STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000251	A. BUILDING: _____ B. WING _____	C 09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL OF NAPERVILLE, THE	200 MARTIN AVENUE NAPERVILLE, IL 60540

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S 000	Initial Comments Complaint Investigation 2277040/IL150828	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d)3) 300.1210 d)6) 300.1220 b)2) 300.1220 b)3) 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident identified as a wandering/elopement risk was provided adequate supervision and failed to develop and implement a procedure for	S9999		

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S9999	Continued From page 2 monitoring residents that leave the facility to ensure they return to the facility. This applies to 2 of 5 residents (R1, R2) reviewed for safety concerns in the sample of 8 residents. This failure resulted in R1 wandering from the facility without being witnessed by facility. R1 was found wandering in the neighboring apartment complex parking lot, and R1 crossed a moderately busy street. The findings include: 1. Face sheet shows R1 is 81 years-old, who was admitted to the facility on 5/25/22. R1 has multiple diagnoses which include cognitive communication deficit, lack of coordination, and difficulty in walking, not elsewhere classified. Minimum Data Set (MDS), dated 7/6/22, indicates R1's cognition is moderately impaired. The same MDS indicates R1 requires supervision and assistance of a staff for walking and transfer. Admission progress notes, dated May 26, 2022, documents: " (R1) was brought into facility by (V18, R1's son) in a wheelchair. Prior to admission to the facility, (R1) was found by the local police disheveled, confused, and repeating sentences. At this time, it was determined by the police that (R1) could not take care of herself. (R1) was taken to the emergency department (ED) and was admitted for acute kidney injury and mild cognitive impairment." R1's assessment for wandering behavior dated 5/24/22, with a lock date of 5/26/22, indicated R1 was at risk for wandering. Facility did not conduct initial assessment of R1 for elopement risk until she eloped on 8/30/22.	S9999		

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S9999	Continued From page 3 Progress note, dated 8/30/22, documents at approximately 8:50 PM, the facility staff received a call from an unknown caller, reporting R1 was seen walking down the block away from the facility. R1 was able to state her name to the unknown caller. The facility did not update care plan addressing R1's elopement/wandering risk behavior. On 9/2/22 at 12:59 PM, R1 was interviewed in the conference room with V4 (Nurse Manager) present during the interview. R1 stated she was out walking; she didn't talk to anyone or bother anybody. R1stated she "minded her own business." R1 continued to state when she went out walking, she didn't have any other purpose, she just wanted to take a walk. She was not aware of the time; she knew it was in the evening. R1 added she did not pay attention to the time, she just kept walking until she reached an apartment complex. R1 didn't know how to get back to the facility. R1 stated she believed she was trying to get where her children were, and she did not know how, but it was possible she had gotten lost. R1 continue to add was looking for her children, but she did not know their address. R1 added she used to live in the city with one of her children and when she wandered off, R1 didn't have thoughts of coming back to the facility. R1 continued to state she was trying to get to her children. R1 could not remember if facility had given her instructions of how far she can go from facility's ground. R1 did what she wanted to do. She wanted to be with her children. On 9/2/22 at 1:12 PM, V4 asked R1 "Do you remember me talking to you?" (Pertaining to the conversation they had, the night after R1 came back from the apartment complex) R1 replied,	S9999		

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S9999	Continued From page 4 "No." On 9/2/22 at 2:15 PM, V6 (Police Officer) stated, "A lady called from an apartment complex and the caller stated she saw (R1) wandering about in the area looking confused. She approached (R1) and asked if she needed help. (R1) was able to state her name, but she didn't know where she came from, or where she was located." V6 then stated he called the facility because he concluded R1 was a resident at the facility, since the facility was nearby. V6 stated R1 was elderly, and the apartment complex was near the nursing home. V6 added the facility was unaware R1 was missing. V6 stated he gave the facility the address of the apartment complex about 150 to 200 yards away from the facility's location. On 9/2/22 at 3:12 PM, V8 (Nurse) stated on 8/30/22 around 8 PM to 8:15 PM, she answered a call asking if the facility was missing a resident. The person who called gave R1's name and their location. V8 stated she immediately looked up R1's name in the computer, and confirmed R1 was one of their residents. V8 approached V9 (Nurse assigned to R1) "to check if (R1) was inside the building. Nobody in the facility knew that she (R1) was missing. The call happened between 8:00 PM to 8:15 PM. No one was located at the reception desk at that time." V8 was not sure how R1 got out, and concluded R1 went through the front lobby. "The person who called said they would bring (R1) back to the facility. (V8) and (V9) stood outside the facility for about 15-20 minutes and waited for (R1). When (R1) didn't come back, (V8) and (V9) went to the neighboring apartment complex. The fire department (NFD) and police department (NPD) were present on site along with a social worker." According to V8, R1 stated, "Did you guys know I	S9999		

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was gone, did you miss me? I can't be in charge of what my mind does." V8 and V9 then went and brought R1 back to the facility. V8 then notified V19, former Director of Nursing, about the incident. The staff who were assigned to R1 were asked when R1 was last seen, and the staff responded around 6:30 PM. "The residents of the facility often sit or stay in the front porch or front of the building until 8:00 PM. Usually the residents go out there after dinner for fresh air or to smoke, and the staff is supposed to ensure that everyone comes back inside before 8 PM."

