STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145830	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care West Chicago	201 West North Avenue West Chicago, IL 60185

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 - 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** 22499 Based on interview and record review, the facility failed to ensure a resident was supervised to prevent the resident from leaving the grounds of the facility, and failed to ensure nursing staff were aware R1 was out of the building resulting in a 6 hour delay in identifying R1 was missing. This failure resulted in R1 leaving the facility grounds at 5:57 PM on [DATE], and being found deceased about 600 feet from the facility's main entrance at 7:50AM on [DATE]. The Immediate Jeopardy began on [DATE] when R1 signed out of the facility, left unsupervised, and failed to return at the expected time. The receptionist failed to notify the nurse R1 had not returned to the facility by the 8:00 PM curfew and nursing staff was therefore unaware R1 was not in the facility until after 11:00 PM, when police were finally notified. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 2:30 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, on [DATE], prior to the start of the survey on [DATE] and was therefore Past Noncompliance. This past non-compliance occurred from [DATE]-[DATE]. The findings include: R1's care plan, dated [DATE], states, Community Access/ Supervised - The resident required the support, care and services of a long term care facility and has been determined by community assess assessment to be able to access the community with supervision. On [DATE] I was assessed as appropriate for Level 2. I was assessed as appropriate for level 3. Interventions include: I am on supervised access to the community. R1's Elopement Risk and Community Survival Skills Assessment, dated [DATE], shows: The resident appears to be capable of outside independent pass privileges at this time. A care plan for outside pass privileges including risk factors for non-compliance for adhering to pass policies and parameters as indicated. This area is marked with a No. R1's Physician's Order Sheet, dated [DATE], shows R1 has diagnoses including schizophrenia, delusional disorders, paranoid personality disorder, Attention Deficit Hyperactivity Disorder, and cannabis and nicotine dependence. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145830	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care West Chicago	201 West North Avenue West Chicago, IL 60185

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Psychiatric Note, dated [DATE], states, + (positive for) baseline paranoia, No (SI) Suicidal Ideation, HI (Homicidal Ideation), AH (Auditory Hallucinations), VH (Visual Hallucinations), no other delusions were elicited. R1's EMR (Electronic Medical Record) shows a form titled, Level 2 Pass Privileges Acknowledgement, dated [DATE], that states, I understand that I have earned a level 2 pass privilege, which allows me to sign out of the facility two times per day for 1 hour maximum, between the hours of 9 AM and 6 PM Monday- Friday and between the hours of 10 AM and 7 PM on Saturday and Sunday with a fell ow level 2 or 3 peer. I agree to remain with level 2 or 3 peer while out of the facility. The facility Resident sign in and out log, dated [DATE], shows R1 signed out with a destination of Bench at 12:15 PM, with a time expected of 1:15 PM, and an actual time in of 12:29 PM. R1 then signed out with a destination of Bench at 2:38 PM, with a time expected of 3:38 PM, and an actual time in of 2:47 PM. Finally, R1 signed out at with a destination of Bench at 5:57 PM, with a time expected of 6:57 PM. R1 did not return to the facility following this sign out. The Facility Reported Incident, dated [DATE], states, On [DATE], resident was out on pass and was reported deceased . Resident went out on pass on [DATE] and was observed to not return to the facility. On [DATE] at 1:57 PM, V8 (Receptionist) said he has worked at the facility for about two months. There are red and blue cards at the front desk. Residents with a red pass can leave the facility three times a day, an hour at a time. (R1) was a red pass; he was allowed to leave for one hour, if they don't return, I should notify the nurse. On [DATE], (R1) left at 5:57 PM, he went outside to smoke and came back to give me his lighter, and told me he was going outside for a little longer. I left at 8:00 PM, at end of my shift, there was a random rush of things that I was busy with. Normally, I check the sign in sheet, and I forgot to notify the nurse (R1) did not return from his pass. On [DATE] at 2:09 PM, V11, Registered Nurse (RN), said she was R1's nurse from 3:00 to 11:00 PM. She saw R1 last around 4:30 PM to 5:00 PM in