

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510324	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2024
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NAME OF PROVIDER OR SUPPLIER AUBERGE AT NAPERVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1936 BROOKDALE ROAD NAPERVILLE, IL 60563
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A 000	Initial Comment FRI (Facility Reported Incident): #IL172261 - Substantiated. Complaint Investigation: #2474307/#IL173853 - Partially Substantiated Complaint Investigation: #2475237/#IL175163 - Partially Substantiated Complaint Investigation: #2475743/#IL175845 - Not Substantiated Complaint Investigation: #2476199/#IL176402 - Partially Substantiated FRI (Facility Reported Incident): #IL176906 - Substantiated FRI (Facility REported Incident): #IL176976 - Substantiated Complaint Investigation: #2476989/#IL177485 - Not Substantiated Complaint Investigatipn: #2477343/#IL177951 - Partially Substantiated	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident.	A2050		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A2050	<p>Continued From page 1</p> <p>b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident.</p> <p>c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident.</p> <p>(Source: Amended at 47 Ill. Reg. 13264, effective August 30, 2023)</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview and record review, the establishment failed to report to the Department a medication error in which a resident (R10) required an emergency medical attention at the establishment.</p> <p>Findings include:</p> <p>R10 is a 71-year-old, male resident admitted to the establishment on June 25, 2024 with diagnoses of Alzheimer's dementia with psychosis, depression, cognitive deficit, gait abnormality, and diabetes mellitus type 2.</p> <p>The establishment's Charting Notes for R10 dated July 2, 2024 at 5:57 PM showed, "Resident is lethargic, drowsy, sleepy, but easily arousable. 911 to send him out to ER. When paramedics arrived, the resident refused to go to the hospital. POA was by his side..."</p>	A2050		

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A2050	<p>Continued From page 2</p> <p>E1 (ED) added R10 was drowsy, acting over medicated, very sleepy. The neuro doctor told staff he's going to be fine. The fire dept/paramedics came and did safety check. Resident was up and walking in 20 minutes.</p> <p>However, the establishment's Employee Coaching and Counseling Statement dated July 3, 2024 showed there was a verbal warning given to a nurse (Employee: Abeba Eshetu) regarding an issue of Policy and Procedure violation. A description of the incident and/or performance concern showed: "Charge nurse was counseled by HSD regarding medication error. A medication was discontinued per Dr. Nandra. Charge nurse failed to read new orders and administered medication to resident. Time frame for improvement: Immediately. Charge nurse understands the severity of her actions, moving forward Abeba (Nurse) will double check order and medications prior to administering."</p> <p>E1 explained there were two prescribing doctors/neurologists. Both of them prescribed meds. Two meds with two different dosages were given. There was a medication change due to the resident's behavior.</p> <p>R10's July 2024 Medication Administration Record showed Olanzapine (Zyprexa) 2.5 mg 1 tab at noon, Olanzapine 5 mg 1.5 tabs (7.5 mg) every morning, and Olanzapine 5 mg 1 tab every morning were marked as discontinued. The counseled employee's initial (AE) was on the July 2, 2024 box for Olanzapine 5 mg tab to indicate the employee gave it on that date although the medication was discontinued.</p> <p>E1 confirmed this incident was not reported to the Department as the resident was not sent to the</p>	A2050		

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A2050	Continued From page 3 hospital.	A2050		
A4010	<p>Section 295.4010 Service Plan</p> <p>This Regulation is not met as evidenced by: Type 1 Violation</p> <p>Section 295.4010 Service Plan</p> <p>a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan.</p> <p>b) The service plan shall be developed by:</p> <p>1) The resident, resident's representative or any individual requested by the resident.</p> <p>2) The manager or manager's designee; and</p> <p>3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care.</p> <p>c) The service plan shall be signed and dated by all individuals involved in its development.</p>	A4010		

