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	IL6001580	A. BUILDING: ____ B. WING ____	C 09/20/2024

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S 000	Initial Comments Complaint Investigation: 2486907/IL177346	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 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		

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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.

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.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to properly monitor and supervise a resident (R1) with known risk of elopement. This failure resulted in R1 eloping from the facility 03/11/2024. R1 was found deceased in an abandoned building one month later by local police on 4/19/2024.

Findings include:

Facility reported incident dated 03/11/2024 documents at 6:30pm, alarm was activated from the first-floor South exit. R1 was noted exiting the facility through the South fire exit door and staff did not find R1.

Nursing Progress notes dated 03/11/2024 19:30 document R1 left the facility without permission or pass. Search conducted throughout unit and

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outside facility without any sightings of the resident. Police called to file a missing person report.

A local Chicago news article dated 03/13/2024 documents in part, the Police Department is asking for the public's help in locating R1, a missing 66-year-old man with Dementia.

R1's death certificate dated April 19th, 2024, documents R1 cause of death as Atherosclerotic Cardiovascular Disease, and further documents in PART II- other significant conditions contributing to death but not resulting in the underlying cause given in PART I as Chronic Substance Abuse, Dementia.

R1's current face sheet documents R1 was admitted to the facility on 05/13/22 and R1 has diagnoses that include but not limited to Dementia, Bipolar, and Post-Traumatic Stress Disorder.
R1's MDS/Minimum Data Set dated 03/05/2024 documents that R1 has a BIMS/Brief Interview for Mental Status score of 10/15, indicating that R1 is cognitively impaired.

On 09/12/2024 at 12:07pm, V22 (Social Services Director) stated R1's community survival skills assessment was completed on 3/5/2024, and it documented that R1 is not sufficiently alert, oriented, coherent, knowledgeable, and not able to navigate safely on community streets by himself. V22 further stated R1 does not know the facility address or location, or how to contact the facility in an emergency, and R1 is not able to refrain from harm or socially inappropriate behavior while out in the community independently. V22 stated based on these assessments, R1 was not able to go out into the

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community independently safely and R1 needed a facility escort.

On 9/10/2024 10:45 am, V1 (Administrator) stated that R1 left in March against Medical Advice, V1 stated that R1's case is a closed case. V1 stated she was informed by staff that R1 left the unit on 3/11/2024 during the evening shift and R1 left through one of the side doors. V1 stated she is not the one who completed R1's report to the State Agency. V1 stated R1 left the facility AMA (Against Medical Advice). V1 stated R1 called the facility (V1 did not provide a date or time) and stated R1 would not be coming back to the facility. V1 stated R1 spoke to V8 (receptionist) when R1 called. V1 stated R1's call was not documented. V1 stated facility's camera footage only goes back five days therefore there was no footage for 3/11/2024.

On 09/10/2024 at 1:59 pm observed R3 walking out of the second-floor elevator. R3 stated that he just returned from smoking outside. R3 stated that he has been living in the facility for six years. R3 stated that he uses the elevator and the stairs to leave the second floor by himself without any restrictions. R3 stated they (facility) changed the code on the elevator about two or three months ago, but a CNA (Certified Nursing Assistant) told him the code. R3 stated that prior to the facility changing the code, the code was the same for about five years. Surveyor questioned R3 if there are residents that he has seen trying to leave, R3 stated that there was a resident but that resident left. R3 stated that R1 stayed in the room across from R3's room.

R3 stated that he thinks R1 left through the South stairs (as R3 pointed at the South stair's doorway). R3 stated that he thinks R1 left through

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the basement exit. R3 stated that R1 didn't want to be at the facility. R3 stated that R1 asked him which way to get out from the floor, and R3 stated that he told R1 that he can open the second-floor South door and just press the button that is on the wall to turn off the alarm. R3 stated that R1 would get anxious and R1 had episodes of not knowing what he (R1) was doing. R3 stated that one time, R1 grabbed R3's belongings and placed them on the floor aggressively and R1 told R3 to leave. R3 stated that R1 was also a smoker. R3 stated that he observed staff escort R1 and other residents to go on smoking breaks.

