21 documents	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 11 R11 tried leaving the facility on the west pavilion. R11 escorted back into the building. R11 reported trying to leave due to breakfast being late. Staff reminded R11 breakfast was at 8AM and it was now 9:30AM. A Nursing note dated 6/23/21 documents R11 left the building and was found sitting just out the building. R11 agitated and cursing at staff. R11 is threatening to leave again. A Nursing note dated 8/20/21 document R11 exhibited an unauthorized exit and was immediately brought back into the building. R11 placed on behavior monitoring for 72 hours. The Elopement/Unauthorized Leave Risk Review dated 6/15/21 documents R11 is at risk and should be placed on the Elopement Risk Protocol. The Elopement/Unauthorized Leave Risk Review dated 8/20/21 documents R11 is at risk and should be placed on the Elopement Risk Protocol. The Elopement Risk List 2021 dated 8/10/21 does not list R11 as an elopement risk on this day. The policy titled, "Elopement Risk Assessment," documents, "2. Risk factors that will be assessed include the following: a. Independent ambulation with or without assistance, b. Pre-admission or history of elopement, c. Purposeful exit seeking, d. Restless, aimless pacing, e. Verbalization of wanting to leave the facility and/or go home, f. Grabbing doorknob or pushing on exit door, g. A cognitive impaired individual who is a follower, h. Inability to differentiate safe from unsafe	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008064	A. BUILDING: _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CHICAGO HEIGHTS	490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411

(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
S9999	Continued From page 12 situations, i. Diagnosis of Alzheimer's, Dementia, Schizophrenia, Brain Injury, j. Inability or refusal to follow instructions. 3. Should an elopement risk be determined; interventions will be immediately initiated to protect the resident in a reasonable manner and as approved by the physician 4. The physician and family/sponsor will be notified of the resident assessment findings, and suggested interventions to protect the resident. 6. The Social Service Department will notify Facility Staff and initiate interventions necessary to protect the resident. Interventions include, however, are not limited to the following: a. Relocation to a secure unit, b. Bed alarm and/or chair alarm, c. Use sign in/sign out record, d. Psychological consult, e. Personal alarm arm or ankle bracelet, f. 15 minute to one-hour observations, one-to-one observation, h. Behavior management programs. "A"	S9999		