STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014658	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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 2117821/IL139475	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 300.1210 c) 300.3210o) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3210 General o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to supervise a resident with active exit seeking behavior that was assessed as a high risk for elopement. R1 was observed leaving the facility grounds by the Administrator on 10/21/21. This applies to 1 of 6 residents (R1) reviewed for safety and supervision in the sample of 7. These failures resulted in R1 eloping from the facility for approximately 8 hours without the facility knowing her location. R1 was located approximately 5 miles from the facility by a staff member driving in her car. R1 was returned to the facility by staff. R1 was found cold, hungry, scared, with mud on her pants, a scrape to her knee, and reported she had fallen. Findings include:	S9999		

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On 10/23/21 at 8:34 AM, R1 ambulated into the facility conference room, accompanied by V19 (Certified Nursing Assistant - CNA). V19 was present for the entire length of this interview. R1 was fully dressed, wearing a light grey jacket. R1 was asked how she was feeling, and she replied, "So, so; I miss my parents and son." R1 reported that her parents lived on [specific road in current city]. R1 said "I was in another facility behind the hospital before I left. I left because I wanted to be with my parents (interviews established that R1's parents have been deceased for over 10 years)." R1 stated, "I walked right out the front door; nobody knew. It's a long walk to [the road mentioned above]. I got tired. My parents must have sold the house. I sat on a big bench, my dad made, in the yard of my old house for a while. Then I went to [named a local bar] (bar has been closed approximately 10 years) and had a couple of drinks. Then I went back to the house to get some stuff I needed. My parents weren't home. I got in after that (R1 would not divulge how she gained access to the home)." R1 was asked how she returned to the facility and she stuck up her thumb and stated, "Hitchhiked." R1 stated, "I talked to my Mom on the phone. They haven't exactly sold the house, but they put it on the market. I can't handle all this sh**. Mom took me to the hospital with the check. My head ain't on right. I have trouble thinking (R1 holding her head in her hands)." R1's speech was slow, her affect was flat, she frequently looked at the ground, and her hands, and she repeatedly put her head in her hands during this interview.

On 10/23/21 at 8:31 AM, V1 (Administrator) said he reviewed the video from 10/21/21 (the day R1 left the facility unsupervised). At 9:32 AM, V1 said he was unable to pull up the video after 24 hours.

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S9999	Continued From page 3 V1 said R1 left the facility AMA (Against Medical Advice) on 10/21/21 and was gone approximately 7 hours. V1 said R1 walked right out the front door but refused to sign AMA paperwork. V1 said V18 (RN/Restorative & Wound Manager) saw R1 on [the same road identified by R1]. V1 had no evidence of an initiated AMA form for R1 showing R1 refused to sign. R1's Face Sheet dated 10/27/21 showed diagnoses to include obstructive hydrocephalus, hypoxic ischemic encephalopathy, chronic obstructive pulmonary disease (COPD), heart attack, stroke, cerebellar stroke syndrome, idiopathic scoliosis, bipolar disorder, major depressive disorder, general anxiety disorder, and adverse effects of cocaine, benzodiazepines, and amphetamines. R1's quarterly facility assessment dated 9/16/21 showed R1 had moderate cognitive impairment. R1's Care Plan initiated 6/9/21 showed, "[R1] has impaired cognitive function r/t (related to) medications. Cognition may fluctuate at times ... The resident may show confusion or difficulty remembering things. Give simple instructions and break up tasks into smaller ones. Reorient the resident and give reminders when needed. Reassure the resident if they become anxious. Help the resident get to and participate in enjoyable and social activities. Report a new or worsening confusion to the nurse." R1's Electronic Medical Record did not contain an admission social history assessment or community safety skills assessment. R1's Health Status Note dated 6/9/21 at 11:03 PM, showed, "Resident continues to wander, not	S9999		

