STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments Complaint Investigation 2395361/IL151467 - 330.710 cited 2395864/IL162082 - 330.3620, 330.710, 330.2620 cited Facility Reported Incident IL161253 of 5/12/23 - 330.710 cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 330.3620 General Building Requirements Every existing facility shall: g) Have each exterior door equipped with a signal that will alert personnel in the area if a resident leaves the building. Any exterior door that is supervised during certain periods during the day or night may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. This requirement was NOT met as evidenced by: On 9/10/23 at 10:41 AM, there were multiple residents sitting in the main open area of House 3. This area had dining tables, a lounge area and furniture. Residents were walking and sitting in the lounge area and at the dining tables. The door located at the side of the dining room, next to the kitchen, was closed but did not appear to be latched. The door was easily pushed open and no alarm sounded. V2 (Director of Nursing-DON) exited the building with the surveyor. V2	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

said it was "intentionally" left open, to let them [residents] out. Directly outside the door was a large fenced in area and sloped sidewalk. The sloped sidewalk led to a sidewalk that extended behind house 3, house 2, and ended at the side of house 1. The spot visible from the dining room where the door was unalarmed, was the patio area. The rest of the back yard and fenced area was out of visualization from inside the dining room. After walking outside, V2 then said the door should be alarmed and he needs to check with maintenance.

On 9/10/23 at 10:50 AM, V3 (Caregiver) was in the dining room in house 3. V3 said the doors should be locked (front) and alarmed at all times. If the alarm goes off, we check right away. If there is no one at the door, we go outside and check. V3 said the alarm just broke on the dining room door. Maintenance knows it is broken. V3 said it is usually hard to open.

On 9/10/23 at 1:35PM, V2 said all the residents are at risk for elopement. They are always at risk, trying to get out.

On 9/11/23 at 2:33PM V1 (Executive Director) said the door off the dining room in house 3 should be alarmed. V1 said she found out "yesterday" that it was broken. She is working with maintenance on auditing doors and door alarms.

The 3/25/22 facility policy Resident Operations-Admission Criteria Policy states: Purpose: To ensure the potential resident's needs meet the admission criteria and the appropriate care provided from the early stages of dementia throughout their end of life needs. Practice- Admission Criteria - Resident must

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S9999	Continued From page 2 have some type of memory loss/dementia and/or cognitive impairment. The facility 6/4/2022 "Facility Operations-Door Alarm policy states Purpose: to Ensure the safety of residents and maintain the door alarm system. Plan: Door alarms shall be always alarmed. (C) 2 of 3 330.710a) 330.710c)1)2)3) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services, and social services. 3) A policy to identify, assess, and develop strategies to control risk of injury to residents...	S9999		

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S9999	Continued From page 3 This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to identify a new skin condition prior to becoming an advanced stage and requiring amputation for a resident with a history of wounds, failed to ensure an order was obtained for wound care completed by facility staff, failed to document wound care provided by facility staff, and failed to ensure wound care was being provided by a home health agency. The facility failed to assess a resident's need for laryngeal tube care and put a plan of care into place. The facility failed to notify the practitioner/provider and update a plan of care for a resident expressing suicidal thoughts, and after eloping. This applies to 3 of 4 residents (R1, R2, R3) reviewed for nursing care in the sample of 5. The findings include: 1. R1's face sheet showed he was admitted to the facility on 11/17/21 with diagnoses to include dementia without behavioral disturbance, mood disorder due to known physiological condition, and psychosis not due to a substance or know physiological condition. R1's June 2023 Physician Order Sheet showed an order dated 11/17/21 for "Skin Checks Weekly - complete Skin Evaluation in [electronic health record] on admission and weekly on assigned day." R1's Service Plan Initiated 11/29/21 shoed, "Bathing... Check skin with bath/shower and report any reddened/open areas to Nurse..." R1's medical record showed he was discharged	S9999		

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S9999	Continued From page 4	S9999		

to the acute care hospital on 5/12/23 and returned to the facility on 5/25/23.

