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	IL6002026	A. BUILDING: _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING CENTER	4314 SOUTH WABASH AVENUE CHICAGO, IL 60653

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S 000	Initial Comments Complaint Investigation 2380495/IL155484	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690c) 300.1210b) 300.1210d)6) 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. Section 300.690 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interviews and record review, the	S9999		

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S9999	Continued From page 2 facility failed to monitor and supervise a resident (R2), who was placed on facility's 24-hour safety monitoring, who has a history of illegal substance abuse and suicidal ideation. This failure resulted in R2 eloping from the facility and presenting at a county hospital reporting hallucinations and suicidal ideation with a plan to jump into the lake. Finding include: According to a face sheet, R2 is a 58-year-old resident admitted to the facility on 12/09/2022. According to psychiatric rehabilitative service coordinator note dated 12/09/2022, R2 has a history has a psychiatric diagnosis of suicidal ideation, depression and the history of bipolar disorder and schizophrenia. R2's Minimum Date Set assignment dated 12/20/2022 indicated R2 has a Brief Interview for Mental Status (BIMS) score of 15, which indicates resident has intact cognitive response. R2's care plan dated 01/09/2023, indicated R2 has a history of substance abuse and self-harm or suicidal ideation. Nursing Progress Note dated 01/10/2023 authored by V16 document: "Resident noted with unauthorized departure from the facility today, staff has presented statements due this action, MD, social services, DON, and administrator are aware, no guardian/family listed, resident is responsible for self." Safety Checklist (dated 01/10/2023) documents R2 as being in another resident's room at 4pm. The checklist does not list R2's whereabouts starting from 5pm as R2 eloped.	S9999		

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S9999	Continued From page 3 On 01/31/2023 at 9:40am V1 (administrator) stated, "R2 is no longer at the facility. R2 just left and later that day we found out that R2 was at the hospital. R2 did not even sign out against medical advice (AMA), R2 just left. R2 was no trouble as a resident, maybe on occasion R2 would use vulgar language. R2 came from the sister facility to be closer to the city. R2 would go outside and smoke and would return. On 01/10/2023, we were passing trays for diner, and we realized that R2 was not here at the facility. R2 left the building and never came back. We believe that R2 left when they went out to smoke and R2 never returned. The smoke break was at 2:30pm and we believe that R2 left the facility premises during the smoke break. R2 was never a resident who we were concerned about because R2 never attempted to leave or elope. On 01/11/2023, we received a call from the community behavioral hospital, informing us that R2 was there and wanted to know if he could return. The facility's admissions department contacted the hospital and informed the hospital that we would take R2 back to the facility. They never brought the resident back and the admissions director called the hospital several times to follow up if R2 was returning. R2 did not have a pass to go out into the community alone because R2 was still being evaluated. When R2 was admitted here on 12/09/2022, R2 was still in the process of being evaluated for an independent community pass. At the time R2 left, he was able to go into the community only with supervision and was in the process of being evaluated for an independent community pass but did not possess an independent community pass at the time R2 eloped from the facility. When the residents go out to smoke, they go out to the patio. The exit door to the patio is locked. The patio is monitored by 4 to 5 staff members when the residents are	S9999		

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S9999	Continued From page 4	S9999		

outside smoking. I did not conduct an investigation on how R2 eloped, we did a whole house search and since R2 is alert and oriented, we did not report it to the police. R2 had his jacket on him at the time R2 left because he was outside smoking so he must have planned to elope.
Residents at times do attempt to climb the fence to elope from the smoking patio, that's why we have staff there to monitor the residents and prevent them from eloping. I really don't know if R2 escaped from the smoking patio. There were no door alarms going off, so the process of elimination indicates that R2 eloped from the smoking patio. It is possible for residents to elope from the smoking patio. If the resident is alert and oriented, we don't investigate on how they eloped. If they are alert and oriented it's their decision if they want to leave. R2 had the capacity to make his own decision and R2 had the capacity to leave the facility. R2 never expressed the desire to leave the facility. As of right now, I do not know how R2 left, this is only our suspicion that R2 eloped from the smoking patio. R2 somehow ended up in the community psych hospital and did not get his medication and was cold and hungry and probably ended up at the psychiatric hospital. There is a loophole of how R2 eloped, so there are other residents who are potentially able to elope from the facility. We are aware of the fact that there is a loophole on how R2 escaped, and we are monitoring other residents closely. I honestly don't know how R2 escaped it is only our suspicion that R2 escaped from the smoking patio. We did not put in any new interventions, since R2 eloped, we are just closely monitoring the residents and the doors are locked. R2 has a diagnosis of schizophrenia so R2 does have a history of psychiatric disorder. As of right now, the last we know R2 was at the

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S9999	Continued From page 5	S9999		

hospital, and I believe R2 was discharged. R2 was not suicidal at the time. In R2's diagnosis R2 does have suicidal ideation but R2 wasn't suicidal at the time. I did not report this incident to the IDPH because R2 was alert and oriented and R2 wasn't a problem."