the big dining room. Around 8:00 PM, she asked V9, Certified Nursing Assistant (CNA), if R1 ate dinner, she said she did not know. During her evening med pass, she asked R3 (R1's roommate) if he had seen R1. R3 said to check another resident's room. She continued passing her medications because residents were insisting on getting their medications. About 10:30 PM, she was searching for R1, but did not call a code pink (missing resident). During shift change, she reported to V9 (CNA) R1 was missing, and she started searching for him. V11 said she was not aware R1 left to go out on pass at 5:57 PM. V8 did not report to her R1 did not return to the facility. R1 had a red pass; he was able to go out unsupervised for two hours at a time, up to three times a day. She reported off to V12, Licensed Practical Nurse (LPN), that R1 was missing, and they could not locate him. On [DATE] at 4:36 PM, V12 (Licensed Practical Nurse/LPN) said she came in at 11:00 PM. V12 said, (V11) was at the medication cart and endorsed to me (R1) did not receive his medications because he was not in his room and the staff searched for him, but could not locate him. She (V11) called (R1's) family and they had not seen (R1). She called and the police and reported (R1) as a missing person. (R1) had a red pass and could go out on pass unsupervised for two hours. Nursing is not notified when a resident signs out on pass. The receptionist should notify nursing if a resident does not return. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145830	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care West Chicago	201 West North Avenue West Chicago, IL 60185

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:40 AM, R2 said she and R1 were friends. They were both smokers, and he was an angel. R1 has a red pass, which is now a green pass. Red passes could leave the facility up to three times a day two hours at a time without supervision. We would go out on walks together and would talk about life. That day on [DATE], we were outside at 4:15 PM for a smoke break, he mentioned he had this lucid dream about being on another planet seeing other beings and said the dream ended, he was at peace. After the smoke break it was dinner time, R2 saw R1 grab his tray, and after dinner, at 6:00 PM, she went outside to smoke in the front of the building. She saw R1 outside with his coat on and blanket on, and then saw him walk back inside of the building and walk back out. She didn't think anything of it, and went back inside the building. At 8:00 PM, the last smoke break outside, she went outside and R1 did not show up. R1 had never missed a smoke break. She continued her evening and got ready for bed. Sometime about 11:30 PM, she heard the door open and the staff said they were doing a room check. (V12-LPN) asked me if (R1) was in my room and told me (R1) was missing. R2 said she got dressed and went to look for R1. She told the staff he was outside about 6:00 PM, and did show up the 8:00 PM smoke break. R2 said V11 (RN) was in a panic because (R1) had not taken his medications and she started drilling me about his whereabouts. She told the staff to check the sign out sheet; we found the clipboard and (R1) was signed out at 5:57 PM and the sign in time was blank. The male receptionist who was at the desk was new, he knew (R1) did not return. Then I checked the red cards, when a resident leaves the front desk gives them a red pass they have to return when they come back. She checked the entire stack and did not find his red pass. R1 does not have a phone. R2 said she told the staff to call the police, this was unusual for R1, and it was cold outside. She called a mutual friend of theirs, who was a resident at the facility about 1:00 AM, and told him R1 was missing, and asked if he heard from him. R1 had not returned his emails the last couple of days. R2 said she spoke to the police when they arrived about his whereabouts. The next day about 8:30 AM, she was outside and saw several police cars race to the back of the building. After some time, she saw V6 get out of the police car and he was wreck. She knew R1 was found. R2 said the nurse did not know he was missing, the receptionist did not tell the nurse he did not come back, and no one knew how the sign out system worked. She was telling the staff how it works when someone signs out. Now they changed it all. On [DATE] at 12:46 PM, V7 (Behavioral Aide) said she worked a double shift on [DATE] from 6:30 AM to 10:00 PM. She saw R1 last about 4:15 PM, out on the patio during the smoke break. When she left at 10:00 PM, no one knew R1 was missing, there was no code pink called, the nurse did not ask her about or report to her that he was missing. R1 was friendly, liked to walk a lot, and had no behaviors. Residents are allowed to leave