R1's shower sheet dated 5/11/23 showed R1 refused his shower and had no skin concerns.

R1's complete medical record showed no documentation of identifying a wound to R1's left second toe prior to sending R1 to the acute care hospital for treatment.

R1's nursing progress note entered on 5/12/23 at 11:39 AM showed, "Patient was sent to the hospital due to sore on the left leg and second toe; it appears to be infected. I spoke with the doctor at [acute care hospital] where he was taken. Home health was also available during the time he was sent out."

R1's acute care hospital documentation 5/23/23 showed, "... Presenting Complaint: foot wound, Diagnosis: L (left) 2nd toe gangrene with osteomyelitis... Patient was admitted with worsening L 2nd toe wound... He underwent partial amputation of the L second toe on 5/15 with podiatry...."

R1's nursing progress note dated 6/26/23 at 3:25 PM showed, "Patient's POA (Power of Attorney) was called to notify them about the changes on the patient foot post op and also asked about the follow up appointment that was canceled..... As of today the foot has a yellowish-brown drainage. NP (Nurse Practitioner) was notified and she instructed to send him out to the hospital. Patient at this time has been scheduled for pick up to the hospital."

R1's nursing progress note dated 6/27/23 at 4:28 PM showed "Patient was discharged from the

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S9999	Continued From page 5	S9999		

hospital early hours of today and I met patient upon resuming my shift. Hospital papers show diagnosis of toe infection but the discharge note show "Surgical wound does not appear to be infected. X-ray and imaging did not show concerning findings." This note did not show notification made to the POA or the Nurse Practitioner regarding R1 returning from the hospital.

The facility provided shower sheets dated 5/15/23, 5/18/23, and 5/22/23 showing bed baths were given with no skin concerns. R1 was not present in the facility from 5/12/23 through 5/25/23.

On 9/10/23 at 11:55 AM, V6 Caregiver said they do skin checks with showers and changing residents. V6 said new skin conditions should be written on the resident's shower sheet and reported to the nurse.

On 9/10/23 at 3:38 PM, V2 DON (Director of Nursing) said the facility nurses do weekly skin assessments. If there is nothing found we don't document. If there is a skin concern found it is documented on the shower sheet as a skin assessment. V2 said the nurses at the facility do not provide wound care. V2 said R1 has had home health services for a long time and thinks the home health nurses should have identified R1's wound to his toe. V2 said the caregivers at the facility do skin assessments too but they are providing care so they do not assess head to toe. V2 said the caregivers would document the new skin condition and let the nurses know. V2 said the nurses would then assess the area and complete an incident report.

The facility's policy and procedure with effective

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S9999	Continued From page 6	S9999		

date of 6/1/22 showed, "Resident Operations-Home Health Services Policy, Purpose: To ensure that residents who have experienced a change of condition resulting in a decline will have the opportunity to be evaluated for home health services such as PT (physical therapy), OT (occupational therapy), ST (speech therapy), Skilled Nursing and/or Behavioral Health Nursing as recommended by a physician, Director of Nursing, Nursing and/or Executive Director... Plan: If ordered by a physician and approved by the resident representative, to coordinate the evaluation and treatment of the resident. If deemed appropriate for home health care services- PT, OT, ST, Skilled Nursing... 2. If a resident has an acute wound, nurse may dress wound based on assessment, notify NP (Nurse Practitioner), 3. If a resident has a chronic wound, notify NP, obtain order for home health services..."

The facility's policy and procedure with effective date of 6/1/22 showed, "Resident Operations-Individual Service Plan Process Policy, Purpose: All residents will have an updated, completed Individual Service Plan... Practice: The initial ISP Process may include the following components in addition to the ISP format:... I. Skin Observation..."

2. R3's face sheet showed he was admitted to the facility on with diagnoses to include hypothyroidism, Parkinson's Disease, dementia without behavioral disturbance, neurocognitive disorder with lewy bodies, and hypertension.

