STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145180	A. Building B. Wing	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Chicago Heights	490 West 16th Place Chicago Heights, IL 60411

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review the facility failed to prevent resident to resident assault for 1 of 6 resident (R2) reviewed for physical assault. This failure resulted in R2 being hit in the head by a co-peer unprovoked. Findings Include: R2's diagnosis: schizophrenia, intellectual disabilities, and type 2 diabetes. R2 was admitted to the facility 1/9/18. R3's diagnosis: schizophrenia and psychotic disorder. R3 was admitted to the facility on [DATE]. A Nursing note dated 8/10/21 documents R2 noted with a bruise to the right eye and bump to the mid forehead. R2 reported R3 hit R2. A police report was filed. R2 and R3 were separated. A Social Service note dated 8/10/21 documents R2 came to the therapist office with a bruised right eye and alleged being hit by R3. A Nursing note dated 8/10/21 documents R2 reported R3 hit R2. R3 admitted to hitting R2 and no reason was identified. R3 monitored closely for safety. R3 was sent to the hospital for evaluation. The Final Abuse Investigation dated 8/14/21 documents on 8/10/21 R2 reported that R3 struck R2 in the face. R2 was noted to have a bruised right eye and a raised bump on the mid forehead. R3 reported becoming irritated with R2 because R3 believed R2 kept calling R3's name out. R3 was sent to the hospital for evaluation. On 8/17/21 at 11:00AM, V4 (PRSC) stated, R3 talks to herself a lot so she does have hallucinations. I think R2 tried to get involved in a conversation R3 was having with herself and R3 got upset. This would be physical abuse. On 8/17/21 at 11:48AM, V6 (PRSC) stated, R2 came to the office and when R2 turned around, I saw R2 had some bruising to R2's eye underneath it. R2 told me someone hit her. When I asked who it was, she told me the small girl in her room. Maybe there was a little bit of swelling but that's all I can remember. I went to tell the nurse and we also called the DON and the administrator. I know R3 does have a lot of hallucinations and delusions, so I don't know if that caused R3 to hit R2. This would be physical abuse. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/17/21 at 12:07PM, V7 (Nurse) stated, R2 came up to the office and I saw bruising to R2's eye. R2 indicated it was her roommate that hit her. I went to talk to R3 to see if I could see what happened but R3 told me R3 didn't want to talk about it and was becoming agitated when I brought it up. R3 did tell me R3 hit R2. This would be physical abuse. On 8/17/21 at 1:36PM, a black and purple discoloration is noted under R2's entire right eye socket. The right eye is slightly more swollen than the left eye. When asked what happened to R2's eye, R2 stated, She hit me, and pointed at the bed to the left of R2's bed. R2 stated, She hit me in my eye. I don't know why she hit me. I went and told the nurse what happened. R2 was unable to recall any other details of the altercation. On 8/17/21 at 3:55PM, V3 (DON) stated, I was notified by the nurse that R2 had a black eye. R2 reported R3 hit her. When I interviewed R3, R3 admitted to hitting R2. I was told R2 asked R3 what R3 was saying when R3 was mumbling. R3 has a lot of hallucinations so R3 talks to herself a lot and responds to the hallucinations. I think R2 thought R3 was talking to R2 and asked R3 what R3 was saying and that's when R3 hit R2. This would be physical abuse. On 8/20/21 at 9:16AM, when asked about the altercation, R3 stated, Yes, I hit her. I forgive her. R3 kept shaking head no when asked any further details about the altercation. The Abuse Risk assessment dated [DATE] documents R2 is at a moderate risk for abuse. R2 can become confused at times but is redirectable. The Psychosocial assessment dated [DATE] documents R2 had a physical altercation with a peer. The Care Plan dated 11/14/18 documents R3 has a potential to be physically aggressive due to diagnosis of psychosis. R3 was in altercations on the following dates: 12/3/19 - scratching a peer, 1/8/20 - agitated and slamming doors, 1/13/20 - R3 was pushed by a peer and R3 pushed back, 8/14/20 - R3 was in a physical altercation with a peer, and 3/13/21 - R3 displayed physical aggression towards a peer. The Care Plan dated 8/24/20 documents R3 has history of being at risk for abuse due to aggressive behavior. The Minimum Data Set, dated dated dated [DATE] documents in Section E documents R3 does experience hallucinations and delusions. The Petition for Involuntary admitted d 8/10/21 documents R3 is in need of immediate hospitalization due to verbal aggression towards staff and peers, physical aggression towards peers, and difficulty in redirection. The policy titled, Abuse Prevention and Reporting - Illinois, revised 1/22/19 documents, The resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .Willful, as used in this definition, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to provide blood glucose monitoring and insulin for a resident with a diagnosis of type 1 diabetes and failed to notify the primary care physician of an abnormal blood glucose level for 1 of 3 (R12) residents reviewed for diabetes management Findings Include: R12's diagnosis: type 1 diabetes mellitus with hyperglycemia, patient's noncompliance with medication regimen, and bipolar episode with psychotic features. R12 admitted to the facility on [DATE]. The Hospital Discharge Medication List dated 5/26/21 documents the following medication orders: insulin glargine subcutaneous injection 100 units/ml - 40 units every morning, insulin lispro subcutaneous injection 100 units/ml - 30 units with lunch, and insulin lispro subcutaneous injection 100 units/ml - 25 units with breakfast. R12 is also ordered a carbohydrate counted diet. On 8/17/21 at 12:07PM, V7 (Nurse) stated, R12 was a diabetic. I don't remember what kind. Sometimes R12 would be compliant and other times R12 would refuse. I remember talking on the phone with R12's mom and she was telling me how severe R12's diabetes were. I told her that R12 was refusing the shots and blood sugar checks sometimes. When they do that, we document it and call the doctor. I don't know why it wasn't documented. When the blood sugar is high then we call the doctor too. We just follow whatever the order says or the sliding scale. I don't know if he had a sliding scale. If it's higher than 350 than we usually always just call to let the doctor know. On 8/17/21 at 3:55PM, V3 (DON) stated, When a resident is admitted the nurses go over the paperwork and put in the orders from the hospital. They go over them with the doctor too. Then the next morning we go over the paperwork again and look at the medical side of it as well as if there's any devices or anything like a pacemaker or something like that we need to be aware of. I don't remember him having diabetes. We monitor for high blood sugars and if we do have an issue, we would let the doctor know. We will just go off with the order said for notifying the doctor. If a resident is refusing insulin or Accu checks the doctor should be notified. On 8/18/21 at 10:02AM, V13 (Nurse) stated, The discharge paperwork from the hospital will have all the orders that you need on it. The admitting nurse will go through the papers and continue the medication and then call the doctor to make sure everything's OK. Doctors normally don't discontinue something that's on the discharge medication list. