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S 000	Initial Comments Complaint Investigation: 2496415/IL176684	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 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 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	S9999		

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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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 are not met as evidence by:

Based on interview and record review, the facility failed to supervise R1 who was diagnosed with Intellectual Disabilities and assessed to be at risk for elopement with a history of exit seeking, trying to open doors, and standing near exits. This affected one of three residents R1 reviewed for elopement. This failure resulted in R1 exiting unauthorized through a first floor window, being found seven hundred 700 feet or 0.1 miles away from the facility in a residential backyard by the local police. R1 was confused and stating R1 was heading home. R1 was identified with the facility bracelet, and electronic monitoring device located on the right wrist. R1 was carrying a tote bag and

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S9999	Continued From page 2 a garbage bag carrying various personal items. The deficient practice was corrected on 08/14/24 prior to the start of the survey and was therefore Past Noncompliance. Findings Include: R1 has a history of Schizoaffective Disorder, Anxiety, Bipolar, Major Depressive Disorder and Intellectual Disabilities. R1's Elopement Risk and Community Survival Skills Assessment dated 6/24/24 documents: Spends time on the first floor or wanders between floors or units, frequently checks status of facility exits and/or stairways? (Checks if others are in areas and/or attempts to open exits), reported/documented episodes of elopement and/or attempts to elope in the last quarter, verbalized a serious/strong intent to leave the facility (pacing, packing belongings, etc.), responds poorly to staff re-direction when roaming into areas that are "off limits" or unauthorized, becomes agitated, confused and/or disoriented or displays consistently poor judgement (i.e., would not be able to safely care for him/herself outside of the facility): Yes. The resident knows the facility name in case of an emergency, the resident verbalizes understanding of potentially dangerous situations, such as walking alone after dark, straying into an alley, accepting rides from strangers, carrying valuable items where they can be easily seen: No. At risk to elope and should be placed on the elopement risk protocol. A care plan for elopement is indicated. A care plan for outside pass privileges including risk factors for non-compliance for adhering to pass policies and parameters is indicated. No. Psych Nurse Practitioner Note dated 7/9/24	S9999		

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documents: R1 informed staff that she was removing windows/screens saying that the birds told her to. After a recent fall, R1 told staff that R1 fell because the birds pushed her. Hospital paperwork dated 8/3/24 documents: Elopement risk screen (behavior assessed in the past 24 hours): Patient (R1) is cognitively impaired with poor decision- making: yes, Patient wanders aimlessly: yes, Patient is exit seeking, trying to open doors, is standing near exit: yes. Assaultive behavior (in the past 24 hours patient has displayed the following): Impulsivity: yes, unwillingness to follow directions: yes, unwillingness to follow direction. Sleep disturbance: yes (unable to sleep through the night: patient was unable to identify why) number of hours sleep per night: 1-4, sleep disturbance type: difficulty falling asleep and frequent awakening. Hospital Psychiatric Progress Note dated 8/12/24 documents: Precautions: Elopement. Level of observation: close observation/every 15 (fifteen) minutes. Discharge to skilled nursing facility 8/12/24.

On 9/4/24 at 12:45PM, V13 (Nurse) stated that V13 saw R1 at the beginning of her shift round. R1 was in her room sitting in the chair by the window. V13 reported that the last time the CNA (V16) saw the resident was in her room, sitting in the chair by the window. V13 stated there was no alarm sounding at any time during V13's shift. Approximately at 3:30AM, a police officer rang the bell. I let him in, and he asked if we know R1. I said yes and he reported to me that R1 was found in someone else's backyard. The Police officer found a window open in a room, the screen was off. This room was an adjoining room from R1's room. The Officer said they are taking R1 to the hospital. V13 called R1's POA (Power of Attorney), Administrator (V1) and DON (V2).

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V1 came in early to the facility.

