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
	IL6005375	A. BUILDING: _____ B. WING _____	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LIEBERMAN	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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 Probationary License/Change of Ownership: Warren Barr Lieberman is NOT in compliance with the Skilled Nursing and Intermediate Care Facilities Code (77 Illinois Administrative Code 300) for this Survey.	S 000		
S9999	Final Observations Probationary License/Change of Ownership: STATEMENT OF LICENSURE FINDINGS: 1/2 300.1210b) 300.1210d)6) 300.1220b)3) 300.1220b)8) Section 300.1210b) 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. Section 300.1210d)6) 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:	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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. Section 300.1220b)3) Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.1220b)8) Supervision of Nursing Services 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.	S9999		

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S9999	Continued From page 2 These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor and prevent a confused resident with known exit-seeking behaviors from exiting and wandering out of the facility. The facility also failed to implement the interventions they set in place to keep the resident safe due to elopement risk. This failure affected one (R1) of four residents reviewed for supervision and resulted in R1 being able to elope from the facility on two separate occasions, one of which he was found on a high traffic road, main road. Findings include: R1 is a 74 year old with diagnoses listed in part (but not limited to): aphasia, adjustment disorder with disturbance of conduct, symptoms/signs involving cognitive function and awareness, and gait and mobility abnormalities. Initial care plan dated 10/12/2021 reads in part (but not limited to): "(R1) presents with risk for elopement. He is disoriented to place, has impaired safety awareness and has been observed wandering aimlessly. Hospital note confirms poor insight, judgement and lack of self/safety awareness. At one point he told staff "I want to get out of here. I want to run." 10/17/21: (R1) demonstrated agitation over the weekend and was focused on leaving; does not recognize self-care and cognitive deficits; has (tracking bracelet alarm) in place; staff to monitor. 10/23/21: (R1) demonstrated agitation over the weekend and was focused on leaving; walked into the elevator and refused to step out of the elevator despite encouragement from staff; (R1) started pushing staff. 911 was called.	S9999		

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10/12/21 Goal: (R1) will remain meaningfully engaged and will not try to leave the unit and will not injure or harm self.
Interventions: Apply personal safety alarm and /or tracking placement alarm per physician's order. Check for proper functioning as recommended. Post a picture of (R1) at the desk near the elevator and one at the facility main desk. Alert staff to his wandering and elopement potential."

R1's 10/13/21 elopement risk evaluation created by V4 (Social Service Director) determined that R1 was at risk for elopement with interventions for a personal safety alarm device and for frequent monitoring.

A second elopement risk evaluation created on 10/16/21 by V4 again showed that R1 was at risk for elopement and concluded that "Resident is at risk for elopement at this time. (Tracking placement alarm) was placed on resident's ankle. Resident's picture was placed in the elopement binder located at the front desk with his name and room number. Frequent monitoring is in place. Staff will continue to assess resident for elopement risk."

On 11/29/21 at 2:20 PM, V3 (director of nurses) stated, "It was on a Saturday (October 16) and he (R1) was a patient on the 3rd floor. I received a call from the facility that (R1) was missing and I don't live too far from the building so I was driving around looking for (R1) and the nurses in the building were looking for him throughout the building. There were 4 other nurses that went outside to search for him too. After driving around for half an hour, (R1) was found on (named main road) sitting by building parking lot (quarter mile away). I drove him back to the facility and (R1) should have been on the 5th floor dementia unit

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but I can't answer why he wasn't placed there to begin with because the admissions department and administration put (R1) there. I think there was a possible problem with the alarm. The receptionist (V5) recognized the alarm but I don't know why it didn't ring. I know we inserviced him about the elopement policy."

12/6/21 at 1:55 PM V5 (Receptionist) stated, "I know there were a couple of alarms going off that day. I didn't know (R1) had escaped. I knew only after I was told he did. I also wasn't told that the door shouldn't be propped open because I usually see it propped open and no one told me it needed to be closed. I don't know what kind of alarm goes off and there are different noises so I don't know that there are differences in the alarms." Surveyor asked about the training he received before or after the incident occurred, V5 stated, "I only work part time on the weekends. I just got a lecture on the subject of elopements but I can't say I was given any demonstration or provided any subject material."