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A4010	<p>Continued From page 4</p> <p>d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)</p> <p>e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the establishment failed to ensure residents in the Memory Care Unit, who are assessed as average to high risk for fall, have fall interventions in place in their Individualized Service Plans (R1, R4, R5, R6, R7, R8, R9, R11). They failed to make changes to the initial interventions after each fall incident. They failed to address a resident's fall risk and fall incident in the Service Plan (R12), and they also failed to put interventions in the Service Plans for residents who are assessed as elopement risk (R2, R3, R4). The establishment also failed to update the Individualized Service Plan of a resident (R10) to reflect his behavior of picking up arts and crafts material in the Activity Room and putting it in his mouth. They failed to put interventions in place to help prevent this from reoccurring and help provide safety and supervision for the resident.</p> <p>These failures contributed to a resident's hospitalization after a fall, surgery, and death (R1), a resident's hospitalization after a fall,</p>	A4010		

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A4010	<p>Continued From page 5</p> <p>surgery, stay at a health care facility, hospice care, and death (R7), resident injuries such as hematoma to the head, and hospital ER evaluation and treatment (R6), bleeding with laceration across the middle of the nose, and hospital ER evaluation and treatment (R9), skin tear, and bruise (R11), bump on right side of forehead and hospital trip for evaluation and treatment (R12).</p> <p>Findings include:</p> <p>R1 was an 89-year-old female resident admitted to the establishment on March 14, 2024 With diagnoses of hearing loss, Mitral Valve prolapse, depression, hyperlipidemia, HTN, and CAD.</p> <p>E2 (LPN) confirmed R1 had a fall in the establishment. E2 said R1 was forgetful and was assessed as a high risk for fall resident. R1 had a wheelchair as assistive device. E2 added after her fall in the establishment, she was transferred to a local hospital. R1's family came to retrieve her personal belongings and confirmed to staff members R1 was transferred to another hospital for surgery. She eventually died at the hospital.</p> <p>R1's Charting Notes showed she had several fall incidents in the establishment during the month of March. The same charting notes showed R1 had a fall follow-up on March 24, 2024, was observed on the floor on March 25, 2024 at 6:45 PM, was found in a sitting position on the floor and complained of pain to wrist, slid out of her bed on April 12, 2024 at 3:16 AM. It culminated in a fall on April 15, 2024 when R1 was observed on the floor in the restroom shower area. R1 was sent to the hospital via ambulance. Confirmation from the</p>	A4010		

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A4010	<p>Continued From page 6</p> <p>nurse at the hospital showed R1 had fracture to her radius and right hip.</p> <p>R1's Service Plan dated April 13, 2024 did not show any changes to the fall interventions after each fall occurrence. There was no initial fall service plan in place upon her admission to the establishment on March 14, 2024, even if the resident was assessed as high risk for fall, that was presented during the survey. There was also no analysis conducted for the root cause of each fall upon which to base the fall interventions on.</p> <p>R2 is an 86-year-old female resident admitted to the establishment on August 17, 2021 with diagnoses of dementia, anxiety, hypertension, dyslipidemia, DVT, fall.</p> <p>R3 is a 92-year-old male resident admitted to the establishment on November 1, 2023 with diagnoses of HTN, dementia, and diabetes mellitus type 2.</p> <p>E1 (Executive Director) confirmed an incident involving R2 and R3 happened. E1 added R2 was able to get out of the building and was found in the sidewalk. R3 opened the door for R2 to get out of the building. R3 remained in the vestibule when staff members came and responded to the door alarm. E1 said they have a receptionist in the building until the time the receptionist goes home by 5 PM. E1 added R4 pushes chairs in front of the door. Some residents push chairs by the front door. These residents have been monitored based on their Service Plan.</p> <p>The establishment's Interim Service Plans for R2 showed, "On May 25, 2024, R2 was noted outside on the parking lot in wheelchair. Front door alarm sounded saying assistance needed</p>	A4010		

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A4010	<p>Continued From page 7</p> <p>when this writer noted resident outside the door."</p> <p>The establishment's Interim Service Plan for R3 showed, "On May 25, 2024, front door alarm sounded, and the resident was noted on the hallway pushing the 2nd door trying to open it. Brought back inside without incident."</p> <p>The Charting Notes for R2 and R3 confirmed what is in the Interim Service Plan.</p> <p>R2's Charting Notes dated May 25, 2024 at 9:27 PM showed, "Front door alarm sounded saying assistance was needed at the front door. When this writer arrived, this resident was noted outside the building in parking lot in her wheelchair voicing "I want to go home." This writer went and brought the resident back inside the facility without any incident, a/o, stable condition with no visible signs of any distress noted. POA was made aware, needed staff will be made aware. Will continue to monitor resident for elopement.</p> <p>R3's Charting Notes dated May 25, 2024 at 9:23 PM showed, "Front door alarm sounded saying assistance was needed at the front door. When this writer arrived, this resident was noted in the hallways standing at the 2nd door pushing the door open. This writer went and brought the resident back inside the facility. No incident. A/O in stable condition with no visible signs of any distress noted. Daughter made aware. All needed staff will be made aware. Will continue to monitor resident's elopement.</p> <p>The Service Plans for both R2 and R3 showed they are both elopement risks. However, there are no interventions that were put in place regarding elopement prevention.</p>	A4010		

