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	IL6006605	A. BUILDING: _____ B. WING _____	C 02/01/2021

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S 000	Initial Comments Facility Reported Investigation (FRI) Incident of 1/9/2021, IL/130064	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)2)3) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	S9999		

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met evidenced by: Based on interview, and record review, the facility failed to monitor, and prevent a resident with a history of elopement from leaving the facility unwitnessed, and without supervision. R1 could not be found in the facility. This failure applies to 1 of 4 residents (R1) reviewed for supervision in the sample of 4. The findings include: R1 was admitted on 4/1/2020 with diagnoses including schizoaffective disorder bipolar type, anxiety disorder, major vascular neurocognitive disorder with behavioral disturbance, dementia, hypertension and GERD (Gastroesophageal Reflux Disease), according to the medical records. The MDS (Minimum Data Set) dated 11/5/2020 showed a BIMS (Brief Interview for Mental Status) score of 3 (severe cognitive impairment). V12's (Psychologist) psychological evaluation dated 6/9/2020 shows R1 has a history of multiple elopement attempts from prior facilities where he resided. R1's neurocognitive test results dated 6/9/2020 show, "his neurocognitive	S9999		

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impairments suggest he requires 24-hour supervision in order to ensure his safety, and security." "2. Thus, he does not appear to have the capacity to go into the community independently without supervision, or escorted accompaniment. "Out on Pass" privileges for this resident are not recommended." "5....He does not appear capable of making reasonable and well thought out decisions that are within his best interest."

V15's (Psychiatrist) progress notes dated 12/25/2020 show R1 was seen via telehealth. On 1/21/2021 at 8:18 AM, V15 stated R1 needed 24-hour supervision and whatever it takes to keep R1 safe.

The facility's final incident report sent to the state survey agency dated 1/9/2021, showed R1 was missing from the facility on 1/4/2021 at approximately 7:00 PM.

Police Summary Case Report dated 1/5/2021 shows that on 1/5/2021 (day after R1 eloped), at 10:00 AM, V1 (Administrator) reported R1 as missing to the local police since 1/4/2021 but was found at the nearby local hospital. The report also shows V11 (Police Officer) called the hospital and spoke to the charge nurse for the Emergency Room. The nurse told V11 (Police Officer) R1 was "walking along I-88 and was brought into the ER by a passerby around 0930 hrs (9:30 AM) on 01/04/21." The Nurse stated R1 was "admitted to the hospital for having an altered mental status as well as other symptoms regarding being cold."

According to the Weather Underground Website (wunderground.com), the temperature in North Aurora, IL on 01/04/2021 from 6:07 AM - 10:09 AM was 25 degrees Fahrenheit.

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On 01/14/2021 at 1:55 PM, V11 (Police Officer) stated he did not go to the hospital to see R1 but was informed that R1 was found walking along I-88 but had no information on the exact location. (I-88 is an interstate highway which is approximately 3 miles from the facility).

On 01/12/2021 at 1:25 PM, V2 (Registered Nurse/RN) stated that on 01/04/2021, he was the nurse assigned to R1 during the morning shift (7:00 AM- 3:30 PM). V2 stated he was passing medications from approximately 7:00 AM - 9:00 AM and did not see R1 throughout the medication (med) pass. V2 stated R1 would normally be in his room or walking in the hallways. V2 stated he did not look for R1 after he finished administering the other residents' medications. V2 was asked if he looked for R1 to give his scheduled 12:00 PM medication, V2 stated he did not look for, nor see R1 throughout his shift. V2 stated he did not give R1 any of his scheduled medications during his shift. V2 stated it was a busy shift and he completely forgot about R1. V2 stated he left the facility at 2:00 PM on 01/04/2021. V2 stated that at approximately 8:00 PM on 01/04/2021, V7 (Nurse) who was working the evening shift called him to ask if he knew R1's whereabouts. V2 stated it was only at this time that he realized he had not seen R1 all day.

On 01/12/2021 at 4:00 PM, V7 (Nurse) stated he worked the evening shift on 01/04/2021 and was assigned to care for R1. V7 stated he arrived at 3:00 PM and made rounds. He did not see R1 at that time. V7 stated he began passing medications at 4:00 PM and was unable to find R1 at that time. V7 stated when he finished giving medications to the other residents, he looked for R1. V7 stated when he could not find R1 in the

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facility, he alerted all the other nurses, and CNAs (Certified Nursing Assistant) in the other hallways at approximately 6:30 PM. Everyone searched for R1 but was unable to find him. V7 stated he called V1 (Administrator) at that time to notify her that R1 was missing. V7 stated V1 instructed him to drive around the neighborhood to search. V7 stated he drove around the neighborhood for about 10-15 minutes and returned to the facility, unable to find R1. V7 called and reported back to V1 that he was unable to find R1. V7 stated V1 (Administrator) and V8 (Social Service Director) arrived at the facility and took over locating R1. V7 stated he also called V2 (Nurse), who worked the morning shift on 01/04/2021 to ask what happened to R1 and V2 did not know.

On 01/12/2021 at 2:30 PM on a telephone interview, V4 (Certified Nursing Assistant/CNA) stated she was employed by an agency and worked on 01/04/2021 at the facility during the morning shift. V4 stated she started at 6:00 AM and was assigned to care for R1. V4 stated she began the shift by getting the dependent residents to the dining room for breakfast and at some point, she saw R1 speed walking towards her in the middle hallway. V4 was unable to provide the specific time when she last saw R1. V4 stated R1 eats his breakfast in his room and usually, goes back to sleep afterwards. V4 stated she was busy providing care to the other residents that she was not aware that R1 was missing. V4 was asked how often she made rounds. V4 was unable to give a specific frequency but stated that she walks through the hallways often.