On 9/10/23 at 11:30 AM, R3 was sitting in the common area. R3 had a bandage wrapped around his left forearm.

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S9999	Continued From page 7 On 9/10/23 at 11:20 AM, V2 DON said he had just changed R2's dressing to his left forearm earlier in the day. V2 said R3 scratches and picks at his arms causing wounds. R3's September 2023 Physician Order Sheet showed no orders for wound care to his left forearm. R3's September 2023 Treatment Administration Record showed no treatments for R3's left forearm documented. R3's September 2023 Nursing Progress notes showed no documentation regarding changing the dressing to R3's left forearm. R3's Home Health Services documentation provided by the facility dated 9/8/23 showed, "... Discoloration to bilateral feet, dryness, will text [Nurse Practitioner]. Cluster of new small skin tears left arm..." R3's home health did not indicate what the current treatment order is for R3's left forearm skin tears or that a treatment was completed. On 9/10/23 at 3:38 PM, V2 DON said the nurses at the facility do not provide wound care. V2 said he applied a "general" dressing for R3. 3. R2's facility face sheet printed on 9/10/23 shows he was admitted to the facility on 7/5/23 with diagnoses to include unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, chronic ischemic heart disease, chronic obstructive pulmonary disease, chronic gout, and presence of pacemaker.	S9999		

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S9999	Continued From page 8	S9999		

R2's Brief Interview for Mental Status assessment dated 7/5/23 shows R2 was not able to repeat any given words, was not able to report the correct year (missed by more than 5 years), was unable to report the correct month or day of the week, and could not recall any given words. This assessment shows it was incomplete and required further assessment. No further assessment was completed in R2's record.

R2's Physician Order dated 7/5/23 shows "Laryngeal Tube cleaning (see instruction) three times a day for Laryngeal tube cleaning" There were no instructions identified on how to clean the laryngeal tube.
R2's Physician Order dated 7/7/23 shows "oxygen to laryngeal tube by mask PRN Masks/Liter Flow 2-3 Liters to Keep Oxygen Sats Greater than 88 % but no greater than 92% as needed for low O2 Sat".
R2's Physician Order dated 7/11/23 shows "Ipratropium-Albuterol Inhalation solution 0.5-2.5mg/3ML inhale orally two time a day by Nebulization [medication delivered in the form of a mist into the lungs] Duoneb"

R2's Nurse Progress noted dated 7/5/23 shows " ...resident admitted to House 1 [from acute care hospital] ...A/O x 2 (person, place), non-verbal (he can hear us, but unable to talk due to [diagnosis] of laryngeal cancer/ surgery-laryngeal tube placed in his neck) ...can use oxygen PRN if O2 sat is less than 88%...

R2's nurse progress notes show on 7/8/23 at 2:38PM, the writer called POA (Power of Attorney) and notified her of the resident's continuous intention to leave the facility. Writing on paper that his son took his 30K from his account.

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S9999	Continued From page 9 On 7/13/23 at 5:34PM, the progress note shows "writer was notified by caregivers that resident was physically aggressive. Hitting and pushing tables in the common area. Reorientation and redirection provided. Resident refused larynx tube to be cleaned. Stated he would do it himself if needed. Resident also states he needs a lawyer and that his son was trying to steal his money. ED [Executive Director) and POA notified [Power of Attorney]." R2's nursing progress noted dated 7/20/23 at 2:07PM shows...POA was notified resident refused his "larynx care". "Resident can be verbally aggressive. Threatening to hit staff and break down doors. Reorientation and redirection provided ..." R2's 7/21/23 progress note shows "spoke with POA about resident intention to find a means to kill himself if she doesn't come visit and make plans to take him back home. Per resident, he has no active plans to kill himself and he doesn't wish to be dead. He just wants to go back to his home where he can drive his truck and control his finances. Writer scheduled a 10PM face time call with POA and resident where POA reassured resident that is finances was safe and she was doing the best for him. POA was calm after the phone call. Denying any plans to kill himself. Writer stayed with resident through the night for observation ...ED notified." On 9/10/23 at 11:00AM, V10 (Licensed Practical Nurse-LPN) said she was working on 7/29/23 as the nurse at the facility. V10 said this was her first day working there. V10 said there was no nurse on night shift and the last time there was nurse there was around 8:00PM the night before.	S9999		