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S9999	Continued From page 4 able to follow directions, continued to enter other resident rooms. Resident is not steady while walking but not able to follow direction to use walker ..." R1's IDT Review note dated 6/29/21 at 10:51 AM, showed, "Care plan held with brother/POA via phone ... She has no other place to go ..." R1's Social Services Progress Note dated 9/12/21 at 9:04 AM, showed, "[R1] remains alert and oriented with forgetfulness noted ... She was living at home prior to admission and is unable to return there. Plan is to remain in ltc (long-term care) ..." R1's Health Status Note dated 9/24/21 at 6:39 PM, showed, "Resident observed with increased confusion, wandering throughout the facility, no elopement attempts at this time ..." R1's Psychiatric Nurse Practitioner (NP) Provider Note dated 10/5/21 at 9:19 PM, showed, " ... She is distressed about issues with children. Reports poor sleep. Able to carry on conversation, speech slow, some words not clear, very tangential ... Staff reports some wandering and ambulating unassisted. NP (Nurse Practitioner) entered patient room and [R1] has belongings packed and she said she was ready for discharge, was being discharged later in the day. NP asked her plans, she stated she would be living with her grandmother as her mother was sick with a stroke. Spoke with Social Services and these statements were not true. Patient had been hanging near the doors and was considered a flight risk ... Displays of inappropriate behavior; belongings packed, sitting by door, elopement risk ... Patient reports feeling: anxious to go home ... Insight: limited ... GDR (Gradual Dose Reduction) not recommended due to long	S9999		

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S9999	Continued From page 5 standing mania r/t (related to) bipolar dx (diagnosis) and continues to have behaviors including wandering, aggression and psychosis with delusions and decrease in dose may exacerbate delusions, depression, or anxiety, increasing the distress for the patient ..." The facility did not perform an Elopement Risk Assessment after these concerns were noted by the nurses and the psychiatric NP. The facility did not implement interventions to prevent elopement and did not have an updated Elopement Risk Assessment or Elopement Risk Care Plan initiated until 10/22/21 (the day after she eloped for 8 hours.) R1's Provider Note dated 10/20/21 at 2:39 PM (late entry, entered on 10/21/21 at 3:10 PM by V13 [Primary Nurse Practitioner -NP] - while resident was missing from facility) showed, "Reports several days now that she is leaving. She has packed her belongings every day. She has been asking for cigarettes despite not having smoked since her arrival ..." R1's Provider Note dated 10/20/21 at 4:21 PM, by V16 (Psychiatric NP), showed, "She reports good support system at home with her mother currently taking care of her minor children (mother is deceased) ... Feels as though she is competent to return home at this time. She is distressed about issues with the children ... Staff reports some wandering and ambulating unassisted, possible exit seeking. Patient had been hanging near the doors and considered a flight risk. This NP spoke with the patient again about waiting until she was ready to care for herself before she would be discharged and the importance of getting clearance for discharge before leaving, the importance of not leaving unattended, no	S9999		

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S9999	Continued From page 6 elopement. Patient said she understood ... Spoke with her about planning and not eloping, she said she understood. Increased lurasidone (antipsychotic medication) previous visit ... Displays of inappropriate behavior: belongings packed, sitting by door, elopement risk ... Patient reports feeling: anxious to go home ..." R1's Electronic Medical Record (EMR) did not contain a progress note with information regarding R1 leaving the facility, unsupervised, as of 10/27/21 at 11:28 AM. R1's EMR did not contain any AMA discharge paperwork. R1's EMR did not have any information scanned into the miscellaneous tab regarding R1's unsupervised departure from the facility. R1's Provider Note dated 10/20/21 at 4:21 PM was the last documented assessment of R1. R1's physician orders showed no order for R1 to have unsupervised passes off grounds. No discharge planning notes were documented. R1's Health Status Note dated 10/21/21 at 4:09 PM showed, "Resident placed a call to the Administrator requesting to come back to the facility. Resident will be admitted back to the facility." R1's Admission Summary dated 10/21/21 at 4:23 PM, showed, "[R1] was admitted to [her same room] ... The resident was ambulatory upon arrival to facility ...The resident displayed behaviors of agitation and/or anxiety. Resident has history of elopement or exit seeking behavior ..." (After R1 had left the facility grounds the same day.) R1's Provider Note dated 10/21/21 at 4:30 PM, showed, "The resident was examined in her room after readmission ... Constitution: No acute distress, but appears tired and fatigued ... Skin:	S9999		

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Cool, and dry, without rash. Minor abrasion to right knee without open area or bleeding. She had mud to the same pant leg that corresponds with her reporting a fall while walking ..."

