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
	IL6002661	A. BUILDING: ______ B. WING ______	C 07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENUES AT SPRINGFIELD	525 SO MARTIN LUTHER KING DR SPRINGFIELD, IL 62703

(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 #2244966/IL148368 Complaint #2244896/IL148272	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.695a)3) 300.695b)3) 300.695d) 300.1210b) 300.3240e) 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 300.695 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 3) Sexual abuse - sexual penetration,	S9999	Attachment A Statement of Licensure Violations	

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intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit).

b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:

3) Sexual abuse of a resident by a staff member, another resident, or a visitor;

d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c).

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.

Section 300.3240 Abuse and Neglect

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of

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the facility. (Section 3-612 of the Act)

These requirements ae not met as evidenced by:

Based on observation, interview and record review, the facility failed to prevent abuse and neglect for two of 8 residents (R1, R13) reviewed for abuse/neglect in the sample of 14. This failure resulted in the facility neglecting and allowing R1, a known alcoholic, to continually leave the facility unsupervised and gain access to alcohol which resulted in R1 sexually abusing R13. This has caused R13 to become embarrassed, uncomfortable and scared/frightened of R1.

Findings include:

1.The facility's policy, "Abuse Prevention and Reporting-Illinois" dated 12/21, documents, "Guidelines: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. If the stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired, then placement on the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each resident's individual needs and preferences rather than staff convenience, and as long as the resident, surrogate or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident needs and preferences." Per this policy, "Neglect is defined as the failure to provide goods and

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S9999	Continued From page 3 services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." The policy further documents, " Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to: unwanted intimate touching of any kind, especially of breasts or perineal area. Generally, sexual contact is nonconsensual if the resident either: appears to want the contact to occur, but lacks the cognitive ability to consent, or does not want the contact to occur. " R13's Face Sheet documents her diagnoses to include: Conversion Disorder with Seizures or Convulsions, Major Depressive Disorder, Bipolar Disorder, and Schizoaffective Disorder. R13's Minimum Data Set, MDS, dated 5/31/22 documents R13's memory is alright, and she is moderately cognitively impaired. It documents she requires extensive assist with bed mobility, transfers, dressing, and toileting. It documents her balance is unsteady and she requires staff to assist to stabilize. It also documents she requires a wheelchair for mobility and is frequently incontinent of bowel and bladder. R13's Care Plan dated 3/25/22 documents "Resident is at medium risk for abuse/neglect as noted from Abuse screening r/t (related to) mental illness. Interventions include: Evaluate resident's responses to interventions and provide safe and secure environment." R13's SS (Social Service)-Abuse/Neglect Screening dated 6/28/22 documents: "Risk measure for likelihood for a history of previous/ recent mistreatment and/ or potential future problems/ symptoms related to mistreatment." The Screening documented R13 was at high risk	S9999		

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S9999	Continued From page 4 for abuse. R13's Progress Notes, dated 6/28/2022 6:13 PM documents "Resident reported an allegation of inappropriate touch. POA (Power of Attorney), Ombudsman and MD (Medical Doctor) notified." The facility's "Preliminary 24-hour Abuse Investigation Report" dated 6/28/22 identifies R13 as the resident who was allegedly abused and identifies the offense as physical abuse. On 6/29/22 at 12:15 PM V5, Psychosocial Rehab Service Coordinator (PSRC) stated when she was leaving the evening before, 6/28/22 at about 4:30 PM, one of the Certified Nurse's Aides (CNAs) in the dining room said, "(R1) just touched R13's breast." V5 stated she asked R13 what happened and R13 stated he (R1) touched her neck first and moved his hand down to her breast. V5 stated R13 stated she was embarrassed because there were other people in the dining room. V5 stated the CNAs told her R1 was intoxicated and R13 told her R1 was drunk. V5 stated she does not understand why V1, Administrator, lets R1 go out into the community every day. V5 stated V1 said corporate says you cannot hold a resident against their will. V5 stated no staff go with him when he leaves to supervise him. V5 stated R1 is kept on the elopement risk flier just in case he doesn't come back one day. On 6/30/22 at 1:00 PM R13 stated R1 had touched her breast two evenings before, on 6/28/22, when she was in the dining room for supper. R13 stated, "(R1) was drunk, he always goes out of the facility and gets drunk. I was just sitting in my chair, and he came up and put his hand on my neck and then touched me down my shoulder and my breast." R13 put her hand at the	S9999		

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S9999	Continued From page 5 back of her neck and slid her hand down her shoulder and over her breast to demonstrate how R1 had touched her. "I still don't feel good about it, and I'm pissed off. I hadn't talked to him, and it just came on all of a sudden. (V5) was there and told him to get his hands off of me. (V5) told me it's not right for him to put his hands on me." R13 stated V5 texted V1, Administrator and she came to the facility. R13 stated there is always a CNA in the dining room during meals and the two CNAs in the dining room that evening both saw what R1 did to her. R13 stated nobody offered to move him away from her in the dining room after it happened. She stated she was scared R1 might do it again. She stated she is kind of scared and a little frightened of R1, and that evening "It embarrassed the hell out of me because he did it in front of everyone in the dining room. No other man in the facility has done this before. I just don't feel good since it happened, I'm more uncomfortable, not really depressed. I feel like maybe he should go to jail. Nobody asked me if I wanted the police called. I don't sit at the that table anymore with my friends because he sits there, and I would rather sit around all girls. The staff told me I was sitting at the wrong table this morning, but I felt more comfortable not sitting at my old table." On 6/30/22 at 1:30 PM V5, PRSC, stated she talked to R1 after the incident when he inappropriately touched R13, and he told V5 that he would work on having more appropriate behaviors when she worked on getting him discharged into the community. V5 stated she did not know if V1 called the police at the time of the incident or not. V5 stated she did not feel R1's behaviors had changed, and although she did an updated Skills Assessment for R1 today that documents "resident appears to be capable of	S9999		

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outside pass privileges at this time" she does not feel he is safe to go out in the community on his own because he continues to come back into the facility intoxicated on most nights. V5 stated R1's intoxication on the evening he inappropriately touched R1 in a sexual manner probably did contribute to his behaviors. V5 stated R1 has had aggressive behaviors towards staff and peers when he has been intoxicated in the past.

On 6/30/22 at 10:22 AM during phone interview with V13, Certified Nurse's Aide, CNA, she stated she witnessed R1 walk up to R13 and swiped his hand across R13's breast. V13 stated it looked like R1 was saying something, but CNA could not hear what was being said. V13 stated R1 tries to grab staff in a sexual manner, and they document and report to nurse. V13 stated she has not witnessed R1 touching residents in a sexual manner prior to the occurrence on 6/28/22. V13 stated she has heard R1 speaking inappropriately to other residents.

On 6/30/22 at 10:35 AM during a phone interview. V25, CNA stated R1 walked up to R13 and rubbed his hand across her breast. V25 stated R1 was definitely being sexual with his actions. V25 stated she has not witnessed R1 speaking inappropriately to other residents and stated, "I would not like it if (R1) had touched me in that manner."