An internal incident report for R1 completed by V2 (executive director) and provided to surveyor on 11/29/21 reads in part (but not limited to): "On Saturday, October 16th around 11:08 AM, the nurse supervisor placed a call to the director of nursing reporting the resident could not be found on the unit. The nurse noticed at the time resident was missing and was last observed by the elevator at 10:30 AM. All staff on that unit were aware this resident was an elopement risk. The receptionist was notified the resident was missing at this time. The receptionist heard the alarm and notified maintenance immediately who verified the alarm was sounding due to a resident with a wanderguard triggered it. Immediately a team was conducting a head count, while another was

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searching outside for the resident. The director of nurses and another nurse located the resident down the road from the facility near road. Resident was redirected to get in assigned nurses car/ The resident stated he left in an attempt to return to his home. Resident did agree to go back to the facility and was safely returned to the 5th floor unit. Root Cause Analysis: The resident was placed on the 3rd floor unit instead of the 5th floor unit. The 5th floor unit is the unit where the tracking placement alarming unit can be found, in addition to the 1st floor exit doors. The 5th floor unit prevents elopement risk residents from exiting the unit, thus, the resident should have been placed on this floor. Due to no tracking placement alarm on the 3rd floor unit, the resident was able to take the elevator down to the lobby and exit via the front door entrance. The door entrance was already opened when the resident got to the lobby. The alarm sounded when the resident exited. Receptionist kept the front entrance sliding door manually opened. Due to the door being manually left open, the door did not close automatically, thus disarming the tracking placement system. The alarm went off, but the sliding door was already left open, permitting the resident to exit the facility."

On 11/29/21 at 2:40 PM, surveyor asked V3 (director of nurses) whether R1 had previous attempts at leaving the facility, V3 stated, "Yes, there was a previous elopement on October 13. I think it happened in the evening and I was told he was in the parking lot by the physician parking spaces." Surveyor asked whether any alarms were triggered at this time and whether an investigation was initiated, V3 stated, "I think they were alarms because the maintenance man (V17) happened to be nearby and saw (R1) and brought him back inside the building.

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S9999	Continued From page 6 Administrator would be the one doing this investigation." On 11/29/21 at 2:45 PM, surveyor asked V2 (executive director) about the initial elopement of October 13, V2 stated, "I didn't do an incident report investigation because I didn't consider it an elopement as R1 was still considered on the premises." Surveyor asked whether (R1) left the physical building and exited the two separate bank of double doors and front doors, V2 stated, "Yes he was outside in the driveway." Surveyor asked if there was any root cause investigation on R1 having exited the facility, V2 stated, "No I did not do one." On 11/30/21 at 11:35 AM, interview with V17 (maintenance director) stated, "It was in the evening (October 13) and it was dark. I recall (R1) was fully dressed and had a jacket on. He looked very distinctive is why I knew he was a resident here. I just came off from the elevator on the first floor when I heard the alarm going off. I ran outside. (V10) was the receptionist and she told me "(R1) just went out." He was right in the front by the circle driveway. He was calm and he appeared confused. I tried to approach him but I did not touch him and I said how are you? Are you Japanese? He told me he was but he was talking nonsense. I said lets go inside and he just accompanied us back inside. It was around 7:30 PM and I brought him back to 5th floor and the 5th floor supervisor took over. I don't remember her name but she was the manager on duty. Asked which floor the resident went back to, V17 stated, I remember bringing him to 5th floor." Records show R1 was a resident of the 3rd floor and remained on the 3rd floor until a second elopement incident on October 16 when R1 was then moved to a secure unit on 5th floor.	S9999		

