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	IL6001143	A. BUILDING: _____ B. WING _____	C 08/29/2024

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S 000	Initial Comments Complaint Investigation 2495990/IL176165 Facility Reported Incident of 8/21/24/IL177300	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3) 300.610a) 300.1210a) 300.1210b) 300.3240a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999		

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

Section 300.3240 Abuse and Neglect

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

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a vulnerable resident (R6) was free of physical abuse inflicted by staff. This failure resulted in R6 sustaining multiple injuries including a closed head injury

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and contusions (bruising) of the right thumb and forearm.

Findings include:

R6 is 59 years old and admitted to the facility 1/19/24 with diagnoses that include schizoaffective disorder, bipolar disorder, and other mental health disorders. According to the minimum data set, R6 is alert, however, is assessed to have mild cognitive dysfunction. Facility reported incident of 8/21/24 described an altercation with R6 and V15 a Certified Nursing Assistant (CNA) during the evening (3pm-11pm) shift. According to nursing progress notes, V16 LPN witnessed V15 CNA hitting R6 while in bed. V16 immediately intervened by removing V15 from the room and assessed R6 for injuries. R6 was transferred to the hospital and returned in the early morning with diagnoses of a closed head injury, and contusions (bruising) of the right thumb and forearm.

R6 was observed 8/29/24 at 11:16am alert and oriented to person and place. R6 was walking with a moderately steady gait and was appropriately dressed and groomed. During this interview, R6 was exhibiting some flight of ideas when conversing. Regarding the incident that occurred 8/21/24, R6 said 'someone came in and put the tray down on the bedside table. Somehow, I got hit in the head with the table. The nurses and everybody came in and I was bleeding he couldn't remember the details, but there was something about the table.' R6 didn't remember going to the hospital, but said, he was picked up in an ambulance, and they took some X-rays before bringing him back to the facility. R6 said again that he didn't remember exactly what happened, but said his head hurt and has been

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hurting a lot. R6 was noted to be grimacing and pointing to the front left side of his brow and forehead. The right hand was observed to be significantly swollen compared to the left hand and arm which appeared normal. R6 flexed the right hand and said it still hurts to close the hand. R6 said that he can't think of any time an incident has happened that anyone in the facility hurt him and said that he has not been hurt by anyone before. R6 said that he has not seen the person (CNA) since that evening.

Progress note written by nurse on duty V16 LPN (Licensed Practical Nurse) states: "While the writer was passing meds [medications], she observed a CNA leaning towards the resident and hitting him, the writer then observed the resident stand up and throw his bedside table at the CNA. The CNA begin to state that she was placing the resident's snacks on his nightstand and the resident begin to holler at her and throw a cup of water at her. The writer separated the CNA from the resident and told her to leave. A head to toe assessment was completed and the writer observed redness and swelling to the left side of the forehead and redness to the left jaw and an abrasion to the right hand (vitals) 129/87 74 18 97.4 98% on RA. The resident was sent out via 911 for further evaluation, the local police was made aware ...the writer also spoke with the resident's father, the administrator and the DON, the writer also left a voicemail with the NP for a return call. The resident was transferred to hospital.

V16 LPN was interviewed on 8/29/24 at 12pm. V16 said while getting ready to pass medication, V16 was outside of R6's room, and V15 CNA didn't realize V16 was standing there. V16 witnessed V15 hit R6 and R6 got up off the bed to

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defend themselves. V16 instructed V15 to clock out and leave the building, and then assessed R6. R6 was holding their head, and V16 called 911 for transport to the hospital and to make a police report and then called the administrator and Director of Nursing.

On 8/29/24 at 12:26pm, V15 CNA said that they went to respond to an activated call light from R6 and found that it had been tangled. According to V15, R6 became suspicious that V15 was taking their belongings and began to yell and threw a cup of water at V15. V15 said that R6 kept attacking V15 by throwing cups, and the bedside table. V15 tried to block R6's attempts of attacking but would not specify in what manner. V15 said when R6 threw a cup of water V15 slipped, fell onto R6 and R6 kicked V15 in the abdomen while R6 was lying in the bed. V15 said they started yelling and when the nurse came, yelled at the nurse "the resident attacked me- Do Something!" V15 said that working with R6 before, R6 isn't known to be aggressive nor does R6 display agitation. V15 denied having any training regarding abuse or being provided with the abuse policy at the time of hire (July 2024). However, based on review of the personnel file, V15 completed a post-test for abuse and resident's rights and provided signatures indicating completion. During the interview, V15 shared that they haven't been back to the facility since the night of the incident and 10 minutes prior to this interview, said that the Administrator V1 terminated employment over the phone. V15 said that if they could have done anything differently, they would have stepped away from R6 when they became agitated and went to get the nurse.

