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
	IL6014823	A. BUILDING: ______ B. WING ______	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE REHABILITATION	2425 EAST 71ST STREET CHICAGO, IL 60649

(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 Investigation 2388545/IL165516	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3100d)2) 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 300.1210 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	S9999	**Attachment A** Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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resident to meet the total nursing and personal 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.

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.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3100 General Building Requirements

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S9999	Continued From page 2 d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to follow their elopement policy for monitoring a cognitively impaired resident (R2) with severe mental illness, who was assessed to have cognitive impairment, and assessed to be at risk of elopement, failed to have a physician order for unsupervised outside pass, and failed to obtain consent from state guardian to be discharged from facility. These failures resulted in R2 eloping from the facility on 10/10/23. R2 was located at a restaurant 4 miles away from the facility and refused to go back to the facility and facility discharged R2 AMA (Against Medical Advice). Findings include: R2's admission diagnoses include but not limited to schizophrenia, noncompliance with medications regimen, bipolar disorder, current episode depressed, severe with psychotic features and diabetes. R2's (10/10/23) BIMS (Brief Interview Mental	S9999		

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Status) summary score was blank.

R2's (10/9/23) Admission Clinical Evaluation with Braden Scale documented in part, 42. Risk Alerts: i. May attempt exit. 44. Impairments- General: a. Cognitive. 47. Trauma Exposure: B. other comments: Received A/O (Alert and Oriented) X3 (Time 3), verbally responsive, speech impaired, Ambulatory, gait unsteady. After arrival resident kept getting up unsupervised, responds to re-direct, doesn't last, must reiterate all instructions. C/O pain to LLE (Left Lower Extremity), comfort following Tylenol. PMH (Past Medical History) of falls, violent behavior tendencies, fall and elopement precautions initiated. Will continue to monitor.

R2's Order Appointing Plenary Guardian of a Person with a Disability documents, in part, 4. In accordance with 11a-3 and 11a-12 of the Probate Act, by clear and convincing evidence, the Respondent is a person with a disability and: a. totally lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the care of his or her person. 6. The appointment of a Guardianship ad litem WAS necessary for the protection of the Respondent or to make a reasonably informed decision on the Petition. Entered date 4/17/2023.

On 11/28/23 at 10:40 am, V23 (Liaison) stated, "(R2) was one of the patients the hospital wanted me to see. She (R2) had a sitter when I (V23) saw her. I explained, the sitter needs to be discontinued for 48 hours before the facility can take her (R2). She (R2) had a sitter for safety to monitor her (R2) for transfers. The Facility was able to accept (R2) after being without a sitter for 48 hours. The hospital sent hospital records and discharge paperwork to me (V23). I kept in

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contact with the social worker at the hospital and was not made aware of R2 having a guardian. I did speak to (R2), and she (R2) was aware of the facility and what type of facility it was. (R2) did a verbal consent that she (R2) agreed to come to the facility. I'm the one who accepts the residents that come to the facility. I speak to admissions and send over the paperwork notifying them of the admission. When I talked to (R2), she asked questions and answered questions appropriately. (R2) never discussed about wanting to go to a group home".

On 11/28/23 at 3:30 pm, V3 (Hospital Social Worker) stated V3 was having a hard time placing R2 and V23 (Liaison) assisted with R2's placement and accepted the resident at the facility. V3 said, "I sent a referral packet to (V23 Liaison). When the resident goes to the facility a packet goes with them also". Surveyor asked if V3 was aware of R2 having a guardian. V3 stated, "Yes, I knew R2 had a guardian and had been in communication with the guardian". Surveyor asked V3 if the paperwork for the legal guardian was sent in the referral packet or in the documents sent to the facility. V3 stated, "Everything in the chart was sent to the facility and I put in my notes that R2 had a guardian on several occasions". V3 stated she told V23 that R2 had a guardian. V3 said V23 knew V3 was having a hard time placing R2. The guardian wanted R2 placed in a facility.

