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	05/10/2023

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to follow their discharge planning policy by failing to identify the discharge needs of a resident, failed to have an active discharge care plan with measurable goal and failed to involve the resident and their representative in the development of a discharge plan. This failure affected one of one (R1) resident reviewed for resident discharge. Findings include: R1 is a [AGE] year-old male who was admitted to the facility on [DATE], with past medical history including, but not limited to bipolar disorder unspecified, moderate intellectual disability, essential primary hypertension, hyperlipidemia, type 2 diabetes mellitus without complications, nicotine dependence, other symptoms and signs involving appearance and behavior, etc. Review of progress note by V10 (Psychiatric Rehabilitation Services Coordinator/PRSC) dated 1/27/2023 at 9:55AM reads: Writer met with resident to check on their well-being and mental state after returning from hospital. Resident stated that he is interested in transferring to another facility. There is no significant change in resident's behavior, and they are appropriate for this facility. Writer will continue to monitor situation. On 1/31/2023 at 17:35 V10 documented: Resident approached writer (for the seventh time) about getting an independent pass. Writer denied resident request and explained that because he was just readmitted from the hospital that he was ineligible for a pass at this time. Resident stated that he understood. Writer will revisit topic on a later date. On 5/2/23 at 10:40am, V2 (Chief Nurse Officer Regional) said that the plan was for R1 to discharge back to a supportive living facility (which is similar to where he was prior) sometime in June. V2 continued to state that R1 is alert and oriented with a BIMS of 15; he left on 3/28, he signed out on pass. R1 has no guardian and no POA (Power of Attorney). We found out that he wasn't coming back when we spoke with his mother on 4/5, that's when his mother confirmed that he wasn't coming back. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan initiated 1/7/2023, with no goal stated that resident verbalizes the need to leave the facility. Interventions includes discuss with family and representative the discharge planning process, provide resident and/or family representative education that may include daily activity plan, diet, treatments, medications, etc., provide services according to car plan in an effort to enhance optimum wellbeing that may include any or all of the following: therapies as ordered, dietician consult, pain management, wound care, IV treatment. Review of facility release of responsibility and leave of absence form showed that R1 signed out at 10:15AM on 3/28/2023 to go out to the front of the building but never signed back in. On 5/2/2023 at 1:40PM, V10 (PRSC) said: I have been working here for about a year and R1 was my resident. He was hospitalized back in January because he eloped, and we were monitoring him so it wouldn't happen again. When he eloped the first time, it was because he wanted to go out into the community. The last time he left, he looked and didn't come back. I categorize elopement as an unauthorized exit. No point when I talk to him there, he expressed issues with wanting to leave the facility because he said he didn't have anywhere else to go. As far as discharge, R1 was looking to transfer to a different facility, and I was working with him to get discharged . He didn't want to share a room with other people. He had expressed it to me. At some point I called around to a few places but none of them had single rooms and so I asked his mom and his sister to come up with some suggestions and let me know. Surveyor requested documentation of any referrals that V10 might have sent out to other facilities or any documentation of discharge planning with the resident or family, but none was presented. During an interview with R1's relative on 5/3/23 at 2:49PM V20 (Family Member) said, R1 never finished high school and has exhibited psychiatric problems since he was a young adult. V20 said, R1 can feed himself and dress himself, but he needs help with his other needs such as cueing for maintaining hygiene and taking medications. V20 indicated that R1 cannot make sound decisions and because of this, she became his representative payee after his grandmother, who was the previous payee, passed away. V20 said, R1 ended up in another nursing facility in (name of city), after being hospitalized at some point when he left this facility. On 5/5/23 at 11:23AM, R1 and V21 (Family Member) were interviewed over the phone. R1 said, I was on a red pass and went outside and kept going. I went to see if I could find another nursing home to go to. I was hoping to transition to an independent facility with a single room and I didn't know that I would be sharing a room with three other people before I got here. I was gone for about a week. I am staying at (homeless shelter) right now. When I left, I went to my sister's house and she gave me $15, that's all the money that I had. I came back to the facility but a white woman in the therapy office said I couldn't come back unless I went to the hospital first. I went to the hospital, and they said I still couldn't come back. They didn't help me get there. I walked to the fire department across the street and told them that they wouldn't let me come back and they took me to the hospital and then they sent me to another hospital, and I stayed there for about a week. I still had belongings like a bag of clothes and stuff, but they didn't tell me I could get it. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/23 at 2:36pm (Director of Behavioral Health) said, when R1 came back from the hospital, he went through the assessment period. He was saying that the reason he wanted to leave was because he wanted more air. He is very high functioning with a high BIMS (cognitive status). He went through the process and petitioned, earned a peer pass and there were no issues or concerns. We consider him leaving as AMA (against medical advice) because he had a pass when he left. I didn't read his referral packet to look at his history. When we realized that he left, we followed the Code Pink policy, search local businesses, family is called; they said he chooses to be homeless. He was considered discharged after speaking to the mom. The mom called and said he chooses to be homeless. I don't know if he had belongings left in the facility. Residents sign out at the MHT (mental health technician) desk and the MHT gives the pass to the residents and lets them out of the door with the code. 5/1/2023 at 1:40PM, V1 (Administrator) said, we got an IJ (immediate jeopardy level deficiency) in February for R1 eloping, then he left in March as AMA. He went out on a community pass and did not return. 5/5/2023 at1:39PM, V1 (Administrator) said that R1 came back to the facility after he left for some days inquiring about food and they explained to him that he was considered gone AMA and that he would have to go to the hospital for an evaluation. 5/8/2023 at 10:54AM, V4 (Director of Behavioral Health) said that she is the one that notifies the ombudsman about resident discharges, she completes them on a monthly basis, she completed the January, February, and April notifications. V4 said that she did not complete the March one because she was on vacation but someone else completed it. Surveyor requested to see the completed forms for the last four months. Review of ombudsman notification of discharge/transfer for the month of April presented by V4 did not have R1 listed as being discharged in April. The same document for the month of March documented that R1 was discharged on [DATE], the same day that he left the faciity on pass. R1's discharge location was listed as homeless and the comments stated, resident eloped from community pass. Review of facility census showed that resident was active as a resident until 4/5/2023. Surveyor presented this observation to V1(Administrator) and V4 (Director of Behavioral Health). V1 said, R1 did not elope, that is an awful use of the word. We realized that he was not coming back after speaking to the mother, R1 was not discharged in March and should have been on the April discharge list. 5/9/2023 at 2:24PM, V30 (Bookkeeper) said that no one notified her that R1 had been discharged . She saw it on the facility census and updated her record. R1 was discharged from the facility on 4/5/2023. 