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A4010	<p>Continued From page 8</p> <p>R2's ISP dated July 22, 2024 Elopement Risk section showed, "High elopement risk, she frequently expresses a desire to go home, she is able to move independently throughout the community, she also has a history of elopement from home."</p> <p>R3's ISP dated May 29, 2024 Elopement Risk section showed, "High risk of elopement due to cognitive impairment. He is able to ambulate throughout the community without standby assist."</p> <p>R4 is a 76-year-old male resident admitted to the establishment on August 30, 2023 with diagnoses of Alzheimer's, chronic diarrhea due to short gut syndrome, HTN, B12 deficiency, and anxiety.</p> <p>R4 is also an elopement risk resident per his Individualized Service Plan dated March 28, 2024, but the elopement risk section does not have any individualized interventions to help prevent an elopement incident. The ISP showed: "High risk for elopement. He has dx of Alzheimer's and is able to ambulate independently throughout the community. He requires redirection by staff members; often wanders without sense of purpose and exit seeks by pushing exit doors and sounding the alarms. Staff will address all care needs, and complete purposeful rounds to ensure safety."</p> <p>The same ISP for R4 also showed he is currently assessed as high risk for fall d/t ambulation without an assistive device, advancing Alzheimer's, and current medication regimen. There are no fall interventions that are in place to help prevent fall incidents.</p>	A4010		

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A4010	<p>Continued From page 9</p> <p>R5 is a 75-year-old female resident admitted to the establishment on November 1, 2023 with diagnoses of dementia, hyperlipidemia, weight loss, and depression.</p> <p>Charting Notes for R5 dated September 13, 2024 showed, "Caregiver called nurse to report resident had a fall. Resident was noted in a side lying position on the floor on the side of her bed. C/O pain to the head. When asked by this writer if she hit her head, she said yes, and her head was hurting. Assisted X2 from the floor to a standing position. A/O, resident voiced she felt dizzy ...911 called to send resident to the hospital for evaluation. POA was called and made aware resident was going to be sent to the hospital for evaluation. NP Lisa made aware. All needed staff made aware. 911 arrived and resident was taken to the hospital. BP 145/91, P 110."</p> <p>R5's Individualized Service Plan dated July 26, 2024 showed, "R5 is currently assessed as high risk for fall d/t dx: dementia, ambulation without an assistive device, current medication regimen. Staff will monitor and complete purposeful rounds to ensure safety."</p> <p>There are no changes made to the fall interventions in R5's ISP based on a conducted fall root cause analysis. The latest fall incident was not addressed in the service plan.</p> <p>R6 is a 90-year-old female resident admitted to the establishment on December 12, 2023 with diagnoses of dementia, chronic UTI, fall risk, constipation, major neurocognitive disorder, psychosis, major depressive disorder, generalized anxiety disorder.</p>	A4010		

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A4010	<p>Continued From page 10</p> <p>Charting Notes for R6 showed she was noted on the floor in his room in a supine position on July 27, 2024, was observed sitting position in the bathroom on August 3, 2024. Noted with hematoma to the head approx. the size of half an egg. R6 was sent to ER for evaluation. R6 was noted on the floor in her room in a sitting position on August 6, 2024. The Interim Service Plan dated September 8, 2024 showed she had a fall in her room at 10:24 PM. Another Interim Service Plan dated September 10, 2024 showed she had another fall in the hallway at 7:15 PM.</p> <p>R6's ISP dated March 11, 2024 under Fall Risk category showed she has history of falls. The fall incidents were not addressed in the ISP, and no changes were made to the fall interventions as there was no root cause analysis for the fall that was conducted.</p> <p>R7 was a 75-year-old resident admitted to the establishment on July 25, 2022 with diagnoses of angina pectoris, type 2 diabetes mellitus, dementia, benign hypertension.</p> <p>E1 said R7 was a late-stage dementia resident, had a catastrophic fall in the establishment, was sent to the hospital, came back to the establishment, placed on hospice care, and eventually died in the establishment. E1 confirmed R7 died on January 28, 2024.</p> <p>R7's Charting Notes showed she was ambulating to the dining room on January 5, 2024 and had a fall. R7 was sent to the emergency room. R7 obtained a fracture to her left radius. On January 8, 2024, she had an x-ray to the spine and hip</p>	A4010		