On 11/29/23 at 1:15 pm, V28 (Admissions Director) stated, "I'm the acting admission director. During that time (referring to 10/9-10/10/23) the facility did not have an admission director". V28 stated, V28, V2 Director of Nursing (DON) and V23 (Liaison) reviewed the paperwork for R2. V28 stated V23 completed an

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S9999	Continued From page 5 in-person interview with R2 and that V23 can accept residents at the bedside. V28 said, "We (V28, V2, V23) noticed R2 had a 1:1 sitter and requested she be cleared of a sitter for 24 to 48 hours prior to R2 being admitted because that is something we are unable to accommodate. The case was reviewed to see if R2 was taken off the 1:1 sitter. If any clinical concerns, we put it at a yellow. V2 was looking at the paperwork for clinical concerns. We (V28/V2) requested updates to be sent to see if R2 was stable. The updates came in on 10/9/23, before R2 came to the facility and was reviewed by me (V28) and V2". Surveyor asked if V28 was aware of R2 having a state guardian. V28 stated, "I cannot recall if I was told about R2 having a legal guardian. The whole packet was reviewed including the nursing notes and case management notes by us (V28, V2, and V23). In that packet I did not notice any information about a guardian. We did not know a guardian was in place for R2. A resident with a guardian would not have the ability to say they want to leave if a guardian is in place without a guardian's consent". V28 stated, R2 was admitted to the facility between 6:00 pm and 7:00 pm on 10/9/23. On 11/28/23 at 2:05 pm, V2 DON stated, "The liaison sends the referral packet to review, and I look at it to determine if the resident could come on a clinical level. The liaison can make the decision of who comes but I review all the paperwork before they get here. I reviewed R2 and she did have some behaviors noted. I told V23 if R2 does not have any behaviors in 24-48 hours then we can take her (R2). R2 was stable and within a day or two and R2 came into the facility. I was not aware of R2 having a guardian. I did not see that in the record."	S9999		

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On 11/21/23 at 9:34 am, V16 LPN (License Practical Nurse) stated, "I'm not sure what time R2 came into the facility. I did the admission for R2. R2 kept asking about a pass for the next morning. I told R2 she can ask social service about a pass tomorrow. R2 did say she (R2) did not want to be here. I did have to redirect R2 several times about a pass. R2 was at the nurse's station with other staff when I went to pass medications". Surveyor asked V16 what time V16 started to pass medication. V16 stated, "I do not remember. I noticed (R2) was not at the nurse's station. I went to her (R2's) room, bathroom, the dining room, down the stairwell and elevators, to look for R2". Surveyor asked V16 what time V16 noticed R2 was not at the nurses' station and what time did V16 start to search for R2. V16 stated, "I cannot remember the time. Staff searched the whole building; she (R2) was not there (in the building). A code yellow (elopement/missing person) was called. The supervisor (V15) heard the code yellow and came upstairs. I went outside to 71st/exchange and south shore drive, and I did not see her (R2). The police were called. When residents are high risk for elopement we monitor and post CNAs (Certified Nursing Assistant) in the hallway by their rooms". Surveyor asked V16 what time code yellow was called. V16 stated, "I do not remember the time".

On 12/6/23 at 7:47am V16 (LPN) stated, "I did not assign any staff to watch R2. I did not hear any door alarms by the exits on the second floor go off. So, R2 must have gone down the elevator and out the front door". Surveyor asked V16 if a community skills assessment check list should have been completed on R2 before saying R2 is safe to go into the community. V16 stated, "Yes, a community assessment should have been done

