STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146185	A. BUILDING _____ B. WING _____	**09/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LITTLE SISTERS OF THE POOR	**2325 NORTH LAKEWOOD AVENUE CHICAGO, IL 60614**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **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** Based on interview and record review the facility failed to ensure supervision to prevent a resident from exiting the facility without staff supervision for 1 of 4 residents reviewed for elopement risk. R1 was found hours later in a hospital emergency room 7.8 miles away from the facility. Findings include: R1 has [DIAGNOSES REDACTED]. R1's MDS (Minimum Data Set) BIMS (Brief Interview For Mental Status) score is 15 indicating intact cognitive response. Mood indicated trouble falling and staying asleep. Feeling tired and having little energy. Behavior of wandering not exhibited. Functional status indicate walk in room independently. Balance during transitions and walking not steady, but able to stabilize without staff assistance. Mobility devices cane/crutch, walker. R1 was admitted to the facility on [DATE]. On 09/02/20 at 12:42 PM, V1 (Administrator) stated R1 went to the emergency room at a hospital in Evanston. We do not know how he got there. The tape shows how R1 dodged staff on the second floor. There is no surveillance tape after he entered the stairway. On 09/02/20 at 01:42 PM, V8 (Certified Nurse Assistant) stated R1 used the rollator walker to ambulate. On 09/02/20 at 2:13 PM, Facility tour of exit door alarms done by surveyor with V9 (Maintenance Director). V9 stated to exit through the exit doors there is a code and there is a 15 second default. All exits have the same code. If the red light is on, the alarm will go off as soon as the door is opened. There is an exit door through the chapel (exit door next to the chapel).The exit door through the dining room exits to the alley. Auditorium exit door to the back of the building. V9 stated all of the doors trigger at the front desk and nurse station on one east. The breezeway to the exit door has two additional connecting doors if opened it triggers the alarm to the main breezeway exit door. Exit door to the park can be used with the button and a key. There are cameras at the exit and cameras in the hallway. The first floor exit door with an alarm leads to the park. The second first floor exit door leading to the park. V9 stated this door must remain locked at all times. On 09/02/20 at 2:43 PM, V10 (Registered Nurse) stated no resident should know the exit code. On 09/02/20 at 2:57 PM, the surveyor viewed the video surveillance tape with V3 (Director of Nursing). Video time stamp dated 8/13/20 at 12:16 AM V11 (Licensed Practical Nurse) was observed sitting at 2nd floor nurse's station. V3 stated the camera is located just above the nurse station. There were 2 staff members on the floor. Time stamp 1:28 AM, V12 (Certified Nurse Assistant) was observed sitting at the nurse station looking down hallway. Time stamp 1:29 V12 got up from nurse station and R1 started down the hallway with his rollator walker and face mask on toward the nurse station, turned left through the center of hallway opening to the opposite side of hallway and proceeded to walk pass the back side of the nurse's station. Time stamp 1:31 AM, R1 turned around and headed back in the direction in which he came. Time stamp 1:33 AM, R1 was observed coming back past the back side of the nurse station. 1:35 AM R1 was out of view. V3 stated there are no cameras in the stairwell. On 09/03/20 at 9:00 AM, V13 (Security Guard) stated on 08/13/20 I sit at the monitors and glance up at the video monitors ever now and then. I start at 8:30 PM - 7:30 AM. I round and check the doors at 8:30 PM, 12 AM and 3AM. When the exit doors are open the alarm will trigger at the front. I am thinking that the resident knew the code because I did not get a notification. I go to the exits on the outside to make sure everything is locked up. All of the doors were locked at 12 AM. The code was posted at several of the doors. On 09/03/20 at 9:21 AM, V12 (Certified Nurse Assistant) stated R1 did not want you to come in his room pass a certain time. On 8/12/20 the previous CNA said he complained that he had not had a bowel movement and wanted Milk of Magnesia. I did not check on him until 5:45 AM. I noticed the lights were on and called his name. There was no response. I informed the nurse and we started searching for