On 6/30/22 at 9:30 AM V1 stated it is the policy of the facility to only notify the police of an allegation of abuse if it is sexual in nature or if there is physical harm. She stated R13 told her she was sitting in the dining room and R1 put his hands on her shoulders and then moved it down to her breast. V1 stated R13 told her R1 had come up to talk to her and said "hi" because they have talked

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in the past.

On 7/1/22 at 3:00 PM V21, Medical Assistant (MA) for V24, R1's Medical Doctor (MD) stated V24 does not have any specific recommendations for R1 and will discuss it with the nursing home. V21 stated they did not have any report of R1 being sexually inappropriate to a female resident when she reviewed R1's communication notes.

2. R1's Face Sheet documents his diagnoses to include: Epilepsy, Schizoaffective Disorder, Chronic Migraine Without Aura, Intractable, with Status Migrainosus, Alcohol Abuse, Anxiety, Gastro-Esophageal Reflux Disease, Behet's Disease, and Unspecified Injury of the Head.

R1's Discharge Orders (Order Summary Report) dated 4/2/21, from previous facility (admitted from there) documents the order, "May go out on LOA (Leave of Absence) with Responsible Party and Meds" There was no order on these orders or R1' s current orders that he may go out independently into the community without supervision.

R1's document, "SS (Social Service)-Community Survival Skills" dated 2/9/22 documents the following assessment components and answers: "The resident appears to refrain from self-harmful and/or socially inappropriate behavior while in the community (including abstaining from alcohol and illicit drugs, avoiding persons who constitute a bad influence and is able to practice "harm reduction" strategies. The answer to this assessment component was filled out "no". The Skills form documented "The resident knows how to ask for/seek help in an emergent or problematic situation and the resident has knowledge of potentially dangerous situations, such as walking alone after dark, straying into an

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alley, accepting rides from strangers, carrying valuable items where they can be easily seen." The answer to this assessment component was "cannot be determined." The Skills form documents "The resident has the ability to adhere to pass privilege policies, e.g., getting permission to leave, signing out, respecting parameters and curfews, informing staff upon return; and The resident is able to behave with respect while in the community and there have been no problems or concerns (reported or witnessed) with his or her conduct over the past 7 days, and The resident sufficiently follows rules addressing medication compliance, participation in his/her treatment plan, appropriate hygiene and grooming and treats others with respect." The answers to these components were "cannot be determined. Under "Recommendations and Outcomes", it documents, "The resident does not appear to be capable of unsupervised outside pass privileges at this time." Under comments it documents, "(R1) does go into the community with family sometimes. (Facility) does not provide unsupervised passes."

R1's Minimum Data Set (MDS) dated 5/3/22 documents he entered the facility on 4/5/21 from another nursing home. The MDS documents he is cognitively intact. Under behaviors, the MDS documents R1 has verbal behavioral symptoms directed toward others (for example (e.g.) threatening others, screaming at others, cursing at others) and he has other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). R1's MDS documents these behaviors put the resident at significant risk for

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wandering risk assessment score of 9.0. At risk for wandering. Interventions include: Complete Wandering Risk Assessment upon annual, quarterly, and prn. Monitor quarterly and prn for least restrictive measures."

R1's Care Plan dated 5/18/22 documents, "(R1) has a history of Alcohol Abuse." Interventions for this care plan include, "Allow resident to voice frustration related to situation, no alcohol use, etc. If resident goes out on pass remind resident of risks of consuming alcohol while out. Observe for signs and symptoms of withdrawal from alcohol abuse (e.g., nervousness, shakiness, anxiety, irritability, rapid emotional changes, depression, difficulty with thinking clearly, bad dreams, headache, swearing, nausea, vomiting, loss of appetite, insomnia, rapid heart rate, confusion, hallucinations, agitation, fever (if noted, document and report to MD)." This care plan is not updated with R1's current daily abuse of alcohol or any interventions to address or treat his alcohol abuse.

R1's Care Plan documents, "(R1) is at high potential future risk for abuse/neglect related to high-risk score for abuse/neglect revised on 5/27/22. Interventions for this care plan include: Encourage and educate resident to speak to staff if feeling uncomfortable with a situation and to remain calm. (R1) will receive meetings with Social Services to assist with feeling secure within his environment. Provide reassurance with negative feelings occur. 11/10/21 Encourage (R1) to discuss negative feelings. Report any verbalization of abuse or neglect to administrator immediately."

R1's Fall Risk Assessment dated 5/3/22 documents his score of 13, indicating he is at risk

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of falls.

An untitled document dated 5/3/22 signed by V24, R1's Physician, documents, "(R1) is current patient of (V24). At this time due to the patient's healthcare needs it is not safe for him to leave his community against medical advice."

R1's Progress Note dated 5/11/2022 at 2:37 PM documents, "Social Service Note Note Text: (Psychiatrist) is here to see (R1). (R1) appeared upset and informed (psychiatrist) that he would like a pass to the community. (Psychiatrist) states that he is not able to provide a community passes to the residents. (R1) became upset and walked out of meeting."

R1's Progress Note dated 5/11/22 at 2:38 PM documents, "Resident seen by (psychiatrist) at this time. Resident is verbal and answering MD coherently. MD stated it was his choice to go AMA (against medical advice) if he wants to, but overall, he does not make the full decisions. Writer asked for a diagnosis for Geodon, MD stated to discontinue order at this time. No new orders."

R1's Progress Note dated 5/13/22 at 5:40 PM documents, "This afternoon resident was upset that he could not leave facility after a time that was arranged. At this time resident was noted to have crawled out a resident window and left. Resident was found outside walking where staff approached resident to explain that if this is what he's doing then he needs to sign AMA paperwork. Resident did sign paperwork and resident's medications were given to him."

R1's Progress Note dated 5/14/22 at 12:07 AM documents, "Patient returned to facility at 11:45

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S9999	Continued From page 12 PM without any of his belongings or medication. He stated that he didn't mean to leave and wanted to come back. Writer spoke to administration and patient was let back in. Writer placed call to (MD) office to make him aware that patient has returned without incident but does not have any of his medications and belongings. Writer is awaiting a return call. Patient skin is intact; no bruising noted; no signs of harm or injury noted." R1's Progress Note dated 5/24/2022 at 5:58 PM documents, " Social Service Note Note Text: PRSC (Psychosocial Rehabilitation Services Coordinator) spoke with (R1) about his behavior. (R1) goes into the community to visit family independently and stated to sometime drink alcohol during visit, who lives across the street from the facility. (R1) has also went to the store where his friends hang and drink alcohol or stand outside with them talking. PRSC explained the dangers of him using alcohol/substances while out of the building and greatly encouraged him to only visit his family across the street without drinking so that he can enter the facility sober after he visit. (R1) agreed to visit his family without drinking and to not hang with friends near stores or outside. He agrees to stay sober during independent community outings." R1's Progress Note dated 5/26/2022 at 5:00 PM documents, " Nursing Note Note Text: Res returned to the facility. CNA notice a can of beer on the resident's pocket. Writer asked the res and try to search the res pocket. Res became agitated. Administrator was informed about the incident. Writer called the doctor's office to get an order for a can of beer, awaiting callback. Will keep monitoring the res behavior."	S9999		