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	IL6013601	A. BUILDING: _____ B. WING _____	C 09/12/2023

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S9999	Continued From page 10	S9999		

V10 said the DON called and gave her training on the phone because it was her first time at the facility. V10 said R2 had a trach and had trach supplies in his room. V10 said it looked like the resident was responsible for his trach.

On 9/10/23, at 1:35PM, V2 (Director of Nursing) said R2 could take care of the laryngeal tube himself. V2 said he could suction himself and clean his tube. He had oxygen and supplies in his room. V2 was asked about the order for nursing staff to clean his laryngeal tube 3 times a day, see instructions. V2 said he thought there was a note somewhere about how the care should be done. V2 said R2 was alert and oriented but not all the time. It would depend on if he could make his own decisions because he had dementia. V2 (Director of Nursing) said R2 was high risk for eloping. V2 said R2 got away in the middle of the night to the community and the caregivers could not find him. V2 said he was not sure when he was found missing, and "I can't remember where he was found".

On 9/10/23 at 1:38PM, V11 (Registered Nurse) said she was working the day of 7/19/23. R2 had already been returned to the facility after eloping. When she arrived to the facility, the [caregiver] told her the resident went out and was brought back by the police. V11 said she thinks R2 was taking care of his trach himself. She said she would approach him to do trach care and he would want to do it himself. V11 said she did it for him a few times. He had oxygen in his room and equipment in his room but she never used it. V11 said yes, they did suction him, but there was not much mucous. V11 said he also had breathing treatments.

On 9/11/23 at 2:33PM, V1 said they complete a

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S9999	Continued From page 11	S9999		

pre-assessment on the resident prior to accepting them. V1 said they do not accept any residents with tracheostomies (surgically created hole in airway to help breathe). V1 said R2 had a "lary tube" which was used for his voice box, it had nothing to do with breathing or airway obstruction. R2 could take care of it on his own and was admitted because he was "combative" had "dementia" and "poor reasoning". V1 said she was notified by police that R2 had left the facility with his suitcase (on 7/18/23). V1 said R2 was returned around 4:45 -5:00AM (7/19/23) by the police. V1 said "absolutely" she would consider this an elopement.

On 9/11/23 at 3:14PM, V9 (Nurse Practitioner) said she saw R2 at the facility on 7/14/23. V9 said she asked the facility to get information on R2's trach, and why he had it. V9 said that is how he breathed. He did not have the valve needed to speak, it (laryngeal tube) was used for breathing. V9 said he was alert but had dementia. He communicated by writing. V9 said she did not recall being notified of R2's elopement, she thinks she would remember that. She was not notified he had suicidal thoughts. She said she had made a psychiatry referral for (R2) to be evaluated for his dementia.

There was no documentation in R2's record on how or when to suction R2's laryngeal tube. There was no documentation on what supplies were needed for R2's laryngeal tube, how care should be provided, and the size of the tube if it would need replaced etc. The facility was unable to provide a plan on how the care should be provided to R2's trach. There was no plan of care for R2's elopement, or suicidal thoughts. There was no order for a psychiatry evaluation or evidence the referral was made.