On 9/2/22 at 3:40 PM, V9 (Nurse) V8 notified V9 about the call she received regarding R1. They were told they were bringing R1 back to the facility, but after a while when R1 did not come back, V8 and V9 went to the apartment complex to get R1. R1 told them she was looking for her son. R1 was alert and oriented, with some confusion. According to V9, R1 was last seen inside the facility around 6:30 PM, and outside around 7 PM. V9 stated the receptionist sits in the front lobby until 8 PM. Some of the residents will go in and out of the building. The facility lacked a specific procedure for monitoring residents leaving and returning into the building. V9 stated, "(R1) left the building at a busy time; the nurses were passing medications and staff was not aware (R1) left the building until they received the call." V9 also said, "The receptionist is the one who usually monitors the ins and outs of the residents. They have the sign out and sign in logbook at the front desk."

On 9/2/22 at 11:47 AM, V4 (Nurse Manager) stated, "(R1's) elopement happened on the 30th of August at around 8:15 PM. A staff notified (V4) about (R1) being seen in the neighboring apartment complex. (V8) and (V9) went to pick up

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S9999	Continued From page 6 (R1), and (V6, Police Officer) followed them and talked to (V4)." On 9/2/22 at 11:15 AM, V14 (Housekeeper) stated R1 walks with a walker, and uses her wheelchair for mobility. V14 is very familiar to R1, they talk every time she works in the unit where R1 resides. V14 likes to sit in the front patio like other residents, and never attempted to wander off the facility before. V14 has a good rapport with R1, but V14 noticed R1 was becoming more forgetful lately. On 9/6/22 at 3:28 PM, V13 (Agency Certified Nursing Assistant/CNA) stated, "It was the first time I (V13) worked with (R1). (R1) was fine the entire shift. She was pretty much independent; she was able to verbalize when she needed help. (R1) walks with use of walker." At around 6:35 PM on 8/30/22, V13 was checking all her residents, and changing incontinence brief of those residents who needed it. V13 saw R1 standing at the door of her bedroom, and they talked briefly. At around 8:20 PM, V13 couldn't find R1; she alerted the nurse (V9). V13 started looking for her. When V13 talked to V9 again, she was told R1 was with the police officer (V6), and they would bring her back in the facility. V13 also said some residents are not elopement risk, and they are allowed to sit in the front patio or front of the building. V13 "guessed (R1) likes to be on the front patio"; some residents expressed they had seen her in the front of the building prior to leaving the facility grounds. V13 added, "There is no sign out sheet for the residents, and the only way to find out if a resident is outside, is to go outside to the front." V13 stated the staff had no way of finding out if a resident comes back. On 9/2/22 at 2:05 PM, V15 (CNA) stated she	S9999		

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S9999	Continued From page 7 floats everywhere in the facility. V15 said she goes to the front porch to check on residents to make sure they are okay. V15 added they have no specific method to monitor resident's location. V15 also stated she is unaware of which residents are at risk for elopement. On 9/7/22 at 2:03 PM, V16 (Restorative Aide/CNA) stated she used to be a CNA for years. V16 stated when she works on the floor, she checks her resident frequently. V16 added she was unaware of a procedure for monitoring residents going outside, and she did not know if the front desk clerk did this task. On 9/2/22 at 12:50 PM, V7 (Receptionist) stated she's in the reception desk from 8 AM until 4 PM, and another person takes over from 4PM to 8PM. V7 stated, "The only sign out sheet the facility has is when family picks up a resident to go on a pass somewhere, or if a resident has an appointment outside. However, if they only go out and sit in the front patio, they don't need to sign out." At 4:36 PM, V7 (Receptionist) stated all residents can go outside, except for those residents with a (electronic monitoring device). On 9/2/22 at 10:07 AM, V31 (Maintenance Director) stated he was not aware R1 eloped/wandered off of the facility grounds. V31 stated, "The front door lobby is opened from 7:45 AM through 8:00 PM and locked at 8:00 PM. The only way to open the door is via a key code that only the supervisor knows. Residents with (electric monitoring devices) that come near the doors will activate the alarms. At 7:45 PM, the computer that controls the door, automatically locks all the exit doors. It still alarms but it does not open unless the person pushes it hard. These exit doors can't just be opened because it's	S9999		

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S9999	Continued From page 8	S9999		

heavy."