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S9999	Continued From page 7 by social service before we (facility) said R2 can go into the community safely". Surveyor asked V16 if V16 was aware R2 had a state guardian. V16 stated, "No, I was not aware of R2 having a state guardian." On 12/18/23 at 12:45 pm, V37 (CNA) stated, "I don't remember if I got a new resident referring to (R2) on 10/9/23". V37 stated, if a new resident comes into the group of rooms V37 is assigned to, then it would have been V37's admission. V37 stated she does not remember R2 being in the facility. On 12/7/23 at 5:32 pm V33 CNA (Certified Nursing Assistant) stated, "R2 was there before my shift (10pm to 6am). R2 woke up at 4:00 am and came to the nurse's station. R2 said her house had caught fire and she (R2) needed somewhere to live and that is why she (R2) is here in the facility. R2 said she wanted to go to her cousin's house at 5:00 am and asked if the cousin could come pick her (R2) up. She (R2) kept asking for a pass. The nurse (V16) told R2 that she could not leave. R2 was fully dressed and had a coat on. R2 kept trying to go toward the elevator. I (V33) tried to distract her by talking to her and moving her away from the elevator". V33 stated, "(R2) seemed like she (R2) was special needs. R2 had a speech impediment, walked with a limp, and had a certain look about herself (R2)". Surveyor asked V33 to explain "a certain look". V33 stated, "R2 appeared to be mentally delayed. It was hard to understand what she (R2) was saying". Surveyor asked V33 if V16 told her that R2 was an elopement risk. V33 stated, "V16 did not say she was an elopement risk or on any elopement precautions". V33 further stated, "The way R2 was looking, I would not let R2 outside alone, but V16 did not tell me to	S9999		

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watch R2."

V33 (CNA) Time Log form dated 10/9/23 documented V33 clock in time at 10:00 pm and clock out time at 6:00 am.

On 11/30/23 at 11:30 am, (V31) LPN stated, "I was the oncoming nurse for the day of Oct 10th. I was running late that day, I got to work around 7:30 am. I set my work bag and coat down at the nurse's station and started making rounds on the floor because the nurse (V16) was still on the medication cart down the hallway. I started on the side that R2 was on. I looked in the room and the bed was messed up. Then I went to the other side to finish my rounds. After I finished my rounds, I asked the nurse (V16) was there someone assigned to that room because the bed is messed up and no one is in there. V16 said, 'Yes someone came in last night' so we (V31, V16) started looking for her (R2) and checked all rooms on the unit. The nurse V16 said she had just saw her (R2) at the nurse's station. The CNAs on the unit started looking for R2 in all rooms on the unit, and we alerted the night shift supervisor (V15) that R2 was missing. V15 (Night Supervisor) took over after that. A code yellow was called. The other staff on the other floors were saying no one was out of place on the other floors. When I (V31) came in that morning, I did not notice R2 at the nurse's station. There were two CNAs and an orientee CNA at the nurse's station". Surveyor asked if there were any staff at the front desk in the lobby when V31 entered the building. V31 stated, "I am absolutely positive there was no one at the reception desk when I came in because it was still dark in the lobby".

V31(LPN) Time Log form dated 10/10/23 documented V31 clock in time at 7:35 am.

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On 11/21/23 at 9:00 am, V15 (LPN/Night supervisor) stated, "On 10/10/23 morning I was sitting in the lobby when I heard a code yellow called. I do not remember the time it was called. I ran upstairs and ask who (referring to eloped resident) it was. The staff said it was R2 the new admission. We (Staff) searched the building and grounds outside. We got into our cars to look for R2 but did not see R2. The CNAs were on foot in the neighborhood, and I was in my car looking for R2. 911 was called to make a missing person report. The CNA (Certified Nursing Assistant V20) who came in at 6:00 am, said R2 was at the nurse's station because they (V20) talked to her (R2). The CNA (V20) stated she turned their head then R2 was gone. R2's mother called the facility and said R2 was at M******* on 95th and Jeffrey. I saw her at M******* eating food. R2 left out of M******* and went across the street to the dollar store then got on the bus. V5 (Social Worker) and V18 (Receptionist) came to 95th and convinced her (R2) to get off the bus. The police and fire department came to 95th street to assist with R2. R2 stated she (R2) did not want to go back to the facility and decided to go with the paramedic to the hospital". V15 stated she does not remember the time they went to 95th and Jeffrey. V15 said, "The nurse (V16) stated R2 had been asking about a pass. She did have a bus pass on her. R2 said it was in her shoe". V15 stated, high risk elopement residents are monitored.