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A4010	<p>Continued From page 11</p> <p>due to constant complaint of back pain. R7 had fracture to her left hip and was sent to the hospital. R7 was sent to a health care facility, came back to the establishment on January 16, 2024 and was admitted to hospice for comfort measures for pain.</p> <p>R7's Individualized Service Plan dated January 16, 2024 under Fall Risk category showed, "High fall risk due to medication regimen. Staff will perform purposeful rounding and repositioning in order to minimize falls while in room.</p> <p>There was no Interim Service Plan made or presented regarding fall interventions prior to the resident's fall on January 5, 2024. The Service Plan fall interventions were not individualized.</p> <p>R8 is a 73-year-old female resident admitted to the establishment on January 21, 2022 with diagnoses of dementia with behavioral disturbances, cognitive impairment, anxiety, history of knee replacement and right hip pain.</p> <p>Charting Notes for R8 showed she had various fall incidents in the establishment or being found sitting on the floor, some without injuries and some with minor injuries such as skin tear.</p> <p>R8's Individualized Service Plan dated August 22, 2024 showed R8 is currently a high risk for fall resident. R8's ISP did not reflect the changes to the fall interventions based on the fall root cause analysis that should have been conducted.</p> <p>R9 is a 75-year-old male resident admitted to the establishment on December 1, 2023 with diagnoses of Alzheimer's; type 2 diabetes</p>	A4010		

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A4010	<p>Continued From page 12</p> <p>mellitus; major neurocognitive disorder; anxiety disorder, unspecified; mood disorder, unspecified.</p> <p>E1 (Executive Director) said R9 is impulsive, often forgets to use his walker, had bad foot, needs to use brace for his leg. R9 is ambulatory.</p> <p>The establishment's Charting Notes for R9 dated June 23, 2024 showed, "Resident came to the Wellness Office at 11:50 PM and reported his nose was bleeding. Upon assessment, a laceration was noted across the middle of his nose. When asked what happened, resident voiced he fell and hit his face. 911 was called to send resident to the hospital for evaluation...resident was taken a/o in stable condition to the hospital for evaluation..."</p> <p>The same Charting Notes dated June 27, 2024 had another unwitnessed fall in his room. He hit his face. Bump was noted on the right side of his forehead. He was noted sitting in his chair holding a tissue to his nose due to bleeding. Resident was unsure what happened. 911 was called and resident was sent to the hospital for evaluation.</p> <p>The establishment's Individualized Service Plan dated July 6, 2024 showed, "High risk for fall due to decreased in safety awareness and diagnosis of Alzheimer's. He is on medication to help increase blood pressure. Staff will complete purposeful rounds to ensure safety and all necessary care needs are met."</p> <p>R9's fall incidents in the establishment were not addressed in the ISP. There were no fall interventions outlined in the service plan based on the root cause analysis of the fall incidents that is supposed to be conducted after each fall</p>	A4010		

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A4010	<p>Continued From page 13</p> <p>incident.</p> <p>R10 is a 71-year-old, male resident admitted to the establishment on June 25, 2024 with diagnoses of Alzheimer's dementia with psychosis, depression, cognitive deficit, gait abnormality, and diabetes mellitus type 2.</p> <p>E1 said R10's family told her R10 attempted to eat glass and beads on August 1, 2024. According to the family member, it happened in the evening when the daughter was with him. E1 said they reviewed the video. R10 was walking in the activity room with the daughter by his side. R10 picked up a clear material from a flower arrangement. It was not glass or beads. E4 (LPN) was in another resident's apartment and was not within the vicinity of R10 and his daughter. R10's daughter did not stop R10 while he was picking up the material.</p> <p>The establishment's incident report dated August 1, 2024 showed, "Time of incident: 7:45. This nurse was contacted via phone by resident's daughter. Resident's daughter stated her father was eating glass. Immediate prevention of re-occurrence: all of the arts and craft items have been placed inside of a locked cabinet."</p> <p>R10's Service Plan dated 7/8/2024 was not updated to reflect and address this behavior of R10 to alert staff members to watch this behavior in order to prevent this from happening again.</p> <p>R11 is an 80-year-old female resident admitted to the establishment on October 26, 2023 with diagnoses of cognitive impairment, HTN, dementia, depression, and unspecified psychosis.</p>	A4010		