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S9999	Continued From page 13 R1's Progress Note dated 5/26/2022 5:31 PM documents, " Nursing Note Note Text: Writer received a call back from (MD). Res can have 1 can of beer for today as per doctor's order. Monitor the res behavior, and if any changes in behavior keep (MD)informed." R1's Progress Note dated at 5/30/2022 2:40 PM documents, "Nursing Note Note Text: Res returned to the facility with a can of beer. Writer confiscated the can of beer." R1's Care Plan was not revised after R1 brought alcohol into the facility on 5/26 and 5/30/22. R1' s Progress Note dated 6/1/2022 at 11:24 AM documents, " Social Service Note Note Text: (R1) attended a social service group on 06/01/2022 10:00 AM and spent 15 minutes in this group. (R1) attended Symptom management community re-entry skills management group. The group topic discussed included: 1:1 provided. PRSC provided active listening and positive feedback. PRSC provided (R1) a worksheet to discuss his recovery plan which include how alcohol/drugs affects his chances in life, make a list of what he want to accomplish and his plan to achieve, his support system, his hx of drinking and methods he used to quit. PRSC also discussed having a more structured daily routine. (R1) goes into the community independently and tends to return to the facility appearing and acting drunk. (R1) admits to drinking alcohol while in the community. PRSC informed (R1) that (a representative from an independent living facility) will be here to consult with him tomorrow 5/2/22, to discuss possible independent living plans as he requested.(R1's) participation in the group was noted as Passive Observed. (R1) responded to others in a(n) agreeable manner. (R1) Discussed	S9999		

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topics, such as (R1) displayed a nonchalant mood, he agreed that he remembered the previous discussion about not using substances while in the community but showed no concern. (R1) accepted the worksheet and nodded "yes" to completing it. (R1) chooses not to communicate with PRSC, agreed to be present for his visit tomorrow with (representative). The plan for (R1) is to continue with 1:1 sessions.
The interdisciplinary goal for (R1) is to understand and implement the plan of care to reduce distressing symptoms. (R1) will work on focusing on his recovery plan and not use substances to help reduce distressing symptom."

R1's Progress Notes dated 6/6/2022 at 1:02 PM documents, " Nursing Note Note Text: Patient has been going on outings daily and drinking alcohol writer and administrator has educated the patient on going out and his safety while drinking also writer placed call to (V24) to make him aware of what the patient has been doing; there are no new orders, and no changes patient may continue to go out."

R1's Care Plan was not revised with progressive interventions to address R1 leaving the facility daily and drinking alcohol.

On 6/28/22 at 8:15 AM R1 was signing out for a walk as surveyors entered the facility, and then V18, Licensed Practical Nurse (LPN) entered the code and let him out the door. R1 had an unsteady gait and he held onto the door frame to walk out.

R1's Physician Order Summary Report dated 6/29/22 includes the order, dated 4/5/21, "Resident requires skilled care." His physician orders do not include an order for R1 to go out on

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pass independently.

On 6/29/22 at 9:20 AM V14, Laundry Aide, stated she sees R1 down on the corner at the liquor store every day. She stated he usually signs out after breakfast and stays out all day then comes back in the evening drunk. V14 stated R1 came back one day carrying a beer. She stated she does not feel he's safe being out on his own in this neighborhood. She stated a bad person might get ahold of him. V14 stated she has seen R1 down there panhandling at the liquor store. She stated every time he comes back, he smells like alcohol.

On 6/29/22 at 9:40 AM V18, Licensed Practical Nurse (LPN), stated we have let the MD know about R1 going out and coming back drunk almost every day. She stated sometimes he's fine but other days is very drunk and belligerent. V18 stated R1's gait is very unstable in his ambulation, and then he gets out there drinking, in a bad neighborhood. She stated, "I don't feel he is safe. He would not think about drinking water instead of alcohol on the really hot days we've had. He has brought alcohol back with him; I have pulled three of those airplane sized bottles of alcohol off of him, we think he is bringing it for some of the other residents." V18 stated R1 does not have any family in the neighborhood. V18 stated V1, Administrator, informed staff that it is any resident's right to sign out on pass whenever they want, and that when they sign out on pass, they are not the facility's responsibility.

On 6/29/22 at 10:35 AM V12, Certified Nursing Assistant (CNA) came and told writer that someone had called another one of the CNAs and told her R1 had just been hit by a car down at the liquor store. Surveyor drove past the liquor

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store, at 10:50 AM, and R1 was sitting in a chair in the shade behind the liquor store with several other men and was holding a tall can of beer. He did not appear to be in any distress. Writer drove past same location on same day at 2:30 PM and R1 was still there.

On 6/29/22 at 12:36 PM V3, Minimum Data Set (MDS) nurse stated R1 goes out on pass almost every day and when he returns, they have found beer, little bottles of liquor and marijuana on him and he gets belligerent when staff try to take it away from him. V3 stated she cannot explain R1 being able to continue to go out on pass even though he returns almost every night intoxicated. She stated, "I was not a part of that decision to let him go out. That was the Administrator's and Corporate's decision." V3 stated, "I don't feel like he (R1) is safe to be out of the facility on his own. His gait is very unsteady, and you add alcohol to that, and you know he's going to have falls. He really needs help because of his drinking." V3 stated no one goes out with R1 when he is out on pass to offer any supervision. She stated he does not always come back for meals, and he is losing weight since he is going out.

On 6/29/22 at 12:59 PM V1 Administrator stated she is aware R1 goes out on pass and stated she is aware he has returned intoxicated. She stated she had stopped his going out because he was not safe, but then he attempted to elope, and since she has been letting him go out again, he hasn't tried to elope again. She stated V5 needs to update R1's elopement assessment because he is not an elopement risk. V1 stated R1 can sign out after breakfast, and he has to come back before dark. V1 stated she is going to have to have a meeting with R1 to set guidelines and tell him if he doesn't follow them, he won' t be able to

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go out on pass. V1 stated V5 has had several 1:1's with R1 regarding his drinking and behaviors.

On 6/29/22 at 2:45 PM V13, CNA stated, "I don't think this is the place for (R3). He goes out and drinks alcohol every day, and usually when he comes back in the evenings, he is belligerent and drunk with the staff and other residents. V13 stated, "He is very verbal. I'm not touching him to search him because he has threatened to hit me and has jumped at me before. He sometimes doesn't even know where he is. We report his behaviors and that he comes back drunk every night to the administrator. It takes three if us to get the beer he brings back away from him." V13 stated she does not feel R1 should be allowed to go out on pass because he hangs out at the liquor street down the street. She stated he has returned to the facility so drunk before that he has defecated on himself. V13 stated R1 has been sexually inappropriate towards her and other staff when he is drunk. She stated they have taken contraband including bottles of liquor, beer and pills that are not his from him.