5/9/2023 at 2:02PM, V29 (Medical Director) said that said that when a resident leaves the facility and does not return, the first thing is to file a missing person report even if the resident was gone for 10 minutes. If for any reason the facility cannot find a copy of the report, it should be re-filed. V29 added that AMA is not when a resident signs out and absconded from the facility, if a resident wants to leave AMA, they should sign the AMA form, even if they refuse to sign, the facility should explain to the resident the risks of leaving AMA. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Document titled, Discharge Planning Guidelines (review date of 1/2/23) presented by V1 (Administrator) includes: .discharge planning is the process of creating an individualized care plan, which is part of comprehensive care plan. It involves .to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting. The same document stated that discharge begins at admission and is based on the resident's assessment and goals for care, desire to be discharged , and the resident's capacity to discharge. The same document continues that discharge planning process should include, but not limited to the following: ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. Involve the resident and the resident representative in the development of the discharge plan and inform the resident and resident representative of the plan. Address the resident's goal of care and treatment preferences. Inquire about their interest in receiving information regarding returning to the community. If the resident indicates an interest in returning to the community, the facility will document any referrals to local agencies or other appropriate entities made for this purpose.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to ensure and document that a resident/resident representative and the local Ombudsman were notified prior to discharge. This failure affected one of one (R1) resident who was discharged from the facility after not returning timely while being out on a community access pass. Findings include: R1 is a [AGE] year-old male who was admitted to the facility on [DATE] with past medical history including, but not limited to, bipolar disorder unspecified, moderate intellectual disability, essential primary hypertension, hyperlipidemia, type 2 diabetes mellitus without complications, nicotine dependence, other symptoms and signs involving appearance and behavior, etc. Review of facility release of responsibility and leave of absence form showed that R1 signed out at 10:15AM on 3/28/2023 to go out to the front of the building but never signed back in. Progress note dated 3/31/2023 at 12:06 PM documented that the Psychiatric Rehabilitation Services Coordinator/PRSC called R1's mother to inform her of resident's pass access and his departure from the facility, mother told the staff to let her know when resident returns. Progress note documented by V10 (PRSC) dated 4/5/2023 at 18:48 (6:48 PM) states in part that the writer spoke with resident's mother who informed him that resident was located and prefers to live in the street over returning to the facility .writer explained the 10-day policy. Further review of resident's record did not show any documentation that the resident or his representative were informed of the discharge/bed hold policy. There is also no documentation that the Ombudsman was notified of the discharge or resident's absence from the facility. 5/2/23 at 10:40AM, V2 (Chief Nurse Officer Regional) said that the plan was for R1 to discharge back to a similar facility as he was previously (supportive living) in June. R1 is alert and oriented with a BIMS of 15 (cognitive status). He left on 3/28, signed out on pass. R1 has no guardian and no POA (power of attorney). We found out that he wasn't coming back when we spoke with his mother on 4/5, that's when his mother confirmed that he wasn't coming back. 5/8/2023 at 10:54AM, V4 (Director of Behavioral Health) said that she is the one that notifies the Ombudsman about resident discharges. She completes them monthly; she completed the January, February, and April notifications. She did not complete the March one because she was on vacation but someone else completed it. Surveyor requested to see the completed forms for the last four months. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Ombudsman notification of discharge/transfer for the month of April presented by V4 did not have R1 listed as being discharged in April. The same document for the month of March documented that R1 was discharged on [DATE] (same day he left the faciity on pass). R1's discharge location was listed as homeless, and comments stated that R1 eloped from the community on pass. Review of facility census showed that resident was active until 4/5/2023. Surveyor presented this observation to V1(Administrator) and V4 (Director of Behavioral Health). V1 said, R1 did not elope, that is an awful use of word. We realized that he was not coming back after speaking to the mother. R1 was not discharged in March and should have been on the April discharge list. 5/9/2023 at 2:24PM, V30 (Bookkeeper) said that no one notified her that R1 had been discharged . She saw it on the facility census and updated her record. R1 was discharged from the facility on 4/5/2023. 5/9/2023 at 2:02PM, V29 (Medical Director) said that AMA (Against Medical Advice) is not when a resident signs out and absconded from the facility. If a resident wants to leave AMA, they should sign the AMA form, even if they refuse to sign, the facility should explain to the resident the risks of leaving AMA.

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F 0626 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to allow a resident to return to the facility after being out on a facility provided pass. The facility did not properly discharge the resident and did not have documentation of efforts to provide the resident with proper notice of discharge. This failure resulted in R1 being in the community unsupervised and without therapeutic medication. R1 was subsequently admitted to the hospital for aggression and presented with exacerbation of mood and psychotic symptoms. The Immediate Jeopardy began on [DATE] when the facility failed to allow a resident to return after being out on a facility provided pass. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 11:54AM. The survey team verified by observations, interviews, and record review, that the Immediate Jeopardy was removed on [DATE] but noncompliance remains at Level Two because additional time is needed to evaluate the effectiveness of the interventions implemented. Findings include: R1 is a 37- year-old male who was admitted to the facility on [DATE], with past medical history including, but not limited to bipolar disorder unspecified, moderate intellectual disability, essential primary hypertension, hyperlipidemia, type 2 diabetes mellitus without complications, nicotine dependence, other symptoms and signs involving appearance and behavior. The facility's Release of Responsibility for Leave of Absence form is used as the facility's sign out sheet for all residents. This form showed that R1 signed out at 10:15AM on [DATE] to go out to the front of the building but never signed back in. On [DATE] at 10:40am, V2 (Chief Nurse Officer Regional) said that the plan was for R1 to discharge back to a similar (supportive living) facility as he was previously in, before June. R1 is alert and oriented with a BIMS 15. R1 was taking his medication and was not part of the [NAME] Program because he was short term. He was last seen by the psychologist on [DATE]. R1 left on ,d+[DATE]. He signed out on pass and had no guardian or POA. We found out that he wasn't coming back when we spoke with his mother on ,d+[DATE]; that's when his mother confirmed that he wasn't coming back. On ,d+[DATE] R1's mother said that he's probably at a relative's house or a shelter. Then we reached out to shelters to see if he was anywhere. We did not have his cell phone number and the mother would not give it to us. He never came back for his medication and his belongings. R1's sister came to pick up his personal belongings on ,d+[DATE]. (continued on next page)