On 09/10/2024 at 2:07pm, R4 was observed in her room seated on her wheelchair next to her bed talking to R5 (roommate) who was seated on the bed. R4's BIMS (Brief Interview for Mental Status) dated August 27, 2024, documented as 15/15, indicating R4 has intact cognitive abilities. R4 stated she knows the code to the elevator and pulled out a paper from her pocket and showed surveyor the code for the second-floor elevator. R4 stated she uses the code to get in and out of the elevator to go to the patio on the first floor, to go to the other units. R4 stated facility staff give residents the elevator code.

R5 asked R4 what the elevator code was, R4 gave R5 the code. R4 stated the elevator code was not a secret and residents just ask the facility staff for it, and it is given to them. R4 stated she has not seen staff prevent anyone from getting on the elevator.

On 9/10/2024 2:16 pm observed exit signs on the basement ceiling leading to an exit door in the basement, no observation of any poster or signage alerting that there is an alarm that goes off when the door opens. Surveyor opened the

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door, and an alarm went off. Surveyor observed that the door leads to the outdoors. Surveyor heard an overhead announcement "code 99 basement door".

On 09/10/2024 2:18 pm, surveyor observed several staff members hurried to the door. V2 stated that she does not have the key to turn off the door's alarm. Observed V4 (Assistant Administrator) and other staff rush towards the exit door. Observed V2 rush to a nearby storage/utility closet and observed V2 obtain a key with a pole stick Attached to it. Observed V2 use key to turn off the door's alarm in the basement (South exit).

0n 09/10/2024 and 09/11/2024 during tour of the units, surveyor observed residents putting in the elevator code and operating the elevator to go up and down the units.

On 09/12/ 2024 at 10:07am, V27 (R1's family member) stated he found out that R1 was missing from the facility from a local Chicago news article dated 03/13/2024. The news article notes Chicago police had put out a plea for R1, who was missing from the facility and police were asking for public assistance to help find R1. V27 stated R1's family was notified by local Police that R1 was found deceased in an abandoned building. R1's date of death was listed as 4/19/2024. V27 stated R1's family have not yet received the death certificate. V27 stated he and R1's family members went to the facility to try and find out what happened to R1, but they were told to leave the premises. V27 stated the local police report number dated 4/19/2024 is HV2400009283.V27 sent police report to the State Agency on 09/18/2024.

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Local police report number HV2400009283 dated 4/19/2024 documents:
-On 19 April 2024 at approximately 1219, Reporting Officer (R/O) #400 was dispatched to W154th street apartment # 4 in reference to a suspicious subject in an abandoned apartment building. Upon arrival R/O entered the abandoned apartment and observed a male black subject age approximately 30-35 years old sitting face up on a black in color couch located in the living room of the apartment. The subject was wearing a gray in color shirt, blue jeans with no shoes. R/O also observed subject's body was decomposed.

On 09/10/2024 at 1:50pm during the tour of the second floor unit with V18 (Registered Nurse-RN/supervisor/Infection control Preventionist) and V2(Director of Nursing-DON), V18 stated the second floor unit houses residents with mixed need such as residents who need supervision because these residents have diagnosis of Dementia, residents who need assistance with ADL (Activities of Daily Living)and also residents who are alert and ambulatory. V18 stated residents exit the second floor by asking the nursing staff for the elevator code and residents can go to the first and fourth floor units where the vending machines are located or go to smoke outside of the facility at the front of the building or at the patio which is located on the first floor on the North side of the building.

V18 showed surveyor the exit on the South side of second floor and stated there is a code but there is also a release button on the side of the stairs that if the door is opened from the side of the unit and the release button on the side of the stairs is pushed, the alarm will not go off the person can leave the unit without activating the

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alarm. V18 stated some residents know how to use the release button to get out of the unit without triggering the alarm.

V2 stated the second floor is a locked unit because some residents who reside on the unit have Dementia, are confused and/or are at risk for falls. V2 stated the second floor is a semi locked unit because the residents with Dementia, are confused and can attempt to leave the unit/elope. V2 stated residents on the second floor who are not confused, residents with a BIMS (Brief Interview for Mental Status) of above 11/15 meaning their cognation is Moderate or intact can get the elevator code from the nursing staff.

