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
	IL6015333	A. BUILDING: _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FOREST PARK	8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130

(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: 1996403/IL115326	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1220 b)3) 300.1220 b)8) 300.2900 d)2) 300.3100 d)2) 300.3240 a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 300.1220 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. The plan shall be reviewed at least every three months.

8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

Section 300.2900 General Building Requirements
Section 300.3100 General Building Requirements

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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

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor a cognitively impaired resident with known exit seeking behavior, for attempts to leave a nursing unit unescorted by staff, and check the functioning of a resident's electronic monitoring device daily according to the facility's policy.

As a result, on 8/24/2019, R1, a cognitively impaired resident, left a monitored nursing unit by an elevator without staff being alerted, and left the building from an exit door, which was not alarmed at the time. A body matching R1's description was later found by local police in the river.

This deficient practice has the potential to affect R2, R4, R5, R6, R7, and R9, who were identified as elopement risks and reside on the same floor as R1.

Findings include:

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S9999	Continued From page 3 On 8/30/2019 at 9:37 AM, the surveyor observed video footage of taped recording of R1 leaving the building on 8/24/2019. V1(Administrator), V2 (DON-Director of Nursing), V11 (ADON-Assistant Director of Nursing), V20 (Assistant Administrator), and V21 (Maintenance Director) were present at the time of the viewing. The surveyor saw resident at the service elevator, crossing hallway, and leaving facility via south exit door on 08/24/2019 at 9:26 AM. Housekeeping and Dietary staff are seen in video footage, however, they are not seen with R1. V1 (Administrator), on 08/30/2019 at 10:20 AM, describes the 4th floor as a monitored, semi-secure unit; semi-secure because all stairwell doors are alarmed but not locked, elevators (front and service) require a code to leave unit, and unit has elopement prevention system in place (sensors by front and service elevators). V1 said the exit door did not have an alarm at the time of the incident, and did not require a code to get out of the door. V1, on 09/10/2019 at 4:16 PM, said, "We don't know how R1 got on service elevator; if staff were ignoring the alarm or if resident took off the electronic monitoring device." Observations were made on the 4th Floor on 08/29/2019 from 1:49 PM to 4:05 PM. All elevators are equipped with electronic monitoring sensors, and all require a code to bring the elevator to the floor. The electronic monitoring sensor was frequently alarming when no resident, who wears an electronic monitoring device, was near the sensor. V22 (Licensed Practical Nurse) on 08/29/2019 at 2:15 PM, said, "It just goes off. It's a problem. They (management) know about it. It's been going on for some time."	S9999		

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On 09/03/2019 at 2:20 PM with V12 (Housekeeping Supervisor), surveyor opened south exit door, setting off the alarm. V13 (Maintenance) responded to the alarm over two minutes later. V1 (Administrator), on 09/06/2019 at 3:38 PM, said staff "should respond to alarm as soon as possible, I guess it would depend on the situation."
While on the 4th floor, the surveyor also observed three elevators. All elevators have electronic monitoring sensors and keypads. Staff were observed using a code to bring the elevators to the 4th Floor.

Observations were made on the 4th Floor on 09/05/2019 from 3:46 PM to 4:02 PM. R2 walked slowly past the front elevators. The sensors did not alarm until R2 turned around and walked past the sensor again. R3 walked past the front elevator without triggering the sensors. V8 (Social Service Director) at 3:51 PM, said R3's device didn't trigger the sensors because it was covered by R3's sock. R3's device was uncovered but did not activate the sensors. R4 walked past the front elevators and stood at the Nurses Station; the sensors did not alarm. At 4:02 PM the front elevators sensors alarmed. The code for R4's monitoring triggered the alarm, however, R4 was not near the elevators. At 4:08 PM, R5's monitoring device triggered the alarms; R5 was around the corner, approximately 20 feet away from the sensors.

V21 (Maintenance Director) at 3:56 PM said he didn't know how close a resident had to be to the sensors in order for them to alarm, didn't know why there was a delay in the alarm sounding, or if there should be a delay. V8, at 4:07 PM, said that there should be no delay. V8 said on 08/30/2019 at 1:41 PM, residents' electronic monitoring

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devices were checked weekly prior to R1's elopement; now checked daily.

V1 (Administrator) on 09/06/2019 at 3:38 PM, said he was not aware that the alarm kept going off; no log is kept of electronic monitoring devices codes that trigger the sensor. "We don't monitor it. I guess someone could write it down."

V27 (Vendor) on 09/09/2019 at 1:38 PM, said there should be no delay; the alarm should sound almost immediately; residents' electronic monitoring devices should be checked daily. Manufacturer's Installation Manual (Version 14, page 10) documents, "The daily testing of electronic monitoring device and regular servicing of installed products is recommended to minimize problems detecting wanderers or general door security."
Invoice of 09/06/2019 documents the 4th Floor electronic monitor device will be replaced because it's too sensitive; it goes off if resident is not by elevator.