On 9/2/22 at 2:41 PM, V11 and V12 (both Nurses) stated, "It is hard to monitor residents unless they have a (electronic monitoring device). Most of the time, the nurses find out if a resident is missing when they're giving medication or treatment, and they can't find the resident. They usually check the common areas in the facility. The resident can go out to the front after dinner, but they (residents) should be in by 8PM." V11 and V12 both stated they are new to the facility, and they don't have specific policy and/or process in monitoring the residents' whereabouts. V11 said, "When a resident is missing, they check bedrooms and common areas, and do head counts before raising the alarm for elopement."

On 9/2/22 at 1:17 PM, V5 (Nurse Consultant) stated, "When the facility admits a new resident, the staff must assess them for elopement risk, their cognition and everything, every potential risk. The nurses and social service assess residents for risk behaviors."

On 9/6/22 at 12:56 PM, V17 (R3's spouse) stated they don't need to sign in and out of the facility if they are just sitting at front of the building. V17 stated she has seen staff do activities outside the building such as trivia, however, they don't sit down and monitor residents on regular basis. V17 added she has seen residents go in and out of the facility without staff monitoring.

On 9/8/22 at 12:36 PM, V26 (Director of Rehab/Occupational Therapist) stated they "worked with (R1) from 7/11/22 through 8/11/22. By the time (R1) was discharged from rehab, she needed supervision for activities of daily living (ADL) including ambulation, which means

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S9999	Continued From page 9 someone or a staff in general has a direct vision of (R1)." On 9/9/22 at 11:25 AM, V28 (Physiatrist) stated, "(R1) is alert, but her orientation ranges from 1-2. It means she can tell her name and the place, but can't tell the date and time, and situation. Her cognition fluctuates and she's not oriented times 3 or 4. (R1) requires supervision with transfer and ambulation due to decrease safety awareness." V28 stated, "(R1's) walking is not 100% stable due to her cognition, and (R1) is always going to need supervision to be able to transfer and ambulate safely." On 9/9/22 at 3:21 PM, V29 (Physician) stated, "(R1) is alert and oriented times 1-2, meaning she is alert to herself; sometimes she knows where she's at, and sometimes she does not. (V29) referred (R1) for neuropsychological evaluation to know where (R1) stands, because she's confused, she has some cognitive impairment, and a form of dementia." V29 was not sure if R1 was already seen for neuropsychological evaluation. V29 stated, "Due to (R1's)cognition, (R1) is not safe to be out by herself, and (R1) needs to be monitored by staff when she is outside." On 9/2/22 at 4:50 PM, surveyor drove to the address V6 (Police Officer) provided, where they found R1 wandering. It was 0.1 mile or 176 yards from the facility. There was a street to cross from the facility to the apartment complex with cars passing through (To go to and exit from the neighboring hospital). It was also noted on 9/2/22 and 9/7/22 during observations V7 (Receptionist) has no direct visual accessibility of the residents sitting or standing outside or in the front of the building.	S9999		

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S9999	Continued From page 10 A review of R1's progress notes indicated several episodes of confusion. On 6/16/22, progress notes showed R1 called 911 several times about being robbed of her purse. On 6/29/22, progress notes documents "(R1) alert with some confusion." Progress notes, dated 7/25/22, shows "(R1) was alert and verbally responsive with confusion per usual. (R1) is ambulatory and walks around in her bedroom by herself and during night. Noted several times, turning off control of the air mattress and deflating it. (R1) was given instructions not to mess around with the mattress control but was unable to understand and continued to deflate the mattress." R1's Physicians' (V28, V29) and Nurse Practitioners' (V27, V30) Notes from 5/27/22 through 8/10/22 shows multiple documentation entries R1 is alert and oriented x1 (to self), and a few entries of alert oriented x 1-2 (to self and to place). There were also entries R1 was pleasantly confused and forgetful. On 6/10/22, V29 (Physician) documented R1 needed to obtain neuropsychological evaluation. In addition, on 6/17/22, V29 documented R1 was noted to have continued confusion, and neuropsych has been consulted. However, the facility was unable to present documentation of neuropsychological evaluation for R1. 2. R2 is 84 years-old who has multiple medical diagnoses which include Alzheimer's disease with late onset. R2's Elopement Risk assessment, dated 1/7/2022, indicates R2 is a high risk for elopement.	S9999		

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S9999	Continued From page 11 MDS, dated 7/5/22, showed R2 is moderately impaired in cognitive skills. R2's functional status shows she requires supervision with one person/staff physical assistance while ambulating. R2's active care plan shows R2 has dementia or impaired thought processes related to Dementia, and R2 has tendency to get confused and wander into other resident's rooms. The facility is located beside a big hospital and an apartment complex. The facility also faces a busy or high traffic street where the residents of the apartment complex, other residential area, employees of other establishments, hospital staffs and visitors pass through. On September 2, 2022, from 11:23 AM through 11:30 AM, there were 6 residents including R2, observed sitting in the front porch and in the front of the building without any relatives and without staff monitoring them. On 9/2/22 at 11:30 AM, R2 was ambulating with her walker in the front porch of the building with no supervision or assistance from staff. (B)	S9999		