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S9999	Continued From page 7 On 10/16/2021 10:31 PM V14 (LPN) wrote a nursing entry that read, "Around 10:30 AM, resident was noted in the hallway sitting in front of the elevator. 11:08 Nurse supervisor notified (V3) that resident was missing in the third floor 11: 08 AM code yellow was announced by the receptionist. 11:32 Resident was found outside the facility and the resident was redirected to the facility. Resident was moved to room 537. Resident is monitored every 15 minutes and ongoing. 11:45 AM Doctor Notified, MD gave an order to send resident to the ER for evaluation. 12:15 PM Caregiver one on one put in place for safety monitoring until the ambulance came." On 10/23/2021 at 11:12 AM, A final incident note was entered by V18 (RN) that read in part, "Around 8:15 am, resident went inside the elevator activating the wander guard alarm. Elevator door remained open while resident stood inside. Resident was redirected multiple times by staff and resident son, who talked to him via phone but resident still refused to step out of the elevator. Resident started pushing the elevator buttons and jumped up and down. Elevator floor was noted being lower than the unit floor (threshold) so this writer de-activated alarm and went inside the elevator with the resident. Elevator went down to the 3rd floor and as the door open, resident ran towards the exit door. Resident pushed the door open, stepped out and attempted to barricade himself. This staff was with the resident at all times and redirecting resident. Resident started pushing and raising his hand against staff. 911 was called. Police officer arrived and talked to the resident. Resident calmed down and assisted back to his room. the incident. Dr. ordered resident to go to the hospital for psychiatric evaluation and treatment."	S9999		

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S9999	Continued From page 8 On October 23, 2021, hospital records read in part (but not limited to): "This patient was brought in by EMS from nursing home for evaluation of aggressive behavior. Patient was seen by psychiatric services secondary to exacerbation of major depressive disorder, cognitive impairment, agitation. Patient's workup continued; seen and evaluated by infectious disease and was found Enterococcal Enterobacter UTI (urinary Tract Infection) and with right lower lobe pneumonia." R1 did not return to the facility after hospitalization. (A) 2/2 300.2900d)2) 300.3100d)2) Section 300.2900d)2 General Building Requirements Section 300.3100d)2) General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe environment by failing to have functioning alarms for the safety of residents and staff. This failure affected all 179 residents present in the facility.	S9999		

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Findings include:

On 11/29/21 at 10:15 AM, V1 (Administrator) and V3 (Director of nurses) presented surveyor the facility census list showing 179 current residents in the facility.

Interview with V3 (director of nurses) at 10:50 AM stated, "We had the police come in to the building several weeks ago and normally we have 24 hour receptionists but that one night the receptionist didn't show up or call in so we didn't replace her. That same night, the police were trying to get a hold of someone in the building and I was told they were just able to walk right in and went up to the floors and they found the manager on duty which was (V7) and informed her that one of the residents called 911 because she couldn't get a nurse to come to her room."

Surveyor asked V3 for any incident report detailing the incident and was provided a the local village health department dated 11/16/21 that read in part (but not limited to): "The police department on November 15, 2021 responded to a distress call for a resident (R3). The complainant stated that the nurse on duty identified by the police as (V7) was not responding to her call for assistance. V7 (RN) informed the police that she has responded to (R3) request for assistance. Police noted that the front sliding doors were not secure and no person was on the main level to respond to the police. The officer was able to walk and proceed to the 7th floor unimpeded. The police entered into the front sliding doors without the facility's staff knowledge. A conversation was had with the director of nursing, head of mainenance, and administrator regarding securing the front door

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with the same is not being supervised. The standard for the requires that the same being supervised 24 hours a day. "

11/30/21 at 11:35AM, interview with V17 (maintenance director) stated, " It was in the evening (October 13) and that was the evening that one of the residents left the building and was at the front driveway." Surveyor asked about the incident involving the police, V17 stated, "Yes that happend on the same week and we had no receptionist and the police was able to just walk in the building. I think the police came in early in the morning I heard around 3 or 4 am." Surveyor asked about the door alarms, V17 stated, "We were working on that and the doors are now supposed to be locked and alarmed. There is a doorbell in the front where anyone can ring up to the floors or to the receptionist after hours."

On 11/30/21 at 12:00 PM, V17 showed surveyor the front entrance which appeared to have two sliding doors that were opened with a sensor, a long hallway with a manual door on the side of the hall and two more double doors in the entrance. Outside these doors was the circular driveway that lead to the main road and interior road connecting the hospital and facility. V17 stated, "There is a door bell right outside the exterior doors as I mentioned and inside is the alarm panel that can be triggered if someone from the 5th floor dementia unit comes down." Surveyor asked if there were any policies or procedures on securing the building V17 stated he (V17), would check but did not provide any during the survey.

(C)