On 09/12/2024 at 10:55am, V17 (Maintenance Director) stated there are four exit doors in the building, three on the first floor which includes the main entrance/exit and the North and South exit. V17 stated the other exit door in the basement on the West side on the building. V17 stated all the exit doors have an alarm to prevent residents who are confused from exiting the facility or unwanted individuals from entering the facility. V17 stated there must be alarms on all exit doors to prevent residents from exiting the building because they (residents) can be hit by cars, or they can freeze during the wintertime. V17 stated the alarms go off so that the facility staff can protect/prevent the residents who are attempting to run away from leaving the facility. V17 stated the alarms are a safety precaution to make sure residents are safe in the facility. V17 stated when the exit doors are pushed, the doors open, and the alarm goes off immediately. V17 stated if the alarm goes off, the staff members call a code, and everyone goes to the exit doors to check what is going on.

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V17 stated the second-floor elevator has a code that is used to get in and out of the unit, but V17 stated he does not know why there is a code, and it has been there since V17 started working in the facility, and the code has been the same more than ten years.

V17 stated residents know the code and V17 has seen residents putting in the code and operating the elevator to move up and down the units and outside facility. V17 stated the second-floor South exit door has a keypad with a code, but it does not work, and anyone can go up and down the stairs using the South door exit on the second floor and the alarm will not go off because it is not working. V17 stated the second-floor North exit door has a keypad for a code, but it is an old device, and it does not work, and the residents can go on or off the unit using any of the two doors and the alarm will not go off. V17 stated the 1st floor South exit goes directly to the South parking lot of the building and if you turn left, you go to a busy main road. V17 measured the distance from the first-floor exit door to the main road and it was 45 feet/15 yards. V17 stated maintenance department checks all the exit doors and elevator doors every day to make sure they are working.

On 09/12/2024 a8 11:18am V8 (Receptionist) V8 stated she lets people including visitors, staff, residents in and out of the front entrance door because it is a locked door, and the receptionist must buzz the person in and out of the facility. V8 stated the door is locked so that residents cannot leave/elope by just pushing the door open and leaving the facility. V8 stated the receptionist must monitor the door. V8 stated between March 11th and 15th, during the evening shift, V8 was sitting at the reception desk when V8 heard the

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alarm on the 1st floor South exit door which opens to the parking lot go off. V8 stated she looked at the cameras and saw R1 going out of the door, therefore, V8 called a code 99 to the 1st floor South door. V8 stated all staff went running towards the 1st floor South exit door and started looking for R1. V8 stated after about 10 minutes, staff come back to the facility and stated they did not find R1. V8 stated V19 (Registered Nurse), and V20 and V21 (Certified Nursing Assistants-CNA) got into their cars and drove around the neighborhood looking for R1 but did not find R1.

V8 stated since she started working at the facility, she did not see R1 trying to leave the unit, but V8 has not had any interactions with R1. V8 stated for a resident to go outside, they must have a green community pass, which means the resident can go out to the community independently.
V8 stated she was not aware if R1 had a phone or not, but later that week after R1 left the facility, around March 15th, 2024, V8 stated R1 called the facility in the evening around 7pm and stated he was not coming back to the facility. V8 stated V8 tried to ask R1 to hold on so V8 could transfer R1 to the nurse on duty, but R1 hung up. V8 stated she informed V2 (Director of Nursing-DON) that R1 had called. V8 stated she did not document that she (V8) had received a call from R1.

On 09/12/2024 at 12:07pm, V22 (Social Services Director) stated Social Services is responsible for completing residents BIMS (Brief Interview for Mental Status) assessment and updating the resident's care plan based on the outcome of the assessments.

V22 stated R1's BIMS (Brief Interview for Mental Status) score, dated 03/05/2024 was 10/15

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indicating R1 has moderate cognitive impairment. V22 stated a BIMS score of 10/15 means that R1 has impaired decision-making ability and possibly not oriented to person, place, time, and situation. V22 stated R1 was only oriented to time. V22 stated it was not safe for R1 to go out to the community by himself without a facility escort because R1 had cognitive impairment. V22 stated if R1 went out in the community by himself, R1 could become a victim of a crime, R1 might not remember how to get back to the facility, and R1 could possibly get injured crossing the streets, or R1 can fall and get injured. V22 stated R1 did not have the necessary essentials and survival skills to survival in the community independently.