Police report dated 8/21/24 includes an interview

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with the responding officer and V15 CNA who said that R6 threw water and a cup at V15's face. V15 said that they "got on top" of R6 to stop R6 from throwing anything else and then R6 kicked V15 in the stomach. V15 goes on to say they 'pushed the side of R6's face while getting up.'

On 8/29/24 at 2:36PM, V1 Administrator said, when V15 CNA was interviewed the night of the incident, V1 asked if V15 hit or striked R6 and V15 kept saying "I defended myself" however would not directly answer or offer any elaboration. R6 sustained injuries and V15 wasn't able to give a definitive answer regarding exactly what they did to "defend themselves". V1 said as of today, V15 has been terminated for gross negligence and failure to follow protocol with regard to residents who display aggression.

Care plan reviewed for R6 does not indicate any agitation, violent, or aggressive behaviors prior or current. Witness statements from staff members on duty at the time of the incident also denied R6 having any such behaviors.
The facility Abuse Policy and Procedure revised 1/18 states in part; "This facility desires to prevent abuse, neglect exploitation, mistreatment, and misappropriation of resident property by establishing a resident sensitive and resident secure environment.
(B)

Statement of Licensure Violations (2 of 3)

300.610a)
300.1210a)
300.1210b)

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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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide detailed written notice 30 days prior to the discharge for one resident (R1) by failing to allow R1 to return to the facility while being accounted for on a facility issued community pass. This failure resulted in R1 not being properly discharged and being without medical care and medications for a month before getting a new primary care physician.

Findings include:

R1 is a 54 year old male and admitted to the facility 12/22/23 with diagnoses that included cerebral infarction, diabetes, asthma, hypertension, and substance abuse. On 8/20/24 at 4:09PM, R1 was interviewed over the phone and said that they were discharged from the facility on 7/27/24 without written notice. R1 explained that they were given a "white pass" which gives permission to leave the facility supervised overnight from 7/27/24 to 7/29/24. R1 said that his sister came to the facility to sign R1 out on 7/27/24, and R1 was allowed to leave. Shortly after leaving, the manager on duty (V13) called R1 over the phone and R1 was instructed

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to return to the facility, or he would be considered discharged against medical advice (AMA). V1 Administrator was added to the call and told R1 and R1's sister that R1 should not have been allowed to leave the building, was considered discharged AMA and could not return. R1 said when he returned to the facility on 7/29/24, R1 was not allowed access into his room and his belongings were brought to him via the side door.

On 8/26/24 at 12:21PM, V1 Administrator said, R1 did not express wanting to leave AMA, but we told him that he would be considered AMA if he left because at the time he went on pass, he was supposed to be going to the hospital for a psych evaluation. V1 said on 7/26/24 in the evening, a staff member accused R1 of drinking alcohol outside, away from facility property. When R1 returned, we requested he go to the hospital for evaluation, and he refused. The paramedics came to take him to the emergency room, and when they spoke with the emergency room physician, the physician refused to receive him so they left and R1 remained in the facility. After he refused, staff filled out an involuntary petition for inpatient hospitalization due to "belligerent and verbally aggressive behaviors" that occurred 7/26/24 in the evening. V1 said they were told that R1 was presented with an AMA form, however R1 didn't sign it. V1 denied giving R1 any written notice of discharge.

R1's progress notes were reviewed for 7/26/24 and details of R1 being verbally aggressive were not available to review. V3 Assistant Director of Nursing was also interviewed on 8/21/24 at 3:08pm. V3 said they called V4 Psychiatrist to get an order for involuntary psychiatric admission, however, was unable to define or elaborate how R1 displayed verbal aggression. V3 also said that

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R1 eventually calmed down after staff spoke with him and notified him about the petition.