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F 0626 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 11:23AM, R1 was interviewed over the phone with V21 (Family Member) on a three-way call by the survey team and he said, I was on a red pass and went outside and kept going. I went to see if I could find another nursing home to go to. I was hoping to transition to an independent facility with a single room and I didn't know that I would be sharing a room with three other people before I got here. I was gone for about a week. I am staying at (homeless shelter) now. When I left, I went to my sister's house and she gave me $15, that's all the money that I had. I came back to the facility but a white woman in the therapy office said I couldn't come back unless I went to the hospital first. I went to the hospital, and they said I still couldn't come back. They didn't help me get there. I walked to the fire department across the street and told them that they wouldn't let me come back and they took me to the hospital, then they sent me to another hospital, and I stayed there for about a week. I still had belongings like a bag of clothes and stuff, but they didn't tell me I could get it. My previous facility sent me to the current one because I told them that I didn't want to be there anymore. V21 added that R1 can't manage his own money. If it were left up to him, he would never pay his rent or eat nutritious food. His grandmother was his payee before she died and now my daughter (R1's sister) is the payee. Hospital record dated [DATE] at 6:23PM documents the following: [AGE] year-old male presents to ED for psych eval, patient reportedly left a nursing home and is wanting to go back, however patient was told he needs to come to ED for evaluation prior to returning. Patient denies HI, delusions, hallucination. There are no other complaints at this time. At 10:33PM, the same hospital record documents: Patient discharged , instructions given, follow ups discussed. Patient verbalized understanding, shows no signs of distress, patient is alert and oriented. Patient going back to previous facility, blood pressure elevated, Ed MD aware, patient has no other questions or concerns at this time. At 11:44PM, same medical record documented the following: Facility RN called after receiving over the phone report stating that patient was discharged a week ago, this RN explained to the nurse that was not communicated. What was explained is that the worker and the previous RN was told that patient needed to have psychiatrist evaluation prior to being discharged back to the nursing home. The nursing home RN stated, I just came on shift and was told about this and (ambulance company) won't take him back to you. This is the same nurse who took report prior to patient's departure, she also stated, I am just fulfilling orders and will speak to my management. [DATE] at 10:57AM V27 and V28 (Emergency Medical Technician from the local Fire Department) said that R1 walked up to the station and knocked on the door. He said he came from the nursing home across the street, and they told him to go to the hospital. We didn't talk to the facility at all because we didn't see that there was any point in that once we had assessed him and got him situated on the stretcher. We were pressed for time. I have personally gotten a call from (R1) before, so I was familiar with him and knew that he lived at (facility). R1 called 911 back in January because they were trying to send him to the hospital, and he said that the private ambulance was taking too long. He said he wanted to go somewhere else but ultimately, we ended up not taking him because he needed a psychiatric evaluation, and the nearest hospital wouldn't have been able to treat him for that. I haven't had any additional calls or any instances where a resident has come over to say they are being denied entry. (continued on next page)

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F 0626 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Emergency department physician progress note dated [DATE] at 3:35AM documented: [AGE] year-old developmentally delayed presents for psychiatric evaluation after voluntarily leaving nursing home, returning after 8 days. He states he would like to go back; they are requesting that he be evaluated. Denies any SI, HI hallucinations, bizarre, however this appears to be his baseline. No physical complaints of shortness of breath, vomiting, abdominal pain, calm cooperative .he was subsequently transported via EMS (Emergency Medical System). I was informed subsequently that the supervisor at the nursing home had discharged the resident from their facility, RN (Registered Nurse) did explain to them that this is inappropriate, we were not informed of this, and patient has already been discharged and accepted back to the facility, they will speak to their superior. Hospital record also included hospital nurse's note dated [DATE] at 10:13AM, which documented: patient received from EMS with reports of aggressive behavior .came to this ED yesterday for evaluation, then sent back to the facility but was told he needs inpatient stay and that his medications need to be adjusted. Emergency department nurse's note dated [DATE] at 11:11AM includes received a call from facility administrator stating that patient was out on pass and never returned and was discharged from the system. He reported that patient has displayed this behavior before, administrator was given a fax number to send discharge instructions so that alternative placement can be secured, patient made aware that he cannot return to the facility. On [DATE] at 2:20PM, V12 (Facility 2 representative) stated that the resident was admitted to their facility from ,d+[DATE] to [DATE] with a diagnosis of schizophrenia. R1 was admitted from a psychiatric hospital from [DATE] to [DATE] before coming to their facility. Hospital record dated [DATE] states the following: Patient presents as 37yr year old male previously diagnosed with schizophrenia/schizoaffective disorder presents to the emergency room after exacerbation of mood and psychotic symptoms. Per petition, patient received from EMS with reports of aggressive behavior, patient received alert and cooperative, endorses that he was out on pass for 6 days, attempted to go back to facility and they informed him that he needs a psychiatrist evaluation, and he came to this emergency room yesterday for evaluation, patient then went back to the facility and was told that he needs an inpatient stay and that his medications needs to be adjusted. [DATE] at 3:30PM, V18 (Licensed Practical Nurse/LPN) said that she recalls the resident, he was assigned to the set with R1 on [DATE] but R1 was already gone by the time she came to work on second shift. It was reported to her that R1 was out on community pass and did not return. When they had a head count around 8PM they noticed that the resident was still not back, they searched all the rooms and did not find him. V18 notified the administrator who instructed her to inform all the MHTs (Mental Health Technician) to go out and search for R1 within the area. The administrator also told her to call the police. V18 said that she called the police and gave them a description of the resident. The police asked her if she wanted to file a missing person report and she said no because she was thinking that the resident would come back. V18 stated that she also called the family. V18 was asked if R1 ever expressed the need to leave the facility and she said no, but one time he brought a paper for her to sign stating that he has been of good behavior and taking his medications. V18 said she told him that she could not sign the paper because she does not know him well enough to sign that. V18 also said that she heard that the resident came back to the facility a couple of days later but was sent to the hospital. (continued on next page)