On 6/29/22 at 3:00 PM V16, CNA, stated R1 does need physical assist with ADL's (Activities of Daily Living) including getting dressed and getting his shoes on. She stated he is very unsteady because he is missing part of one of his feet. V16 stated R1 goes out and drinks alcohol about every day and sometimes has bowel incontinence on his way back and needs help getting cleaned up. She stated R1 is not always incontinent, only when he is really drunk. She stated he can get aggressive especially if he tries to sneak alcohol back into the facility and staff stops him but stated sometimes his behaviors are ok when he returns. V16 stated she doesn't think R1 is safe to be out

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in the community because his gait is very unsteady, and it he falls, no one will know.

R1's Progress Note dated 6/30/22 at 8:50 AM documents, "Administrator educated and informed (R1) of the facility policy of not using drugs and alcohol while in the community and returning to the facility intoxicated. (R1) has been informed that if he returns to the facility intoxicated his privileges of independent community outings will be revoked. (R1) replied, "OK" in agreement to adhere to the policy. PRSC witnessed."

R1's SS-Level of Functioning-Skills Assessment dated 6/30/22 documents "Recommended Interventions" as individual counseling, therapy or support, emphasis: one to one sessions to discuss moods and behaviors; Group counseling, therapy or support, emphasis: substance abuse counseling. Under "Community Skills, the assessment documents "Cannot Determine" to the statement, "the resident appears able to refrain from self-harmful and /or socially inappropriate behavior while in the community (including abstaining from alcohol and illicit drugs, avoiding persons who constitute a bad influence and is able to practice "harm reduction" strategies." At the end of this assessment, under "Recommendations and Outcomes" it documents, "The resident appears to be capable of outside pass privileges at this time."

On 6/30/22 at 1:30 PM V5, Psychosocial Rehabilitation Services Coordinator (PRSC), stated she talked to R1 after the incident when he inappropriately touched R13, and he told V5 that he would work on having more appropriate behaviors when she worked on getting him discharged into the community. V5 stated she did

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S9999	Continued From page 19 not know if V1 called the police at the time of the incident or not. V5 stated she did not feel R1's behaviors had changed, and although she did an updated Skills Assessment for R1 today that documents "resident appears to be capable of outside pass privileges at this time" she does not feel he is safe to go out in the community on his own because he continues to come back into the facility intoxicated on most nights. V5 stated R1's intoxication on the evening he inappropriately touched R1 in a sexual manner probably did contribute to his behaviors. V5 stated R1 has had aggressive behaviors towards staff and peers when he has been intoxicated in the past. V5 stated she does not have any programs or classes to address R1's alcohol abuse or other residents' alcohol or substance abuse. She stated she thought that would be a good idea and will contact (psychiatric hospital) and get more information. On 6/30/22 at 3:40 PM during a phone interview, V20, Psychiatric Nurse Practitioner, stated she did not think V28, Psychiatrist, would necessarily recommend Alcoholics Anonymous or Narcotics Anonymous because residents should have already been withdrawn from any substances when they are admitted to the facility. V20 stated she does feel like some type of programming to discuss addiction and education on drug and alcohol abuse would be good. V20 stated residents with a history of alcohol and drug abuse should not have access to these things in the facility and if they are, then that's a problem. V20 stated it is very dangerous for R1 to be drinking alcohol and still receiving his medication. She stated that it is very scary that R1 has continued to receive his medications even when staff are aware he has been drinking. The staff should hold his medications if he is intoxicated.	S9999		

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On 6/30/22 at 3:55 PM V1 stated V5 did a new skills assessment with R1 on 6/30/22 and on 6/1/22 V5 had educated him regarding his use of alcohol, and he has to follow the guidelines outlined on that assessment or his privileges for outside pass will be revoked. V1 acknowledged that R1 has continued to abuse alcohol and return to the facility drunk since V5 talked to him on 6/1/22.

On 6/30/22 at 4:05 PM R1 was observed standing behind the liquor store down the street from the facility. The outside temperature was 88 degrees.

R1's Progress Note dated 7/1/22 at 9:49 AM documents, "(R1) came into the facility intoxicated though he has been previously informed of his privileges being revoked if this behavior continued. (R1) was informed that his community outing privileges are revoked. (R1) appeared anxious/agitated. He refused 1:1 with PRSC and chose to isolate and keep to himself. PRSC informed him that he can speak with PRSC when he is ready about his feelings and coping skills."

The facility's forms, Release of Responsibility for Leave of Absence" dated 5/19/22 through 7/3/22 was reviewed. This document is the form residents sign when leaving the facility. R1 signed out of the facility several times a week during May and June 2022 even though his care plan, elopement assessment, and SS-Community Survival Skills all document he is not appropriate for outside pass and is identified as an elopement risk.

The facility's form, "Release of Responsibility for

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Leave of Absence" contains an entry dated 7/1/22 at 1:30 PM of R1 signing out of the facility after his pass privileges were revoked. It does not document the time he returned.

R1's Progress Note dated 7/5/22 at 10:19 AM documents, "This am resident drooling, sweating, unable to talk clearly, difficult for resident to be awakened by staff. Resident unable to make eye contact. VS (vital signs) 158/85, Pulse 103, Temp 97.8. (MD) and administrator notified. Writer sent resident out to (local hospital) per (ambulance) via stretcher." (B)

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Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210d)2)
300.1210d)3)
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.

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

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.

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.

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These requirments are not met as evidenced by:

Based on observation, interview and record review the facility failed to provide behavioral health services to address alcohol and drug addiction/abuse for 3 of 3 residents (R1, R3, R10) reviewed for behavioral health services in the sample of 14. This failure resulted in R3 taking drugs, becoming unresponsive and requiring hospitalization for toxic overdose and aspiration pneumonia. In addition, R1, an alcoholic, continually leaves the facility, returns to the facility inebriated, and has verbal, physical and sexual aggression towards other residents.

Findings include:

1. R3's Face Sheet documents he was initially admitted to the facility on 3/25/19 and his diagnoses to include: Bipolar Disorder, Current Episode Depressed, Severe Without Psychotic Features, Insomnia, Antisocial Personality, Major Depressive Disorder, Type 2 Diabetes Mellitus, and Schizoaffective Disorder.

R3's Hospital Discharge Plan dated 3/25/19 documents R3's Primary Diagnosis at discharge as Schizoaffective Disorder, Traumatic Brain Injury, and Polysubstance Abuse.