him. When I looked down the hallway I thought a resident was trying to get out of bed. I never physically got up to see where the noise was coming from. When making rounds I check on the residents. I do not enter everyone's room. If you open the door to exit the building the alarm sounds. On 9/03/20 at 9:54 AM, V11 (Licensed Practical Nurse) stated we have routine vitals on every resident and the CNA (Certified Nurse Assistant) had gone into R1's room at 6:20 AM. We usually do not go into his room from 7 PM - 7 AM because he did not want to be disturbed. The CNA came and told me R1 was not there. We started checking the whole floor and did not see him. Rounds are done a 12 AM, 2 AM and 5AM. I am not sure if R1 knew the exit code. On 9/03/20 at 10:18 AM, V15 (Licensed Practical Nurse) stated R1 liked to keep to himself. He is alert and oriented x 3 (Person, Place and Time), walks without a walker in his room but when he is out of the room in the hallway he uses the rollator walker. I do not know if he had the code to exit the building. He did not want to be disturbed after 8 PM because he liked to be in bed asleep by then. On 8/13/20, R1 left in the middle of the night. He had to have gone down the stairs and he had the rollator walker. On 9/03/20 at 10:49 AM, V2 (Second Floor Supervisor) stated R1 did not come out of his room often. He had not complained that he wanted to leave the facility. He would make excuses of pain and not enough output to get to the hospital. He did not want to be disturbed during the night and kept his door closed. All of the exit door codes are the same with a sign posted. It is not posted at all of the exit doors. R1 would have seen that sign. In the apartment breezeway the exit doors have the same code. He walked pretty fast with a walker and does not need that much help. He would have had to carry the walker from the second to the first floor. We did not know what time he left until we looked at the cameras. On 9/03/20 at 11:24 AM, V3 (Director of Nursing) stated R1 had a suprapubic catheter and usually liked to go to the urologist or hospital to have it changed. On 8/12/20 he had no behavior and did not like coming out of his room. There was a sign on his door that he does not want to be disturbed during the night because he had trouble falling asleep. Rounds are made every 2 hours. If something is going on they should be done more frequently. Something triggered V12 (Certified Nurse Assistant) to look down the hallway. V12 should have gotten up to go see what was going on. When there is a noise it should be investigated. It could have been a situation where a resident needed assistance. On 9/03/20 at 12:48 PM, V1 (Administrator) stated R1 had never gone out at night. He was very self-determined but would always let the staff know when he wanted to leave the building up until that one time. When the residents leave the building they are required to sign out. The exit code is posted at the door to the courtyard. They started to search the unit, grounds, called the hospital emergency room and he wasn't there. On 09/03/20 at 01:44 PM V1 (Administrator) stated glass was found in the sink in R1 bathroom. We were not sure where it came from. On 9/03/20 at 11:45 AM, V4 (Assistant Director of Nursing) stated R1 kept his door closed and did not want staff to come in his room at certain times. On 8/13/20 when I heard he was missing I figured he had gone to the hospital. I called the hospital and they said he wasn't there and that is when they told me he was at the emergency room . R1 had a visit with a friend a week before and he may have learned about the exit code then. I watched some of the video and R1 had half his body in the room looking down the hallway. On 09/03/20 at 12:10 PM V18 (Restorative Nurse) stated I did the assessment for R1 and he needed supervision and setup with most of his care. He is able to walk with the rollator walker with supervision. We don't allow resident to walk the stairs. R1 did not like people to come into his room. No one could disturb him until morning. On 9/03/20 at 1:48 PM, V21 (Medical Doctor) stated R1 had complications with [MEDICAL CONDITION]. I believe he was depressed and refused the antidepressants because he didn't like the way they made him feel. He could walk very well with the walker. At night time