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F 0626 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 1:11PM V4 (Director of Behavioral Health) said that she does not know of anytime R1 returned to the facility after he left. V4 does not normally work the weekend. If resident showed up, the facility could have given him verbal direction on how to get to the hospital. Surveyor asked V4 why the facility would give the resident verbal direction and she said, he is independent and out in the community, he was considered as gone AMA (against medical advice) after he signed out on a pass and did not return. V4 was asked if R1 still had belongings at the facility after he went out on a pass and she said that she is not sure if the resident had any belongings; if he did, staff could have assisted him. V4 added that R1 never told her that he wanted to be discharged . [DATE] at 1:39PM, V1 (Administrator) said that R1 came back to the facility after he left, inquiring about food and they explained to him that he has gone AMA and would have to go to the hospital for evaluation. V1 said that the facility called the hospital ahead of time and they were requesting a referral. They went back and forth with the hospital about it. V1 added that he was not present at the facility when R1 returned, a staff member called him, and he cannot recall who the staff was because he does not work on weekends. V1 was asked if they asked R1 to sign the AMA paper at that point and he said, no, I am not sure why not. V1 said that he asked someone at the facility to give R1 a sandwich since R1 said that he was hungry. [DATE] at 2:02PM, V29 (Medical Director) said that that when a resident leaves the facility and does not return, the first thing is to file a missing person report, even if the resident was gone for 10 minutes. If for any reason the facility cannot find a copy of the report, it should be re-filed. V29 added that AMA is not when a resident signs out and absconded from the facility. If a resident wants to leave AMA, they should sign the AMA form; even if they refuse to sign, the facility should explain to the resident the risks of leaving AMA. V29 said that when R1 came back to the facility after being away for several days, telling him to go to the hospital on his own is the worst thing to do, especially for someone with a history, they should have put him in a safe place and made sure that he is stable and called an ambulance to take him to the hospital and take it from there. Review of facility AMA (Against Medical Advice) policy revised [DATE] stated in part that it is the policy of the facility to acknowledge the right of a resident to sign him/herself out of the facility without the consent of or an order from the attending physician providing that the resident has the decisional capacity to do so. Under procedure, the policy states that prior to leaving the facility, discharge planning must identify the discharge destination, and ensure it meets the resident's health and safety needs as well as preferences. The resident's physician will be notified of the resident's request to leave the facility against medical advice. The nurse on duty will provide the resident and/or legal guardian of information regarding the resident's current treatment and medication regimen. Medications will be provided to the resident or the legal representative with physician conversation that harm would ensue without such medications. Any resident or legal representative choosing to discharge or be discharged without the consent of, or an order from the attending physician is expected to sign the AMA form. In the event that resident is signing himself/herself out AMA, his/her legal representative and /or family member will be notified by facility personnel. Resident leaving the facility against medical advice is responsible for their own transportation with the safety of the resident maintained. If resident is unable to physically transfer/discharge self from the facility safely, the facility will notify the resident's representative/POA, and ombudsman. APS (Adult Protective Services) will be notified if the facility feels the AMA discharge setting does not meet the resident's post discharge and appears unsafe. (continued on next page)

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	145180	A. Building B. Wing	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0626 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy. 1. R1 no longer resides at the facility. 2. Education will be provided to the IDT team, admissions, Social Service staff and Nurses on proper discharge and transfer using revised policy for Bed hold/discharge transfer policy. Director of Nurses, Assistant Director of Nurses and Psychiatric Rehabilitation Services Director will be responsible for in-service. Initiated [DATE] 3. Elopement risk, unauthorized leave, community survival assessment will be revised by corporate and will be used to provide education to the nursing and social service staff. Initiated [DATE] 4.The following policies were reviewed and revised: -Therapeutic pass -Bed/hold discharge/transfer notice -AMA policy -ALL WILL INCLUDE circumstances under which we would not accept the patient back and any conditions required prior to re-admission. Initiated [DATE] to be completed by [DATE] 5. These policies and revised assessment will be used to provide training to all nursing staff, social service staff and IDT. The training will be provided by corporate staff. All prn, part time and on leave staff will be re-educated prior to next scheduled shift. Staff will acknowledge information via signature. Initiated [DATE] to be completed by [DATE] 6. The Medical Director was notified by the Administrator and reviewed the facility's immediate action plan. He agrees with immediate action plan. Initiated [DATE] 7. QA team met to review policy and procedures changes including the Medical Director. Administrator, Assistant Administrator will conduct audit of discharged residents weekly. To be completed on [DATE] 8. Policy on bed/hold/discharge transfer and therapeutic pass will be sent to each responsible party and each resident who is their own responsible party and acknowledged by signature. Mail will be sent certified. Any returned not signed will have a call placed and will be witnessed by two staff and documented as such. To be completed on [DATE]

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F 0641 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to accurately assess a resident for an independent outside pass. This failure affected one (R1) of three residents reviewed for resident assessments and resulted in R1 being approved for an independent community pass despite having a documented history of elopement and self-care deficits. R1 did not return to the facility after leaving on pass and was subsequently admitted to the hospital with a diagnosis of schizophrenia, exacerbation of moods and psychotic symptoms. Findings include: R1 is a [AGE] year-old male who was admitted to the facility on [DATE], with past medical history including, but not limited to: bipolar disorder unspecified, moderate intellectual disability, essential primary hypertension, hyperlipidemia, type 2 diabetes mellitus without complications, nicotine dependence, other symptoms and signs involving appearance and behavior, etc. Per record review, facility Minimum Data Set (MDS) assessment dated [DATE], section G (functional) coded R1 as requiring supervision for all ADLs including ambulation on and off unit. Section C (cognition) of the same assessment coded R1 with a BIMs score of 15. On 5/1/23 at 10:38AM V21 (Family Member) said, R1 left the facility before in January improperly dressed without coat and socks on, in the cold. He was originally transferred to this facility because he needed treatment for his mental health and assistance with activities of daily living. V21 said she begged staff not to give R1 a pass to the community because he was likely to leave and not return and he was unable to take care of himself without assistance. When V21 was notified that R1 left on pass and did not return on 3/28/23, she called the facility and asked why staff would give him a pass when R1 already showed that he can't take care of himself. On 5/3/23 at 2:49PM V20 (Family Member) said, R1 never finished high school and has exhibited psychiatric problems since he was a young adult. V20 said, R1 can feed himself and dress himself but he needs help with his other needs such as cueing for maintaining hygiene and taking medications. V20 said that R1 cannot make sound decisions and because of this, she became his representative payee after his grandmother, who was the previous payee, passed away. V20 said that R1 ended up in another nursing facility in (name of city) after being hospitalized at some point when he left this facility. Further review of resident's medical record shows the following progress note documented by V10 (Psychiatric Rehabilitation Services