During his interview, R1 said that when he returned to the facility from being out on an independent pass 7/26/24, he participated in a blood alcohol test using a breathalyzer. According to R1 and R1's progress notes, when V7 Substance Abuse Program Coordinator tested R1, with a result of 0.02. R1 said that he refused going to the hospital because he was not intoxicated, he was cooperating with the staff, and he got angry because a staff member took a photo of him while off the facility premises. When R1 refused to go to the hospital, the staff suddenly accused R1 of being aggressive in order to force him to go to the hospital. According to listed medical diagnoses, and care plan, R1 was not being treated for any psychiatric diagnoses and did not have a history of aggression while residing in the facility.

On 8/22/24 at approximately 3:00pm, V4 Psychiatrist said that he evaluated R1 while he was in the facility and said R1 did not have any psychiatric difficulties and did not require management of any psychiatric medications. V4 said typically a resident who requires emergent inpatient psych evaluation will be admitted within a few hours, and if there was an emergency where the resident was displaying violent behavior, the facility would call 911 to immediately remove the resident. V4 said that alcohol levels decrease 30 points per hour after the person stops drinking and the legal limit is 0.08. V4 said a level of 0.02 is really low and would not demonstrate an intoxicated person and after about an hour the level would likely be zero.

The facility presented the "white pass" form for

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overnight visits dated 7/27/24 to 7/29/24. The form was signed by R1's social worker, the nurse on duty, the receptionist and R1's sister. When this survey began on 8/20/24, the lobby was observed to have double locked doors entering the lobby and entering the resident care area. Access to both doors is only permitted by the receptionist.

On 8/27/24 at 12:26pm, V14 Receptionist said they were on duty at the time R1 left the building. V14 signed the white pass and copied R1's sisters' identification. V14 said that no person is able to enter or leave the facility without the receptionist giving access.

On 8/21/24 at 1:28PM, V9 Receptionist explained that the "white pass" is provided to the resident by the nurse and requires a nurse's signature and permission to leave the facility. V9 said, the resident initially asks for the pass and then different departments have to fill it out before coming to the front desk. Once it has been filled out, the receptionist will have the family member or whoever is picking up the resident fill out the information on the sheet and we take their identification to upload in the system. V11 Social Worker said, that in order for residents to leave the facility overnight, they initiate a request from social services who will fill out the top portion of the form indicating when the resident is leaving and returning to the facility, the reason for the visit and with whom they will be visiting. Social Services is responsible for applying this information and then signing the form. After that, the nurse will review and sign the form indicating whether medications are required for the visit. Lastly, the resident takes the form to the front desk, the receptionist reviews it before allowing the resident to leave.

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On 8/27/24 at 10:35AM, R1 said when he returned to the facility from overnight pass on 7/29/24, R1 was restricted access into the building and not allowed to his room. R1 said his belongings were brought to him via the side door and he was refused medications. Physician order sheet active at the time of discharge included medications for asthma, high blood pressure and diabetes. R1 said it took approximately four weeks to get an appointment with a new primary physician out in the community. R1 reported having some medications left over at his family's home, but was completely out for about a week, while waiting for his appointment. During that time, R1 frequently experienced cramps and pain in his extremities, requiring him to limit activities which negatively impacted his ability to work. Additionally, R1 was working with an agency to find housing in the community, and R1 was planning to move out of the facility within a few weeks. However, when the facility discharged R1, the agency was unable to help him any longer.

The facility presented the white "Pass Request Form" for R1 dated 7/27/24. The form was signed by V11 Social Worker, V10 Registered Nurse.

Discharge report summary as of 8/20/24 listed R1 discharging from the facility against medical advice (AMA) on 7/27/24 at 9:33AM.

The active discharge care plan for R1 was last revised 4/22/24 and stated "Resident wishes to be long term and has no plans on discharging at this time."

The facility's policy and procedure tilted "Discharge Against Medical Advice" revised 7/24 states:

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"Policy: It is the policy of this organization to provide medical and psychosocial care to residents of the facility. In the majority of situations, it is not in the resident's best interest to leave Against Medical Advice (AMA). Staff are to: (1) utilize good public relations skills to try to talk the person who wants to leave AMA out of leaving and (2) contact the attending physician (and notify the psychiatrist) and an administrative representative prior to allowing the individual to leave the premises.
Purpose: To define the facility's responsibility when a resident discharge him/herself from the facility without the consent of or an order from the attending physician. Procedure: 1. Staff shall provide appropriate attention and make a reasonable effort to prevent a resident from leaving AMA (Against Medical Advice). 3. Assess the resident's competence to make the AMA decision (vital signs, mental status-including the presence or absence of hallucinations and delusions, judgment, reasoning, awareness, and insight). If there are questions about the individual's ability to provide "informed consent", there should be no consideration for an AMA discharge. If the person is insistent on leaving, his/her only option will be hospitalization, and this includes involuntary psychiatric hospitalization. 4. Explain and document a discussion of the reasons to remain in the facility and all of the potential serious risks associated with leaving. 5. Explain and document efforts to persuade the resident to remain in the facility. 6. Explain and document your ongoing concern for the resident and his/her well-being (and in some cases, the well-being of his/her family members). 7. Use all available resources to prevent a resident from leaving AMA. This may include the social worker, nurses, nursing assistants, activity staff, a family member, or even a friend. 8. If available, involve

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BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

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the resident's responsible party (e.g., family). They may be able to talk the resident out of leaving. Also, if the resident does leave and an untoward event occurs, the responsible party would have been appropriately informed about the AMA discharge. Use your best judgment as to what must remain confidential. Confidentiality should take second priority to your efforts to assure the resident's continued health and safety. 9. Negotiate and compromise with the resident. Assess what is bothering/upsetting the individual and attempt to find an equitable solution (e.g., if the person doesn't have independent outside privileges, perhaps he/she can enjoy a cigarette on the patio). Try to find a resident "buddy" to help the person adjust and offer support. 10. If the person is still insisting that he/she is going to leave, follow instructions from the attending physician (e.g., if the person is not competent, hospital transfer may need to occur)."

(B)

Statement of Licensure Violations (3 of 3)

300.610a)
300.1210a)
300.1210b)
300.1210c)
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

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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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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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:

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 evidenced by:

Based on interview and record review, the facility failed to restrict independent community access to a resident (R3) who was known to be refusing psychiatric/medically necessary medication and exhibiting active delusions and hallucinations. This failure resulted with R3 going out for a "walk" unsupervised and not returning to the facility. R3 was found three days later by local law enforcement, lying on the ground in the community, and taken to the emergency room where R3 was assessed with active psychosis.

Findings include:

R3 is a 64 year old female who originally admitted to the facility 4/30/2019 and has diagnoses that include schizoaffective disorder-bipolar type, generalized anxiety disorder, hypertension, and diabetes. The list of medical problems also

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includes a history of experiencing hallucinations and suicidal ideations. R3 is a ward of the state and has been appointed with having a state guardian since 9/26/1988.

Progress notes were reviewed and indicated R3 has demonstrated a history of delusional behaviors and refusing medications. R3 has also left the facility on 2/24/24 while using independent pass privileges and failed to return at the specified time.

On 2/14/24 Social Services wrote "[R3] has been presenting with increased delusions." On 2/22/24, Social Services notes "Resident has been presenting with refusal of medications." On 2/24/24, Social Services and nursing wrote that R3 went out with a community pass in the morning, and called the facility to say she would not be returning. The facility filed a police report with the local department. Nursing note written 2/25/24 said that R3 returned to the facility in the morning and appeared to be having paranoid thoughts and delusions which prompted nursing staff to seek involuntary hospitalization for a psychiatric evaluation. R3 was hospitalized and returned to the facility 3/1/24.
When R3 returned to the facility, the Social Service Director assessed R3 to be appropriate for independent community access and reinstated the green pass on 3/29/24 according to the "Community Survival Skills Assessment". On 3/30/24, Social services notes in the monthly summary that R3 continues with experiencing hallucinations and delusional behaviors.

On 7/26/24, R3 left the facility with a green pass and did not return. R3's "Community Pass Program" sheet for July 2024 showed that R3 signed out of the facility 7/26/24 at 2:50pm to go

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on a "walk" and was signed by the receptionist on duty. According to the Medication Administration Record of July 2024, R3 refused medications 23 times, including those prescribed for schizophrenia, hypertension, and diabetes prior to being granted access to leave the facility. No interventions were documented to address these concerns.