R3's Preadmission Screening (PAS)/Mental Health (MH) Level II Notice of Determination form dated 3/25/19 documents R3 is eligible for Nursing Facility. It further documents, under "Special Services": Professional Observation (MD (Medical Doctor)/RN (Registered Nurse) for medication monitoring, adjustment and/or stabilization; Instrumental Activities of Daily Living training/ reinforcement; Mental Health

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Rehabilitation activities, Aggression/Anger management; Illness Self-Management; Community re-integration activities; and Substance use/abuse management. The PAS/MH Level II Notice documents, under "Substance Use/Abuse assessment "Patient has a lengthy history of substance abuse issues. Recognizes that he struggles to say no and stay away from substance abuse outside of a controlled setting and voices a desire to stay clean. Primary drugs of choice have been meth and heroin but admits to use of marijuana, K2, crack cocaine and alcohol on occasion as well." Under "History of Anti-social/Maladaptive/Risk Behavior Assessment" the PAS Notice documents: "Criminal Justice System involvement, moderate, timeframe: March 2019: recent charges for disorderly conduct; has had past charges for substance abuse."

R3's Minimum Data Set, MDS. date 3/2/22 documents he was admitted to the facility on 3/25/22 from a psychiatric hospital. It further documents R3 is alert and oriented, and experiences "other behavioral symptoms not directed toward others (e.g.(for example) physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds" According to the MDS these behaviors put R3 at significant risk for physical illness or injury, significantly interferes with his care and significantly interferes with his participation in activities or social interactions."

R3's Care Plan dated 3/2/22 documents the following: (R3) has a history of bringing contraband (marijuana) into the facility from the community. 12/9/21 (R3) shared a vape with a

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peer in the building. (R3) is no longer able to vape on facility grounds per administrator, guardian aware. (R3) asked another male resident to crush his Klonopin and snorted it, "I was feeling anxious"- revised 3/1/22." The Interventions documents "Appropriate staff to search (R3) upon entering the facility to ensure no contraband or vaping material is on his person and for the safety of himself and others." The Care Plan documents "(R3) is resistive to care/non-compliant related to anxiety. (R3) was found to be pocketing his medications-4/20/21." The Care Plan intervention documented "Educate resident of the possible outcome(s) of not complying with treatment or care. Praise the resident when behavior is appropriate." R3's Care Plan documents "Trauma informed care (R3) has a long substance abuse Hx (history). He was admitted to the hospital for suicidal thoughts and has had several hospitalizations. (R3) stated that he was a cutter and used this as a coping skill to ease the pain. Date Initiated: 08/12/2020." The Care Plan interventions documented "Provide (R3) with supportive care and services to promote a sense of safety and well-being. Provide emotional support. Determine resident's coping mechanisms. Ensure the safety of Resident and others. Date Initiated: 05/22/2020."

R3's "SS (Social Service) Community Survival Skills," dated 3/2/22 at 10:17 AM documents the answer "no" to the statement, "The resident appears able to refrain from self-harmful and/or socially inappropriate behavior while in the community (including abstaining from alcohol and illicit drugs, avoiding persons who constitute a bad influence and is able to practice "harm reduction" strategies."

R3's Progress Note dated 5/13/22 at 9:20 AM

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documents, " Called down to room. Resident not responding, just lying in his bed. Small brown sputum coming from mouth. Called 911. Resident was sat up and responding, still confused. Ambulance took resident to (local hospital). Called responsible party, mother and sister. No answer. Report given to (local hospital)."

R3's Hospital Records dated 5/13/22 document a communication from Emergency Medical Service (EMS) on 5/13/22 at 9:13 AM:" Last known well is 5:30 AM. Staff found him unresponsive with vomit in his airway. Fire for him to wake up but he is still very lethargic. No complaints other than feeling tired. Sugar is 578 and he is diabetic. Think he aspirated. Lung sounds are congested with low sets (saturation). Working on getting those up. Be there in 10."

R3's Progress Note dated 5/13/22 at 1:00PM documents, "Writer called (local hospital) for update on resident. Writer was informed that resident had been intubated for proper airway. It was stated to writer that resident might have aspirated yet nothing is for sure at this time. Resident's parents are at the hospital."

R3's hospital medical records include the documentation, "Medical Decision/Rationale" dated 5/13/22: "Pt (Patient) is a 45 year old male with a past medical history as noted above who presented to the emergency department due to concerns for altered mental status, hyperglycemia, hypoxia, and possible aspiration. All critical diagnoses were considered. On arrival the patient was on a non-rebreather saturating at 90%. He was intermittently responsive. He was able to answer questions when prompted, however, was unresponsive at times. Given his recent potential aspiration, altered mental status,

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and unstable vital signs (including hypotension, tachycardia, and hypoxia) patient was intubated for airway protection and more controlled management of ventilation. Differential in this patient is quite broad with includes etiologies related to his diabetes and hyperglycemia including DKA (Diabetic ketoacidosis) and HHS (Hyperosmolar hyperglycemic state), infectious acute hypoxic respiratory failure secondary to aspiration or infectious process, toxic overdose, sepsis, or other critical etiology. Workup includes labs, EKG, and imaging to evaluate potential differential. Disposition- ICU (Intensive Care Unit).

Hospital Records dated 5/13/22 include laboratory results of Drug Screen dated 5/13/22 at 11:37 AM which document R3 was positive for Benzodiazepine, cannabinoids, cocaine and methadone at that time.

R3's Hospital Medical Records document his Discharge Diagnoses, dated 5/31/22, as: Acute Respiratory Failure requiring intubation, MRSA/Candida Pneumonia, Toxic Metabolic Encephalopathy secondary to Polysubstance Abuse, Hx of Schizoaffective Disorder and Polysubstance Abuse, Rhabdomyolyses, Elevated Liver Function Tests, and Type 2 Diabetes Mellitus uncontrolled with hemoglobin A1c of 9.7.

On 6/28/22 at 10:45 AM V5, Psychosocial Rehabilitation Services Coordinator (PRSC) stated she had seen R3 the day before he went to the hospital, and he had seemed fine to her. She stated just a few days before he went to the hospital, he had been on a home visit with his mother. V5 stated when R3 goes on home visits his mother takes him to the marijuana dispensary

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and lets him buy whatever he wants. V5 stated she had not seen R3 do any illegal substances, but staff have reported that sometimes he looks "high" and that he sleeps a lot. V5 stated R3's mother came and got his belongings and verbalized that she was upset because she did not feel like staff checked on R3 enough and was upset because it was his roommate who found him unresponsive and not the staff.