R1's (Psychiatric) Provider Note dated 10/22/21 at 10:05 AM, showed, "Patient new symptom recent impulse control issues. Reports of patient wandering, seeking tobacco, packing belongings, talking about returning to the community to live with mother or grandmother ... However, counseled patient on recovery necessary to be able to care for herself before discharge. [R1] continues to suffer cognition deficits. Patient alert to self, place, but not situation, time, date. [R1] is unable to provide a reason why she is at the facility (situation), confabulates several different scenarios for arrival and being cared for. [R1] cannot tell the date, time. Visit last week patient stated Obama was president. Patient physical recovering, ability to ambulate unassisted, has led patient to believe she can leave the facility .... Patient claimed mother was there to visit earlier in the day, mother was not. Patient suffering delusions. Will add midday quetiapine (antipsychotic medication) for impulse control issues and delusions ..."

R1's Health Status Note dated 10/22/21 at 10:11 AM, showed, "Care plan held with brother, HCPOA (Health Care Power of Attorney) and family friend. Discussed new order for Seroquel 100 mg, titrate q (every) 2 days by 25 mg until taking Seroquel 200 mg at noon. Total 600 mg daily. Medication is for impulse control and bipolar disorder. Discussed referral to a psychiatric lock down unit as well. Brother would like to try the medication first. Brother stated he has not been in close contact with his sister for a long time. Also, that she used street drugs and ETOH (alcohol) all

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S9999	Continued From page 8 her life and was a 'runner' ..." On 10/23/21 at 9:46 AM, V7 (Unit Manager) said she is the unit manager for Long-term Care and R1 resides in her department. V7 said she was working 10/21/21 and was involved in the Code Green. V7 said the facility completed a complete head count, but R1 was gone. V7 said that R1 had told her that her family lived on [specific road]. V7 said she interviewed R4 (R1's roommate) and she reported that R1 had been up all-night packing. V7 said all the managers went out in their cars and "scoured the city." V7 stated, "It was cold and rainy that day." V7 said R1 was gone from around 8 AM to 4 PM. V7 said when R1 returned to the facility, she was tired and looked exhausted. V7 said she was not aware of R1 making statements that she wanted to leave. On 10/23/21 at 10:20 AM, R4 (R1's roommate) said she knew R1 left, but she doesn't know what time. R4 said she usually wakes up around 8:00 AM and when she woke up, R1 was gone. R4 said R1 told her she was going home a couple days before she left. R4 said R1 packed all her stuff up the night before she left. On 10/26/21 at 10:00 AM, V11 (Licensed Practical Nurse - LPN) said she started working at the facility on 10/13/21. V11 said on 10/21/21 she was R1's nurse, and that was her first time working R1's hall assignment. V11 said she was not familiar with R1. V11 said she saw R1 in bed when she made her first rounds at approximately 6:45 - 7 AM. V11 stated, "I seen her walking down the hall around 7:45 - 8 AM. I thought she was going to breakfast. Later one of the CNAs came up to me and asked where R1 was. I told them the last time I saw her, I thought she was heading to the dining room. They told me that she was not	S9999		

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in the dining room." V11 said she is unsure what time, but a Code Green was called, and everyone started doing head counts and looking for R1. V11 stated, "I had never talked to R1 before," and said she was unaware if someone spoke to R1 before she left the building, unsupervised. V11 stated, "No one told me she was an elopement risk." V11 said there are green binders on each unit and by the front desk containing information about residents that are at risk for elopement.