the facility for two hours. The receptionist gives them a red pass when they leave, and turn it when they return. The receptionist should notify the nurse if a resident does not return. On [DATE] at 10:50 AM, V9 (CNA) stated, I did my head count at the beginning of my shift just before 4:00 PM, and I saw him then. He eats in the unsupervised dining room and I was in the supervised dining room, so I did not see him at dinner time. It was the end of my shift and I heard the nurses (PM and Night shift) talking that the PM nurse (V11) was not able to give him his medications because she hadn't found him. I had already clocked out, but (V11) said she was going to go upstairs and look for him, and me and the other PM shift nurse left. I didn't know he was missing until the next day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145830	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care West Chicago	201 West North Avenue West Chicago, IL 60185

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	An undated typewritten interview with V6 (Behavioral Aide) states, I came to work a little before 8:00 AM. Nursing staff told me (R1) was missing. I knew that (R1) usually walk in the direction of the golf club, so I went to look there and found him on the wooden path neatly covered with a blanket over him. I immediately called 911 and the dispatcher told me to perform CPR (Cardiopulmonary Resuscitation) if I can. I removed the bag and started CPR. The police came shortly after and took over. (V6 was called 6 times by Surveyors between [DATE] and [DATE]. V6 did not return any of the phone calls and was not able to be interviewed.) On [DATE] at 9:58 AM, V2, Director of Nursing (DON), said she was in the evening on [DATE] doing in-services with the staff. V11 (RN) notified her she could not find R1, she instructed staff to drive around the building and search the facility. She instructed V12 (LPN), the night shift nurse, to call the family and the police. The police were called around 11:15 PM. The police arrived before midnight and we verified with the video he left about 6:00 PM. She received a call the next day around 8:30 AM; R1 was found behind the facility in a wooded area, deceased . She believes R1 had a green community pass. On [DATE] at 9:27 AM, V1 (Administrator) said he was notified on [DATE] R1 was missing when he did not return back from his community pass. (R1) left the facility at 5:57 PM; (R1) had a green pass and could leave the facility unsupervised for two hours. About 11:00 PM, the police were notified and could not locate (R1) when they conducted their search. On [DATE], around 7:00 AM, (V6, Behavioral Aide) found (R1) behind the facility in the wooded area with a bag over his head and blanket over his body, deceased . (V6) called the police immediately. On [DATE] at 2:30 PM, V15 (Police Officer) stated, The (first) call came in somewhere after 12:00 AM. I responded with another officer, I was training. You will have to get the FOIA (Freedom of Information Act) form for any information because I don't want to give you wrong details about anything, but it is all in my report. We had several resources out there, dogs, [NAME], we were searching local businesses in case he went in somewhere to get warm. We didn't find him. That is all in my report. That may take a few days to get because everything has to be completed before they will release any of it. On [DATE] at 11:20 AM, V13 (Detective) stated, Behind the Assisted Living (building next to facility) to the northeast of the facility there is a wooded area. There is a driving area and a walking path back there. He was found ,d+[DATE] feet inside that wooded area. The body had already been removed by the time I got there. Another officer took the initial report that the medication pass was at 9:00 PM, and (R1) wasn't there for the medications at 9:00 PM. They called the police at 1:00 AM, per the police report. According to one of the staff, when a resident has a Level 3 he has the most amount of freedom, and they are required to be back by 6:45 PM. On [DATE] at 2:40 PM V14 (Psych Nurse Practitioner) stated, I had no concerns at all about him. He was very stable. Alert and oriented, very sweet, and involved with many of his peers. I don't think he was ready to live out in the community on his own, but he could go out. I don't know all the facility policies, but I would want to make sure all the residents were supervised because they do have a mental illness diagnosis. R1's Death Certificate was requested on [DATE] and again on [DATE], but it was not available at the time of survey exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145830	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care West Chicago	201 West North Avenue West Chicago, IL 60185