On 12/5/23 at 8:13 am V15, (LPN) stated, "The front doors to the facility were opened at 6:00 am on 10/10/2023 and I was sitting in the lobby until the staff got here. I did leave the lobby to answer call lights. I was in the lobby when a code yellow was called. I do not remember what time the code yellow was called. I went outside and got in

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my car and looked for R2. I did not see her (R2). I came back to the facility and then I received a call at the desk that R2 was on 95th street. When I got to where R2 was, she did have on a coat, but I don't remember if she had her belongings with her".

On 11/21/23 at 12:09 pm, V20 (CNA), stated, "I came in around 7:00 am and I saw R2 at the nursing station. She (R2) was standing at the nursing station, and I asked her was she (R2) OK. R2, she said yes. She (R2) was pacing and got a chair and sat next to me (V20) and was talking and saying she was from around here and new to the area. She (R2) kept saying she wanted to leave. I got up to go make rounds and then we (staff) noticed we didn't see her (R2) anymore. We (Staff) started looking around for her (R2) in the rooms, bathrooms, and outside. No one could locate her (R2), that's when we (staff) noted she (R2) had eloped. A code yellow was called. I went outside to the neighborhood and looked. I did not see R2, so I came back into the facility". Surveyor asked V20 what time code yellow was called. V20 stated, "I do not remember".

On 12/5/23 at 11:30 am, V20 CNA stated, "I asked the nurse was R2 a new person. The nurse V16 (LPN) said yes, and don't make R2 angry because R2 was agitated. R2 had sat next to me at the nurse's station and was agitated. (V16) said to keep an eye on her, but (V16) did not say she was an elopement risk. V16 did not assign me to watch R2 as a 1:1. I had other residents, and I was orienting a new CNA (V21). I did not keep a constant eye on R2 because I was charting and had the new CNA (V21)". Surveyor asked V20 what does 'keep an eye on mean"? V20 stated, "Just check in on her (R2) frequently.

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It's not a constant observation like 1:1". V20 stated, R2 was fully dressed that morning and that was unusual that early in the morning. R2 had a coat on at the nurse's station.

V20 (CNA) Time Log form dated 10/10/23 documented V20 clock in time at 6:42 am.

On 11/21/23 at 11:50 am, V19 stated, "I came in that day around 6:00 am, and there was a conversation that a resident was missing, and I was asked if I saw her (R2) at the nurse's station. I do not remember seeing a resident at the nurse's station. A code yellow was called, staff looked around the building and outside. I did not leave the building. In report that morning I was told a new resident was here. I did have my assignment at that time. Once we get our assignment and report we go and check on the residents. I do not remember if she was in my group, but if a resident was missing out of my group, I would have reported it to the nurse. I do not remember anyone missing. I have had in-services on elopement on what to do and high-risk elopement residents will be on constant surveillance."

V19 (CNA) Time Log form dated 10/10/23 documented V19 clock in time at 6:00 am.

Facility daily floor assignment sheet for 6A-2P on 10/10/23 documents V19 was the assigned CNA for R2.

On 11/20/23 at 1:30 pm V5 (SW/Social Worker/Duet Director) stated, R2's admission was in the evening on 10/9/23. V5 stated, "I had not seen (R2). That morning when I got to work, the nurse told me R2 had left. When the nurse told me the name, I said I just saw her at the bus

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SOUTH SHORE REHABILITATION	2425 EAST 71ST STREET CHICAGO, IL 60649

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stop. I remembered (R2) from another facility". V5 stated, "I got to work between 8 am and 9 am. I went to look for (R2) and saw R2 get on the bus. I followed the bus until it stopped. Me (V5) and (V18 Receptionist) another staff member, followed the bus. R2 got off the bus and got on another bus that was already there. R2 got off the bus on 95th street and went into M******* on 95th. I talked to R2 and tried to get her to come back. R2 ran out of M******* into the dollar store. The police were called. When the police came, R2 was at the bus stop again and got on the bus. We (V5 and V18) got on the bus to try to get R2 off the bus by talking to her with the police. R2 got off the bus. The fire department and the ambulance came and took R2 to the hospital. R2 refused to come back to the facility. I (V5) asked R2 why she came to the facility. She (R2) said the hospital told her she was coming to a group home not a nursing home and she did not want to be in a nursing home. R2 was trying to go to her (R2) brother's school. I called R2's brother on my cell phone and told him (R2's brother) R2 left the nursing home and is refusing to come back to the nursing home. The brother told R2 to go back to the hospital if she did not want to come back to the facility. R2 agreed to go to the hospital. R2 agreed to sign out of the facility as an AMA (Against Medical Advice)". V5 stated, "I was not aware of R2 having a state guardian." V5 stated, "The purpose for the community assessment form is to see if a resident can navigate in the community safely and to assess if they know how to seek help if they get lost. The community assessment form was not completed because R2 came after hours and R2 had left before it could be completed".