On 10/26/21 at 10:23 AM, V12 (LPN) said she had worked at the facility since 9/1/21 and was usually assigned to the long-term care area (where R1's room is located). V12 stated, "I thought I saw her around 8:15 AM, at the nurses' station." V12 said she was working when R1 returned to the facility. V12 said she would not say that R1 is alert and oriented, but she is able to make her needs known. V12 said she wasn't aware R1 wanted to leave the facility. V12 said R1 is confused at times. V12 stated, "I personally do not think she should be allowed to leave AMA. I've had quite a few conversations with her that don't make sense. She thought she was 25 and her Mom was 52, but her mother has to be in her 70s, at least, and I think she's (R1) the same age as me."

On 10/26/21 at 8:15 AM, V9 (Agency CNA) stated, "I know all about what happened that day. At 10:41 AM, V9 said she had worked at the facility off and on since July 2021 and usually worked in the Long-term Care area. V9 stated, "Thursday around 7:50 - 7:55 AM, [R1] came to the station and wanted to use the phone. She was already frustrated and cussing. I walked away. Later I was looking for her in the dining room and she wasn't there. I reported to V17 (CNA), she was the CNA that had her. V17 (CNA)

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told V3 (Assistant Director of Nursing - ADON). We started looking right away. We went all over the building and grounds. V9 said a meeting was called with her and she was asked what R1 wanted at the nurses' station because they saw it on the video. V9 stated, "I heard they called it an AMA. How can they do that when we looked for her all day?" V9 said she left at 2:30 PM and R1 had not returned yet. V9 stated, "One of the nurses found her by [same road previously identified by R1] and brought her back." V9 said R1 had gotten out of the building before, on the previous Sunday and was supposed to be on 15-minute checks. V9 said the facility never notified R1's brother/POA. V9 stated, "Her brother came in to visit (the day she left) and the same nurse that found her (V18), told him that she (R1) was missing. They never called him." V9 said R1 was very confused.

On 10/26/21 at 11:21 AM, V13 (Primary Nurse Practitioner (NP) said, "she works for the facility and is in the building, every day except Wednesdays. (The Late Entry Progress Note was dated 10/20/21, a Wednesday)." V13 said she was not in the building on 10/20/21. V13 said the last physical assessment she had completed on R1 was the week prior to 10/21/21. V13 said R1 was alert and oriented and could make her own decisions. V13 said she became aware that R1 was gone between 8:45 - 9 AM. V13 stated, "While we were looking, someone was reviewing the video from the hallway. Once we determined she left the building, I found out what she was wearing. I went in my car to the neighborhood behind the building. I think five cars went out. I was in my car from 9:15 AM - 2:30 PM." V13 said she was here when R1 returned, around 4:30 PM, and she did a physical assessment. V9 stated, "She said she was cold and scared. She

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told me she fell a couple times, on uneven ground. She had mud on her pants and a little scrape on her right knee. She was cold and hungry. It was drizzling out that day. She told me she wanted to talk to her Mom and Dad." V13 said she was not aware that R1's parents were deceased. V13 stated, "[R1] had not been discharged from the facility because of impulsivity due to long-term drug use and issues with her brain from the stroke. I felt it wasn't safe for her to be alone," and arrangements hadn't been made. V13 stated, "I wouldn't trust her to maintain her medication schedule, with the Bipolar and stroke, her brain doesn't quite work the way it should. My concern (on 10/21/21) was that she didn't have her medications when she left."

On 10/26/21 at 12:15 PM, V14 (Receptionist) said she arrived to work on 10/21/21 at approximately 7:55 AM. V14 said once the front doors are opened for the day, the alarm will not go off if someone walks out the front door. V14 stated, "[V1 - Administrator] was standing there with R1 and I thought he was handling the situation. No one told me she was an elopement risk." V14 said the purpose of the Green Binder is to notify staff of residents at risk for elopement. V14 said the book contains a picture of residents at risk for elopement and some information about them. V14 said she's not sure if V1 talked to R1 because she was focused on her phone call but saw them together in her peripheral vision. V14 said she saw R1 walk out the front door. V14 said after R1 left, "It was chaos." V14 said R1's brother came to visit 10/21/21, but she wasn't sure what time. V14 stated, "When she came back, she was tired and upset her parents weren't at the house."

