STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510162	A. BUILDING: _____ B. WING _____	C 01/09/2025

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FRANCISCAN VILLAGE OF LEMONT	1260 FRANCISCAN DR LEMONT, IL 60439

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A 000	Initial Comment Facility Reported Incident: IL174662/FRI 5.24.24-Substantiated	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan - Level 3 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. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. 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	A4010		

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A4010	Continued From page 1 contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; 4) Any risk being negotiated; and 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment. i) The service plan shall be reviewed and revised if necessary immediately after a	A4010		

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A4010	Continued From page 2	A4010		

significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

This requirement was not met as evidenced by:

Based on record review and staff interviews, the establishment failed to:

-address in the service plan a history of elopement and exit seeking behavior for one resident (R1) who managed to elope off of the memory care unit;

-ensure newly hired staff are made aware of residents who have a history of eloping or exit seeking behavior.

These failures have the to probably to affect all resident who reside on the memory support unit.

Findings include:

R1 is a 73 year old resident who has diagnoses of Alzheimer's disease with early onset, Senile degeneration of the brain, Anxiety, Major depressive disorder and Insomnia. R1 initially moved into assisted living 9/1/23. R1 was transferred to the memory support unit shortly thereafter for observation due to a history of leaving without notice from the assisted living building.

The incident and accident report dated 5/24/24 shows R1 was discovered walking outside by Walker Street. Investigation initiated on 5/24/24 (6:50pm) concludes R1 followed a new care aide (E1) to the stairwell exit, after the door alarm

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A4010	Continued From page 3	A4010		

code was put in by E1. R1 was assisted back to Memory Support. R1 stated he did not remember the incident and that he has dementia when asked about where he went.

The progress notes for the month of May 2024 were reviewed and show the following:

-5/11: R1 was pacing up and down hallway this shift. R1 was exit seeking. R1 has a working wander guard on his right ankle

-5/24: writer noted R1 sitting in gathering room with CNA just before receiving phone call that R1 had off the floor and was found on another floor. R1 questioned on where he had gone and how he had gotten there. R1 stated, "I don't know. I have dementia." R1 was asked about his whereabouts and R1 said he had no recollection

-5/27: R1 was seen pacing hallway back and forth

5/28: R1 pacing up and down memory support corridor for hours at a time. R1 prefers to pace up and down hallway to burn off energy

5/29:R1 continues with symptoms of anxiety and wandering. Remains an elopement risk

On 1/7/25 at 11:40am E2 stated, "R1 first lived in AL (assisted living). R1 was very active. R1 loved to exercise and walk around the campus. R1 tried to elope a few more times prior to this incident. The one care aide said she checked on R1 at 10pm. We don't know when R1 walked out. When R1 lived is independent living, R1 got out twice. We ended up moving R1 to memory support for his safety. We had a new student here (E1). They spoke. R1 said he was a family member so E1 not knowing let him get out. E1

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A4010	Continued From page 4	A4010		

saw him by the exit. When the care aides did their rounds, they didn't see R1 in his room. A search was done. R1 was found on Walker Street. E1 realized it was this particular resident after hearing the staff discussing how did R1 get out since an alarm didn't sound. This happened on E1's first day of resident care training. I ended up referring him to a new facility because we just couldn't meet R1's needs."

On 1/9/25 at 12:35pm via telephone interview E1 (resident care aide) stated, "I was working on the 200 unit floor. I was still in training on my first week. This was my first time on the memory support unit and I didn't know the residents. I was shadowing another CNA (E3). We were changing a resident who had a bowel movement. E3 told me to go get a mask, that's why I took the stairs. I entered the code to go down the steps. I saw R1 and apologized to him because I almost closed the door on him. I said I'm sorry. R1 said no worries and that he was going for a walk. I went on my way but I did see R1 leave out of the door leading to the outside. Before it was time to punchout, I hear the nurses talking about a resident who had gotten out of the building. As they were talking about how R1 could've gotten out. I realized that was the same man that was behind me."

The service plan dated 3/13/24 shows a focus of safety elopement risk. However the service plan was not revised to include interventions to address R1's history of exit seeking prior to moving into the memory support unit and successfully eloping from the establishment. The service plan does not include interventions to address R1's pacing and exit seeking behavior after the elopement from the memory support unit.

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A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting - Level 3 a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; 2) Description of any injury to the resident; 3) Description of any change in the	A6010		

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A6010	Continued From page 6 resident's physical, cognitive, functional, or emotional condition; 4) Any actions taken by the licensee; 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents. This requirement was not met as evidenced by: Based on record review and staff interviews, the establishment failed to ensure the safety of one resident (R1) who has a diagnoses of Alzheimer's disease with early onset and a history of exit seeking and elopement behavior. R1 managed to elope off the memory support unit unbeknownst by a new resident care aide who was not familiar with the residents on this unit. R1 managed to elope from the memory support unit and was outside for an unknown amount of time.	A6010		

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A6010	Continued From page 7 Findings include: R1 is a 73 year old resident who has diagnoses of Alzheimer's disease with early onset, Senile degeneration of the brain, Anxiety, Major depressive disorder and Insomnia. R1 initially moved into assisted living. R1 was transferred to the memory support unit for observation due to a history of elopement. The incident and accident report dated 5/24/24 shows writer (E2, assisted living manager) was notified that R1 was noted walking outside by Walker Street. Investigation initiated on 5/24/24. (6:50pm) concludes R1followed a new care aide (E1) to the stairwell exit, after the door alarm code was put in by E1. R1 was assisted back to Memory Support, R1 did not remember the incident, stated he has dementia when asked about where he went. On 1/7/25 at 11:40am E2 stated, "R1 first lived in AL (assisted living). R1 used to work for the FBI and said he didn't sleep nights. R1 was very active. R1 loved to exercise and walk around the campus. The one care aide said she checked on R1 at 10pm. We don't know when R1 walked out. When R1 lived is independent living, R1 got out twice. We ended up moving R1 to memory support for his safety. We had a new student here (E1). They spoke. R1 said he was a family member so E1 not knowing let him get out. E1 saw him by the exit. When the care aides did their rounds, they didn't see R1 in his room. A search was done. R1 was found on Walker Street. E1 realized it was this particular resident after hearing the staff discussing how did R1 get out since an alarm didn't sound. This happened on E1's first day of resident care training. I ended up	A6010		

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A6010	Continued From page 8	A6010		

referring him to a new facility because we just couldn't meet R1's needs."

On 1/9/25 at 12:35pm via telephone interview E1 (resident care aide) stated, "I was working on the 200 unit floor. I was still in training on my first week. This was my first time on the memory support unit and I didn't know the residents. I was shadowing another CNA (E3). We were changing a resident who had a bowel movement. E3 told me to go get a mask, that's why I took the stairs. I entered the code to go down the steps. I saw R1 and apologized to him because I almost closed the door on him. I said I'm sorry. R1 said no worries and that he was going for a walk. I went on my way but I did see R1 leave out of the door leading to the outside. Before it was time to punchout, I hear the nurses talking about a resident who got out of the building. As they were talking about how R1 could've gotten out. I realized that was the same man that was behind me."

At 2:30pm, E1 said E3 told E1 to go get a mask because the stool was quite odorous. E1 didn't know about the masks on the floor. R1 was found outside near Walker Street. This was after dinner time.

E2 presented documentation showing R1 was transferred to another long term care facility on 7/17/24. E2 said this transfer was in the best interest of R1. The establishment could no longer meet R1's needs.