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The undated facility policy (at the time of this incident) titled Behavior Management Level Program states, Level 2 Expectations (Pass with staff only) This pass level will be for a minimum of 30 days prior to being considered for Level 3 Level 2 Privileges- Eligible to participate in 2 additional smoke breaks with supervision in the front of the building. In small level 2 groups. May participate in Level 2 gatherings with activity department. The facility policy titled Therapeutic Leave of Absence dated [DATE] states, .2. Psychiatric Facilities Only: Resident will apply for pass privileges. This will be reviewed by the IDT and the physician and will be signed by all participants. 3. Each resident leaving the premises should be signed out on leave of absence. 4. Establish an agreed upon time frame for return to the facility with the resident and/or the accompanying party. 7. Resident should be signed back in upon return to the facility from leave of absence 8. If a resident does not return to the facility within ,d+[DATE] hours of the agreed upon time without communication from the resident or family representative, the following will be initiated: Family, Physician and Police will be notified. The Immediate Jeopardy that began on [DATE] was removed, and the deficient practice was corrected on [DATE], prior to the survey starting on [DATE]. The facility had taken the following action to correct the noncompliance: 1. R1 is no longer a resident at the facility. Completed [DATE] 2. All Community survival risk assessments were reviewed for accuracy, updated accordingly and all Care plans were reviewed to validate they match. Assessments were reviewed by IDT team composed of Administrator, DON, and Social Service designee. Completed [DATE] 3. All staff have been re-educated on the facilities therapeutic leave of absence policy. Any staff on leave or unavailable staff were educated via phone and again before next scheduled shift. Administrator, Assistant Administrator, DON, and Assistant Director of Nursing/ADON conducted the training. Policy details that all residents leaving the premises should be signed out, establish an agreed upon time frame for return to the facility, sign back in upon return to the facility, and what to do if a resident does not return at the agreed upon time. All new hires and agency staff (if utilized in the future) will be educated on this policy prior to working their first shift. Completed [DATE] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145830	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care West Chicago	201 West North Avenue West Chicago, IL 60185

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Facility receptionists were educated by their supervisor on the pass return protocol; Protocol states Only residents with green pass can leave the facility unsupervised, all residents leaving must sign out and establish an agreed upon time for return. Residents must sign back in upon return from pass. If resident fails to return at the agreed upon time, the 1st floor nurses station will be notified before their next scheduled shift. Competed [DATE] 5. No resident goes out on independent pass without having a current Community survival/elopement risk assessment completed and CP updated. Completed [DATE] 6. The pass privilege list was reviewed by the facility IDT composed of Administrator, DON, and Social Service designee, and compared to the response report of current elopement risk/community survival assessments. Completed [DATE] 7. All residents identified as having exit seeking behaviors were reviewed by a Social Service designee and care plans were updated as appropriate. Completed [DATE] 8. All residents with a history of suicidal ideation/suicidal attempts have their independent pass privilege assessment signed by a physician/provider. Completed [DATE] 9. Updated Medical director on event and details. Medical director notified of incident on [DATE] by the facility DON and reviewed the facility's immediate action plan. He agreed with the immediate action plan. Completed [DATE] 10. Administrator and/or designee will audit 5 residents' 2X per week for 6 months to ensure resident's community skills assessment and care plan are accurate. Completed [DATE] 11. Director of Nursing and/or designee will audit the resident sign in/out log daily for 3 months then 2X per week for 3 months to ensure that all residents are accounted for. Completed [DATE] 12. Community pass policy reviewed with IDT and medical director Completed [DATE] 13. QAPI review with Medical Director to review incident and plan of action. IDT conducts assigned regular rounds during shift to ensure visual monitoring and staff supervision. Action plan will be reviewed monthly at QAPI meeting. Completed [DATE].