On 6/28/25 at 1:25 PM V12, Certified Nursing Assistant (CNA) stated she found R3 unresponsive in his bed the morning he was sent to the hospital. She stated she had made a quick round when she first arrived to work, which was her usual routine, and R3 was awake and talking at that time, and told her he was not coming to breakfast. V12 stated this did not surprise her because the night shift nurse had let her know that R3 and some of the other male residents had been hanging out in one of their rooms until about 4:00 AM that night. V12 stated she came back down to let R3 know his breakfast tray was up there in case he changed his mind, and that was when she found him lying on his side with brown sputum coming out of the corner of his mouth. She stated she called out his name and he did not respond, and when she touched him and he still did not respond, she yelled for V3, MDS Nurse to come help. V12 stated V3 sent her to get his nurse, stating, "We have to get him out of here," V12 stated the ambulance got there right away and took R3 to the hospital. She stated he was starting to respond on his way out the door. V12 stated the next day she approached R10, one of the residents R3 hangs out with, and asked him what they had been doing the night before R3 went to the hospital. V12 stated R10 told her R3 had been using cocaine and taking pills the night before he went to the hospital. She

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stated R10 told her R3 calls some guy on the phone and then they bring him stuff through the window in his room. V12 stated another resident, R12, who was R3's roommate, kept saying he thought R3 had overdosed. V12 stated she reported what R10 reported to her to V3, MDS Nurse, V5, PRSC and V1, Administrator. R12 stated R1 is another resident who brings things into the facility. She stated he goes out every day and comes back drunk. She stated she has taken bottles of alcohol from him when checking him back in, and one time he grabbed her breast and made sexual comments to her when she was having to search him.

On 6/29/22 at 10:53 AM during phone interview, R3 stated he was now residing in a facility in (Illinois city). R3 stated he got some of his drugs from another resident in the facility but did not want to say anyone's names. R3 stated he also got drugs from the crack house across the street from the facility. He stated he was smoking a cigarette out his bedroom window and that is how he met them, just through the window. R3 stated he knew it was a crack house because he saw all the traffic in and out if there. R3 then stated, "I didn't get any of it from another resident. I was in a coma for 5 days and I forget things." He stated he only got drugs through his window a couple of times. He stated he did the drugs when he returned to the facility from his home visit. R3 stated no staff in the facility ever got drugs for him. He stated he doesn't remember staying up the night before with his friends, but he was in a coma for 5 days and can't remember. He stated he talks to his friends at this facility, and they told him R12, his roommate, found him not breathing, and got R10, who then got the staff. R3 stated they told him at the hospital that he overdosed and swallowed his vomit and that's what made

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S9999	Continued From page 30 him stay in the ICU for so long. R3 stated, "I almost died." R3 stated he did not attend any groups for substance abuse at the facility, but he has had treatment before in the hospital. V5 stated she knew R3 had a history of substance abuse, the facility does not have any type of programs or treatment specifically for alcohol or substance abuse. On 6/28/22 at 3:20 PM R10 stated R3 had been getting "stuff" including cocaine, through his window from the guys across the street. He stated he has seen these men come to R3's window and hand him things. R10 stated the night before R3 went to the hospital they were hanging out in R10's room and R3 took some Thorazine, Methadone (R10 stated it was the liquid kind), and cocaine. R10 stated this was not the first time he had seen R3 get drugs from across the street. R10 stated he waits until about 1:00 AM when the staff are all up front in the lobby to get stuff through the window. R10 stated R3's mother gives him an allowance of $120 a week and brings him a lot of groceries which he sells to other residents. R10 stated some of the other residents sell their pills, stating R9 sometimes sells his Xanax, and another resident gives his Thorazine away because he does not like it. R10 stated R1 brings back those little bottles of alcohol and sells them to other residents. R10 stated R12 had walked into his room and saw R3 not looking right on that morning and had come and got R10, who then told V12 that there was something wrong with R3 and she got the nurse right away. R10 stated he did not talk to any other staff besides V12 about what goes on in the facility and what R3 did that night and stated nobody has asked him about it. R10 stated, "I just stick to pot. I don't do any of those other drugs. Sometimes we do smoke pot in our rooms if	S9999		

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someone is able to bring it back or get some."

On 7/6/22 at 4:00 PM during phone interview, V19, Registered Nurse (RN) for V25, R3's Physician, stated V25 said he would like to see programs done in the facility to address resident's substance abuse problems, but he does not know if R3 would have participated in the programs because R3 did not feel he had an addiction problem. V19 stated V25 stated R3's overdose definitely could have contributed to his aspirating, which then caused his need for hospitalization.

2. R1's Face Sheet documents his diagnoses to include: Epilepsy, Schizoaffective Disorder, Chronic Migraine Without Aura, Intractable, with Status Migrainosus, Alcohol Abuse, Anxiety, Gastro-Esophageal Reflux Disease, Behet's Disease, and Unspecified Injury of the Head.

R1's document, "SS (Social Service)-Community Survival Skills" dated 2/9/22 documents the following assessment components and answers: "The resident appears to refrain from self-harmful and/or socially inappropriate behavior while in the community (including abstaining from alcohol and illicit drugs, avoiding persons who constitute a bad influence and is able to practice "harm reduction" strategies. The answer to this assessment component was filled out "no". The Skills form documented "The resident knows how to ask for/seek help in an emergent or problematic situation and the resident has knowledge of potentially dangerous situations, such as walking alone after dark, straying into an alley, accepting rides from strangers, carrying valuable items where they can be easily seen." The answer to this assessment component was "cannot be determined." The Skills form documents "The resident has the ability to

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adhere to pass privilege policies, e.g., getting permission to leave, signing out, respecting parameters and curfews, informing staff upon return; , and The resident is able to behave with respect while in the community and there have been no problems or concerns (reported or witnessed) with his or her conduct over the past 7 days, and The resident sufficiently follows rules addressing medication compliance, participation in his/her treatment plan, appropriate hygiene and grooming and treats others with respect." The answers to these components were "cannot be determined." Under "Recommendations and Outcomes", it documents, "The resident does not appear to be capable of unsupervised outside pass privileges at this time." Under comments it documents, "(R1) does go into the community with family sometimes. (Facility) does not provide unsupervised passes."

R1's Minimum Data Set (MDS) dated 5/3/22 documents he entered the facility on 4/5/21 from another nursing home. The MDS documents he is cognitively intact. Under behaviors, the MDS documents R1 has verbal behavioral symptoms directed toward others (for example (e.g.) threatening others, screaming at others, cursing at others) and he has other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). R1's MDS documents these behaviors put the resident at significant risk for physical illness or injury, and significantly interfere with R1's care, and with his participation in activities or social interaction. R1's MDS documents behaviors significantly intrude on the privacy and activity of others, and significantly

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disrupt care or living environment. The MDS also documents R1 rejects care. Per the MDS, R1's behaviors have gotten worse at the time of the assessment. The MDS documents R1 requires limited assist of one staff for bed mobility, transfers, and personal care, and is not steady when moving from a seated to standing position, when moving on and off the toilet, and during surface-to-surface transfers, and is only able to stabilize with staff assistance.

R1's Care Plan dated 4/19/21 documents: Trauma informed care (history of gun shot, physically abused in the community). The interventions for this this Care Plan document "Provide resident with supportive care and services to promote a sense of safety and wellbeing.; Psychiatry/Psychology services as scheduled."