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A4010	<p>Continued From page 14</p> <p>E1 (Executive Director) said R11 is a fall risk and have issues with impulse control. E1 added R 11 has been declining rapidly.</p> <p>The establishment's Charting Notes for R11 on August 5, 2024 at 9:35 PM showed, "Resident noted in a sitting position on the floor of the 300 hallways. A/O X1, assisted X2 staff from the floor to a standing position and then walked to the chair to sit down in activity. Resident was noted with an unsteady gait. Ambulating with her cane. When asked did she hit her head, resident said yes, and that she was having a little pain. Skin tear noted on the lateral side of her right hand. 911 was called and resident was sent to Edwards Hospital for evaluation. Christine, POA, was made aware. All needed staff made aware."</p> <p>The charting notes dated July 27, 2024 showed she was found on the floor by her doorway in a supine position. No injuries were seen.</p> <p>The following charting notes for August 5, 6, and 7, 2024 showed there was fall follow-up conducted in the establishment without further injuries or discomfort.</p> <p>R11's Individualized Service Plan dated May 23, 2024 under Fall Risk section showed, "Currently assessed as an average risk for fall d/t ambulation with an assistive device. She is requiring reminders by staff to use cane when ambulating for safety and current medication regimen."</p> <p>R11's Charting Notes dated July 7, 2024 indicated R11 had a fall with no injury. Post fall bruise was noted on July 13, 2024 per charting notes.</p>	A4010		

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A4010	<p>Continued From page 15</p> <p>The fall incident was not addressed in R11's Service Plan. There were no individualized interventions that were put into placed based on the root cause analysis of the fall incidents, so no changes were made to the fall interventions.</p> <p>R12 is an 84-year-old female resident admitted to the establishment on August 1, 2024 with diagnoses of dementia, depression, hypertension.</p> <p>E1 (Executive Director) said R12 is a fall risk resident due to poor impulse control. E1 added she uses wheelchair as an assistive device. She has been starting to get ambulatory as PT/OT treatment has been started.</p> <p>The establishment's Charting Notes for R12 dated August 9, 2024 at showed, "This writer was called to the main activity and this resident was noted in a sitting position on the floor. It was also reported by staff she hit her head; was noted by caregiver holding her head. Upon assessment, a bump was noted to the back of her head, c/o pain and discomfort. Assisted x3 from the floor to her wheelchair. Body assessment done. No redness, bruise noted at this time. ROM X4 extremities as tolerated with no c/o voiced. Due to resident hitting her head when she fell, 911 was called and arrived. Resident was sent to Edwards Hospital for medical evaluation. POA was called with no answer, needed staff made aware. VS: 97.7, 68, 127/94, SPO2 98%."</p> <p>The Charting Notes showed R12 was returned to the establishment on August 10, 2024 at 2:10 AM, A/O in stable condition with 3 EMTs with no visible signs of any distress noted. No new orders were given.</p>	A4010		

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A4010	<p>Continued From page 16</p> <p>Additional Charting Notes for R12 showed on August 11, 2024, R12 was found on the floor in stable condition. On August 12, 2024 at 6:50 AM, R12 was noted down on one knee on the side of her bed in early AM A/O in stable condition. On August 16, 2024 at 6:15 AM, R12 was observed in her restroom laying on her right side. R12 obtained a bump to the right side of her forehead. NP notified and ordered for resident to be sent out to the ER. R12 came back from the emergency room at 10:18 AM with no new order.</p> <p>R12's Individualized Service Plan dated August 8, 2024 did not contain any fall intervention section. R12's fall incidents were not addressed in the Service Plan.</p> <p>E1 said the management team will make sure the resident's Service Plans will be updated and interventions will be in place for each resident's condition and issue.</p>	A4010		
A4060	<p>Seciton 295.4060 Alzheimer's and Demential Programs</p> <p>This Regulation is not met as evidenced by: Type 2 Violation</p> <p>Section 295.4060 Alzheimer's and Dementia Programs</p> <p>a) Except as provided in this Section, Alzheimer and dementia programs shall comply with provisions of the Act. (Section 150(a) of the Act)</p>	A4060		