Coordinator/PRSC) on 1/31/2023 at 9:32AM - Resident approached writer (for the seventh time) about getting an independent pass. Writer denied resident request and explained that because he was just readmitted from the hospital that he was ineligible for a pass at this time. Resident stated that he understood. Writer will revisit topic later. Progress note dated 1/31/2023 at 14:30 (2:30PM) states in part: It was brought to writers' attention that resident has an unauthorized exit from the facility. Resident Mother notified facility that resident visited sisters' home and was provided funding to return to facility. Facility aware of resident exit. At this time, a missing person's report has been filed and awaiting Resident return. MD, Administration and Nursing aware of all the above. [sic] (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	Elopement risk assessments dated 1/30/2023 and 2/24/2023 documented that R1 has history of wandering and elopement, has a diagnosis of dementia and/ or mental illness, has reported and documented episodes of elopement and has signs of compromised decisional capacity and substantially impaired judgement and /or physical limitations that would place the resident at risk in the community. assessment dated [DATE] concluded that the resident is at risk to elopement and should be placed on an elopement protocol; the assessment of 2/24/2023 however concluded that R1 is not at risk of elopement at this time. Another elopement assessment initiated by V10 (PRSC) dated 3/23/2023 documented that R1 does not have a history of wandering or elopement, does not have a diagnosis of dementia and/or mental illness, does not have documented episodes of elopement and /or attempts to elope and does not have signs of decisional capacity and substantially impaired judgement that would place him at risk in the community. The same assessment was signed by V4 (Director of Behavioral Health) on 3/29/2023. R1 left the faciity on an independent pass on 3/28/23. On 5/3/2023 at 2:50PM, V10 (PRSC) was asked why the elopement assessment for 3/23/2023 stated that R1 does not have a history of elopement and no documented episodes of elopement as well as not having compromised decisional making capacity, and why the document was signed by another staff the day after the resident left the facility. V10 said, I guess the answer to those questions should have been a yes because R1 has eloped before. Looking at the elopement risk assessment dated [DATE], I initiated the assessment. I don't know why it was signed and locked by V4. I usually create my own documents and sign them so that they are locked. This document may have been looked over by V4 which is why she signed it. When an assessment is open, the information can be changed before it is locked. V10 added, I created the elopement care plan on 2/16/23 for the Plan of Correction for the elopement that happened on 1/31/23. I discontinued the care plan on 2/24/23 because we decided that he could work on getting a community pass. R1 does not any active care plan in place for elopement or exit seeking behavior. 5/1/23 at 2:36PM, V4 (Director of Behavioral Health) said that she signed the elopement assessment initiated on 3/23/2023 by V10 on 3/29/2023 because she noticed that the PRSC who initiated the assessment did not lock it; so, she locked it and signed it. V4 stated that she did not change anything in the assessment and did not look at the resident's history. When asked if it is possible for someone to make an adjustment to as assessment if it is not locked by the person that initiated it, she said, yes. 5/5/23 at 11:23AM, R1 was interviewed over the phone. R1 was alert and oriented but responded slowly, speaking with disorganized thoughts. R1 said, I was on a red pass (independent) and went outside to smoke and kept going. I went to see if I could find another nursing home to go to. I was hoping to transition to an independent facility with a single room and I didn't know that I would be sharing a room with three other people before I got here. When I left, I was gone for about a week. I was hopping trains most of the time. I didn't take any medication from the facility and didn't have any food. Facility progress note dated 3/29/23 at 8:02PM written by V26 (Assistant Director of Nurses/ADON) said that V21 (R1's mother) was called and left a voicemail. Progress note dated 3/30/23 at 2:50PM said that R1's mother called the facility saying she needed to speak with a manager and wanted to know why we gave her son community access so he could run away. (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	On 5/3/23 at 2:00PM, V12 (Facility 2 Representative) said, R1 was admitted to them from a local hospital on 4/18/23, where he had an inpatient psychiatric evaluation from 4/10/23 to 4/18/23. Hospital record dated 4/10/2023 states the following: Patient presents as 37yr year old male previously diagnosed with schizophrenia/schizoaffective disorder presents to the emergency room after exacerbation of mood and psychotic symptoms. A job summary for social services presented by V1 (Administration) states that the primary purpose is to implement the programs of the social services department, to assure that the medically related emotional and social needs of the resident are met/maintained on as individual basis, to safeguard health, safety and welfare of all manner in accordance with facility's established policies and procedures applicable laws and regulations and the directions of your supervisor who include the PRSD, administrator and/or other members of the facility's management to whom such persons report. The responsibilities listed include, but not limited to completing proper documentation upon admission, quarterly, and annually. Documenting the resident's progress on a regular basis, including incidental, monthly, and quarterly notes. Contacting community agencies for the purpose of resident referral.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570 Based on observation, interview, and record review, the facility failed to maintain professional standards of practice by staff documenting on behalf of other staff members. This failure applied to one of one (R1) resident reviewed for medical records. Findings include: R1 is a 37- year-old male who was admitted to the facility on [DATE], with past medical history including, but not limited to bipolar disorder unspecified, moderate intellectual disability, essential primary hypertension, hyperlipidemia, type 2 diabetes, nicotine dependence and other symptoms and signs involving appearance and behavior. Facility sign-out/in record presented by the facility shows that R1 signed out to the front on 3/28/23 at 10:15AM. According to progress notes dated 3/28/23, R1 was granted an independent community pass. During an unsupervised smoke break, R1 left the facility and did not return. Progress note written by V6 (Group Facilitator) on 3/28/23 read: PRSC was notified that resident has not returned from community access pass. PRSC called emergency contacts on file and was able to speak with resident's sister who said she has not seen or heard from resident. Administration and nursing staff notified. PRSC will continue to monitor the situation. On 5/3/23 at 3:28PM V6 said, I am not a PRSC, and I don't have any idea and can't remember why I wrote a note on behalf of the PRSC. I can't remember why I did that or who told me R1 was missing. I wouldn't be the first person to be notified that he was missing. That would probably have been my supervisor. I don't know what I did after writing that note. If a resident was missing, I don't have any responsibility other than telling my supervisor. On 5/3/23 at 3:40PM V10 (PRSC) said, I probably asked V6 to write that note for me because I left the facility. I could have written it myself, but I was already gone. Surveyor asked V6 and V10 if it was common to document on behalf of anyone but themselves and they responded no it was not. Facility policy titled, Documentation- Electronic Health Record (revised 11/2/18), includes: Identification of the author of a medical record entry by that author, and confirmation that the contents are what the author intended, and that the entry made is complete, accurate and final (authentication) made by electronically signing the document using unique password as signature: Initials are supported by a signature log, or electronic signatures with assigned identifiers.