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) he would get angry and ask could you wait until morning. It would have been challenging for him to carry his rollator walker down the stairs. On 9/03/20 at 2:01 PM V2 (Second Floor Supervisor) stated there is nothing specific to check on residents every 2 hours. On 9/03/20 at 2:14 PM, Surveyor viewed second screen of video surveillance tape with V3 (Director of Nursing). Time stamp 8/13/20 at 1:33 AM R1 headed toward medication room by the elevator. Time stamp 1:34 AM R1 was observed turning around then exited second floor using stairway. Time stamp 1:36 AM V12 was observed checking hallway near stairway that R1 exited. Record review of Daily fire walk log dated 07/15/20 - 09/02/20 indicated Door alarm checks were done daily. Psychiatry Progress notes dated 08/06/20 reviewed reads in part R1 with moderate anxiety and mild depression. Non-compliant with some medication, anxiety, depression; staff also reports patient symptoms were exacerbated by isolation/restrictions. [DIAGNOSES REDACTED]. Nurse on duty went to his room right away and noticed resident was not there. Nurse observed a broken piece of glass in the washroom sink, and resident's shoes and rollator walker was not there but, his house shoes was by the bed. Resident insists not to be disturbed at night. Resident has a note he puts by the door not to come in room from 8pm till 7am unless he calls - care planed by social worker. Nurse and CNA went round the floor and opened every door but could not find resident. Progress note dated 8/13/2020 at 8:23 Health Status Note Text: written by V4 (Assistant Director of Nursing) reads I called the hospital and they said R1 was is in their ER. He came in at 3:23 AM. Record review of care plan states the primary [DIAGNOSES REDACTED]. Because of mental problems he complains of trouble sleeping, being over tired, showing paranoid and delusions. He does not like to be disturbed during the night. Psychophysiologic [MEDICAL CONDITION]. Ambulation: Uses cane to ambulate in the room and rollator in the corridor. Blames sleep issues on staff who come in and check on catheter output. Empty Foley bag prior to sleep. Do not check output until morning. Record review of Resident rules signed by R1 read Residents planning leaves of absence must notify the nursing department at least 24 hours in advance, Residents are requested to sign in and out at the front desk when leaving the home and when returning. Record review of Faxed report to the state health department dated 8/13/20 reads in part it is determined that: this intelligent, alert and self-determined resident freely left the building according to his own plan, carefully and intentionally evading nursing staff and security personnel, equipment and procedures that are in place. While it is not known how the resident disabled the door alarm, the alarm is being changed to one with a different code to prevent the recurrence of such an incident. Record review of the Hospital Medical records dated 8/13/20: R1 arrived at 3:22 am was seen in the emergency room Complaint: Generalized Body Aches, Psychiatric Evaluation. Diagnosis: [REDACTED]. He tried to jump on the CTA (Chicago Transit Authority) rail in an attempt to electrocute himself which was unsuccessful. He then proceeded to try to cut his own throat with the intention of cutting his jugular vein but was unable to do so. Superficial lacerations on the neck. Sad affect. Medically cleared for inpatient psychiatric placement. Policies: Record review of Missing Residents revised 11/11/19 read in part whenever a resident is not accounted for the following will take place: nursing assistant will notify the charge nurse, charge nurse will instruct the unit staff to look for the missing person, if the resident still cannot be found, the director of nursing and unit supervisor will be notified. The DON (Director of Nursing) notifies the Administrator, all personnel in the building will be alerted to look for the resident, and a room to room search will be instituted in all departments. Assigned personnel will institute a search of the outside grounds. If the resident still cannot be located, the local police department will be notified. The charge nurse will notify the attending physician, and the unit manager will notify the responsible party. The nurse will make out the incident report and the DON will notify the state health department. Review of the Routine Resident Checks dated 05/2006 read in part a routine check will be made on the certified nursing unit throughout each twenty-four (24) hour shift by nursing personnel. The check involves entering into each Resident's room.