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A4060	<p>Continued From page 17</p> <p>h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall:</p> <p>3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who:</p> <p>A) May wander; and</p> <p>B) May need supervision and assistance when evacuating the building in an emergency.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview and record review, the establishment failed to implement their policy and procedure regarding residents who are considered and assessed as high risk for elopement.</p> <p>This failure created a substantial probability of harm to the residents in the Memory Care unit. This resulted in 1 resident's (R2) ability to get out of the building into the parking lot and 1 resident's (R3) ability to get out of the main door into the vestibule of the building leading into the 2nd door out of the building.</p> <p>Findings include:</p> <p>R2 is an 86-year-old female resident admitted to the establishment on August 17, 2021 with diagnoses of dementia, anxiety, hypertension,</p>	A4060		

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A4060	<p>Continued From page 18</p> <p>dyslipidemia, DVT, fall.</p> <p>E1 (Executive Director) confirmed an incident involving R2 and R3 happened. E1 added R2 was able to get out of the building and was found in the sidewalk. R3 opened the door for R2 to get out of the building. R3 remained in the vestibule when staff members came and responded to the door alarm. E1 said they have a receptionist in the building until the time the receptionist goes home by 5 PM. E1 added R4 pushes chairs in front of the door. Some residents push chairs by the front door. These residents have been monitored based on their Service Plan.</p> <p>During the survey process, some residents were seen hovering every now and then by the main entrance door trying to open it. Concierge/Receptionist was present until 5 PM to deter the residents from going out the door.</p> <p>R2's ISP dated July 22, 2024 Elopement Risk section showed, "High elopement risk, she frequently expresses a desire to go home, she is able to move independently throughout the community, she also has a history of elopement from home."</p> <p>The establishment's Interim Service Plans for R2 showed, "On May 25, 2024, R2 was noted outside on the parking lot in wheelchair. Front door alarm sounded saying assistance needed that when this writer noted resident outside the door."</p> <p>R3 is a 92-year-old male resident admitted to the establishment on November 1, 2023 with diagnoses of HTN, dementia, and diabetes mellitus type 2.</p>	A4060		

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A4060	<p>Continued From page 19</p> <p>R3's ISP dated May 29, 2024 Elopement Risk section showed, "High risk of elopement due to cognitive impairment. He is able to ambulate throughout the community without standby assist."</p> <p>The establishment's Interim Service Plan for R3 showed, "On May 25, 2024, front door alarm sounded, and the resident was noted on the hallway pushing the 2nd door trying to open it. Brought back inside without incident."</p> <p>The Service Plans for both R2 and R3 showed they are both elopement risks. However, there are no interventions that were put into place regarding elopement prevention.</p> <p>The Charting Notes for R2 and R3 confirmed what is in the Interim Service Plan.</p> <p>R2's Charting Notes dated May 25, 2024 at 9:27 PM showed, "Front door alarm sounded saying assistance was needed at the front door. When this writer arrived, this resident was noted outside the building in parking lot in her wheelchair voicing "I want to go home." This writer went and brought the resident back inside the facility without any incident, a/o, stable condition with no visible signs of any distress noted. POA was made aware, needed staff will be made aware. Will continue to monitor resident for elopement."</p> <p>R3's Charting Notes dated May 25, 2024 at 9:23 PM showed, "Front door alarm sounded saying assistance was needed at the front door. When this writer arrived, this resident was noted in the hallways standing at the 2nd door pushing the door open. This writer went and brought the resident back inside the facility. No incident. A/O</p>	A4060		