Police report reads in part: On 08/14/2024 at approximately 0321 Hrs. Officer responded initially for a suspicious person call. Throughout the duration of the call, it developed into a crisis intervention - mental health call. The caller advised of a subject with gray hair sitting in his backyard. As we responded, the caller advised that the subject had begun walking to the side of the house. Upon arrival, Officer located said R1 in the driveway between two parked vehicles While approaching R1, officer observed R1 to be carrying a tote bag and a garbage bag containing various items appearing to originate from a hospital/nursing home. R1 immediately asked if officer could give her a ride to "Chicago" and R1 appeared as though R1 was in a rush to leave as majority of R1's conversation was trying to get to Chicago and at one point trying to walk past responding officers. While asking further preliminary questions, R1 appeared to believe that R1 was already in Chicago and pointed west believing R1 was headed towards Chicago. R1 wanted to go towards 105th and Pulaski but was not able to relay any valid address. R1 also stated that R1 had just left a relative's house a few minutes ago and was unable to articulate her reasoning for deciding to walk out at this time. Officer was able to locate a medical bracelet on R1's person as well as a location monitoring device on R1's wrist (with no address). Due to the above, Fire Department (FD) was contacted and shortly arrived. Spoke with Facility staff. Initially was unaware of R1 not currently being in their facility. After officer spoke with Nurse (V13) it was confirmed that R1 was a patient of theirs. Officer later located an open sliding window where it is presumed R1 had exited the facility. FD arrived and ultimately transported R1 to local hospital for

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further evaluation. Later received a call from Facility's Administrator (V1) who advised that V1 will advise State of this incident.

Nurse's notes dated 8/14/24 at 4:06AM, reads in part: At approximately 3:30a (sic) entered the facility via the side entrance. Officer reported R1 being spotted in the backyard of a home located near the entrance to the facility. Police were called. Officer reported no signs of distress and R1 will be taken to local hospital for further evaluation. R1 was noted by officer to have biohazard bags filled with belongings stating R1 wants to go home.

Nurse's notes dated 8/14/24 at 4:49AM, reads in part: Writer notified POA of the incident and resident being transferred to local hospital for further evaluation. Administrator, DON, and PCP notified.

Google map was used to get the distance from facility to the neighbor house is (700 feet) 0.1 mile.

Handwritten statement provided by the facility from Nurse on duty (V13) reads in part: V13 rounded 11PM to 11:10PM on 8/13/24. Observed R1 in her room, sitting in a chair located near the window of her room. CNA after assisting another resident nearby note R1 in her room at approximately 1AM. At approximately 330AM officer entered facility via side entrance stating that R1 was spotted in the back yard of a homeowner near the entrance to the facility's parking lot. Officer went on to say R1 stated "She wants to go home" and was noted to have a biohazard bag filled with "Belongings" officer stated that R1 will be taken to hospital for further evaluation. Writer notified Administrator (V1),

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DON (V2) and POA.

V16 (CNA assigned to R1 that day) handwritten statement provided by the facility, reads in part: "I did my rounds and checked approximately 1230AM to 130AM. I witnessed R1 awake and moving around her room as she normally is. I later returned to her room to change her roommate at approximately 1:30AM to 2:30AM, R1 was not her in room, I assumed she was in the bathroom as water was running in the restroom. At Approximately 3AM officer came and asked if we were missing a resident named R1.

On 9/6/24 at 3:35PM, V16 (CNA) was assigned to R1 on day of elopement. V16 said this was her first time working with R1 in a while but said she recalls R1 being an elopement risk from working at the facility. V16 said she recalls doing rounds and seeing R1 folding clothes but did not think she was packing at that time. V16 said R1 had behavior of moving her items and folding clothes. Around 2:00 AM, but unsure of exact time she went to check on R1's roommate and V16 said she did not see R1 in the room. V16 said the bathroom light and water was running and assumed R1 was in the bathroom. V16 said she did not check to see if R1 was in the bathroom because R1 was independent with care. V16 said a little bit later the police were at the door asking about R1.

On 9/4/24 at 3:30PM, V1 (Administrator) stated that around 330AM on 8/14/24, V1 received a call from nurse on duty, that R1 had gotten out of the building. R1 was close to the property, by the driveway and from house back yard next door. The neighbor called the police, the police noticed wander guard bracelet on, called FD to take the resident to the hospital. As soon as the

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ambulance came and took R1, the police officer came and spoke with the nursing team. "I came to the facility immediately and started my investigation". Elopement assessment updated for all residents; windows were checked for security. We learned that R1 was able to get out of the facility through the window in an adjacent room. The window was totally and completely out of the window frame placement. And the screen was taken off and placed near the bedroom wall. Window leaning against the outside wall. R1 returned in the facility, contacted the psych team and let them know what had happened. They initiated an Involuntary petition for safety. No videos to view. DVR not working at the time of the incident.

On 9/5/24 at 11AM, V1 (Administrator) stated that there is no specific elopement risk protocol written, it is individualized per residents need. It is added to the care plan and the intervention is what the facility staff follows.