On 10/26/21 at 12:33 PM, V16 (Psychiatric NP)

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said she started at the facility three months ago and the facility has had three administration changes, so she communicates directly with V4 (Social Services Director). V16 said R1's physical function was improving and "mentally she was more clear than I've ever seen her." V16 said R1 didn't have a lot of family. V16 stated, "Three weeks before this (leaving facility unsupervised 10/21/21), she had her stuff in a bag." V16 stated, "(R1 is) Alert and oriented. She doesn't know the date and time. She is able to make her needs known. Sometimes her thoughts are off, and it can be difficult to follow her story." On 10/29/21 at 4:06 PM, this surveyor reviewed R1's 10/5/21 Psychiatric Provider Note with V16. V16 stated, "I had a conversation with [R1] about her mom and her son being bullied that sounded very lucid. I went to talk to [V4 (Social Services Director)] about it and found out that R1 was delusional, and her parents were dead." V16 said V13 (Primary Nurse Practitioner) was aware I talked with social services and that R1 was delusional because her parents were dead. V16 stated, "[R1] was alert and oriented, but she absolutely was NOT able to make her own decisions." V16 said the facility was aware R1 was packed and planning to leave those two weeks, then she eloped.

On 10/26/21 at 12:58 PM, V17 (CNA) said she was R1's CNA on 10/21/21. V17 said she was taking care of R4 (R1's roommate), when R1 asked her to use the phone. V17 said she told R1 to ask the nurse. V17 stated, "I continued to provide care to her roommate. Later I was checking on everyone in the dining room, that's when I noticed she (R1) wasn't there. I started asking around. They called a Code Green (Elopement) and we looked everywhere."

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S9999	Continued From page 13 On 10/26/21 at 1:30 PM, V4 (Social Service Director) said R1 has had at least one care plan. V4 stated, "I believe it was on the telephone with him (R1's brother/POA). She wants to return to the community. I talked to her brother and he wants her more stabilized. It didn't sound like being with him was an option (for discharge). Her parents are no longer alive." V4 was asked if R1 could discharge to the community alone. V4 replied, "Right now I would recommend someone being with her. Someone to help with medication management and emotional support." V4 said R1 has good and bad days. V4 said Code Green is a resident Elopement Alert. V4 said the facility doesn't typically call a Code Green when a resident leaves AMA. V4 said before R1 left the building on 10/21/21, she hadn't started any discharge planning. V4 stated, "Usually a resident will call a ride and we know they're leaving. This was a little different. She basically just walked out the door." On 10/29/21 at 2:53 PM, V4 stated, "Typically I go in to see residents and an initial Social Services Assessment would be done on admission. I don't see one in her (R1's) chart. The purpose of an admission social services assessment is to find out the discharge plans and to find out more about them (the resident). I found out her parents died the week her brother came. I think it was like a week ago (V4 couldn't recall a date)." This surveyor reviewed R1's 10/5/21 Psychiatric Provider Note with V4. V4 stated, "I don't think she (V16 - Psychiatric NP) talked to me about it. I can see why it would be confusing that she (R1 was alert and oriented). She varies day to day. Her brother reported (R1's) parents died 16 years ago." On 10/26/21 at 2:15 PM, V18 (RN/Restorative and Wound Manager) said stated, "We were concerned about the weather. It was rainy and	S9999		

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cold. I brought her back. I knew her parents used to live around here. She was walking up [road previously identified by R1, approximately 5 miles from the facility], by the golf course. She was walking back (toward the facility). I rolled down the window and asked if she was OK. I asked if she needed a ride back. She said, 'its cold out.' I called administration to let them know I saw her and asked if she could come back. I think she was just done with the place. I don't think she anticipated the weather that day."