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/21 at 11:58AM, V17 (Primary Physician) stated, If you don't take your insulin, you can go into diabetic ketoacidosis because your sugars will be so high. It's not a good thing to do. If it is left untreated, you will go into a diabetic coma and can die. If they aren't taking their insulin or their blood sugar is too high, they need to call the doctor and see if they should be sent to the hospital. The guardian also has to be notified of this. All I can say is to follow the protocol they have. If someone isn't taking their medication for longer than a day or two then I would say send them to the emergency room to get them checked out. We would have to ask do they have the capability of refusing. I don't remember this resident. But if they had orders in place on the discharge medication list then I most likely would've followed what they were already doing. Again, I would tell you to follow the protocol because each resident is different so whatever the number is in their protocol go off of that. That is why I should be notified of a high blood sugar. The Physician Order Sheet dated 8/18/21 documents R12 is ordered a regular, general diet. The medication orders were as follows: insulin lispro subcutaneous injection 100 units/ml - 30 units in the afternoon and insulin glargine subcutaneous injection 100 units/ml - 40 units once a day. The Medication Administration Record (MAR) dated 05/2021 documents R12 did not receive the insulin lispro injection on 5/29/21 or 5/31/21. The MAR also documents R12 refused the insulin glargine injection on 5/28/21. There is no documentation a doctor was notified of the missed any missed insulin doses. There is an order for blood glucose monitoring three times a day before meals that is dated 5/30/21. No documentation of blood glucose monitoring is noted before this date. The first documented blood glucose was at 9PM on 5/30/21 and is documented as 441 mg/dL. A normal blood glucose range is 60 - 100 mg/dL. The next blood glucose on 5/31/21 at 7:30AM is documented as 239 mg/dL. R12 had a total of two blood glucose checks while in the building from 5/26/21 to 5/31/21. There is no documentation that a doctor was notified for either elevated blood glucose. The Care Plan dated 5/30/21 documents R12 is a type 1 diabetic and is insulin dependent. The policy titled, Admission of a Resident, documents, .10. Using information obtained (during the nursing assessment), contact the physician, ensuring that all admission orders cover all aspects of required care and treatment. Inform the physician of allergies and diet requests or needs. The policy titled, Hyperglycemia, documents, Residents will be monitored for S&S of diabetic coma (also known as hyperglycemia). A condition that occurs in diabetic residents when they do not receive enough insulin to metabolize carbohydrates, when there is increased stress or infection. The onset is gradual. Should you observe a diabetic resident, or should a diabetic resident complain of any of the following symptoms an accu-check will be done (should any symptoms exist, the accu-check would reveal a blood sugar >300). Report all changes in the diabetic resident's condition to the physician IMMEDIATELY.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Noncompliance resulted in two deficient practices. I. Based on interview, and record review, the facility failed to monitor and supervise three residents (R1, R11, and R12) that were at high risk for elopement for four residents reviewed for elopement in a total sample of sixteen. This failure resulted in R12 eloping from the facility during smoke break on [DATE] and was found deceased on [DATE]. This was identified as an immediate jeopardy situation that began on [DATE] and was removed on [DATE]. V1 (administrator) was informed of the immediate jeopardy on [DATE]. The immediacy was removed on [DATE], but the deficiency remains at a level 2 harm, until the facility can be evaluated for the effectiveness of the interventions implemented. Findings Include: R12 R12's diagnosis: type 1 diabetes mellitus with hyperglycemia, patient's noncompliance with medication regimen, and bipolar episode with psychotic features. R12 was admitted to the facility on [DATE]. The Admission Hospital Records dated [DATE] documents R12 is an elopement risk due to R12 attempting to run away from the hospital on this day. The Discharge Records document R12 has type one diabetes with poor compliance with insulin. R12 needs a more structured setting for managing the diabetes. A Nursing note dated [DATE] documents R12 fled facility on foot, wearing all white, including a white baseball cap. Code was enacted, and staff search the area to no avail. Non-emergency police were informed as well as R12's guardian. The Police Report dated [DATE] documents police assisted in a wellness check of R12 when R12's family member could not get an answer at the door of R12's apartment. When the police officer entered the apartment, R12 was noted on a mattress and deceased . R12's body was stiff and had what appeared to be dry brown vomit coming out of R12's mouth. The Police Report dated [DATE] documents officers were at the morgue on [DATE] during an autopsy in a death investigation for R12. R12's blood sugar was tested and was 1500 (normal blood sugar range is ,d+[DATE] mg/dL). The doctor performing the autopsy told the office that R12 had lethal levels of blood glucose and vitreous glucose. Vitreous glucose means the glucose level is greater than 200 mg/dL. Because glucose levels decline rapidly after death, a postmortem vitreous glucose level greater than 200 mg/dL is indicative of diabetes mellitus, diabetic ketoacidosis (a serious complication of diabetes that causes a build-up of acids in the blood when blood sugar levels are too high), or nonketotic hyperosmolar coma (coma resulting in person with a very high blood glucose level). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:07PM, V7 (Nurse) stated, That day (R12) was talking on the phone with his mom and yelling. I heard him say he wanted to go home. (R12) seemed to calm down. I didn't hear anything else from him. Then I heard he left out the gate during smoke break. I didn't think he was an elopement risk. If they have a prior elopement, then that makes them an elopement risk automatically. I was never told anything about him eloping. On [DATE] at 3:55PM, V3 (DON) stated, I was called and told (R12) left during smoke break. They told me (R12) left out the gate. The nurses go over the admission paperwork and then myself and the admissions department will go over it again the next day. I don't remember him having an elopement history. On [DATE] at 10:35AM, V14 (family member) stated, I was called around 4PM that day and was told by the nurse that he eloped. He had called me an hour or two before on his cell phone. I was concerned when I was talking to him because he was starting to yell and argue over little things with me again. I called the place back to talk to the nurse to tell them I thought he might need a high level of care because of how he was acting when I was on the phone with him, but I never got answer. It was later they called to tell me he left, and they tried to look for him, but they couldn't find him. He called me a couple days later saying he had made it to Chicago near 95th by the train and was taking the train home. I know he was staying at a Dunking Donuts and they would give him all the day old donuts and juice. Without insulin, I'm sure that was not good for his diabetes at all. We are in Carbondale. He told me he was going to stay with a friend for a while, but he wouldn't tell me exactly where. I tried telling him to come home because he needed his insulin. He would get upset when I would mention it and kept telling me he could do it on his own. I just kept encouraging him to at least go to the pharmacy and get his insulin. I heard from him a couple days later and he said he broke into his old apartment and had his insulin. This was on Saturday ([DATE]). He asked us to bring him somethings and we did and left it there for him. The next day we got a text from him saying he was feeling good and had a sore throat. We told him to go to the hospital because all the clinics were closed. We didn't hear from him that day and thought he went or must have felt better. We called again on Monday to see how he was and had no answer on his phone. My husband called again on Tuesday and it went straight to voicemail, so we knew something was wrong. My husband went over there and knocked on the door, but he did answer. He called the police and go the landlord to come open the door. When they went into his apartment, he was deceased . We had to send his body to the coroner for testing and the coroner called me to tell me the final report was still pending but R12's blood sugar was 1500. When the police searched his house, he did have insulin and the supplies in the fridge, but I don't know if he took any of it like he was supposed to. I called and spoke with a nurse a day after he was admitted and told them he tried to escape from the hospital, and he needed to be watched closely. I told the staff he was a high elopement risk and he still got out. On [DATE] at 11:13AM, V15 (PRSC) stated, We are supposed to do an L formation outside. All the staff members get in the shape of an L so we can see all sides. I don't remember him being an elopement risk. We have a binder of people that are elopement risks that we update when there is an elopement. I don't know how often it is updated. No, we don't take this outside with us. On [DATE] at 12:52PM, V16 (Mental Health Technician) stated, When a resident is an elopement risk, you have them sit near you or away from the gate. I don't remember this resident but if he got out, he probably just opened the gate. The gates aren't locked and when it's two staff members trying to watch thirty or more people things can happen. I don't think there is a certain formation we can make to watch. You just pick a spot where you can see as many people as possible. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:58AM, V17 (Primary Physician) stated, If you don't take your insulin, you can go in diabetic ketoacidosis because your sugars will be so high. It is not a good thing to do. If it is left untreated, you will go into a diabetic coma and can die. On [DATE] at 11:10AM, V19 (Psychiatrist) stated, We get residents all the time that attempt to elope. Some are successful in eloping and others just talk about leaving all the time. Then there are residents who don't show behaviors initially then start to show signs after a few days. If someone was an elopement risk, I would expect an extra person be with that resident if they are outside the building. The Elopement/Unauthorized Leave Risk review dated [DATE] documents R12 is not at risk for to elope at this time and placement on the Elopement Risk Protocol is not indicated. The question on the form Is there a prior history of wandering/elopement and/or does the resident verbalize a strong desire to leave? is documented as no. The Community Survival Skills assessment dated [DATE] documents R12 does not appear capable of unsupervised outside pass privileges as this time. Per facility policy and due to COVID, R12 is not eligible for independent pass privileges at this time. The Elopement/ Unauthorized Leave Risk review dated [DATE] documents R12 is at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. The Care Plan dated [DATE] documents R12 is an elopement risk/wanderer related to exit seeking, history of attempts to leave the facility unattended, impaired safety awareness, and R12 wanders aimlessly. R12 has type 1 diabetes mellitus and is insulin dependent. The Minimum Date Set (MDS) Section E dated [DATE] documents R12 does have a behavior of experiencing delusions. R1 R1's diagnosis: schizophrenia, bipolar disorder and chronic viral hepatitis C. R1 admitted to the facility on [DATE]. The Admission Hospital Records dated [DATE] document R1 was hospitalized for safety and stabilization after escaping from nursing home multiple times. Intake reports document R1 was found in the cellar of a house after being heard talking to self. A Social Service Note dated [DATE] documents per the hospital records, R1 escaped from the previous facility several times and will be placed on elopement risk protocol. A Social Service note dated [DATE] documents R1 was previously at another facility and left unauthorized from there six times in eight months. A Nursing note dated [DATE] documents R1 left the facility unauthorized during smoke break and was brought back in by staff. 