R1's face sheet documents R1 is a 64 year old admitted to the facility on 07/15/2019 with diagnoses including: Unspecified Symptoms and Signs Involving Cognitive Functions Following Cerebral Infarction (stroke), Altered Mental Status, Alcohol Dependence With Intoxication, Unspecified; Unsteadiness on Feet, Wernicke's Encephalopathy (neurological condition), Vascular Dementia with Behavioral Disturbance, Acquired Loss of Eye, History of Falling, Neurosyphilis (bacterial infection of brain or spinal cord).

R1's MDS (Minimum Data Set) assessment, dated 07/24/2019, indicated the resident had moderate cognitive impairment.

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R1's hospital record Progress Note of 07/10/2019, documents, "Per sitter/RN (Registered Nurse), he has been wandering out of his room and occasionally trying to leave the unit" and Progress Note of 07/11/2019 documents, "He was significantly agitated and trying to leave the floor."

R1's facility's progress note of 07/18/2019 at 2:10 PM documents R1 was transferred from the 3rd floor to the 4th floor after R1 was noted at the Nurses Station on the 3rd Floor with a bag filled with his belongings, stating he was leaving to catch the bus.

R1's "Community Survival Skill" Assessment, dated 07/24/2019, documents "The resident does not appear to be capable of unsupervised outside pass privileges at this time. Resident needs supervision."

R1's "Elopement/Unauthorized Leave Risk Review", dated 07/24/2019, documents, "At risk for elopement and should be placed on the Elopement Risk Protocol. A care plan for Elopement is indicated."

R1's Care Plan titled, "I am an elopement risk/wanderer r/t (related to) impaired safety awareness" (initiated 07/27/2019, revised 08/26/2019) documents the following interventions: -Assess for fall risk, identify pattern of wandering, intervene as appropriate, monitor for fatigue and weight loss, Elopement Prevention Device #72. The care plan had no specific monitoring intervention beyond the electronic device. There is no interim care plan to address R1's wandering and exit seeking behavior.

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Facility's incident report of 09/04/2019 documents: Elopement with possible adverse outcome. Awaiting police information.

Local police department missing person report narrative, with dates of 08/24/2019 to 09/04/2019, contained the following information: V15 (Detective-Local Police Department) was contacted 09/04/2019 by V16 (Detective-Neighboring Police Department) regarding R1. "V16 related on August 30, 2019 a body was located on the south branch of local river. The body was subsequently sent to Medical Examiner's Office where an identification was unable to be made. V16 reviewed a missing person flyer regarding R1 and noted the clothes that R1 was last seen wearing, matched the body that was located. V16 documented, the medical examiner's office reported due to the body being in the water anywhere from three days to three weeks physical identification could not be made. V16 reported the body was found to have dentures with R1's last name written on them.

On 09/09/2019, both V16 (Detective) at 9:39 AM and V26 (Medical Examiner's Office) at 9:33 AM, confirmed the body retrieved from the local river had an electronic device attached to the leg.

The facility's 4th floor direct care staff on duty the day of R1's elopement were interviewed about R1's elopement incident and plan of care for monitoring R1.

V6 (Registered Nurse/RN) reported on 08/29/2019 at 11:13 AM and 09/10/2017 at 11:26 AM, "I saw him (R1) that morning during initial rounds in his room, his elopement prevention device was on, and again in the dining room between 8:30 AM and 9:00 AM. I did notice him at

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approximately 9:30 AM getting onto the elevator. He said he wanted to go downstairs. I re-directed him to his room, he did go back to his room. I don't remember if his elopement prevention device triggered the alarm. I went on to do my medication pass then around 10:45 AM-11:00 AM, I went to check on him. He wasn't in his room or dining room, I called a Code Pink (code called when resident can't be found)." V6 said she never received training about the electronic monitoring device system, elopement risk, and wasn't informed how frequently to check residents who are at risk for elopement prior to R1's elopement.

V4 (Licensed Practical Nurse/LPN) on 08/30/2019 at 10:02 AM stated, "I was passing medications out, V6 was getting ready to medicate him and she asked did I see (R1). I told her I saw him earlier. V6 already looked in his room. All staff on unit looked for him, but Code Pink called before 4th floor staff started to look for him."

V5 (CNA-Certified Nursing Assistant) on 08/30/2019 at 10:37 AM reported, "V6 (RN-Registered Nurse) asked me around 10:30 AM if I had seen R1. I last saw him between 8:30 AM-9:30 AM. I said he has an elopement prevention device on, and I'll start looking for him. I looked for him, I couldn't find him. I came across V6 again, she asked me if I found him I said no, she said ok I'm going to call a Code Pink. I came down to reception and told receptionist that I'm going to look for him outside. I drove east and west down the main road but didn't find him."