On 10/26/21 at 2:28 PM, V2 (DON) stated, "We learn from these situations. I did not see R1 before she left (on 10/21/21). [V1 - Administrator] talked to her that morning (V1 said V2 determined R1 was alert and oriented prior to her leaving the facility the morning of 10/21/21, but V2 said she did not see her that morning). She left without her medications. The managers were out looking for her most of the day. [V18 - RN] found her, she called me, and asked if (R1) could come back. From what [V18] was telling me, she had a visual (of R1) and she was walking in the direction of the facility. The brother was here to visit that day, while I was gone. [V18 - RN] notified him then. He didn't know she was gone before he came to visit. I told them to notify the brother. I told [V18] because she was the one left in the building. She was not an elopement risk before this, but she is now. I found out that she had been packing her belongings, after she was gone. I was not aware." V2 said when someone leaves AMA, the facility generally would not look for them. V2 stated, "She didn't have her medications. To me it was an unsafe discharge, and I didn't want her outside in that weather. She's on a lot of psychiatric medications."

On 10/27/21 at 9:48 AM V18 said she did not call

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R1's brother. "Nobody asked me to call him. Her brother came to visit between 10 - 11 AM. I had contact with him then. He didn't know she was gone. He asked if he could look for her. I told him yes, it's his sister. I assume he didn't know because he came to visit. I told him she left, I did not use the words AMA or elopement. I just found out her parents were dead that day. She had talked about her Mom to me before and asked to call her. I would not consider someone alert and oriented that was trying to talk to deceased parents or trying to visit them. She had a phone number, we would call it, and it would ring. I don't think anyone asked if they were alive before this."

On 10/27/21 at 10:07 AM, V3 (ADON) said he did not talk to R1 the morning of 10/21/21. V3 said he was told they couldn't locate R1. V3 said head counts were immediately initiated and he searched the perimeter of the property. V3 said he was not aware of R1 wandering around the building before she left on 10/21/21. This surveyor asked V3, if a resident was considered alert and oriented if they are trying to call and visit their parents that have been dead for over 10 years. V3 replied, "Alert and delusional. If my family member was doing that, then I would not want that to happen to them (allowed to leave AMA), but they have their rights." V3 said the road in front of the facility is busy and anyone could get hit by a car if they are walking down the side of the road. V3 said R1's POA/Responsible Party should have been notified as soon as possible. V3 stated, "Because it's the right thing to do." V3 said the brother/POA may have been able to provide some place for us to look for R1.

On 10/27/21 at 10:49 AM, V1 (Administrator) said he watched R1 walk out the front door. V1 stated, "She wouldn't stop, just kept walking. I walked to

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the front doors, but she's alert and oriented, so I didn't precede to chase her down. V1 said the managers had a meeting and discussed R1's medications and diagnoses. V1 said V2 (DON) said we should look for R1 because she needs her medications. V1 said he called the police department around 10 AM. V1 said he reported to the police that R1 had left the facility AMA and he was concerned about her medications. V1 said he requested a welfare check at her old apartment. This surveyor asked V1 why the facility was looking for R1 all day if she left AMA. V1 replied, "Medications are very important for schizoaffective. I said that to the police." V1 said he did not complete an AMA form with R1. V1 stated, "Usually we try to explain risks/benefits, but she wasn't having it. That opportunity didn't happen. She wasn't having it. She knew what she was doing." V1 said R1's brother did come to visit on 10/21/21, but he is not sure what time. V1 said V18 (RN) talked to R1's brother/POA when he arrived at the facility. This surveyor reviewed R1's EMR with V1 at 11:28 AM. This surveyor requested to see documentation that R1 left the facility AMA. V1 said he did not complete an AMA form and he did not enter a progress note. V1 replied, "I don't know why nursing didn't do a progress note. They should have." V1 said he could document in the progress notes and should have entered a progress note. V1 said discharge documentation should be completed and an AMA should be documented. R1's last progress note was dated 10/20/21 at 2:39 PM, the first progress note on 10/21/21 (the day R1 eloped) was at 4:09 PM. V1 said there was not an AMA form in R1's record at this time. V1 said he did not attempt to complete the form when R1 left the building. V1 was asked how R1's mental capacity was determined on 10/21/21. V1 stated, "I determined she knew what she was doing because she went