72-hour behavior monitoring initiated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Social Service note dated [DATE] documents R1 left unauthorized during smoke break and was picked up by staff down the street. R1 requested to go to the hospital and reported will attempt to leave again in not sent. R1 continues to be on elopement risk protocol. During the smoke break on [DATE] at 1:15PM, 67 residents were outside with four staff members, on [DATE] at the 3:15PM, 54 residents were outside with five staff members, and on [DATE] at 11:15AM, 71 residents were outside with four staff members. R1 sat on a bench or on the ground each smoke break. Staff was not within close proximity of R1 for the entirety of the smoke break. There was no closer monitoring noted for elopement risk residents. On [DATE] at 11:24AM, V5 (PRSC) stated, She eloped from the previous facility and the police brought her to the hospital. Her family had her transferred here because they were concerned about her escaping the other facility so many times. She walked out the gate both times. When I did her assessment, I put her at high risk. We tell the staff verbally when there is a new admission that is a high risk. There is also a list at the nurse's station and in the offices. I don't know how often that is updated. The staff should be passing on in report who is high risk if they are new. On [DATE] at 2:05PM, V10 (Nurse) stated, I was her nurse the first time she left. I don't think she was on the elopement list then. I wasn't told she was a high risk. I didn't know she left the other facility that many times. On [DATE] at 2:54PM, V11 (CNA) stated, She just walked out the gate that I know. That was her second time leaving. I was standing by the gates by the basketball gates, so I didn't see her leave. At that time, she was an elopement risk so whoever was on that side should have been watching her. On [DATE] at 3:07PM, V12 (Activity Aide) stated, This time she just walked out the gate. It isn't locked and she jumped over the other fence. I was passing out cigarettes and saw her leave. There was one or two other people out there I think but I can't remember. No one was standing by that side she left one. I don't know of any list of elopement risk. I just know who to watch for and if people are looking suspicious you watch them. I have another resident that I trust stand over by the gate now. I couldn't watch everyone and pass out the cigarettes at the same time. On [DATE] at 3:20PM, V18 (Mental Health Technician) stated, I was outside, and I was standing over by the area where I can see both sides. This was on the East side. I didn't see her leave. I just saw her bag going over the fence. The girl (V11) said she opened the gate and then jumped the other fence. I ran through the building and left outside through the [NAME] side doors and caught up to her. We just get report from the shift before us on who to watch. I think I was told to watch her. It was my first day alone so I was watching everyone, and she must have just left when I was watching someone else. On [DATE] at 3:55PM, V3 (DON) stated, She made attempts to leave on both sides. The [NAME] side area was closed down and all residents go to the East side now so staff can watch them all in one area. We have elopement risk list at each nurse's station. She is an elopement risk now. Signs of elopement are pacing, checking the doors, voicing they want to leave, and attempts of leaving the facility without staff being aware. She wasn't on the list when she was first admitted . She was put on after the first elopement. I believe her family called admissions to let them know she eloped from the previous facility. The elopement risk list is updated quarterly or when there is a new elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Elopement/ Unauthorized Leave Risk review dated [DATE], [DATE], and [DATE] document R1 is at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. The Care Plan dated [DATE] documents R1 is an elopement risk related to history of elopement at previous facility. On [DATE] and [DATE], R1 left the facility unauthorized during smoke break. The Community Survival Skills assessment dated [DATE] documents R1 does not appear capable of unsupervised outside pass privileges as this time. R1 is not appropriate for outside pass privileges based on reported history of socially inappropriate behavior and unauthorized leave from other nursing home. The MDS Section E dated [DATE] documents R1 does have a behavior of experiencing delusions. R11 R11's diagnosis: schizoaffective disorder, psychotic disorder, and type 2 diabetes. R11 admitted to the facility on [DATE]. A Code Pink was called at approximately 2:43PM on [DATE] in the central wing. R11 was accompanied by staff returning to the building around 2:45PM. It was reported R11 exited the facility during an activity. V20 (Activity Aide) was running a music activity and had about twelve residents inside and seven or eight residents outside. R11 opened the gate and left. The video was replayed by V2 (Assistant Administrator). The video showed R11 open the gate and walk on the path to the west side of the building. Staff found R11 about three minutes after R11 exited the gate. R11 was brought back to R11's room. R11 was agitated at this time and refused to talk with surveyor. On [DATE] at 3:05PM, V20 stated, I was doing an activity by myself. I had about 12 residents inside and maybe seven or eight outside. I kept going back-and-forth from inside to outside to keep checking on everyone. I was inside and one resident came in and tapped me on the shoulder and told me R11 left out the gate. I called the code pink and asked for the other residents to come inside. R11 was found on the employee smoke patio and R11 had walked over to the west side door. No, she's not an elopement risk we were doing a music therapy where I play music and I just kind of let the residents do whatever they want. Some play basketball and some play cards and others just sit there and listen to the music. I don't take more than 20 residents for an activity by myself. Normally I have a mental health tech with me but I know some of them are training today and their schedules are a little different because we just hired a bunch of new people, so it was just me today doing the activity. A Social Service Note dated [DATE] documents R11 tried leaving the facility on the west pavilion. R11 escorted back into the building. R11 reported trying to leave due to breakfast being late. Staff reminded R11 breakfast was at 8AM and it was now 9:30AM. A Nursing note dated [DATE] documents R11 left the building and was found sitting just out the building. R11 agitated and cursing at staff. R11 is threatening to leave again. A Nursing note dated [DATE] document R11 exhibited an unauthorized exit and was immediately brought back into the building. R11 placed on behavior monitoring for 72 hours. (continued on next page)

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	145180	A. Building B. Wing	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Chicago Heights	490 West 16th Place Chicago Heights, IL 60411