R1's Care Plan, initiation date of 4/5/21, also documents: "(R1) is an elopement risk and has made statements of eloping. He refused to come back to the facility while visiting a friend in the community. He attempted to leave the building AMA (against medical advice). R1 is able to go into the facility (community?) independently but is required to sign out and sign in. R1 is encouraged to not use alcohol while out in the community and to not stand near liquor stores talking with friends. R1 entered the facility in the last evening appearing drunken." (Revised 6/1/22).

R1's Care Plan dated 5/18/22 documents, "(R1) has a history of Alcohol Abuse." Interventions for this care plan include, "Allow resident to voice frustration related to situation, no alcohol use, etc. If resident goes out on pass remind resident of risks of consuming alcohol while out. Observe for signs and symptoms of withdrawal from alcohol

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abuse (e.g., nervousness, shakiness, anxiety, irritability, rapid emotional changes, depression, difficulty with thinking clearly, bad dreams, headache, swearing, nausea, vomiting, loss of appetite, insomnia, rapid heart rate, confusion, hallucinations, agitation, fever (if noted, document and report to MD)." This care plan is not updated with R1's current daily abuse of alcohol or any interventions to address or treat his alcohol abuse.

An untitled document dated 5/3/22 signed by V24, R1's Physician, documents, "(R1) is current patient of (V24). At this time due to the patient's healthcare needs it is not safe for him to leave his community against medical advice."

R1's Progress Note dated 5/24/2022 at 5:58 PM documents, " Social Service Note Note Text: PRSC (Psychosocial Rehabilitation Services Coordinator) spoke with (R1) about his behavior. (R1) goes into the community to visit family independently and stated to sometime drink alcohol during visit, who lives across the street from the facility. (R1) has also went to the store where his friends hang and drink alcohol or stand outside with them talking. PRSC explained the dangers of him using alcohol/substances while out of the building and greatly encouraged him to only visit his family across the street without drinking so that he can enter the facility sober after he visit. (R1) agreed to visit his family without drinking and to not hang with friends near stores or outside. He agree to stay sober during independent community outings."

R1's Progress Note dated 5/26/2022 at 5:00 PM documents, " Nursing Note Note Text: Res returned to the facility. CNA notice a can of beer on the resident's pocket. Writer asked the res and

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try to search the res pocket. Res became agitated. Administrator was informed about the incident. Writer called the doctor's office to get an order for a can of beer, awaiting callback. Will keep monitoring the res behavior."

R1's Progress Note dated 5/26/2022 5:31 PM documents, " Nursing Note Note Text: Writer received a call back from (MD). Res can have 1 can of beer for today as per doctor's order. Monitor the res behavior, and if any changes in behavior keep (MD)informed."

R1's Progress Note dated at 5/30/2022 2:40 PM documents, "Nursing Note Note Text: Res returned to the facility with a can of beer. Writer confiscated the can of beer."

R1's Care Plan was not revised after R1 brought alcohol into the facility on 5/26 and 5/30/22.

R1' s Progress Note dated 6/1/2022 at 11:24 AM documents, " Social Service Note Note Text: (R1) attended a social service group on 06/01/2022 10:00 AM and spent 15 minutes in this group. (R1) attended Symptom management community re-entry skills management group. The group topic discussed included: 1:1 provided. PRSC provided active listening and positive feedback. PRSC provided (R1) a worksheet to discuss his recovery plan which include how alcohol/drugs affects his chances in life, make a list of what he want to accomplish and his plan to achieve, his support system, his hx of drinking and methods he used to quit. PRSC also discussed having a more structured daily routine. (R1) goes into the community independently and tends to return to the facility appearing and acting drunk. (R1) admits to drinking alcohol while in the community. PRSC informed (R1) that (a representative from

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an independent living facility) will be here to consult with him tomorrow 5/2/22, to discuss possible independent living plans as he requested. (R1's) participation in the group was noted as Passive Observed. (R1) responded to others in a(n) agreeable manner. (R1) Discussed topics, such as (R1) displayed a nonchalant mood, he agreed that he remembered the previous discussion about not using substances while in the community but showed no concern. (R1) accepted the worksheet and nodded "yes" to completing it. (R1) chooses not to communicate with PRSC, agreed to be present for his visit tomorrow with (representative). The plan for (R1) is to continue with 1:1 sessions. The interdisciplinary goal for (R1) is to understand and implement the plan of care to reduce distressing symptoms. (R1) will work on focusing on his recovery plan and not use substances to help reduce distressing symptom."

R1's Progress Notes dated 6/6/2022 at 1:02 PM documents, " Nursing Note Note Text: Patient has been going on outings daily and drinking alcohol writer and administrator has educated the patient on going out and his safety while drinking also writer placed call to (V24) to make him aware of what the patient has been doing; there are no new orders, and no changes patient may continue to go out."

R1's Care Plan was not revised with progressive interventions to address R1 leaving the facility daily and drinking alcohol.

There is no documentation in R1's medical record that R1 is receiving any type of behavioral health services for his alcohol abuse.

On 6/28/22 at 8:15 AM R1 was signing out for a

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	IL6002661	A. BUILDING: ____ B. WING ____	C 07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENUES AT SPRINGFIELD	525 SO MARTIN LUTHER KING DR SPRINGFIELD, IL 62703

(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
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walk as surveyors entered the facility, and then V18, Licensed Practical Nurse (LPN) entered the code and let him out the door. R1 had an unsteady gait and he held onto the door frame to walk out.

R1's Physician Order Summary Report dated 6/29/22 includes the order, dated 4/5/21, "Resident requires skilled care." His physician orders do not include an order for R1 to go out on pass independently.

On 6/29/22 at 9:20 AM V14, Laundry Aide, stated she sees R1 down on the corner at the liquor store every day. She stated he usually signs out after breakfast and stays out all day then comes back in the evening drunk. V14 stated R1 came back one day carrying a beer. She stated she does not feel he's safe being out on his own in this neighborhood. She stated a bad person might get ahold of him. V14 stated she has seen R1 down there panhandling at the liquor store. She stated every time he comes back, he smells like alcohol.

On 6/29/22 at 9:40 AM V18, Licensed Practical Nurse (LPN), stated we have let the MD know about R1 going out and coming back drunk almost every day. She stated sometimes he's fine but other days is very drunk and belligerent. V18 stated R1's gait is very unstable in his ambulation, and then he gets out there drinking, in a bad neighborhood. She stated, "I don't feel he is safe. He would not think about drinking water instead of alcohol on the really hot days we've had. He has brought alcohol back with him; I have pulled three of those airplane sized bottles of alcohol off of him, we think he is bringing it for some of the other residents." V18 stated R1 does not have any family in the neighborhood. V18

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stated V1, Administrator, informed staff that it is any resident's right to sign out on pass whenever they want, and that when they sign out on pass, they are not the facility's responsibility.