On 9/6/24 at 11:36AM, V19 (Maintenance Director) said he has been working for the facility for about 5 months and left about two weeks ago. V19 said he received a call form V1 on day of incident and came to the facility. He said they inspected the whole building that day. There were 2 to 3 windows that were observed to be cracked but not broken that were replaced. V19 said they attached wood strips to all the windows that day to prevent the windows from being taken out of the frame. V19 said the window was missing from the room R1 went out of and was located in the bushes on the property but unsure exactly where. V19 said the lock was in place on the window. V19 said he did screw in the screen to the window frame on R1's windows after the incident in case she came back to prevent her from

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leaving through the window. V19 said he had received report but is unable to recall how R1 had pushed her screen or was playing with the screen, but the screen was not all the way out of the window. V19 said he doesn't recall fixing the window or screen prior to the incident. V19 said he had also received reports of R1 pushing the window slats in the common hallway outside of her room but was unable to say who or when it was reported to him. V19 said he had supplies on hand and replaced window pieces with plexiglass.

On 9/6/24 at 2:50PM, V23 (CNA) said she was familiar with R1. V23 said R1 had behaviors of pushing out her screen window. V23 said when she comes to work, she walks by R1's window and some days you would see the screen on the ground. V23 said she also saw R1 carrying the screen window around the facility with her. R1 would also remove the window slats from windows in the common hallway and carry them around. V23 was unable to recall exact dates of above when asked.

Care plan Focus Problem such as: R1 had a behavior problem r/t I take off my wander guard sometimes even when I'm redirected, I take it off dated 2/7/24. Interventions: Assist the resident to develop more appropriate methods of coping and interacting with others. Encourage the resident to express feelings appropriately (11/10/23). Administer medications as ordered. Monitor/document for side effects and effectiveness (11/2/23). Monitor resident and redirect when behaviors occur.

R1 is an elopement risk/wanderer r/t Disoriented to place dated 5/6/24. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food,

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conversation, television, and book. Resident prefers (10/9/23). Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate (10/9/23). WANDER ALERT: wander guard on right wrist (6/24/24).

Code Pink Policy with a reviewed date of 11/15/2018, reads in part: Should an employee discover that a resident is missing from the facility, he or she should: Immediately report the missing resident to the Charge Nurse or Nursing Supervisor. Review the physician Order to determine if the resident is out on an authorized leave or pass. Alert the staff by announcing "Code Pink" over the paging system. Inform staff of the name of the missing resident and visualize picture of resident if available. Make a thorough search of the building and the premises. Notify Administrator and Director of Nursing immediately if resident is not found after the search. The Administrator and Director of Nursing will evaluate the situation and develop a plan of action based on the individual resident.

Elopement Policy with an Update date of August 2012 reads on part: Nursing Personnel must report to the Administrator and Director of Nursing all reports of elopement or attempted elopement. It is the responsibility off all personnel to report a cognitively impaired resident found outside the facility or attempting to leave the facility to charge nurse immediately. Should an employee notice a cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown or is attempting to leave the facility, he/she should: Attempt to prevent departure/re-direct resident back to facility.

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Aperion Care Hillside Removal Plan for Past Non-Compliance

1. The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific tag) at the time the situation occurred

2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted, and

3. There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific tag.

DESCRIPTION OF OCCURRENCE: R1 exited the facility through a window and was returned to the facility without injury.

ACTION TAKEN

1. R1 is no longer in the facility. Prior to hospital transfer she was assessed with no injuries identified. Completed by the nursing team upon return to the facility, under supervision of the DON. 8/14/24 completion.
2. Residents of the facility were reassessed for risk of elopement. This was completed by social services or designee. 8/14/24 completion.
3. Care plans for residents at risk were reviewed to ensure appropriate individualized interventions were in place. Completed by social services and nursing or designee. 8/14/24 completion.
4. All staff were in serviced on facility elopement procedure including elopement prevention. This

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S9999	Continued From page 11 was completed by administrator and DON or designee. 8/14/24 completion. 5. Windows to the resident rooms and common areas have been serviced to ensure they remain in safe working order and are secure. This has been completed by the regional maintenance director or designee. 8/14/24 completion. 6. A QAPI meeting was held with the medical director to discuss the elopement and action plan associated with it. 8/14/24 completion. 6. A QA tool has been initiated to check facility windows to ensure they secure. This will be completed 5x weekly for six months. 8/14/24 completion. 8. The policy for elopement has been reviewed by the IDT with no changes noted. 8/14/24 completion. 9. The elopement binders were reviewed to ensure accuracy of appropriate residents in the binder. Completed by Administrator and DON. 8/14/24 completion. (B)	S9999		