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Elopement/Unauthorized Leave Risk Review dated [DATE] documents R11 is at risk and should be placed on the Elopement Risk Protocol. The Elopement/Unauthorized Leave Risk Review dated [DATE] documents R11 is at risk and should be placed on the Elopement Risk Protocol. The Elopement Risk List 2021 dated [DATE] does not list R11 as an elopement risk on this day. The policy titled, Elopement Risk Assessment, documents, 2. Risk factors that will be assessed include the following: a. Independent ambulation with or without assistance, b. Pre-admission or history of elopement, c. Purposeful exit seeking, d. Restless, aimless pacing, e. Verbalization of wanting to leave the facility and/or go home, f. Grabbing doorknob or pushing on exit door, g. A cognitive impaired individual who is a follower, h. Inability to differentiate safe from unsafe situations, i. Diagnosis of Alzheimer's, Dementia, Schizophrenia, Brain Injury, j. Inability or refusal to follow instructions. 3. Should an elopement risk be determined; interventions will be immediately initiated to protect the resident in a reasonable manner and as approved by the physician 4. The physician and family/sponsor will be notified of the resident assessment findings, and suggested interventions to protect the resident. 6. The Social Service Department will notify Facility Staff and initiate interventions necessary to protect the resident. Interventions include, however, are not limited to the following: a. Relocation to a secure unit, b. Bed alarm and/or chair alarm, c. Use sign in/sign out record, d. Psychological consult, e. Personal alarm arm or ankle bracelet, f. 15 minute to one-hour observations, one-to-one observation, h. Behavior management programs. The immediate jeopardy was removed on [DATE] at 12:28PM with the acceptance of the following plan: Aperion Care Chicago Heights DESCRIPTION OF OCCURRENCE: The facility failed to monitor and supervise residents during smoking breaks to prevent residents from leaving the facility under unsafe conditions, for R1 and R12 that were at high risk for elopement. ACTION TAKEN: R12 is no longer a resident of the facility R1 continues to reside at the facility. There is no current exit seeking behavior noted. If exit seeking behavior is observed, R1 will be provided diversional therapeutic activities that residents will enjoy doing which will keep resident engaged thereby stopping exit seeking behaviors. R1's Careplan will be updated to include staff intervention to address future potential elopement behaviors: Completed on [DATE] (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Staff were in serviced and trained on procedures of supervising and monitoring residents for elopement utilizing the Elopement Policy and Code Pink Policy/Procedure. The smoking program was updated to reflect increase supervision for those at risk of elopement. There will be a minimum of 3 employees monitoring: 1 will be stationed at the west gate, 1 will be stationed in the middle and 1 will be stationed at the exit door. All residents identified as at risk for elopement will be supervised separately during any outside Activity. Activity staff will be in-serviced on supervision of residents at risk for elopement during outside activities. All staff will be re-educated by V2 DON prior to next scheduled shift. All staff on vacation or on leave will be re-educated prior to returning to work and new hires will be trained during orientation before starting work. V2 DON, verbally conducted in-service initiated at 2pm [DATE]. Staff acknowledge information via signature. Staff competency of policy/ procedure will be assessed with a questionnaire completed with each staff member post in-service Administrator/Managers will continue to monitor all staff for compliance by daily observations of resident smoke breaks. Administrator/Managers will continue to monitor all staff for compliance by observations of Code Pink response if a code response is required: Completed on [DATE] Observation audits will occur daily for three months and any noncompliance will be addressed. If there are concerns noted, reeducation will be provided, and observations will continue. The administrator and or manager on duty will perform the observations on the weekends. 2.Staff will be in serviced/trained on conducting proper elopement risk assessment by Social service consultant: Completed on [DATE] 3.All residents that are at risk for elopement were reviewed for accuracy of their elopement risk assessments. The elopement risk assessments were performed and will continue to be done upon admission, Quarterly, any changes in condition and as needed. Accuracy of the assessments will be audited by the Social service consultant: Completed on [DATE]. Assessment will be reviewed and updated quarterly and as needed. 4.All residents were re-assessed for Elopement Risk. List is updated as of [DATE] Completed [DATE]. Assessments are reviewed and updated quarterly and as needed. 5.All residents assessed at risk for elopement will be supervised during their identified smoking times. Any residents observed or reported with signs of potential exit seeking behaviors will be intervened and addressed accordingly. The smoking program has been revised to 2 separate groups: Group A- residents identified assessed as at risk for elopement. 4 staff will be supervising 24 residents. Group B- residents not assessed as at risk for elopement. 4 staff will be supervising 96 residents (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6.All residents at risk for elopement will be monitored 1 on 1 with staff during outside activity. If Activity staff is unable to provide 1 on 1 monitoring, residents at risk for elopement will participate in indoor activities only. Any residents observed or reported with signs of potential exit seeking behaviors will be intervened and addressed accordingly. The Chicago Heights policy elopement policy is updated as of [DATE]. List of residents at risk for elopement is updated. Mental health techs, behavior aides and activity staff will monitor residents who are high risk during smoking and activity. Department heads will ensure that the departments are compliant with monitoring: Completed as on [DATE] for smoking and [DATE] for activities. 7. All residents at risk for elopement that do not smoke will have their care plans reviewed and updated to include diversional therapeutic activities that residents will enjoy doing which will keep resident engaged thereby minimizing/stopping exit seeking behaviors: Completed [DATE] II. Based on observation, interview, and record review, the facility failed to effectively monitor and supervise residents with a known history of inappropriate smoking behaviors 4 of 4 residents (R13, R14 R15 and R16) reviewed for supervision of inappropriate smoking behaviors. This failure resulted in R13 and R14 smoking inappropriately in a resident bathroom causing the fire alarm to activate and the local fire department responding to the facility. Findings Include: On [DATE], the local fire department responded to the fire alarms in the facility. A large amount of smoke was noted coming out of the resident bathroom in room on the resident wing. R13 and R14 were the residents found to be smoking inappropriately at this time. R13's diagnosis: schizophrenia, bipolar disorder, and nicotine dependence. R13 was admitted to the facility on [DATE]. R14's diagnosis: schizophrenia and delusional disorder. R14 was admitted to the facility on [DATE]. A Nursing note dated [DATE] documents R13 noted with inappropriate smoking in bathroom and was immediately removed and redirected to central station where a complete body assessment was rendered. While facility rendering their head count protocol, R13 became verbally aggressive and attempting to get physical with staff. The doctor gave an order to transfer to the hospital with a psych petition. A Nursing note dated [DATE] documents R14 noted smoking inappropriately in bathroom and immediately removed from area and redirected into central nursing station. Room was cleared for assessment. R14 verbalized no concerns at this time and has been escorted to the dining area for closer supervision. While waiting in dining area for clearance of our head count protocol, R14 started getting anxious and restless and became verbally aggressive towards staff and peers. The doctor was notified of situation and has given an order for transfer to the hospital with petition for harm to self and others. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:30PM while doing rounds with V23 (Mental Health Technician), a strong odor of cigarette smoke was noted in two bathrooms in resident rooms. The staff was unable to identify which resident(s) were smoking in the building. On [DATE] at 12:25PM, V5 (PRSC) stated, I know the fire alarms went off and a code red was called. They were smoking in that bathroom and it set the alarm off. We don't know why they were in that room. That room was searched, and nothing was found. R14 normally doesn't have issues with smoking inappropriately. I have to counsel R14 on it maybe every six months. The first time you are caught it is a verbal warning. The second time your smoke privilege for the next break time is taken away. The third time you are caught is a 24-hour ban. I don't know when the time is reset for the violations. I don't know if it's over a day or a week. On [DATE] at 12:44PM, V21 (PRSC) stated, No residents can keep any smoking materials on them because of safety reasons. They all must be locked up with activities. They can't keep them because they aren't safe to smoke in the building. A lot of residents here have poor safety judgement. I can't really remember R13's behaviors with inappropriate smoking. After they are caught smoking, we counsel them on the policy and update the care plan, but we aren't the only ones who update the care plan. All the other staff can do that too. On [DATE] at 12:56PM, V22 (Mental Health Technician Supervisor), stated, There is a daily list of people who are banned from smoking after their infractions. It changes daily. We don't have a list of any repeat offenders. The staff just kind of knows who to look out for. The MHTs should be checking the people we suspect of bringing in materials. All we can do is have them show us their pockets and check around their waist. We will also do room checks. The daily list is given to the activity aides, PRSCs, and MHTs so we are all aware who can't smoke for today. After their 24-hour ban is up, they can go back to smoke again the next day and then they start back at zero violations. On [DATE] at 2:00PM, V23 stated, The first time is a verbal warning. The second time is they get the next smoke break taken away, but they can go out again after that. The third time they can't smoke for 24 hours. After the 24 hours is up, they start back with no violations. They get a clean slate after they do the 24 hours. We make the repeat offenders open their pockets at the door before they come back in. We just know who they are. We make sure they aren't taking anything off the smoke cart. We don't know how the repeat offenders are getting them in. We don't usually find anything during the searches. We don't know how they are lighting them either. We haven't found any matches or lighters. During the 3:15PM smoke break on [DATE], no residents had their pockets checked by staff before reentering the building. On [DATE] at 3:42PM, V24 (Mental Health Technician) stated, During smoke break, we watch so no one is eloping, and we watch for behaviors. We have the repeat offenders open their pockets in the front and back. I don't think there was any repeat offenders outside. I don't think there is a list. I just know who they are. During the 1:15PM smoke break on [DATE] R15 and R16 were outside smoking even though they were on the smoking ban list for that day. The smoke ban list on the cigarette cart does not list R16 as being on smoke ban. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:50PM, V20 (Activity Aide) stated, I have not seen the sheet at all today. I know there are people that have got caught smoking in the building, but I don't know who. V22 is supposed to relay that to us but it doesn't happen. I don't know who is or is not allowed to smoke. There is no communication with the activity department on who cannot smoke. I know the mental health techs sometimes know who is on ban but there is no communication with us, and we are the ones passing out the cigarettes. During the 3:15PM smoke break on [DATE] R15 came outside to smoke and was told to go back in the building by V20. V22 told V20 it was ok for R15 to smoke because R15's smoke ban time limit was over. R16 attempted to come smoke again and was told to go back in the building by V20. On [DATE] at 3:42PM, V22 stated, R15 can smoke now. R15's 24-hour ban is over. R16 cannot smoke though. R16 was just caught earlier this morning smoking in the building. R16 is being sent out for smoking so I didn't bother to update the list and give it to activities. The Care Plan dated [DATE] documents R13 is an inappropriate smoker. R13 was found smoking inappropriately on [DATE]. No new interventions are noted on or directly after [DATE] in regard to this behavior. There is no further documentation in progress notes of R13's inappropriate smoking behavior on this date. The Smoking Safety Risk assessment dated [DATE] documents R13 is minimally problematic with history of hazardous behavior (i.e., smoking in unauthorized areas or careless use of smoke materials, sustaining burns, fire starting) and begging, borrowing, trading items, and panhandling for smoking materials. R13 requires supervision while smoking and is not able to store smoking materials. The Care Plan dated [DATE] documents R14 is an inappropriate smoker. There is no further description of R14's inappropriate smoking behaviors. There is no further documentation in progress notes of R14's inappropriate smoking behavior on this date. The Smoking Safety Risk assessment dated [DATE] documents R14 is minimally problematic with potential for causing injury to self or others from smoking in unauthorized areas or careless use of smoking materials. R14 requires supervision while smoking and is not able to store smoking materials. The Behavior Management Program and Level Program agreement dated [DATE] documents The following are inappropriate and unacceptable behaviors and will result in immediate pass suspension: 1. Smoking in non-designated areas. This endangers everyone who lives and works in this facility . The Smoking Policy Acknowledgement with no date documents All residents are require to turn in smoking materials to the Activity Department, in which those smoking materials will be distributed by the Activity Staff (lighters, matches, pipes, cigarettes, tobacco). Smoking materials are not allowed in resident's possession . Residents who violate the expectation of the smoking program will be subject to progressive interventions. Staff