V22 stated R1 did not have a personal phone while at the facility and could not call the facility independently after R1 left the facility, and R1 was receiving 30 dollars a month and R1 did not have money when R1 left the building. V22 stated R1 had an ID (identification) bracelet with just his name on it because R1 was an elopement risk resident based on R1's BIMS score and his elopement assessment which was completed on 3/5/2024 and documented R1 had a history of trying to leave the facility in the past. V22 stated the ID bracelet did not have the facility name or address on it. V22 stated R1 was strong enough to push the exit door open, but R1 should have been supervised and redirected by facility staff so he (R1) does not leave the facility by himself because R1 needed staff supervision while outside the facility.

V22 stated leaving AMA (Against medical Advice) means the resident is cognizant, oriented and can make decisions for themselves and decide to leave the facility against medical advice.
V22 stated Elopement is when a resident leaves

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the facility without permission from staff and not having a staff or family escort the resident while out in the community. V22 stated R1 could not make an AMA decision because R1 was cognitively impaired. V22 stated if R1 wanted to leave AMA, staff could not have accepted his AMA because R1 could not make decisions for himself.

On 09/13/2024 at 3:03pm, V19 (Registered Nurse) via phone stated she heard an alert after receptionist called code 99 which means someone escaped. V19 stated she was working on the first-floor unit at that time, and it was almost evening time after 6:00pm, after smoking time which ends at 5:30pm, and it was almost dark outside. V19 stated V8 stated she saw R1 go out through the first-floor South exit door that goes directly to the parking lot. V19 stated when she heard the code, she run towards the South exit door where R1 left and saw R1 a head of her on the sidewalk on Central Road, then R1 turned to the West side block of the building and by the time staff got to where R1 turned, the staff could not see/find R1. V19 stated staff continued looking for R1 and could not find R1. V19 stated she turned back and went to her car and drove around looking for R1 but could not find him. V19 stated there were other staff members (no names provided) who got in their cars and were driving around looking for R1. V19 stated R1 was not found, and staff went back to the facility.

V19 stated she has taken care of R1 occasionally and he did not try to leave the building during the time she took care of R1. V19 stated R1 was a smoker and used to go to the patio or to the front by the front entrance and smoke. V19 stated smoking at the patio is around 8:30am, then 1:30pm, and 5:30pm. V19 stated to smoke at the

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front, the receptionist on duty gives the resident the lighter and cigarettes, and when the residents come back from smoking, they give back the lighter to the receptionist. V19 stated after dinner time which is around 4-5:00pm, the residents are not allowed to go outside the facility.

V19 stated she does not remember how R1 came down the second-floor unit to get to the first-floor South exit. V19 stated staff and some of the residents who are alert to person, place, time, and situation, have the second-floor elevator a code. V19 stated residents who are only alert to self and have illnesses such as Dementia do not have the elevator code because they will forget the code or can use the code to get out of the second floor. V19 stated even if the residents who have Dementia have access to the code and use it to get on the elevator, the receptionist must buzz the residents in and out of the building.

V19 stated anybody can push the exit doors including the first-floor South side exit door and the doors will open, then the alarm will go off. V19 stated all the exit doors have an alarm and the South side of the building exit door it is an emergency exit door with an alarm. V19 stated you cannot open the exit doors from the outside, but anybody can push it open and get outside from the inside, but the alarm will go off.

V19 stated R1 needed to be redirected because he wanted to go outside or to the patio to smoke and R1 had to be reminded it was not yet time to smoke on multiple occasions. V19 stated the nursing staff waited an hour to pass before calling the police as they were searching for R1 to see if R1 would come back to the facility. V19 stated R1 did not come back to the facility after one hour, therefore V24 (Licensed Practical Nurse) called

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	IL6001580	A. BUILDING: ______ B. WING ______	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL NURSING HOME	2450 NORTH CENTRAL AVENUE CHICAGO, IL 60639

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the police to report R1 missing since she (V24) was the nurse on duty for R1 when R1 left the facility. V19 stated she works double shifts most of the time in the morning and in the evening and does not remember if she had done a double shift on that that day. V19 stated she has been working at the facility for fifteen years as a registered nurse.

R1's physician order sheet/POS documents in part the following orders:
- Quetiapine Tab 100mg one tablet by mouth every 12 hours.
-Donepezil 5mg tablet every day at bedtime
R1's elopement risk assessment dated 3/5/2024 documents that R1 is at risk to elope and should be placed on the elopement risk protocol. A care plan for Elopement is indicated.
R1's community survival skills assessment dated 03/5/2024 documents that R1 does not appear to be capable of unsupervised outside pass privileges at this time.
R1's progress note dated 3/11/2024 documents in part that R1 left from facility unauthorized without permission or community pass. Police department called to file a missing person report. There is no known family contact on R1's profile.

