| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004741 | A. BUILDING: _____ B. WING _____ | C 03/21/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINE CREST HEALTH CARE | 3300 WEST 175TH STREET HAZEL CREST, IL 60429 |

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| S 000 | Initial Comments<br><br>Complaint Investigation: 2291838/IL144387 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.610c)1<br>300.1210b)<br>300.1210c)<br>300.120d)6<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>c) The written policies shall include, at a minimum the following provisions:<br><br>1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers. | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>These Requirements were not MET as evidenced by:<br><br>Based on interview and record review, the facility failed to adhere to the decisions documented by a resident's representative by allowing the resident to leave the facility with an unauthorized individual. This failure applied to one (R4) of one residents reviewed for supervision and resulted in R4 leaving the facility without authorized supervision and not returning. | S9999 | | |

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| S9999 | Continued From page 2<br><br>Findings include:<br><br>R4 is an 84 year old male who was admitted to the facility on 11/13/2021 with past medical history including, but not limited to other intervertebral disc degeneration, thoracic region, other forms of scoliosis site unspecified, Alzheimer's disease, Essential primary hypertension, weakness, unsteadiness on feet, etc.<br><br>As documented in medical record, R4 was brought to local Hospital d/t wandering outside a bank. He was evaluated by psych and determined not to have decision making capacity. The goal was to discharge him home with daughter who is the power of attorney (POA), but she was unable to be contacted and when discharged home she was not there, and he returned to hospital. Department of aging was contacted to request a state guardian. He was medically cleared and transferred to Facility on 12/16 for medical management and subacute rehab. (Physician assist progress note dated 12/28/2021).<br><br>Rehabilitation progress note dated 12/20/2021 documents the following: Resident showing signs of confusion at this time as evidenced by resident stating he wants to go home. Resident currently has a temporary case worker who explained to writer that resident is basically homeless at this time and his daughter has not contacted the hospital to inquire about resident in weeks and writer was told that resident and his daughter did not have a place to stay but were moving from hotel to hotel. Resident's daughter had POA for resident's healthcare but due to not being involved in resident's care, resident was awarded a state guardian with Office of State Guardian | S9999 | | |

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| S9999 | Continued From page 3<br>due to resident's inability to make decisions for himself and daughter's inability to provide care for resident.<br><br>Review of court papers appointing a temporary guardian for R4 states the following: the appointment of state guardianship is required because there is no individual suitable and willing to accept the guardianship appointment, removal of the alleged disabled person from any placement is prohibited pending the outcome of plenary hearing.<br><br>On 3/16/2022 at 8:44AM, V5 (State Guardian) said that he is currently the temporary POA for R4, the police are still looking for him but to his knowledge, they have not located him as of last Friday, R4 was lost, he could not find the daughter, the police were called, and they found out that the daughter was the POA, she never followed up with resident, and she was substantiated for neglect. V5 added that he spoke to the administrator and the social worker, he informed them of the court papers, and verbally told the administrator that the daughter cannot take him out and that her visitation should be restricted for now. V5 said that he submitted the court papers to the facility on January 18th.<br><br>On 3/15/2022 at 1:16PM, V1 (Administrator) said that R4 was a client placed in the facility because of allegations of financial abuse by his family, specifically his daughter. Adult protective service placed him in the facility, he was assigned a temporary state guardian, the only restriction the facility was given is that R4 cannot be relocated from the facility, the daughter was allowed to visit resident but was not supposed to take him home. The last time she visited, she told the receptionist that she was taking him to lunch, and he never | S9999 | | |

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| S9999 | Continued From page 4<br><br>returned. At 4:10PM, V1 (Administrator) said that resident's daughter has not taken him out before, he added that families are allowed to take residents out unless there is a restriction, in that case they will leave something at the front desk, R4 did not have any restrictions so no instructions were left at the front desk. V1 added that the case is out of the facility's hand, he was supposed to notify the police if he gets any information and he have not gotten any.<br><br>At 3:10PM, V4 (Receptionist) said that she was sitting at the desk when R4's daughter came in and said that she was taking him out to eat, she have not seen her in a long time but she told her that she was supposed to bring him back by 8:00PM. R4's daughter came in with a 12 pack case of pop, she went upstairs, left the pop up there and came down with two shopping bags and said she was going to do his laundry. V4 added that she had a feeling that she was not going to bring resident back but did not say anything. She asked her if she have the permission to take resident out and she said yes. V4 said that she is not aware of any restrictions on R4's daughter visiting or taking him out, usually the administrator gives family members permission and if he is not in the facility, V4 said she will give him a call, she did not call V1 on that day because she has worked in the facility for 5 years and knows pretty much who goes with who. V4 added that she did not tell the administrator when he came back to the building, did not know that resident did not come back until the following day when the administrator told her. V4 said that there is no system in place as far as residents going out with family members, she just documents it in the sheet they sign when they come in. | S9999 | | |

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| S9999 | Continued From page 5<br><br>At 12:48PM, V7 (Social worker) said that R4 is a nice old man who was confused and disoriented, he was assigned to her after he moved to the 2200 unit, she was told that they could not find the daughter and that resident has a state guardian. V7 said that when a resident is a ward of the state, staff are supposed to call the guardian for permission to do anything, she was aware that his daughter is not supposed to take him out. V7 added that the receptionist was supposed to check the book or ask somebody to do it for her, and she believe that even the administrator should talk to the guardian before giving any permission, the information should be documented somewhere, and all staff should be made aware of it.<br><br>A document presented by V1 (Administrator) titled visitation policy (undated) states in part that it is the facility permits residents to receive visitors subject to resident's wishes and the protection of the rights of other residents in the facility. Under policy interpretation the document states that the above visitation of visitors...will be subject to reasonable restriction, denying access or providing limited or supervised access such as, but not limited to...visitor has been found to be abusing, exploiting, or coercing a resident, facility has obtained a judicial restraining order against a visitor.<br><br>(A) | S9999 | | |