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S9999	Continued From page 12 R2's hospital documentation dated 6/29/23 shows R2 is post tracheotomy with laryngectomy tube, secondary to squamous cell carcinoma of the larynx with laryngectomy in 2020 ...continue suctioning/nebs as needed and watch the oxygen saturation closely. The facility policy dated 3/25/22 "Resident Operations-Individual Service Plan (ISP) Process Policy" shows: Purpose: All residents will have an updated, completed Individual Service Plan. The facility policy dated 6/25/23 "Resident Operations- NP/MD/GP Communications Policy" shows; Purpose: To ensure communication is communicated to a resident's NP/MD or General Practitioner for the purpose of resident continuity of care. The NP/MD or General Practitioner will be notified if ...an Unusual Occurrence form is initiated due to an incident involving a resident such as: ...a change in condition. The facility 6/4/22 policy "Resident Operations-Change in Resident Condition shows": Purpose: To ensure the timely, accurate, and appropriate notification of all parties involved when there is a significant change in condition. Family members, physician, and license specialist will be notified appropriately of significant change in resident condtion. Resident Change of Conditons is defined as: d. Deterioration in behavior or mood to the point where relationships have become problematic. (A) 3 of 3	S9999		

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S9999	Continued From page 13	S9999		

330.780 a)

Section 330.780 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

This requirement was NOT met as evidenced by:

Based on observation, interview, and record review the facility failed to identify how a resident with dementia eloped from the facility and the facility failed to have a record of R2's elopement from the facility. The facility failed to follow their policy to notify the resident's power of attorney and medical provider after a resident eloped.

This applies to 1 of 4 residents (R2) reviewed for safety/supervision in the sample of 5.

The Finding Include:

On 9/10/23 at 9:00AM there was a pink sign in the window of house 1 identifying elopement risk for the building. There was a sign on the door stating to wait 15 seconds after opening to make sure it locked. The house had a door and windows along the front of the facility, facing the street and parking area. To back of the building was a fenced in area, running behind all three housing units.

R2's facility face sheet printed on 9/10/23 shows

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	IL6013601	A. BUILDING: _____ B. WING _____	C 09/12/2023

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S9999	Continued From page 14	S9999		

he was admitted to the facility on 7/5/23 with diagnoses to include unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, chronic ischemic heart disease, chronic obstructive pulmonary disease, chronic gout, and presence of pacemaker.

R2's Brief Interview for Mental Status assessment dated 7/5/23 shows R2 was not able to repeat any given words, was not able to report the correct year (missed by more than 5 years), was unable to report the correct month or day of the week, and could not recall any given words. This assessment shows it was incomplete and required further assessment. No further assessment was completed in R2's record.

R2's nurse progress notes show on 7/8/23 at 2:38PM,the writer called POA (Power of Attorney) and notified her of the resident's continuous intention to leave the facility. Writing on paper that his son took his 30K from his account. On 7/13/23 at 5:34PM "writer was notified by caregivers that resident was physically aggressive. Hitting and pushing tables in the common area. Reorientation and redirection provided. Resident refused larynx tube to be cleaned. Stated he would do it himself when needed. Resident also state, he needs a lawyer and that his son was trying to steal his money ..." R2's nursing progress noted dated 7/20/23 at 2:07PM shows .... POA was notified resident refuse his "larynx care". "Resident can be verbally aggressive. Threatening to hit staff and break down doors. Reorientation and redirection provided ..."

On 9/10/23 at 1:35PM, V2 (Director of Nursing) said R2 was high risk for eloping. V2 said R2 got

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S9999	Continued From page 15	S9999		

away in the middle of the night to the community and the caregivers could not find him. V2 said he was not sure when he was found missing, and "I can't remember where he was found". V2 said he did not know why that information was not documented anywhere in R2's medical record. V2 said all residents are at risk for elopement and the staff should be doing a frequent head count to see where they are. V2 said he did not know the circumstances of the elopement and most investigations are done by the Executive Director (V1). V2 said after an elopement occurs the nurse would do an assessment of the resident, make sure they are ok, and fill out an unusual occurrence report. V2 said they look at the circumstances around the elopement and the situation that occurred. V2 said changes that need made would be communicated to staff in a monthly staff meeting. V2 said R2 "always said he wanted to leave". He was alert and oriented but not all the time. At 3:22PM, V2 said an incident form was not completed for the elopement. V2 said there was no nurse working at the time R2 eloped, that is why it was never documented in his record. V2 said they should have documentation in the record of the elopement. V2 said he did not do an investigation into what happened.