On 11/20/2023 at 3:23pm V18 (Receptionist) stated, "I came to work around 7:15 am on

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10/10/23. When I first got to work, I went to punch in, and staff said R2 was missing and not in the building. I asked staff for a description of R2 and what she was wearing. They said R2 had on grey and a big coat. I went riding around with my wife to see if I could locate R2. I did not see R2 and came back to the facility. I let V5 SW (Social Worker) know that R2 had left the facility. We did an elopement call, Code yellow (meaning elopement). The night shift staff said she (R2) left the building around 6 something that morning. The SW (V5) and I were riding around the neighborhood. The administrator (V1) called the SW and said the mother called and said (R2) was on 95th and Jeffrey at M********. I (V18) do not remember the time V1 (Administrator) called. We (V5 and V18) started driving that way to M********. The overnight supervisor (V15) was already out looking for (R2). I went to 95th street with V5 (SW) to M******** and (R2) refused to get into the car. (R2) kelp walking away from us to one side of the street to the other side of the street, then got on the bus. The overnight supervisor (V15) told the bus driver to not pull off because our patient is on the bus. The police and paramedics were present at that time. She (R2) got off the bus and everyone was trying to encourage her to come back to the facility then the Paramedic told R2, let's go the hospital for a safe discharge and R2 agreed. R2 did talk to her brother at that time also. R2's brother told her to go to the hospital. R2 did get into the ambulance to go to the hospital". V18 stated, "The facility doors are locked every day from 11:00 pm to 6:00 am because we don't have security at that time".

V18 (Receptionist) Time Log form dated 10/10/23 documented V18 clock in time at 8:09 am.

On 11/21/23 at 12:40 pm, V1 Administrator stated

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she was notified around 8:15/8:30 am that a code yellow was called, and everyone was looking for R2. V1 stated, "When I (V1) got here, I talked to V20 (CNA) and V15 (Supervisor). R2's mother called the facility and said R2 had called and said she was at M******** on 95th and Jeffrey. I called V5 (SW) and let her know that the mother said R2 was at M******** at 95th and Jeffrey. R2's mother called back and said she (R2) had no idea R2 was in our building. V5 called and said the police and paramedic are here on 95th and R2 is refusing to come back to the facility". V1 stated V1 was concerned about making sure R2 was cognitively intact to make that decision on not coming back to the facility because R2 was a new resident. V1 stated, "The paramedic determined R2's cognition and stated she (R2) was ok to make her own decisions. R2 went to local hospital with the paramedics. When V5 (SW) was on 95th on the bus, V5 (SW) had me on the phone and I heard R2 saying I don't want to go to a nursing home, I was raped in a nursing home. I'm not going back there". V1 stated, "I was not aware of a state guardian until after R2 left the facility".

On 11/21/23 at 9:40 am V24 (State Guardian Office) stated, R2's elopement was reported to the office by R2's mother. V24 stated, "R2's mother called and said R2 had eloped and was at M********". V24 stated V24 had talked to the administrator after 8:30 am. V24 stated, "R2 had become a ward of the state on 4/17/23. The medical report dated 3/11/23 stated R2 has a moderate intellectual delay with speech difficulty and is incapable of making personal and financial decisions. R2 is not able to sign her own consents".

On 11/28/23 at 12:09 pm, V27 (R2's State

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Guardian) stated, "R2 is not able to sign her (R2) own consents. R2 has been to a couple of facilities because of her (R2) violent behavior". V27 stated, "I talked to someone at facility on Tuesday and that's when I found out R2 had left the facility and ended up at M********. The police were called to assist with R2. R2 should not be signing any consent and should not be in the community alone".

