STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012645	A. BUILDING: _____ B. WING _____	C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON REHAB & HCC	255 WEST 69TH STREET CHICAGO, IL 60621

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S 000	Initial Comments Facility Reported Incident of August 8, 2023 IL163247	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.3240 a) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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care needs of the resident.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide adequate supervision for a cognitively impaired resident (R1); failed to visually check every two hours for the presence of one of four residents (R1) reviewed who were at risk for elopement and wandering; and failed to ensure the facility entrance/exit was secure. As a result, R1 eloped from the facility on the night of 8/07/23, without the facility staff being aware the resident (R1) was missing until the morning of 8/08/23.

Findings include:

According to roster and surveyor's observation of R1's assigned room, R1 was located on the facility's first floor.

R1's admission record showed R1 was admitted to the facility on 10/17/2022, with diagnoses including, but not limited to: non-ST elevation (NSTEMI) Myocardial Infarction, History of falling, Unspecified Dementia moderate with other behavioral disturbances, Restlessness and agitation, other Schizophrenia, Cough Variant Asthma, and Essential (Primary) Hypertension.

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S9999	Continued From page 2 R1's MDS (Minimum Data Set) assessment, dated 07/04/2023, scored R1's BIMS (Brief Interview for Mental Status) as 07, indicating R1 is cognitively impaired. Section G of the MDS coded ADL's (Activity of Daily living) personal hygiene as 2/2 indicating that R1 needs limited assistance in self-performance with one physical assist from staff. R1's medical record fall assessment, dated 5/4/23 and 7/4/23, showed R1 is at risk for falls, with a score of 8.0 as of 05/4/2023, and a score of 7.0 as of 7/4/23. R1's plan of care, with initiated date 3/15/2023, documented under focus, "(R1) is found exploring/elopement/exit seeking familiar setting as evidenced by looking persistently for a way to get out or get home, attempts to get on elevator, attempt to use alarmed fire exit doors." Goals includes, "to safely remain on unit or under supervision." Intervention /task-initiated, date 3/15/2023, listed "to initiate frequent checks and supervision." R1's care plan for mental illness, initiated 2/28/23 and revised 5/08/2023, under focus, documented R1 has a diagnosis and history of severe mental illness, with symptoms manifestation that includes display of unknown risk for factors that includes wandering, elopement risk, and poor safety awareness. Goals set includes R1 taking medication as prescribed. According to the Emergency Medical Services (EMS) report, on 8/07/23, R1 was taken to a local hospital at 9:55pm (21:55). The report documented R1 was found in care of local first responders about two blocks from the facility on a	S9999		

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major street walking in between cars and confused about her location. The bystanders on the scene stated R1 was walking in the middle of the road confused about her location. R1's ER (Emergency Record) documented R1 was confused and appears to have Dementia. Per the facility's documented investigation, the facility had been unaware R1 was missing until 08/08/23 at 8:30am.

R1's ER (Emergency Record), 8/07/23, documented R1 was confused and "appears to have Dementia.

According to the facility investigation report the following staff statements were presented:
-V22, LPN (Licensed Practical Nurse), stated she worked 7pm to 11:27pm on 8/07/23, and was the nurse for R1. V22 made rounds and R1 was refusing care and medications, walking around the floor throughout the night. V22 documented R1 was encouraged to go to bed.
-V28, CNA (Certified Nursing Assistant), documented she worked on 8/07/23 on the 1st floor where R1 was at the time of elopement, but did not hear any alarm, and was not aware of any resident leaving the building (referring to elopement).
-V29 (Housekeeping) stated on Monday (referring to 8/07/23), V29 did not hear any alarm sound.
-V6, CNA (Certified Nursing Assistant) statement, dated 8/08/23, documented, "I started work around 9:00pm and started my rounds around 10:30pm. I opened the door to (R1's) room and investigated her room. (R1) 's bed looked like someone was in it. The covers were on it, and the pillow was there. (R1) has been pretty loud lately, so I was letting (R1) stay quiet, so I did not go over to (R1's) bed." V6 statement included some previous behaviors of throwing garbage can,

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claiming to see someone behind the curtain that was not there, and claiming to see rats that were not there. "I did not see (R1) physically, but saw the blanket and the pillow, which looked like (R1) was in bed." V6 stated she made her rounds at 2:00am or 2:30am, and it was the same thing she saw (referring to 10:30pm). V6 statement documented at 5:45am on doing the last rounds she went back to R1's room. "I must be honest, I thought that (R1) was just quiet and peaceful, so I didn't go into the room to get a look at (R1). (R10 only needs a little supervision and goes to the bathroom independently." V6 indicated she did not hear any alarm besides the one she heard at 7:15am, which was V30 (Painter) for the facility.
-V23 (LPN) undated statement, stated, "On Monday I worked with (R1) from 11pm to 7am. I am going to be honest, did not see (R1) all night. She gets one pill at 6am, but I did not give it to her. I saw her at the elevator around 8 to 8:30, and I asked her to go to her room. (R1) moved away from the elevator area then went back to it. I asked (V27, RN/Registered Nurse) (referring to another staff) if he would be sitting at the nurse's station for a while because (R1) was there and needed to be watched, so I started my medicine, that was the last time I saw R1." V23 stated when she was about to give her medicine, she (V23) found that R1 was missing. "I did not notify anyone that she was missing." The protocol for missing resident is search, page code green and inform the administrator.