On 9/11/23 at 1:46PM, V8 (Paramedic) said R2 was found on a "major intersection" at Lake Cook Road and McHenry Road in the bordering city to the facility. V8 said three teenagers found R2 on the corner. R2 was non-verbal but had a journal he wrote in. He wrote in the journal to call the police, and the police called the paramedics. V8 said R2 had at least two suitcases with him. It was a "good amount of luggage" and we were not sure how he was able to get out of the facility with them. He had a trach (tracheostomy tube) and

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S9999	Continued From page 16	S9999		

couldn't talk. We called the facility to let them know we found him and they had no idea he was out. V8 verified this occurred on 7/18/23 at around 10:00PM.

On 9/11/23 at 1:55PM, V11 (Registered Nurse-RN) said she was working the day after R2 eloped from the facility. V11 said she arrived around 7:15AM. She went straight to house 2 to get her computer, and then to house 3 to pass her meds. When she went into house 1 (where R2 resided) she was told by the staff (caregiver) R2 went out and the police brought him back to the facility. V11 said there was no nurse working when he left the building and when he was returned. I did not ask him (R2) why he left, I did not want to get his brain working again. I told him if he wanted to go outside to let me know and someone would go with him. V11 said she thinks R2 had Kerlix (gauze dressing) to scratches to his arm but she wasn't sure. V11 said she admitted him to the facility (on July 5, 2023). V11 said he was alert and oriented but said he wanted his keys back, his gun back, and his truck back. He said he did not want to be there (at the facility). V11 said she did not know how he left the facility. She said someone told her he left through a window.

On 9/11/23 at 2:33PM, V1 (Executive Director) said every 2 hours the team member should do rounds on the residents. If they can't find someone, they would notify everyone on campus to begin a search. If the resident was not found, they would notify family, complete an unusual occurrence report, and notify public health. V1 said they advise to take a resident (who has eloped) for medical treatment and evaluation. When they return, and when the nurse is onsite, the nurse will assess them. They would do an

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S9999	Continued From page 17	S9999		

in-service for staff and increase rounding. This should all be documented in the record. V1 said she was out of state when R2 was missing. She got a call from a policeman that he was found with his suitcase. I called the facility and had them do a head count. V1 said R2 was returned back to the facility around 4:45- 5:00AM (the next morning). V1 said she is not sure how R2 got out. She called V2 and advised him to do the incident report. V1 said they (V1 and V2) could not find an incident report. V1 was unable to provide any documentation regarding R2's elopement. V1 was unable to provide any documentation from R2's Emergency Room evaluation, prior to being returned to the facility. V1 said she would "absolutely" consider R2 leaving an elopement. There was no evidence any communication occurred with staff after the incident, or the plan of care changed to prevent additional elopements.

V9 (Nurse Practitioner) said she saw R2 on 7/14/23. V9 said she did not recall the facility notifying her that R2 eloped.

Review of R2's record does not show any documentation regarding the incident of R2 leaving the facility unsupervised, his evaluation prior to returning to the facility (hospital documentation), and how he was returned to the facility. R2's record did not show any evidence his POA was notified, or his Physician/NP was notified.

The revised facility policy of 3/2/22 "Missing Person/Elopement/Safe Return" shows: 2. Any resident identified at risk shall have supervision when outside of the homes, or on the grounds, or in the community at large. 3. If a resident's whereabouts cannot be determined ...(l).

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S9999	Continued From page 18 Executive Director will notify the family. (L) A complete report of the incident must be completed and submitted to the administrator for proper licensing notifications. (M) all steps taken in the same return of the resident must be documented in the resident record. When a resident is located, the following steps shall be taken immediately by administrative team: 2. Call to inform family/responsible party and notify team by group messaging app. 5. Complete accident/incident report and all necessary charting (for example, nurse notes, communication shift log, etc) and communicate all information to IDPH. 6. Establish a new plan of care to increase monitoring of resident's whereabouts and inform team of directives for new plan. (B)	S9999		