On 11/29/23 at 10:30 am, V2 (DON) stated, "I don't know why the nurse documented elopement precautions. For an elopement resident we have wonder guards (band around a wrist). Monitoring 1:1 and a locked unit. The nurse did the assessment and deemed her (referring to R2) to be alert and oriented". Surveyor asked V2 if V2 reviewed V16's assessment including that R2 had some cognitive impairments. V2 stated, "I did not see that. I did not see that R2 had a guardian in the admission packet". V2 stated, "R2 walked out of the front door. The camera system was down. R2 was not gone more than 45 minutes".

On 12/5/23 at 1:40 pm, V32 (Maintenance) stated, "I did not know the east wing alarm door had a timer. I just make sure it goes off. The door alarm is supposed to stay on until you put the code in. The purpose of the code is for the alarm to stay on until the code is put in". Surveyor requested V32 to look at the alarm on the second-floor east wing. V32 opened the door and the alarm sounded then went off without putting a code in. Surveyor inquired how long the camara has not been working. V32 stated he is not aware of the camara not working.

R2's (10/10/23) Chicago Fire Department run sheet documented dispatch time for call at 10:06 am, arrived at patient at 10:17 am. Patient care

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report narrative documents in part, "Dispatched to location for psychiatric emergency. S**** S**** staff on scene and states patient left their facility without being discharged and family is concerned for her wellbeing. Patient left hospital several days ago without being properly discharged. Patient (R2) states she needs her medication to feel mentally better but does not want to be placed back into the rehab facility.

R2's progress notes on 10/9/23 at 6:47 am, V16 LPN (License Practical Nurse) documents, in part, "R2 up at 5:00 am, wandering around unit, multiple warnings to not enter other resident's rooms, advised to sit in room or dining room. Perseveration regarding an outpatient pass. Advised to wait to 8/8:30am and speak with social services. Last seen seated at nurse's station at 6:30."

R2's progress notes on 10/10/23 at 7:00 am, V16 (LPN) documented, "Resident (R2) inquired about a pass. Upon last rounds noticed resident left facility on unauthorized pass.

R2's progress notes on 10/10/23 at 7:30 am, V31 LPN documented, "Upon making rounds this nurse noted the resident not in her (R2) room or the dining area. Upon further investigation this nurse was made aware by off going nurse (V16) that this resident (R2) is out of the facility on an unauthorized pass".

R2's progress notes on 10/10/23 at 12:44 pm, V5 (Social Service) documented, in part, "R2 was observed at the bus stop getting on the bus. Writer (V5) and other staff followed the bus until R2 got off the bus at 95th and Jeffrey. R2 went into the M********. The writer parked the car and went into M******** to ask R2 to return to the

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facility. R2 stated that she was not coming back to a nursing home. The writer continued to encourage her to return to the facility. R2 became verbally and physically aggressive toward other staff members. Writer called 911 for assistance. R2 then ran across the street toward the bus and got on the bus and refused to get off. By the time the fire truck and police arrived on the scene. R2 finally got off the bus stop and spoke to the paramedics once they showed up .... R2 agreed that R2 would be discharged from the facility against medical advice ...Writer received a call from R2's state guardian this morning inquiring about her admission to the facility..."

R2's (10/9/23) Elopement Screen form documents in part, 1. Upon Review (a) Is resident cognitively intact in making decisions to exit building (can go outside safely and return). If answer is Yes, skip rest of assessment. Documented YES on form.

R2's community survival risk assessment form not completed upon admission.

R2's Order Summary Report excludes an order for R2 to go outside unsupervised.

R2's Psychiatry Evaluation dated 8/24/23 documents in part, R2 presents as a danger to self and others. Unpredictable and untrustworthy.

Facility job description undated and titled "Administrator," documents, in part, "Administration functions: Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the facility. Ensure that all employees, residents, visitors, and the general public follow the facility's established policies and procedures."

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Facility job description undated and titled, "Director of Nursing," documents, in part, "Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the nursing care facilities."