According to the facility investigation report presented by V1 (Administrator) statement from V23, LPN (Licensed Practical Nurse) dated 08/08/23 documented in part that on Monday 8/7/23, V23 worked with R1 from 11p (pm) to 7a (am). "I am going to be honest; I did not see (R1) all night. R1 gets one pill at 6a (am) but I (V23)

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did not give it to (R1). Around 8:00 or 8:30 R1 moved away from the elevator area then went back to it. I asked V27 RN (Registered Nurse) (referring to another staff) if he would be sitting at the nurse's station for a while because R1 was there and needed to be watched, so I started my medicine, that was the last time I saw R1." "I (V23) found out that (R1) was missing, I did not notify anyone that (R1) was missing." V23 affirms in part that the facility protocol for missing resident is search, page code green and inform administrator (V1). V23 did not follow the facility policy and procedure on elopement.

According to the facility investigation V22, LPN (Licensed Practical Nurse), was contacted via telephone and stated she worked on 8/07/23 from 7am to 7pm, and the last time she saw R1 was around 8:30pm, and was re-directed back to the room. V22 statement indicated V22 did not see R1 after that time.

R1's medication record progress note, dated 8/08/23 timed 2:33pm (14:33), V26, SSD (Social Services Director), documented R1 eloped on 8/08/23. This conflicts with the EMS report that R1 was taken to hospital 8/07/23 at 9:55pm.

Review of facility schedule sheet for January to April 2023 showed Security staff scheduled for 10pm to 6am, but no security staff were scheduled for the 10pm to 6am shift for May to August 2023.

On 8/21/23 at 9:03am, V1 stated R1 eloped on 8/08/23, and V1 was notified at around 8:30am. According to the facility's documented investigation, the facility was unaware R1 was missing until 8/08/23 at 8:30am.

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S9999	Continued From page 6 On 8/21/23 at 9:45am, V20 (Security staff) stated, "The Security staff are supposed to check residents and visitors in and out of the facility and make sure the residents going out are the ones allowed to go out without supervision. The smoking list is by Security, and the resident pictures are in a binder by Security, along with the pictures and list of those who wander and can elope." V20 stated there was usually one Security staff scheduled for the night shift, but lately there has been no security staff at night. On 8/21/23 at 10:04am, V19 (Security staff) who was scheduled for 2pm to 10pm on 8/07/23, stated he works from 2pm to 10pm, and there is no other Security staff scheduled for 10pm to 6am. V19 was not sure how R1 eloped. On 8/21/23 at 11:40am, V19 stated he did not leave the Security post all night. However, the facility's video showed between 9:04pm and 9:10pm, V19 was not at the door monitoring. When this was made known to V19, he stated, "I only left one time to use the bathroom." V19 stated when he is on toilet break or any break, there should be a staff monitoring the door, but there was no staff to relieve him. The Security guard desk and the door leading to the 1st floor residents' area was left wide open. On 8/21/23 at 12:36pm, V1, Administrator, stated, "The doors (referring to the entrance door to the 1st floor residential area) should not be left unattended, without staff supervising (monitoring) the doors. There is usually one Security staff on schedule from 10pm to 6am, but that staff is no longer working at the facility." The facility was trying to get another Security staff to replace the one that was gone. V1 stated the doors should not be left unattended without staff supervising	S9999		

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S9999	Continued From page 7 /monitoring those doors. On 8/22/23 at 9:37am, V7 (Clinical Director) stated, "I oversee the Security staff and their schedule. Regarding security staff staffing, because we (referring to the facility) have residents with behavioral health problems, the facility is required, and must have 24 hour security guards trained in CPI (Crisis Prevention Intervention). Recently, we (Facility) don't have any staff to replace the person who was here on night shift in the past two months, but we are trying to fill that position, trying find some-one." When asked about the purpose of having Security staff 24 hours a day, V7 stated it is to assist with any behavior challenges, and anything the facility may need, and that includes residents who are physically aggressive, at risk for elopement and who wander, and with some residents who need re-direction. Surveyor asked V7 if, in the case of R1's elopement, not having door alarms to alert staff is effective. V7 stated in part, "Yes, I do think it is effective, but I do think there should be a Security staff on duty at night." The surveyor asked V7 about the expectation of staff in monitoring and supervising the residents who are at risk for elopement and who wander. V7 stated, "Staff are to keep eye on them, be aware of where they are." Then the surveyor asked, "In your professional opinion, was this followed in the case of (R1)?" V7 stated, "I digress in answering that question; I'm keeping my answer to myself (with smiling gesture and shrugging of the shoulder)". V7 presented the facility schedule sheet for Security staff presented from January to April 2023, that showed Security staff was scheduled for 10pm to 6am, and from July to August 2023, there was none scheduled. On 8/22/23 at 12:43pm, V24 (CNA) stated, "On	S9999		