9/11/24 1:41 PM via telephone V7 (Psychiatric Nurse Practitioner) stated that he forgot if he was informed or not that R1 eloped from the facility. V7 stated that if a resident has a diagnosis of Dementia, the resident should not be allowed to go out of the facility alone, and the resident should be monitored/supervised by facility staff. V7 stated "If a resident has Dementia and leaves the facility, the resident can get lost, the resident can forget where the resident was going, which way to go and might not be able to come back to the facility". V7 stated a resident with Dementia

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who leaves the facility unaccompanied or supervised by staff might end up far from facility and get lost and might not be able to come back to the facility to take prescribed medications.

V7 stated that the resident with a diagnosis of Dementia would not be safe in the community independently and an accident could happen to the resident. V7 stated that R1 was not totally demented and R1 still had some alertness. V7 stated if R1 could not find shelter while out in the community by himself and if the weather gets cold or hot, R1 can get exposed to below normal cold temperatures or very hot weather temperatures which could affect R1. V7 stated that he (V7) expected R1 to be monitored and supervised by facility staff and further stated that R1 should not have been allowed to go out of the facility into the community unless R1 was accompanied by staff for supervision or family member who is alert enough and responsible with R1. V7 stated R1 was on Seroquel medication and Seroquel is a psychotropic medication given for aggressive behavior. V7 states that R1 might sometimes have behavior disturbance like psychosis. V7 stated that sometimes patients with Dementia have psychotic behavior. V7 stated that psychosis is when someone is having delusions and hallucinations. V7 stated that is why R1 was taking Seroquel medication. V7 stated that R1 was also taking Aricept medication for R1's memory. "Because residents with Dementia have memory loss".

09/11/2024 1:58 PM via telephone V6 (Physician) stated that he got a call from the facility stating that R1 had eloped from the facility. V6 stated that he asked the nurse on duty (no name provided) what happened and V6 stated that the nurse told him that it happened so suddenly,

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when R1 left the facility and facility staff could not reach or catch R1 as R1 was leaving the facility. V6 stated that he told the nurse (V6 cannot remember which nurse) to inform the police department because V6 stated that the facility didn't want anything bad to happen to R1. V6 stated that the nurse also called V2 (DON) and followed the facility protocol for elopement. V6 stated that the next day he was informed that the facility had done what was supposed to be done per facility elopement protocol. V6 stated when he was paged by the facility for another resident, V6 asked about R1 and V6 was informed that R1 didn't come back to the facility. V6 stated that R1 had some psychiatric issues and R1 was diagnosed with Dementia, mild to moderate, history of Bipolar and Post-Traumatic Stress Disorder (PTSD). V6 stated that R1 was able to answer questions appropriately and V6 stated that R1 was able to understand things and follow commands while at the facility. V6 stated any patient with psychiatric history along with mild Dementia to not be allowed to go out of the facility without a responsible family member or an escort because anything can happen to the resident while crossing the road. V6 stated a resident with diagnosis of Dementia and/or psychiatric illnesses can get lost, and, a resident/patient with mood swings can do anything. V6 stated that the facility does not allow residents to go out of the facility independently unless the resident is capable of remaining safe while out in the community. V6 stated that psychiatry was following R1 weekly for management of R1's psychiatric illnesses. V6 stated that R1 never expressed that he wanted to leave the facility.

R1's elopement care plan dated 04/23/2023 documents two interventions which are to assure R1 is wearing ID (identification) bracelet.

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Facility Assessment tool, 07/20203-06/2024 documents:
-Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnosis, intellectual or developmental disabilities noted.

Facility policy titled Missing Resident, no date, documents:
-It is the policy of this facility to report and investigate all reports of missing residents. All residents are afforded supervision to meet each residents nursing and personal care needs. All residents will be assessed for behaviors or conditions that put them at risk foe elopement.
-Unless otherwise identified, all residents who are at risk for elopement when leaving the facility shall be accompanied. The accompanying party shall sign the resident out of the facility on the approved sign-out sheet.

(A)