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to her parents' home and wanted to see her kids." (R1's parents are deceased for over 10 years). V1 said during the IDT meeting, V2 (DON) or V3 (ADON) said "they" knew she was leaving. V1 was unable to clarify who "they" was exactly (V2 and V3 during interview both said they did not see R1 the morning she eloped until after she returned to the facility). V1 said he watched the surveillance video. V1 stated, "I watched her walk out the front door. I couldn't see her down the hallways. I didn't look to see if V2 (DON) or V3 (ADON) talked to her." V1 said she (R1) talked to V9 (CNA). V1 said CNAs cannot perform assessments and are not qualified to determine decisional making capacity. V1 said he did not notify R1's brother/POA that R1 left the building but did have contact with him when he heard there was a post on social media. V1 said that R1 had left the building before, but he couldn't recall when. This surveyor asked if R1's Elopement Risk Assessment was updated, after she left the building previously. V1 said he did not know. This surveyor showed V1, the Provider Note dated 10/5/21 at 9:19 PM, by V16 (Psychiatric NP), that showed "belongings packed and sitting by door ... elopement risk." V1 replied, "This should be communicated to my staff." V1 said he was not aware of this. V1 told this surveyor repeatedly that R1 was going to visit her kids at her parents' home. V1 said he was not aware that R1's parents were deceased.

On 10/27/21 at 4:04 PM, this surveyor drove from the location where R1 was found to the facility. R1 was found near an intersection with a traffic light, on the [specific road R1 named], (which was approximately 5 miles from the facility via the most direct route). R1 stated she walked and hitchhiked to get around. R1 would have crossed several busy roads and/or intersections in her

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S9999	Continued From page 18 walk from the facility to the location she was found. A railroad crossing is present along this route, as well as a large industrial park, with limited sidewalks and increased semi-truck traffic. The www.timeanddate.com/weather/usa/rockford/historical website showed the weather on 10/21/21 was 46 - 52 degrees Fahrenheit with drizzle and fog from 6 AM - 12 PM. This site showed on 10/21/21 from 12 PM - 6 PM the weather was overcast with temperatures ranging from 52 - 54 degrees Fahrenheit. R1 left the facility at approximately 8:13 AM and returned at approximately 4:30 PM. The facility's Standards and Guidelines: SG Resident Elopement (revised 3/27/21) showed, " ... the definition of resident elopement will be as follows: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e. an order for discharge or leave of absence) and/or any necessary supervision to do so ... Procedure: ..3. Time and location where the member was last seen will be established, to include whom they were with, as well as appearance (i.e. clothing). 4. A coordinated search of the unit will be conducted and other units will also be notified and properly searched. Search teams will cover entire units (bathrooms, closets, etc.) as well as all other areas of the facility (lobby, dining rooms, offices). 5. A search of the facility grounds and surrounding area will also be conducted if the resident has not been found within the facility. 6. If resident cannot be located after the facility search, including grounds, then Law Enforcement will be notified. Additionally, the physician and the resident representative (as recorded on admission face-sheet) will be notified also ..."	S9999		

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S9999	Continued From page 19 The facility's Standards and Guidelines: SG Transfer and Discharge (revised 3/21/21) showed, "It is the standard of this facility to provide appropriate transfer and discharge services, documentation that will be included in the medical record, and who is responsible for making the documentation ... Definitions: ... "Resident-initiated transfer or discharge": Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include general expressions of a desire to return home or the elopement of residents with cognitive impairment) ... AMA Discharges: 1. An attempt should be made to ascertain the reason for the resident's desire to leave Against Medical Advice or without a physician's order. 2. If possible, staff should offer alternatives to satisfy the client or rectify concerns. 3. If resident or resident representative still insistent on leaving without the physician's order/AMA, the physician should be notified of discharge from the facility. 4. Staff should attempt to have the resident sign the appropriate paperwork stating that they are leaving AMA. If the resident refuses to sign AMA paperwork, the staff should denote this in the clinical record. 5. If the facility staff feel AMA discharge places the resident in harm, the proper authorities, such as the police and APS/DCR should be notified ..." (B)	S9999		