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A4060	<p>Continued From page 20</p> <p>in stable condition with no visible signs of any distress noted. Daughter made aware. All needed staff will be made aware. Will continue to monitor resident's elopement."</p> <p>R4 is also an elopement risk resident per his Individualized Service Plan dated March 28, 2024, but the elopement risk section does not have any individualized interventions to help prevent an elopement incident. The ISP showed: "High risk for elopement. He has dx of Alzheimer's and is able to ambulate independently throughout the community. He requires redirection by staff members; often wanders without sense of purpose and exit seeks by pushing exit doors and sounding the alarms. Staff will address all care needs, and complete purposeful rounds to ensure safety."</p> <p>The establishment's Elopement Risk (MC) Policy showed, "Upon move-in to a memory care unit, all residents risk for elopement will be evaluated and mitigating interventions placed on the service plan...All interventions will be identified on the resident's Plan of Care and all staff will be made aware of those interventions. For the Procedure: The resident plan of care must contain all interventions to prevent an elopement and all staff must be made aware of those interventions. Any resident actively exit seeking, must have attempts made to involve the minimum an activity; take him/her for a walk, or remove him/her from the door area. May use additional props to redirect the resident away from the exit doors."</p> <p>The Elopement Risk Policy and Procedure was not followed.</p>	A4060		

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A6000	Continued From page 21	A6000		
A6000	<p>Section 295.6000 Resident Rights</p> <p>This Regulation is not met as evidenced by: Type 3 Violation</p> <p>Section 295.6000 Resident Rights</p> <p>a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights:</p> <p>5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes.</p> <p>15) The right to privacy in financial and personal affairs.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the establishment failed to ensure a resident (R13) received the services specified in her service plan related to dental hygiene. They also failed to ensure a resident's (R10) privacy and care information is maintained and shared only by those responsible for his care.</p>	A6000		

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A6000	<p>Continued From page 22</p> <p>This applies to 2 (R10, R13) residents in the sample reviewed for Resident's Rights.</p> <p>Findings include:</p> <p>R13 was a 90-year-old, female resident admitted to the establishment on December 4, 2023 with diagnoses of hypertension, dementia, and anxiety.</p> <p>E1 (ED) said E13 declined rapidly. She needed to be fed and can't do much of her ADLs. R13's daughter is a dental hygienist. She complained R13 was not brushing her teeth daily, so they put a schedule in place for her daily hygiene. R13 was also receiving care from hospice regarding oral care. R13's hair was done in the beauty shop, and she was scheduled to receive the services. E1 said they have a task sheet created to show the task was done by the caregiver as evidenced by the caregiver signing the task sheet. E1 said sometimes the caregivers forget to sign the task sheet. They also have another sheet by the bedside the caregivers will sign after each task, but they don't have the sheet to present during the investigation.</p> <p>The Individualized Service Plan for R13 dated July 1, 2024 showed for Grooming category: Service Needs: Does resident need reminders, cues or set-up assistance during task or is the staff only involved for part of the task and the Resident is able to complete the rest of the task independently? (For example, add toothpaste to toothbrush...) Service Notes: (R13) requires partial assistance with grooming. Staff will assist with set-up of task and (R13) will be able to complete task on her own. Responsible Party: Caregiver.</p>	A6000		

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A6000	<p>Continued From page 23</p> <p>The establishment's Dental Hygiene Log for September 2024 had unsigned spots (September 1, 2, 3, 4, 5, 6, 7, 8, and 9) for R13, which could be an indication dental hygiene was not completed during those times. No other task sheets for the previous months were presented during the survey process.</p> <p>R10 is a 71-year-old, male resident admitted to the establishment on June 25, 2024 with diagnoses of Alzheimer's dementia with psychosis, depression, cognitive deficit, gait abnormality, and diabetes mellitus type 2.</p> <p>E1 (ED) said R10's family spoke with her and claimed the establishment's caregiver gave information regarding R10's condition to the caregivers from the previous facility he resided. E1 added this happened when some caregivers from the other facility came and visited with him. R10's family overheard them talking about him and discussing about his care. The family felt they should not be talking about him and his care as the visitors from the previous facility were no longer currently taking care of him. E1 added she asked R10's family who these caregivers were, but the family members do not know them by name. E1 explained upon advice from corporate, they went ahead and gave an in-service to all staff members regarding HIPAA.</p> <p>An in-service sign-in sheet dated July 2, 2024 regarding Redirection, HIPAA, and behaviors was presented.</p>	A6000		