V7 (CNA) was assigned to take care of R1 on the day R1's elopement. On 08/30/2019 at 12:36 PM and 09/10/2019 at 9:21 AM, V7 said, "This was

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the first time I took care of him. I was told by another CNA that he had an elopement prevention device and we had to make sure he didn't get down stairwell or on elevator. He was in the dining room from 7:30 AM-9:45 AM. Then when I left the dining room, around 10:00 AM, he was at the elevator with nurse, I walked him to his room." V7 said she wasn't told how frequently she should check on R1. V7 defined frequently as every 30-45 minutes. "I did not check on him from 10:00-11:00 AM." V7 said dialysis staff told her R1 was hanging around the service elevator that day. V7 said she did not receive any training about Code Pink, electronic monitoring device system, or elopement risk, and wasn't informed how frequently to check residents who are at risk for elopement prior to R1's elopement.

V9 (CNA) on 08/30/2019 at 3:38 PM said, "I stopped him from getting on the front elevator around 9:00 AM or 9:30 AM. I saw him go around the corner, I thought he was going to his room. His room was near the service elevator. The next time I heard anything was, I think, between 10:30 AM and 11:00 AM. They called a Code Pink and we all went to look for him."

V10 (CNA) on 08/30/2019 at 4:20 PM and 09/10/2019 at 8:54 PM, said, "I was in a resident's room when R1 got off the unit. He does wander, he wanders all the time. I've seen him get on the elevator, I've taken him off the elevator. We re-direct him to his room or Dining Room, if staff aren't paying attention to him he leaves; he will wander and try to find a way to get out. He needs 1:1 supervision. He shouldn't be re-directed to his room because no one can monitor (continuously) him in his room. It's better to re-direct him to the Dining Room, staff are always present. We're supposed to document in

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Point of Care every time a resident has a behavior. They didn't tell me how often to check on him."

V8 (Social Service Director), 08/30/2019 at 1:41 PM and 09/10/2019 at 11:02 PM, said R1 was transferred to the 4th Floor due to behaviors including exit seeking and wandering. V8 said, "I know when he was first admitted to the facility, he tried at least twice to leave, I know because they called his sister." R1 said he wanted to leave the facility and did try to leave while residing on the 3rd Floor. V8 said R1 wasn't appropriate for unsupervised community access due to poor decision making skills. V8 said interventions implemented included placing an electronic monitoring device on resident; moving him to the monitored unit. V8 said, "When R1 was moved to 4th floor we felt it would be better for him to be at a smaller facility with a more secure unit because his behaviors (desire to leave facility, wandering, exit seeking); we felt he might be more appropriate for placement at a SMI (mental health) facility. We did talk to R1's family about placement at another facility because we thought it would be a better fit."
V8 said, "They monitor them (residents at risk for elopement) like very hour or so. To be honest, I would have to ask the nurse how often R1 should have been checked on for his whereabouts, it would be a nursing call, time frames for checks vary. I don't know if there is one (written monitoring policy), to be honest. I'll check with Nursing and get it for you as soon as possible, if it exists. V8 said, "There is no written policy for frequency of monitoring residents at risk for elopement. Staff should check them hourly. We started documenting (on residents with electronic monitoring devices) after R1 eloped."
V8 said there is no written Elopement Risk

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Protocol; protocol consists of placing an electronic monitoring device on resident, move resident to 4th Floor, care plan for elopement. V8 said she conducted in-services prior to R1 leaving facility that discussed elopement risk, electronic monitoring device system, and Code Pink (code called when resident can't be found). "I explained there's a list of residents, who are elopement risks, at all Nurses Station and front desk, if they hear alarm go off they are to see which resident triggered system and check that resident is still on floor." V8 was unable to present sign in list for this in-service, "We looked, we can't find it."

The Facility's Elopement Device policy and procedure, effective 08/23/2017, revised 08/23/2109, included the following under procedure:
3. The elopement alert exit door device will be inspected for proper working daily.
4. The inspection and status of the test will be recorded on a facility-approved log.
6. The anklet or bracelet device will be inspected by nursing personnel once each day.

R1's EMAR (Electronic Medication Administration Record), 08/2019 does not document electronic monitoring device was checked daily for placement prior to 08/24/2019, or on the day R1 eloped. R1's Order Recap Report (Physicians Order Sheet) documents an order to check electronic monitoring device placement with resident every shift for elopement risk, start date 08/24/2019. R2's, R4's, R5's, R6's, R7's and R9's 08/2019 EMARs and Physician Order Sheets documents orders to check residents' electronic monitoring devices were put in place after R1 eloped from facility; Face Sheets document they were admitted to the facility prior to R1's

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S9999	Continued From page 12 elopement. V7 (CNA), on 08/30/2019 at 8:30 AM said, "I didn't check his (R1's) electronic monitoring device because he was up and dressed when I started my shift." (AA)	S9999		