When entering the facility at the start of the survey on 8/20/24, the facility was observed to have a double locked door system in place that prevents independent entry and exit in the lobby and then in the direct resident care areas.
On 8/22/24 at 2:05PM, V6 LPN (Licensed Practical Nurse) said they worked the morning and evening shift (7am- 11pm) of 7/26/24 and recalled last seeing R3 in the early afternoon. V6 said that they had not administered medications in the morning to R3 because she had been refusing medications for days and weeks leading up to that day. V6 said R3's refusals were known to staff and providers. V6 said that they were not aware that R3 had not returned to the facility before ending their shift at 11pm and confirmed they did not administer medications to R3 in the evening, despite signing them as given, because R3 was not in the building. V6 said, according to facility policy, if the residents don't return to the facility while having a green pass, the resident is considered to be discharged against medical advice (AMA).

The facility presented a "Community Pass Agreement" that states in part, " Failure to adhere to any of the policies and procedures of the community pass agreement may result in notification of the physician and constitutes discharge against medical advice.

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On 8/26/24 at 11:46PM, V13 Business Office Manager said they were the manager on duty Saturday morning 7/27/26. V13 said while rounding, they received report from the morning nurse that R3 had gone out on pass the previous day and did not return to the facility during the evening. V13 called the local police department and when they arrived at the facility a missing person's report was filed.

The police report of 7/27/24 noted that an officer reported to the facility for a complaint of missing person. The report indicates that the responding officer collected personal information from the medical record about R3 and reported that information to a statewide data system. The responding officer includes following-up on the entry submitted into the database and noted that R3 had been located on 7/30/24 by a police department in a town approximately 14 miles from the facility and subsequently taken to the hospital. The reporting officer called the hospital and learned that R3 was admitted as an inpatient.

Hospital emergency room notes indicated that R3 was brought to the hospital 7/30/24 at approximately 11:00AM. R3 was thought to be homeless, and was reported lying outside in a residential area, when the police were contacted and brought R3 to the emergency department. R3 was complaining of low back pain, and intermittent difficulty with walking on assessment. R3 also appeared psychotic, and exhibited flight of ideas, and required frequent redirection. Psychiatry was consulted in the emergency room and R3 was admitted to the inpatient behavioral health unit.

On 8/26/24 at 12:21PM, V1 Administrator said that R3 had a history of going out with a green

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pass and not returning to the facility earlier this year. V1 was unsure of when R3 was assessed to have independent pass privileges reinstated after the incident, but said, at some point social services assessed her to be appropriate for independent pass. V1 said, the front desk staff should have noticed that R3 didn't come back and was missing from the facility prior to leaving off duty at 8pm and notified the nurse on duty. V1 would have expected the nurse on duty to notice as well after 8pm. V1 was not made aware that R3 was missing from the facility until the following day on 7/28/24 when the nurse noted that R3 was missing. V1 said the police were called to the facility to file a missing persons report. V1 said a few days later, R3 was found in the community by law enforcement and taken to the hospital. V1 stated "R3 lied to the police and said she was homeless. She is manipulative and voiced that she didn't want to return (to the facility)." V1 said, that they were not aware that R3 was refusing medications at the time R3 was allowed to leave the facility independently because they were not notified by nursing staff.

A Care Plan for "Community Access" was initiated 5/7/19. At the time of initiation, R3 was granted an independent community (green) pass with the permission of the Guardian. The last revision in the "Goal" section is dated 11/22/23 and states "Resident will remain in the facility and request staff to accompany her when wanting to go outside." The care plan focus was updated on 2/24/24 to note that R3's green pass was restricted for 30 days due to failure to return at agreed upon time.

Facility Policy titled: Community Pass Policy revised 7/1/24 states in part; Purpose- to define the facility's and the resident's responsibilities

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S9999	Continued From page 20 when a resident leaves the facility with community pass. Procedure: 1. A "Community Survival Skills Assessment" will be completed by Social Services upon resident admission, quarterly, and when there is a significant change in condition. 2. Decisions regarding pass privileges, including independent privileges or being accompanied by a responsible individual, are determined by physician's orders and social services assessments. Residents who demonstrate consistent maladaptive ad problematic behaviors may not be candidates for independent privileges. 4. The facility reserves the right to restrict/revoke the community pass privilege of a person assessed by the IDT (Interdisciplinary team) or physician or Social Services as a threat to him/herself or others to assure the safety of the individual resident and the neighboring community. V1 said the facility implements the policy that residents who have an independent pass are considered discharged AMA if they don't return from pass, as a way of the facility releasing liability because it is unknown what the resident is doing while outside of the facility. (B)	S9999		