Facility job description undated and titled, "Registered Nurse/RN," documents in part, Summary: "The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Responsibilities: Direct the day-to-day functions of the nursing assistants. Meet with your assigned nursing staff, as well as support personnel, in planning the shift's services, programs and activities. Make written & oral reports/recommendations concerning the activities of the shift as required. Admit, transfer and discharge residents as required. Provide leadership to nursing personnel assigned to your unit/shift. Fill out and complete accident/incident reports and submit to Director as required."

Facility job description undated and titled, "License Practical Nurse/LPN," documents in part, "Summary: The LPN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current

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federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Responsibilities. Direct the day-to-day functions of the nursing assistants. Meet with your assigned nursing staff, as well as support personnel, in planning the shift's services, programs and activities. Make written & oral reports/recommendations concerning the activities of the shift as required. Admit, transfer and discharge residents as required. Provide leadership to nursing personnel assigned to your unit/shift."

Facility job description undated and titled, "Certified Nursing Assistant," documents, in part, "Safety and Sanitation: Immediately notify the Nurse Supervisor/Charge Nurse of any resident leaving/missing from the facility."

Facility job description undated and titled, "Social Worker," documents, in part, "Participate in the facility assessment and assess individual social services needs a resource. Admission, Transfer and Discharge Functions: Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident."

Facility's policy titled, "Elopement and Search Policy" dated 1/23, documents in part, "Standards: 1. All nursing personnel are responsible for knowing the whereabouts of residents they are assigned to care for. Department Directors and Licensed nurses are responsible for conducting resident rounds to monitor resident location and staff are responsible for keeping the nurse informed of a

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S9999	Continued From page 20 resident's whereabouts. In addition, routine walking rounds are made at the beginning and end of each shift by the oncoming an off going supervising nurses to observe or know the whereabouts of each resident. Other observations are made at approximately every two (2) hours by CNA's, during scheduled activity programs, at meals bedtime and during mediation and treatment administration. 3. Residents are not permitted to leave the building alone unless the attending physician approves in writing. 5. Residents who have been identified as cognitively impaired and who have been assessed as an elopement risk will be provided with an alert elopement device (arm or ankle bracelet) or be placed in area of the facility that has a door alarm device with audible sound. 6. When a resident is experiencing periods of confusion or agitation and makes continuous attempts to leave the building, the resident will be visibly observed every fifteen (15) minutes until the behavior is resolved or diminished. In the event the resident continues to attempt to leave the building, a staff member will be assigned to provide one/one supervision until alternative interventions are initiated. 13. The Administrator or a designated staff member is assigned the responsibility of initiating detailed documentation of all action taken and efforts made to locate the resident. Documentation should be performed immediately after the event or at the time of the event. 20. All facility staff will be informed of residents at elopement risk. Direct care staff assignments will be updated to include safety interventions." Facility's policy titled, "Discharge Against Medical Advice" dated 3/2019, documents, in part, "Standards: 4. Prior to leaving the facility, the resident or the legal representative will be informed, in terms he or she can understand, the	S9999		

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resident's current medical condition, including diagnosis. 5. Before leaving the facility, the resident or legal representative will be informed, in terms he or she can understand, of the resident's medication regimen including mediation name, reason/use of medication, dosage, and administration times. 6. Prior to leaving the facility, the facility should attempt to inform the resident and/or the legal representative, in terms he or she can understand, of the resident's current treatment regimen ...10. In the event the resident is signing him or herself out AMA (Against Medical Advice), his/her legal representative and family member listed in clinical record will be notified."

Facility job description undated and titled, "Assistant Maintenance Director) documents, in part, "Ensure that maintenance personnel follow established safety regulations in the use of equipment and supplies at al1 time. Report violations to the director. Make daily rounds to assure that maintenance personnel are performing required duties and to assure that the appropriate maintenance procedures are being rendered to meet the needs of the facility."

On 12/18/23 at 10:11 am, surveyor requested job description for liaison. V1 emailed on 12/18/23 at 1:46 pm stated, no job description for Liaison.
(A)