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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** 44570 There are multiple deficiencies identified. 1.) Based on interview and record review, the facility failed to properly supervise a resident with a known history of elopement who was assessed as requiring staff supervision for ambulation on and off unit; failed to supervise the resident while smoking; failed to have a physician order for unsupervised outside pass privileges; failed to follow their policy for missing resident/elopement; and failed to follow their behavior management level program agreement. These failures affected one of one (R1) resident reviewed for supervision and resulted in R1 leaving the facility on 3/28/23 while on an unsupervised smoke break. While out in the community, R1 was without access to food, shelter, or therapeutic medication and was subsequently admitted to the hospital on 4/10/23 for aggression and presented with exacerbation of mood and psychotic symptoms. The Immediate Jeopardy that began on 3/28/23 when the facility failed to monitor R1 with a known history of elopement, which resulted in the resident leaving the building unsupervised. V1 (Administrator) was notified of the Immediate Jeopardy on 5/8/23 at 11:54AM. The survey team verified by observations, interviews, and record review, that the Immediate Jeopardy was removed on 5/9/23 but noncompliance remains at Level Two because additional time is needed to evaluate the effectiveness of the interventions implemented. Findings include: R1 is a 37- year-old male who was admitted to the facility on [DATE], with past medical history including, but not limited to bipolar disorder unspecified, moderate intellectual disability, essential primary hypertension, hyperlipidemia, type 2 diabetes, nicotine dependence, other symptoms and signs involving appearance and behavior. Review of facility Minimum Data Set (MDS) dated [DATE], section G (functional) coded R1 as requiring supervision for all ADLs including ambulation on and off unit. Facility sign-out/in record presented by the facility shows that R1 signed out to the front on 3/28/23 at 10:15AM. Progress note dated 3/28/23 reads that R1 was granted an independent community pass. During an unsupervised smoke break, R1 left the facility and did not return. During an interview with R1's relative on 5/3/23 at 2:49PM V20 (Family Member) said, R1 never finished high school and has exhibited psychiatric problems since he was a young adult. V20 said, R1 can feed himself and dress himself, but he needs help with his other needs such as cueing for maintaining hygiene and taking medications. V20 indicated that R1 cannot make sound decisions and because of this, she became his representative payee after his grandmother, who was the previous payee, passed away. V20 said, R1 ended up in another nursing facility in (name of city), after being hospitalized at some point when he left this facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident's medical record show the following progress note documented by V10 (Psychiatric Rehabilitation Services Coordinator/PRSC) on 1/31/2023 at 9:32AM: Resident approached writer (for the seventh time) about getting an independent pass. Writer denied resident request and explained that because he was just readmitted from the hospital that he was ineligible for a pass at this time. Resident stated that he understood. Writer will revisit topic later. Another progress note dated 1/31/2023 at 14:30 states in part: It was brought to writers' attention that resident has an unauthorized exit from the facility. Resident Mother notified facility that resident visited sisters' home and was provided funding to return to [the facility]. Facility aware of resident exit. At this time, a missing person's report has been filed and awaiting Resident return. MD (Medical Doctor), Administration and Nursing aware of all the above. Review of resident's care plan did not show an active care plan for risk of elopement. On 5/3/23 at 2:50pm V10 (PRSC) said that I created the elopement care plan as part of the plan of correction for the elopement that occurred on 1/31/23. I discontinued the care plan 2/24/23 because we decided that R1 could work on getting a community pass. On 5/3/24 at 3:40pm V10 said, as far as the elopement assessments, from my understanding because R1 was trying to get a community pass, we couldn't mark him as being at risk for elopement. I scored it as no risk so that he would be eligible to petition for a pass even though he eloped in the past. On 5/1/23 at 10:38AM V21 (Family Member) said, R1 left the facility before in January, improperly dressed without coat and socks in the cold. He was originally transferred to this facility because he needed treatment for his mental health and assistance with activities of daily living. V21 said she begged staff not to give R1 a pass to the community because he was likely to leave and not return and he was unable to take care of himself without assistance. When V21 was notified that R1 left on pass and did not return on 3/28/23, she called the facility and asked why staff would give him a pass when R1 already showed that he can't take care of himself. On 5/5/23 at 11:23am R1 was interviewed over the phone. R1 was alert and oriented but responded slowly, speaking with disorganized thoughts. R1 said, I was on a red pass (independent) and went outside to smoke and kept going. I went to see if I could find another nursing home to go to. I was hoping to transition to an independent facility with a single room and I didn't know that I would be sharing a room with three other people before I got here. When I left, I was gone for about a week. I was hopping trains most of the time. I didn't take any medication from the facility and didn't have any food. Facility Policy titled Community Pass Guidelines revised 11/25/19 states in part: The resident has the right to community access with the consent of the facility, physicians' orders, and the resident' cooperation with the standards described within. Review of most recent physician orders for R1 did not show any order for independent community pass. Further review of facility, Release of Responsibility for Leave of Absence (sign in/out) form (dated 3/28/23) documented that R1 signed out of the facility at 10:15AM to go outside at the front of the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/3/23 at 12:16PM, V1 (Administrator) said, when the residents write front on the sign-out sheet, it usually means they are going out to smoke. When R1 went outside, he was expected to smoke and come back in but since he had a community pass it wasn't unusual that he did not come back right away. On 5/4/23 at 1:45PM V15 (Mental Health Tech/MHT) said, I was working a double on the day that R1 went outside and did not return. He went outside to smoke and didn't come back in the with other residents, but I didn't think too much of it because he had an independent pass. We don't supervise residents who go out to smoke on the front because they have a peer or independent community pass. R1 had had the independent pass for a long time but they never told him about it, so he didn't know. Since I was there later that night, I noticed that it was around 7 or 8pm that he had not returned. I informed V10 (PRSC) and the nurse. I'm not sure what they did after that. Community Survival Skills assessment dated [DATE] was signed by V4 (Director of Behavioral Health) on 3/29/23. R1 left the facility unsupervised on 3/28/23. Most recent care plans reviewed for R1 documented that Level II (peer) and Level III (independent) pass were both implemented on 2/24/23. On 5/2/23 at 12:32PM, surveyor requested documentation that would support R1 going out with a peer pass. V1 said, unfortunately, those documents are not a part of the resident's record and are not kept. They are currently in the shred box. We have some people looking through them to see if we can find them. During the course of this survey, the facility did not provide documentation that R1 went out and was supervised on Level II pass at any time. Review of Smoking Safety Risk assessment dated [DATE] by V10 (PRSC) noted that R1 required supervision while smoking and was not able to store smoking materials. Progress Note dated 3/28/23 at 9:10PM written by V6 (Group Facilitator) reads: staff determined R1 had not returned from community pass. On 5/4/23 at 3:30PM, V18 (Licensed Practical Nurse/LPN) said, I worked 3-11PM shift the day that R1 left. The CNAs were doing head count and noticed that R1 was not in the building. I don't remember seeing him during my shift. I was informed that R1 was on community pass from the previous shift and had not returned around 8pm. I called V1 (Administrator), and he informed me to call the police and then he called and asked the MHTs (Mental Health Tech) that were in the building to go and look for him in the surrounding area. I called the police and gave them a description and they asked me if I wanted to file a missing person's report and I said no because I didn't think he was missing but still out on pass. I called the family to let them know that he had not returned. I heard that he came back to the facility some days later, but they wouldn't let him come back and sent him to the hospital. Facility policy titled, Code Pink- Missing Resident/Elopement revised 11/15/18 states in part: All personnel are responsible for reporting a cognitively [impaired] resident attempting to leave the premises, or suspected of missing, to the Charge Nurse as soon as practical. This includes any resident that did not sign out on pass and/or did not notify a staff member of his or her leaving. The following steps should occur: 3. Notify the sheriff and/or police department and file a missing person report. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility was unable to provide any documentation that a missing person's police report was filed on 3/28/23 for R1. Facility progress note dated 3/29/23 at 8:02PM written by V26 (Assistant Director of Nurses/ADON) said that R1's mother was called and left a voicemail. Progress note dated 3/30/23 at 2:50PM said that R1's mother called the facility saying she needed to speak with a manager and wanted to know why we gave her son community access so he could run away. Progress note dated for 3/29/23 at 8:47 AM was written on 3/30/23 at 2:50pm and said that a missing person's report was filed for R1 with the local police department. Surveyor called the police department and a representative indicated that there was no report filed for R1 missing on that day. Further review of progress notes written on 3/29/23, 3/30/23 and 3/31/23 indicated that facility staff were calling various shelters, hospitals, and the morgue but they were unable to locate R1. Progress note written on 4/5/2023 at 6:53pm by V10 (PRSC) stated, Writer spoke with resident's mother. She confirmed that resident was located and prefers to be homeless over returning to the facility. Administration notified. Writer asked for resident's phone number, but mother declined. Writer encouraged mother to reach out to resident and see if he was interested in returning. Writer also explained the 10 Day policy. On 5/3/23 at 2:00PM, V12 (Facility 2 Representative) said, R1 was admitted to them from a local hospital on 4/18/23, where he had an inpatient psychiatric evaluation from 4/10/23 to 4/18/23. Hospital admission record dated 4/8/23 noted that R1 presented to the emergency room with no complaints reporting that he left the facility and wanted to go back, however was told that he needed to come to the Emergency Department prior to returning. He was evaluated and nurse to nurse communication was documented from the hospital to the facility at 9:32PM. The hospital discharged R1 back to the facility via private ambulance at 10:33PM. At 11:56PM, a nurse from the facility called back to the hospital stating that 'the patient was discharged a week ago'. This nurse was unable to be identified. Further notation states that a facility nurse said, 'I just came on shift and was just told about this and [the ambulance] won't take him back to you'. Facility nurse said, 'I am just fulfilling orders, I will speak to my management.' Fire Department run sheet dated 4/08/23 at 6:18PM stated, in summary, patient presented to EMS as a walk-in patient stating he needed to be mentally evaluated prior to returning to his housing. Patient was assisted to the ambulance and secured and assessed. Patient was transported to [local hospital]. ED (Emergency Department) contacted with report and received no orders. Patient arrived at the ED where care and report were transferred to the [ED RN]. Incident address on the report indicated this fire department station is located across the street within view of the facility. (continued on next page)

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	145180	A. Building B. Wing	05/10/2023

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Aperion Care Chicago Heights	490 West 16th Place Chicago Heights, IL 60411

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/5/23 at 10:57AM V27 and V28 (Fire Department Paramedics) said, R1 walked up to the station and knocked on the door. He said he came from the nursing home across the street, and they told him to go to the hospital because he needed a psychiatric evaluation. We didn't talk to the facility at all because we didn't see that there was any point to that once we had assessed him and got him situated on the stretcher. We were pressed for time. I have personally gotten a call where I responded to him before in January, so I was familiar with him and knew that he lived at this facility. When R1 arrived at the Emergency Department, he was admitted , and staff filled out a Petition for Involuntary/Judicial Admission form. The form dated 4/9/2023 states in part: this petition is being initiated by reason of 1. Emergency inpatient admission by certificate; 2. Emergency admission of the developmentally disabled. [R1] is a person with mental illness who: because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed; in need of immediate hospitalization for the prevention of such harm. The petition goes on to state that this assessment was based on the following: [R1 was] received from EMS (Emergency Medical Service) with reports of aggressive behavior. [R1 was] received alert, oriented, calm, and cooperative, endorses that he was out on pass for 6 days and that he attempted to go back to facility, and they informed him that he needs a psych eval and he came to this ED yesterday for the evaluation. [Thereafter, R1 was] sent back to the facility and was told that he needs an inpatient stay and that his meds need to be adjusted. R1 was transferred to another hospital in (name of city) where he was admitted on [DATE] for a chief complaint of aggression. This hospital record dated 4/10/23 documented that R1 was diagnosed with schizoaffective disorder/ Schizophrenia and Mild interpersonal conflict and was started on quetiapine (an antipsychotic medication). During assessment, in the History and Physical section, it was noted that R1 exhibited psychotic disorganized thought process, appeared to be responding to internal stimuli and exhibited guarded demeanor and paranoid ideation. Behavior appeared impulsive and unpredictable. During this assessment, R1 admitted to having a previous history of poly substance abuse. On 5/5/23 at 1:11PM V4 (Director of Behavioral Health) said, I was not made aware of R1 returning to the facility. If he were to have showed up, we would ask him what he needed and give him verbal directions to the hospital because it was considered that he left against medical advice. If he was coming to pick up his belongings, the staff could've given them to him or called 911 if he was in serious need of care. According to google maps, the distance from the facility to the nearest hospital is 4 miles. On 5/5/23 at 3:40PM V34 (Assistant Administrator) said, it was administration who decided that R1 would be discharged . He did have some belongings that were left behind that his sister came to pick up about a week ago. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/9/23 at 2PM V29 (Medical Director) said, I was not made aware of R1 leaving the facility during a smoking break unsupervised. The staff should be supervising smoking breaks all the time. If the resident left even for 10 minutes, they should have enacted the protocol by going to look for him, to find him. In this case the resident absconded and would not be considered leaving against medical advice. Leaving against medical advice requires an understanding, provided to the resident that they are leaving the facility who is providing care for their needs. They must sign out to ensure their understanding that, even though they may not have access to food, medication, and safe shelter, they are choosing to leave the facility. If they refuse to sign, then that should be witnessed by more than one person and communicated to the administrator. My understanding of the peer pass system is that when a resident first comes into the facility, they have a three-week observation in order to determine if they can follow the rules and be safe in the community. The team says this resident is okay and gradually gives them a pass to go outside- usually for a limited time. Residents cannot be supervisory agents of one another. Someone who needs supervision can go outside and into the community, but they should be escorted by a staff member because staff has some legal standing and a level of responsibility for keeping the residents safe. At the very least, they will be able to observe the resident if they decided to go off and leave because then the staff member would be able to communicate that and the protocols for finding the resident will take place. Common sense tells me that residents cannot supervise each other. If smoking breaks were supervised, it would 100% prevent people from taking off. I haven't been made aware of anything like this happening before but occasionally if someone wants to leave and they let me know. I say to follow the protocol. The circumstances of allowing this resident who has absconded back into the facility, depends, such as how is the resident presenting? Does he appear to be safe to come back into the facility? Sending the patient away at the door would not be advised, particularly if the resident had a relationship with the facility and has recently been living there. They should not have told him to find his way to the hospital alone, but they could have sent him to the emergency room using an ambulance or emergency services to ensure safe transport. The Immediate Jeopardy that began on 3/28/23 was removed on 5/9/23 when the facility took the following actions to remove the immediacy. 1. R1 is no longer at the facility. 2. All residents who successfully petitioned for a community pass and have been deemed able to navigate in the community were reassessed to ensure that their community and elopement assessments are accurate. Initiated 5/5/23 3. All residents were reassessed to determine their ability to smoke unsupervised. Their smoking assessment indicates they are independent smokers. The assessments were updated as appropriate. The Psychiatric Rehabilitation Services Director and the Director of Behavioral Services were responsible for updating the assessments. Initiated 5/5/23 4. The level 2 pass program will be eliminated. Residents wanting independent passes will go on supervised outings with staff. These supervised outings will help facility assess residents trying to obtain an independent pass. Initiated 5/8/23 and ongoing 5.Assessments were reviewed to ensure accuracy, implement interventions as needed and update care plan accordingly. Assessments will be reviewed by Inter Disciplinary Team composed of Administrator, Director of Nurses, and Psychiatric Rehabilitation Services Director. Initiated 5/5/23 and ongoing (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Ongoing education of all staff regarding supervision policy to address that staff are not to leave any area with residents present who require supervision and maintain supervision of any supervised exits, verifying residents' community access pass prior to allowing them to exit facility, and smoke break procedures. Facility will ensure staff understanding of the policy via a QA tool. If it is determined staff do not have a sufficient knowledge base, re-education will occur. All staff will be trained by 5/5/2023 and any staff on leave or unavailable were called and are being in serviced via phone, via zoom call and again before next scheduled shift. The Administrator, Assistant administrator, Human Resources Director, Assistant Director of Nurses were responsible for the staff training. Initiated 5/5/23 and ongoing 7. Elopement and community pass binder are at the front desk and each nurse's station. PRSD is responsible for maintaining and updating the elopement binder. Facility added residents with passes to the elopement binders. Completed 5/5/23 8. The Medical Director was notified by the Administrator and reviewed the facility's immediate action plan. He is in agreement with immediate action plan. Completed 5/5/23 9. QAPI review with Medical Director to review plan of action. IDT conducts assigned regular rounds during shift to ensure visual monitoring and staff supervision. Department heads will be responsible for QA monitoring. Action plan will be reviewed monthly at QAPI meeting. Initiated 5/5/23 2.) Based on interview and record review, the facility failed to monitor residents who were identified as needing staff supervision during smoking breaks and failed to supervise residents without an independent community pass while out in the community with other residents. These failures affected 19 of 25 residents who were reviewed for supervision while smoking with community access. Findings include: According to a list provided by the facility, nine residents (R6, R8, R9, R10, R11, R12, R13, R14 and R15) have been assessed to have a Level II Peer Pass. Of those nine residents, seven of them (R6, R8, R9, R10, R11, R12 and R14) smoke and were assessed to require supervision while smoking (Safe Smoking Assessment). 10 residents (R7, R16, R17, R18, R19, R20, R21, R22, R23 and R24) out of 15 residents who have an independent (Level III) community pass smoke and have been assessed to require supervision while smoking. Smoking assessments for R6, R7, R8, R9, R10, R11, R12, R14, R17, R18, R19, R20, R21, R22, R23 and R24 were reviewed and noted to be updated on 5/5/23. Elopement assessments for theses residents were also reviewed. On 5/8/23 at 12:54PM V4 (Director of Behavioral Health) said, we went and reassessed all the residents who have a community pass to make sure their assessments reflect that they are appropriate to be out in the community. We combined the community survival assessment with the elopement risk assessment. The smoking assessment has a point system that automatically generates the points, but I don't recall what the point scale is evaluating or what the numbers mean on the assessments. It is appropriate for residents to smoke in front of the facility unsupervised because they have a community peer or independent pass. Residents can't light their own cigarettes because they need supervision while smoking. The cigarettes are lit by the receptionist or the MHT (Mental Health Tech) that lets the residents out of the building during smoke breaks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/08/23 at 2:00PM V1 (Administrator) said, we are working on the policy now, and have decided to get rid of the Peer Pass system. We will implement the policies tomorrow once they have been approved. V1 presented revised policy which was approved with the abatement plan on 5/9/23 at 10:30AM. In the Facility's Behavior Management Level Program Level II expectations were revised to indicate that this pass will be with staff only, whereas the previous system in place allowed residents to go out into the community with and be supervised by their peers. On 5/9/23 at 3:35 PM V3 (PRSD) said, per the new policy we have incorporated two additional smoke breaks at 10:45AM and 5:30 PM that will be supervised by either the activity staff or the MHT. We have taken all the blue passes (Peer) and the residents who don't have passes will continue to smoke supervised on the back patio. Residents are now able to go out into the community if they are with staff. All the residents who have been assessed to have a Level II (peer pass) have been reassessed and their care plans have been updated. I, (V4), the psychotropic nurse, V26 (ADON), and the medical team have been updated on the new policy. The goal is for every staff member to be updated on the new policy by the end of business day. Residents still have the opportunity to have a red independent pass where they can go out alone. On 5/9/23 at 3:35 PM V31 (MHT) and V32 (MHT) were interviewed regarding the new policy. V32 said we were just updated coming into the facility that there will be no more blue passes. Residents who leave the building need to be supervised and it will take 30 days to move up a level to get an independent pass. V31 said things that would be looked at in order for a resident to get a level three pass are hygiene, making sure they attend their groups regularly and supervision during group outings to see how they behave. V32 said the residents can go outside as long as activities or the MHT take them out. V31 said this new policy started today. I've been working here for about six months. V32 said I started two months ago. V31 said if a resident is missing or leaves the group while we're outside, we're supposed to report it to the Administrator right away.