On 6/29/22 at 10:35 AM V12, Certified Nursing Assistant (CNA) came and told writer that someone had called another one of the CNAs and told her R1 had just been hit by a car down at the liquor store. Surveyor drove past the liquor store, at 10:50 AM, and R1 was sitting in a chair in the shade behind the liquor store with several other men and was holding a tall can of beer. He did not appear to be in any distress. Writer drove past same location on same day at 2:30 PM and R1 was still there.

On 6/29/22 at 12:36 PM V3, Minimum Data Set (MDS) nurse stated R1 goes out on pass almost every day and when he returns, they have found beer, little bottles of liquor and marijuana on him and he gets belligerent when staff try to take it away from him. V3 stated she cannot explain R1 being able to continue to go out on pass even though he returns almost every night intoxicated. She stated, "I was not a part of that decision to let him go out. That was the Administrator's and Corporate's decision." V3 stated, "I don't feel like he (R1) is safe to be out of the facility on his own. His gait is very unsteady, and you add alcohol to that, and you know he's going to have falls. He really needs help because of his drinking." V3 stated no one goes out with R1 when he is out on pass to offer any supervision. She stated he does not always come back for meals, and he is losing weight since he is going out.

On 6/29/22 at 12:59 PM V1 Administrator stated she is aware R1 goes out on pass and stated she is aware he has returned intoxicated. She stated

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S9999	Continued From page 39 she had stopped his going out because he was not safe, but then he attempted to elope, and since she has been letting him go out again, he hasn't tried to elope again. She stated V5 needs to update R1's elopement assessment because he is not an elopement risk. V1 stated R1 can sign out after breakfast, and he has to come back before dark. V1 stated she is going to have to have a meeting with R1 to set guidelines and tell him if he doesn't follow them, he won' t be able to go out on pass. V1 stated V5 has had several 1:1's with R1 regarding his drinking and behaviors. On 6/29/22 at 2:45 PM V13, CNA stated, "I don't think this is the place for (R3). He goes out and drinks alcohol every day, and usually when he comes back in the evenings, he is belligerent and drunk with the staff and other residents. V13 stated, "He is very verbal. I'm not touching him to search him because he has threatened to hit me and has jumped at me before. He sometimes doesn't even know where he is. We report his behaviors and that he comes back drunk every night to the administrator. It takes three if us to get the beer he brings back away from him." V13 stated she does not feel R1 should be allowed to go out on pass because he hangs out at the liquor street down the street. She stated he has returned to the facility so drunk before that he has defecated on himself. V13 stated R1 has been sexually inappropriate towards her and other staff when he is drunk. She stated they have taken contraband including bottles of liquor, beer and pills that are not his from him. On 6/29/22 at 3:00 PM V16, CNA, stated R1 does need physical assist with ADL's (Activities of Daily Living) including getting dressed and getting his shoes on. She stated he is very unsteady	S9999		

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because he is missing part of one of his feet. V16 stated R1 goes out and drinks alcohol about every day and sometimes has bowel incontinence on his way back and needs help getting cleaned up. She stated R1 is not always incontinent, only when he is really drunk. She stated he can get aggressive especially if he tries to sneak alcohol back into the facility and staff stops him but stated sometimes his behaviors are ok when he returns. V16 stated she doesn't think R1 is safe to be out in the community because his gait is very unsteady, and it he falls, no one will know.

R1's Progress Note dated 6/30/22 at 8:50 AM documents, "Administrator educated and informed (R1) of the facility policy of not using drugs and alcohol while in the community and returning to the facility intoxicated. (R1) has been informed that if he returns to the facility intoxicated his privileges of independent community outings will be revoked. (R1) replied, "OK" in agreement to adhere to the policy. PRSC witnessed."

R1's SS-Level of Functioning-Skills Assessment dated 6/30/22 documents "Recommended Interventions" as individual counseling, therapy or support, emphasis: one to one sessions to discuss moods and behaviors; Group counseling, therapy or support, emphasis: substance abuse counseling. Under "Community Skills,' the assessment documents "Cannot Determine" to the statement, "the resident appears able to refrain from self-harmful and /or socially inappropriate behavior while in the community (including abstaining from alcohol and illicit drugs, avoiding persons who constitute a bad influence and is able to practice "harm reduction" strategies." At the end of this assessment, under "Recommendations and Outcomes" it

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documents, "The resident appears to be capable of outside pass privileges at this time."

On 6/30/22 at 1:30 PM V5, Psychosocial Rehabilitation Services Coordinator (PRSC), stated she talked to R1 after the incident when he inappropriately touched R13, and he told V5 that he would work on having more appropriate behaviors when she worked on getting him discharged into the community. V5 stated she did not know if V1 called the police at the time of the incident or not. V5 stated she did not feel R1's behaviors had changed, and although she did an updated Skills Assessment for R1 today that documents "resident appears to be capable of outside pass privileges at this time" she does not feel he is safe to go out in the community on his own because he continues to come back into the facility intoxicated on most nights. V5 stated R1's intoxication on the evening he inappropriately touched R1 in a sexual manner probably did contribute to his behaviors. V5 stated R1 has had aggressive behaviors towards staff and peers when he has been intoxicated in the past. V5 stated she does not have any programs or classes to address R1's alcohol abuse or other residents' alcohol or substance abuse. She stated she thought that would be a good idea and will contact (psychiatric hospital) and get more information.

On 6/30/22 at 3:40 PM during a phone interview, V20, Psychiatric Nurse Practitioner, stated she stated she did not think V28, Psychiatrist, would necessarily recommend Alcoholics Anonymous or Narcotics Anonymous because residents should have already been withdrawn from any substances when they are admitted to the facility. V20 stated she does feel like some type of programming to discuss addiction and education

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on drug and alcohol abuse would be good. V20 stated residents with a history of alcohol and drug abuse should not have access to these things in the facility and if they are, then that's a problem. V20 stated it is very dangerous for R1 to be drinking alcohol and still receiving his medication. She stated that it is very scary that R1 has continued to receive his medications even when staff are aware he has been drinking. The staff should hold his medications if he is intoxicated.

On 6/30/22 at 4:05 PM R1 was observed standing behind the liquor store down the street from the facility. The outside temperature was 88 degrees.

R1's Progress Note dated 7/1/22 at 9:49 AM documents, "(R1) came into the facility intoxicated though he has been previously informed of his privileges being revoked if this behavior continued. (R1) was informed that his community outing privileges are revoked. (R1) appeared to anxious/agitated. He refused 1:1 with PRSC and chose to isolate and keep to himself. PRSC informed him that he can speak with PRSC when he is ready about his feelings and coping skills."

R1's Progress Note dated 7/5/22 at 10:19 AM documents, "This am resident drooling, sweating, unable to talk clearly, difficult for resident to be awakened by staff. Resident unable to make eye contact. VS (vital signs) 158/85, Pulse 103, Temp 97.8. (MD) and administrator notified. Writer sent resident out to (local hospital) per (ambulance) via stretcher." (A)