On 01/12/2021 at 2:00 PM, V17 (CNA) stated she would see R1 walking in hallways 2 and 3. V17 stated R1 needed prompting to keep his mask on

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and when it's time to eat. V17 stated there was no required frequency when to do rounds.

On 01/19/2021 at 10:25 AM, V1 (Administrator) stated there was no facility policy and procedure on making rounds. V1 stated due to the psychiatric diagnoses of residents, they would become suspicious if staff would make rounds consistently. V1 stated V2 (RN) should have caught sooner that R1 was not in the facility. V1 stated that on 01/04/2021 at night, it was V8 (Social Service Director) who called and discovered that R1 was admitted to the hospital.

On 01/12/2021 at 2:10 PM, V3 (PRSD/Psychiatric Rehabilitation Services Director) stated R1 had been restless prior to elopement due to dementia, which was worsening. V3 further stated she saw behavior in R1 she had not seen before related to dementia.

On 01/12/2021 at 3:00 PM, V6 (PRSC/Psychiatric Rehabilitation Services Counselor) stated R1 has the diagnosis of dementia and has a history of elopement. V6 stated they are looking at guardianship for R1 due to cognitive decline. As an example, she used to be able to instruct R1 to go to his room and put on his shoes and he was able to follow direction. Currently, if instructed the same, R1 would wear other residents' shoes. V6 said she asked R1 how he left the facility on 01/04/2021, R1 was only able to point at the different colored tiles in the hallway and did not say anything regarding the elopement. V6 further stated a care plan for elopement should also be initiated.

According to R1's nurses' progress notes dated 04/09/2020, R1 was up all night trying to exit the building and stated he wanted to leave. R1 was

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S9999	Continued From page 7 able to be redirected. On 01/13/2021 at 10:20 AM, V8 (Social Service Director) presented a handwritten, undated, unsigned care plan on elopement. V8 stated he added "history of elopement" in the handwritten elopement care plan on 01/04/2021 but was unable to provide the original care plan to determine if an elopement care plan was initiated. V8 stated he assessed R1 at the hospital along with V6 (PRSC) prior to the original admission on 04/01/2020. V8 stated there was no documentation of this evaluation in R1's medical records. V8 stated that during hospitalization just prior to admission to the facility on 04/01/2020, R1 got out of the hospital unit where he was admitted and went to another unit. V8 stated R1 at that time, walked in the room hunched at a 45 degree angle, mobility was poor, unable to walk more than a few feet and was unable to stand erect. V8 stated he did not think R1 would be an elopement risk. V8 stated R1 was very pleasant towards him. R1 was quiet, isolative and calm with certain residents and staff. R1 walked up and down the hallways more as he became acclimated to the facility. V8 stated R1 has a history of trying to open an exit door at least a couple of times (not sure which door) and was redirectable. V8 stated that when he was informed on the night of 01/04/2021 that R1 was missing, he made a phone call to the nearest local hospital at approximately 7:45 PM and found out that R1 had been admitted at that hospital. V8 stated that on 01/04/2021, he went to the facility afterwards and was at the facility from 8:00 PM until midnight. V8 stated he and V1 (Administrator) reviewed the videotape recorded on 01/04/2021 from 5:30 AM - 10:30 AM. V8 stated the camera did not capture R1 walking out due to coverage outage and inconsistent video.	S9999		

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S9999	Continued From page 8 On 01/13/2021 at 12:50 PM, the videos was reviewed in V1's (Administrator) office. V1 stated she went back to the facility on 01/04/2021 before 10:00 PM after being notified that R1 was missing. V1 stated she reviewed the videos with V8 (Social Service Director) starting on 01/03/2021. V1 stated she last saw R1 in the facility on 01/03/2021 during the evening shift. Taping from 01/04/2021 at 6:20 AM was reviewed, which showed staff throwing out garbage. There were many missing frames and difficult to find exhibits. The pictures were blurry, choppy and not labeled to be able to determine areas that were monitored. V1 stated the system was old and would wipe off the previous days' sequence. V1 stated the time stamped was an hour early because of the time change. V1 stated they were not able to identify from the videos how R1 left the facility. On 01/21/2021 at 10:20 AM, V16 (Nurse) stated she worked on 01/03/2021 during the night shift and the last time she saw R1 was before breakfast on 01/04/2021 at 7:30 AM. V16 stated he was wearing sweatpants and a dark long sleeve top. On 01/13/2021 at 1:25 PM, V9 (Business Office Manager) stated, generally, since her office was closest to the front door, she was the one who answers when the front doorbell rings. V14 (Transportation Driver) who shares office with her will also answer the doorbell. V9 stated a code is needed to go out of the front door. V9 stated she received a text message from V1 (Administrator) on 01/04/2021 at approximately 10:00 PM to call back. V9 stated she did not see the message until the following morning on 01/05/2021 at 5:45 AM. V9 stated she has no observation of how R1	S9999		

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S9999	Continued From page 9 left the facility. The Emergency Department Physician Report documentation showed R1 was examined on 01/04/2021 at "09:51" (9:51 AM). R1 was brought in by EMS (Emergency Medical Service) after being found wandering outside. When asked why he was wandering outside and where he was going, R1 stated, "I don't know." R1 reported he lived with his sister. The physician's impressions were altered mental status, elevated troponin, hypoglycemia, anemia, and leukocytosis. The hypoglycemia was treated with dextrose. Documentation showed R1 "requires intensive medical treatment, as an inpatient, to prevent further deterioration of condition, as there is an increase risk of morbidity/mortality associated with the patient's medical condition." The physician recommended admission to telemetry. The Nurses' Progress Notes dated 01//06/2021 at 13:55 (1:55 PM) showed R1 was re-admitted to the facility. R1 was alert and oriented x 1-2. "A"	S9999		