Responsibilities: assigned staff will monitor residents on the smoking program; staff will remain in the designated area, during the entire scheduled smoke time with the residents; staff will monitor for residents removing cigarette buds from ashtrays or from the ground; staff will empty ashtrays and sweep before leaving the smoking area as needed; all reports of resident smoking violations must be reported to the charge nurse, mental health tech, activity director or social services, documented, and followed up. Resident smoking is permitted in the designated area: Patio area. R [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on observation, interview, and record review the facility failed to ensure there was enough staff available to prevent/reduce the risk of resident elopement from the facility this affected 1 of 3 resident (R11) reviewed for staffing. This failure resulted in R11 being able to elope from the building during staff directed activities. Findings Include: R11's diagnosis: schizoaffective disorder, psychotic disorder, and type 2 diabetes. R11 admitted to the facility on [DATE]. A Code Pink was called at approximately 2:43PM on 8/20/21 in the central wing. R11 was accompanied by staff returning to the building around 2:45PM. It was reported R11 exited the facility during an activity. V20 (Activity Aide) was running a music activity and had about twelve residents inside and seven or eight residents outside. R11 opened the gate and left. The video was replayed by V2 (Assistant Administrator). The video showed R11 open the gate and walk on the path to the west side of the building. Staff found R11 about three minutes after R11 exited the gate. R11 was brought back to R11's room. R11 was agitated at this time and refused to talk with surveyor. On 8/20/21 at 3:05PM, V20 stated, I was doing an activity by myself. I had about 12 residents inside and maybe seven or eight outside. I kept going back-and-forth from inside to outside to keep checking on everyone. I was inside and one resident came in and tapped me on the shoulder and told me R11 left out the gate. I called the code pink and asked for the other residents to come inside. R11 was found on the employee smoke patio and R11 had walked over to the west side door. No, she's not an elopement risk we were doing a music therapy where I play music and I just kind of let the residents do whatever they want. Some play basketball and some play cards and others just sit there and listen to the music. I don't take more than 20 residents for an activity by myself. Normally I have a mental health tech with me but I know some of them are training today and their schedules are a little different because we just hired a bunch of new people, so it was just me today doing the activity. A Nursing note dated 8/20/21 document R11 exhibited an unauthorized exit and was immediately brought back into the building. R11 placed on behavior monitoring for 72 hours. The Elopement/Unauthorized Leave Risk Review dated 6/15/21 documents R11 is at risk and should be placed on the Elopement Risk Protocol. The Elopement/Unauthorized Leave Risk Review dated 8/20/21 documents R11 is at risk and should be placed on the Elopement Risk Protocol. The Activity Aide Staffing Schedule documents one activity aide (V20) scheduled on 8/20/21 for the entire day.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on observation, interview, and record review, the facility failed to have an effective smoking policy and failed to monitor and supervise residents with repeated inappropriate smoking behaviors 4 of 4 residents (R13 - R16) reviewed for smoking. This failure resulted in R13 and R14 smoking inappropriately in a resident bathroom causing the fire alarm to activate and the local fire department responding to the facility, this has the potential to endanger all residents in the facility due to increased risk of fire hazard. Findings Include: On 8/18/21, the local fire department responded to the fire alarms in the facility. A large amount of smoke was noted coming out of the resident bathroom in room on the resident wing. R13 and R14 were the residents found to be smoking inappropriately at this time. R13's diagnosis: schizophrenia, bipolar disorder, and nicotine dependence. R13 was admitted to the facility on [DATE]. R14's diagnosis: schizophrenia and delusional disorder. R14 was admitted to the facility on [DATE]. A Nursing note dated 8/18/21 documents R13 noted with inappropriate smoking in bathroom and was immediately removed and redirected to central station where a complete body assessment was rendered. While facility rendering their head count protocol, R13 became verbally aggressive and attempting to get physical with staff. The doctor gave an order to transfer to the hospital with a psych petition. A Nursing note dated 8/18/21 documents R14 noted smoking inappropriately in bathroom and immediately removed from area and redirected into central nursing station. Room was cleared for assessment. R14 verbalized no concerns at this time and has been escorted to the dining area for closer supervision. While waiting in dining area for clearance of our head count protocol, R14 started getting anxious and restless and became verbally aggressive towards staff and peers. The doctor was notified of situation and has given an order for transfer to the hospital with petition for harm to self and others. On 8/26/21 at 2:30PM while doing rounds with V23 (Mental Health Technician), a strong odor of cigarette smoke was noted in two bathrooms in resident rooms. The staff was unable to identify which resident(s) were smoking in the building. On 8/26/21 at 12:25PM, V5 (PRSC) stated, I know the fire alarms went off and a code red was called. They were smoking in that bathroom and it set the alarm off. We don't know why they were in that room. That room was searched, and nothing was found. R14 normally doesn't have issues with smoking inappropriately. I have to counsel R14 on it maybe every six months. The first time you are caught it is a verbal warning. The second time your smoke privilege for the next break time is taken away. The third time you are caught is a 24-hour ban. I don't know when the time is reset for the violations. I don't know if it's over a day or a week. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/26/21 at 12:44PM, V21 (PRSC) stated, No residents can keep any smoking materials on them because of safety reasons. They all must be locked up with activities. They can't keep them because they aren't safe to smoke in the building. A lot of residents here have poor safety judgement. I can't really remember R13's behaviors with inappropriate smoking. After they are caught smoking, we counsel them on the policy and update the care plan, but we aren't the only ones who update the care plan. All the other staff can do that too. On 8/26/21 at 12:56PM, V22 (Mental Health Technician Supervisor), stated, There is a daily list of people who are banned from smoking after their infractions. It changes daily. We don't have a list of any repeat offenders. The staff just kind of knows who to look out for. The MHTs should be checking the people we suspect of bringing in materials. All we can do is have them show us their pockets and check around their waist. We will also do room checks. The daily list is given to the activity aides, PRSCs, and MHTs so we are all aware who can't smoke for today. After their 24-hour ban is up, they can go back to smoke again the next day and then they start back at zero violations. On 8/26/21 at 2:00PM, V23 stated, The first time is a verbal warning. The second time is they get the next smoke break taken away, but they can go out again after that. The third time they can't smoke for 24 hours. After the 24 hours is up, they start back with no violations. They get a clean slate after they do the 24 hours. We make the repeat offenders open their pockets at the door before they come back in. We just know who they are. We make sure they aren't taking anything off the smoke cart. We don't know how the repeat offenders are getting them in. We don't usually find anything during the searches. We don't know how they are lighting them either. We haven't found any matches or lighters. During the 3:15PM smoke break on 8/26/21, no residents had their pockets checked by staff before reentering the building. On 8/26/21 at 3:42PM, V24 (Mental Health Technician) stated, During smoke break, we watch so no one is eloping, and we watch for behaviors. We have the repeat offenders open their pockets in the front and back. I don't think there was any repeat offenders outside. I don't think there is a list. I just know who they are. During the 1:15PM smoke break on 8/27/21 R15 and R16 were outside smoking even though they were on the smoking ban list for that day. The smoke ban list on the cigarette cart does not list R16 as being on smoke ban. On 8/27/21 at 2:50PM, V20 (Activity Aide) stated, I have not seen the sheet at all today. I know there are people that have got caught smoking in the building, but I don't know who. V22 is supposed to relay that to us but it doesn't happen. I don't know who is or is not allowed to smoke. There is no communication with the activity department on who cannot smoke. I know the mental health techs sometimes know who is on ban but there is no communication with us, and we are the ones passing out the cigarettes. During the 3:15PM smoke break on 8/27/21 R15 came outside to smoke and was told to go back in the building by V20. V22 told V20 it was ok for R15 to smoke because R15's smoke ban time limit was over. R16 attempted to come smoke again and was told to go back in the building by V20. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/21 at 3:42PM, V22 stated, R15 can smoke now. R15's 24-hour ban is over. R16 cannot smoke though. R16 was just caught earlier this morning smoking in the building. R16 is being sent out for smoking so I didn't bother to update the list and give it to activities. The Care Plan dated 3/25/20 documents R13 is an inappropriate smoker. R13 was found smoking inappropriately on 6/23/21. No new interventions are noted on or directly after 6/23/21 in regard to this behavior. There is no further documentation in progress notes of R13's inappropriate smoking behavior on this date. The Smoking Safety Risk assessment dated [DATE] documents R13 is minimally problematic with history of hazardous behavior (i.e., smoking in unauthorized areas or careless use of smoke materials, sustaining burns, fire starting) and begging, borrowing, trading items, and panhandling for smoking materials. R13 requires supervision while smoking and is not able to store smoking materials. The Care Plan dated 5/2/19 documents R14 is an inappropriate smoker. There is no further description of R14's inappropriate smoking behaviors. There is no further documentation in progress notes of R14's inappropriate smoking behavior on this date. The Smoking Safety Risk assessment dated [DATE] documents R14 is minimally problematic with potential for causing injury to self or others from smoking in unauthorized areas or careless use of smoking materials. R14 requires supervision while smoking and is not able to store smoking materials. The Behavior Management Program and Level Program agreement dated 8/26/21 documents The following are inappropriate and unacceptable behaviors and will result in immediate pass suspension: 1. Smoking in non-designated areas. This endangers everyone who lives and works in this facility . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145180	A. Building B. Wing	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Chicago Heights	490 West 16th Place Chicago Heights, IL 60411

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Smoking Policy Acknowledgement with no date documents All residents are require to turn in smoking materials to the Activity Department, in which those smoking materials will be distributed by the Activity Staff (lighters, matches, pipes, cigarettes, tobacco). Smoking materials are not allowed in resident's possession . Residents who violate the expectation of the smoking program will be subject to progressive interventions. Staff Responsibilities: assigned staff will monitor residents on the smoking program; staff will remain in the designated area, during the entire scheduled smoke time with the residents; staff will monitor for residents removing cigarette buds from ashtrays or from the ground; staff will empty ashtrays and sweep before leaving the smoking area as needed; all reports of resident smoking violations must be reported to the charge nurse, mental health tech, activity director or social services, documented, and followed up. Resident smoking is permitted in the designated area: Patio area. Residents on the smoking program are expected to adhere to the smoking schedule: 7:15AM, 9:15AM, 11:15AM, 1:15PM, 3:15PM, and 7:15PM. All residents are required to comply with the following rules: do not smoke in unauthorized areas, . do not provide other residents with smoking materials while on facility premises, do not accept smoking materials from other residents while on facility premises, do not remove cigarette butts from the ashtray or from the ground, . do not steal smoking materials, do not use unsafe smoking materials. First reported smoking violation after signing the smoking contract: verbal warning given to resident, smoking policy reviewed, unannounced rooms sweeps, and resident informed of next step in rule violation. Second reported smoking violation: smoking policy will be reviewed, unannounced rooms sweeps, smoke break will be revoked following the incident, and resident put on one-to-one observation of smoking at the discretion of the Activity Director and Social Service department. Third reported smoking violation: review smoking policy, unannounced room sweeps, smoking privileges revoked 24 hours following the incident, subsequent violations will incur additional days and may result in up to involuntary discharge from the facility. The facility was unable to provide signed copies of the Smoking Policy Acknowledgement, for R13-R16.