On 01/31/2023 at 10:50am, V1(administrator) identified 8 residents at risk for elopement at the time of investigation. The following residents were identified as being at risk for elopement: R6, R7, R8, R9, R10, R11, R12 and R13.

On 01/31/2023 at 11:32am V3 (social service director) stated, "When a resident elopes and once we are made aware of the elopement, we call a code pink. Code pink means that there is a missing resident or elopement. We search for the resident that's missing in the facility and outside. If need be, we will call the Chicago Police Department. If the residents have family listed on the contact list, we will call them and make them aware. If we cannot find the resident, we will call the police and make a missing police report right away. That is protocol, that when a resident is missing and cannot be found, we have to call the police and make a missing police report. The protocol to call and make a police report when the resident is missing is for every resident, regardless of their cognitive status, a police report must be filed when a resident is missing. It does not matter how alert the missing resident is, when we cannot locate that resident when a search is unsuccessful, we are supposed to call the police immediately."

On 01/31/2023 at 11:52am V4 (psychiatric rehabilitation service director) stated, "R2 was living at our sister facility and was admitted to this facility on 12/09/2022. When we have a new

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S9999	Continued From page 6	S9999		

resident admitted to this facility, we have to do a 72-hour behavior safety check list where we monitor them. After reviewing R2's admission packet from the hospital, we discovered that R2 has a past history of aggression, history of substance abuse and suicidal ideation. The social service department enrolls the resident into the substance abuse program. After reviewing R2's referral packet, R2 was placed on a facility safety monitoring rounding checklist because R2 has a history of suicidal ideation and substance abuse. R2 was residing on the 3rd floor which is a psychiatric floor. The rounding check list requires the staff to monitor R2 every hour and record R2's whereabouts on the checklist. According to the checklist filled out by V15 (psychiatric rehabilitative service aide) on 01/10/2023, R2 was last seen at 4pm, at that time R2 was in another resident's room. After 4pm, R2 was no longer seen. I received a call from V5 (PRSC) stating that they could not find R2 inside facility. Immediately after receiving that call, I notified the V1 (administrator) and explained to V1 that R2 is missing. I asked my staff to document on the computer about the elopement and we updated the care plan and the elopement form. The facility was searched prior to calling me and when they could not find the resident, they called me, and they called the administrator. The administrator did not call the police because R2 is alert and oriented. According to the administrator, if the resident is alert and oriented, we do not notify the police and we do not make a missing police report. R2 did not discharge from the facility, R2 eloped. R2 has a major depressive disorder and schizoaffective disorder bipolar type and schizophrenia and suicidal ideation and cocaine abuse usage and cannabis dependence which is why R2 was admitted to the facility in the first place. Medically, R2 is not fit to leave the facility.

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S9999	Continued From page 7 R2 needs help to be stabilized. R2 has a lot of mental health issues and should on be out of this facility according to his medical history. We do not know R2's mental state at the time R2 eloped. The facility's administrator would be the one who calls and makes a police report." On 01/31/2023 at 3:26pm V6 (certified nursing assistant) stated, "I was the C.N.A working with R2 on 01/10/2023, when R2 eloped. The last time I saw R2 was at 1:30pm, when R2 was going down to smoke a cigarette on the smoking patio. I saw R2 leaving the 3rd floor to go to the 1:30pm smoke break. I do not recall seeing R2 return from the smoke break. R2 never mentioned that he wanted to leave the facility. I finished my shift at 3pm and when I returned to work on 01/11/2023, I was informed that R2 eloped." On 02/01/2023 at 9:56am V7 (certified nursing assistant stated, "I was working on the 3rd floor on 01/10/2023. I saw R2 on 01/10/2023. The last time I can recall seeing R2 was during lunch time. I don't recall seeing R2 after lunch. The last time I saw R2 was during lunch time when I was passing trays. Typically, R2 was usually in his room. I don't recall ever seeing R2 visiting other resident room. R2 kept mostly to himself and stayed in his room." On 02/01/2023 at 12:32pm V10 (primary physician) stated, "They called me from the facility and told me that R2 eloped. They told me that R2 just walked out from the facility. There was no AMA, there was no discharge for R2, he simply just left and walked out from the facility. The facility told me that R2 just left. R2 just ran away. R2 was being monitored for safety at the facility. I think that R2 could have jumped the fence, but I don't know. R2 was being monitored	S9999		

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S9999	Continued From page 8	S9999		

for safety and R2 was a psych patient. Often, the psych residents want to leave the facility and that's what R2 did, he just walked out of the facility. The nursing home was monitoring him for 24 hours a day. Based on the diagnosis that R2 has, R2 needs to be monitored and I hope that R2 does not kill himself or someone else. I thought that the facility called the police and made a police report and reported R2 missing. I thought it is protocol to call the police when a resident elopes. I thought that the facility called the police to report that he ran away."