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8/08/23 when I came, (R1) had already gone missing (eloped). When I came into work, I did my rounds; she usually sits up on the side of the bed, but I noticed she was not in her room, so I thought she was in the dining room for breakfast. But she was not there; then I got busy doing the breakfast cards for the trays. After a while I asked (V17, Restorative Aide/CNA) to help whether (R1) was in the room and then we (staff) started calling Code Green (For missing resident)." V24 stated, "Rounds means I physically see the resident, asking them about their needs, if they are wet (incontinent), change them, but (R1) is continent. Rounds was to be done every 2 hours; about three times during the shift I make my rounds. At 8:30am was the time we knew (R1) was not on the floor, so we called code green and other staff started looking for (R1)."

On 8/22/23 at 2pm, V17 (Restorative Aide/CNA) stated "On that morning on 8/08/23, I was the one that discovered R1 was gone (eloped). When I was doing my rounds at about 8:30am or 9am to get (R1) a breakfast tray, (R1) was not in her room. I checked the dining room, shower room, and I talked to the nurse, (V16), thinking (R1) might have gone for appointment or went out. (V17) stated that the dinner tray was left on the side table, then we did the room search, after then called Code Green because we could not find (R1) in the facility." The surveyor then asked V17 about how often rounds are made. V17 stated, "Every two hours, but I am a Restorative Aide; at times we work on the floor. I know she wanders, but I did not know she could elope. (R1) needs supervision in the community; she cannot function on her own." V17 stated, "It's not safe for her out there."

On 8/28/23 at 9:04am, V1 (Administrator) stated

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when there is no Security staff in the facility after 10pm, all the staff in the facility from that time are responsible for monitoring the residents, which includes the nursing staff.

On 8/28/23 at 9:06am, V2, DON (Director of Nursing) stated residents are monitored through making routine checks. V2 stated, "Rounds are to be made every two (2) hours by nursing staff by visually seeing the residents."

On 08/30/23 at 11:45am, V1 (Administrator) stated the facility policy/protocol on missing resident is to "immediately call code green to alert all staff in the building that a resident is missing. To let the Administrator know, make the Director of Nursing (DON), Assistant Director of Nursing (ADON) aware of the situation." V1 stated it is not appropriate for any of the staff not to call code green knowing a resident is missing. V1 stated, "From the investigation, (V23) did not do the routine checks. She did not make the rounds because she would have known that (R1) was missing. When (V23) knew that (R1) was missing, she did not follow the facility policy and procedure for missing resident the elopement policy. "(V23,LPN) was suspended for 7days without pay, because she did not follow the policy and procedure. And anything could have happened to the resident including death. (V23) neglected (R1)."

On 9/05/23 at 9:54am, V23 (LPN) stated on 8/07/23, she was the nurse for R1 from 11pm to 7am. V23 stated she was the only nurse in charge on the 1st floor after 11pm until 7am. V23 stated she did not make any rounds at 11pm, and "I did not see (R1) throughout the night. I saw her at about 8:30pm; she was by the elevator. Rounds are supposed to be made every 2hours

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and as needed." V23 stated, "I did not see (R1) during the night shift, because throughout the night I did not notice that (R1) was gone, and none of the CNAs told me (R1) was not in here (Facility)". The surveyor then asked when you did become aware R1 was not on the floor and in the room, what is the facility protocol to be followed. V23 stated she is to "search for (R1) and call code green, search all the facility inside and outside, call the Administrator, the doctor, and the family. But that was my mistake. I did not follow the policy and procedure on elopement." V23 confirmed, "(R1) is at risk of danger out there; I did not give the 6am medicine because (R1) was gone." V23 stated the Security guard leaves at 10pm, and after the nursing staff are to monitor the residents. "I did not hear any alarm that night and I did not see (R1) go out of the building." V23 stated, "(R1) is known to wander. There was a time (R1) was found in the elevator on the 2nd floor, and in the basement confused. I know I should have followed the elopement policy and procedure."

On 9/05/23 at 9:58am, V23 stated R1 is cognitively impaired to function well out in the community, and has a BIMS (Brief Interveiw for Mental Status) score of 07. V23 stated, "(R1) is at risk of danger out there (Community)."

The facility policy on Routine Resident checks, dated 9/2020, documented the routine checks policy interpretation and implementation includes "ensuring the safety and well-being of our (referring to the facility) residents, a resident check will be made at least every two (2) hours throughout each 24-hour shift by nursing services personnel, and it involves entering the resident's room to determine if the resident's needs are

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S9999	Continued From page 11 being met, if there has been a change in the resident's condition, if the resident has any complaints, and if the resident is sleeping or needs toileting assistance etc." The facility policy on Elopement and Management of Missing Resident documens the policy includes "minimizing risk of elopement. Elopement is defined as a dependent (cognitive impaired and non-decisional) resident leaving a facility without staff awareness and under circumstances that place the resident 's health, safety, or welfare at risk." (A)	S9999		