On 02/02/2023 at 10:32am V13 (Psychiatric Rehabilitative Service Coordinator) stated, "I was the one that was supervising the smoking session on the day that R2 eloped. There was 4 of us supervising the smoking break. Typically, there should be an activity aide, a CNA, a PRSC and a PRSA. On 01/10/2023, there was only 4 of us supervising the smoke break. I don't remember if an activity aide was there and I don't remember if there was a CNA present. I don't remember seeing R2 on the patio during the smoke break. We monitor the residents during the smoke breaks. We have staff members on each side of the gate and a staff member in the middle to provide supervision during a smoke break. On the day that R2 eloped, I don't remember seeing a staff member on each side of the gate to supervise during the smoke break. There is usually a staff member supervising the front gate, but I don't remember seeing a staff member supervising the other end gate, the gate that is away from the front entrance. We wait until all of the residents come inside from the smoking patio. Once all the residents come in, we lock the door."

On 02/02/2023 at 10:52am V14 (front door

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S9999	Continued From page 9	S9999		

receptionist/Psychiatric Rehabilitative Service Assistant) stated, "On 01/10/2023, R2 came down from the 3rd floor to the front lobby close to 2pm. R2 approached me and requested to speak to V1 (administrator). R2 remained in the front lobby, and I went to inform the administrator, that R2 was requesting to speak to V1, however, V1's door was closed. I came back out to the front lobby to let R2 know that V1 was in the meeting, and I told R2 to come back in 30 to 40 minutes. R2 said R2 would come back to speak to the administrator and got on the elevator. That same day, I saw R2 on the second floor around 3pm, visiting R5's room. That was the last time I saw R2. R2 did not escape during the 1:30pm smoke break because I saw R2 around 3pm on the second floor in R5's room. That was the last time I saw R2. I was informed around 5:30pm that R2 was missing and R5's room was the first place I went to search. I called a code Pink, which is a code called when a resident is missing."

On 02/02/2023 at 11:23am, V15 (Psychiatric Rehabilitative Service Assistant) stated, "On 01/10/2023, I was the one who signed the round sheet for R2 at 3pm and 4pm. The round sheet is used to monitor residents for safety. I witnessed R2 at 3 and 4 pm on the second floor, in R5's room. I did not see R2 in the facility after 4pm."

On 02/02/2023 at 12:28pm V17 (maintenance director) stated, "I checked all the exit doors with alarms in the entire building. All the door alarms are working properly. All the exit doors are secured and locked. After R2 eloped, I checked all the doors and alarms in the building, and everything was working properly. It is a possibility that R2 escaped through the service door in the basement, by the kitchen. We have food delivery and supply delivery, and everything is delivered

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S9999	Continued From page 10	S9999		

through the back service door, so it is possible that R2 escaped through the service door in the basement. We had other residents attempt to elope through the basement service doors. We have cameras all over the facility."

Surveyor, accompanied by V17 (maintenance director), checked all the door alarms in the facility. Surveyor observed the door alarms to be working.

County Hospital Records (dated 01/11/2023) document: Voluntarily brought self in states that he has suicidal thoughts with a plan to jump off a bridge; denies HI and hallucination.

Hospital Records dated 01/11/2023 document: Pt is a 58-year-old male who presented to behavioral hospital as a direct transfer from county hospital Emergency Department. Per hospital fax, pt presented with suicidal ideation with a plan to jump in the lake. Pt also reported visual hallucinations stating that people are following him. Pt has a history of schizophrenia and bipolar. Pt reported that he is compliant with his medications. Pt reported that he lived in a nursing home that provided him with the medication. Pt endorses cocaine. Pt was unable to contract for safety. Pt is a danger to self and is in need of inpatient psychiatric treatment for safety and stabilization of suicidal ideation and psychosis.

Emergency Operations Plan: Elopement vs. Unauthorized/Unplanned Discharge Policy and Procedure (dated 11/17/2022) states: In the event of a possible elopement, the following procedures shall be utilized:
a.) Proper code will be called overhead. b.) An investigation shall be coordinated by the facility

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S9999	Continued From page 11	S9999		

administrator, director of nursing or manager/supervisor on duty. A search will be conducted to assist in locating the resident. d.) The local law enforcement will be notified. e) If the incident/falls into IDPH Reporting Guidelines, designated facility staff will report incident to IDPH within 24 hours.

Progress note dated 01/10/2023 documents, "The writer was notified by the facility staffs that the resident made an unauthorized departure on 01/10/2023. The writer informed the writer, the staffs carried out room search, the resident was located. Psych social will continue to monitor and document as needed."

Progress note dated 01/11/2023 documents, "The nurse M. called from the community behavioral hospital; stating that they have the above resident there and they will be admitting him and wanted to know if he can return. I advised the nurse to call the facility back later in the morning to speak with social services. She stated, OK! The writer also informed the nurse the resident eloped from our facility."

Nurse Practitioner Progress Note dated 01/14/2023 document, "Psychiatry Note Attempted to see patient for evaluation this date but was informed by RN that he was not available because he eloped a few days ago." (B)