STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkshore Estates Nursing & Rehab	6125 South Kenwood Chicago, IL 60637

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** 44314 Based on observation, interviews and record review, the facility failed to supervise and monitor one resident (R1) of 4 residents reviewed for supervision. This failure resulted in R1 eloping from the facility by climbing over the fence surrounding the smoking patio. Finding include: According to a face sheet, R1 is a [AGE] year-old resident admitted to the facility on [DATE]. According to progress notes, R1 eloped from the facility on 04/26/2024. R1's Face Sheet documents the following diagnoses including but not limited to: bipolar disorder, schizophrenia, alcoholic polyneuropathy, local infection of the skin and subcutaneous, cocaine abuse with intoxication, alcohol abuse, tobacco use, hyperlipidemia. R1's Minimum Date Set assignment dated 04/12/2024 indicated R1 has a Brief Interview for Mental Status (BIMS) score of 14, which indicates resident has intact cognitive response. R1's care plan dated 04/09/2024, indicated R1 has a history of substance abuse and has potential for complications such as recurrence of substance use, post-acute withdrawal symptoms, mood and/or behavior disturbance. R1's Nursing Progress Note dated 04/26/2024 authored by V2 (interim director of nursing) documents: Resident AWOL (Absent Without Official Leave), after several attempts this writer spoke with resident on the phone. He denies being in any stress. resident was educated regarding health risks. Stated he would be coming back. Md (medical doctor) and emergency contact were notified. R1's Nursing Progress Note dated 04/27/2024 authored by V2 (interim director of nursing) documents: Call placed to residents' cell. Resident does not plan on coming back to the facility. Police were called to conduct a wellbeing check. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/2024 at 11:05am V4 (maintenance director) stated, I have been the maintenance director here for 2 years. Recently, we have not had any residents attempting to escape from the facility by trying to escape from the exit doors. The smoking patio does not have door to escape by because the door on the fence is locked with a pad lock, so there is no escape route. The only way for a resident to escape from the smoking patio is by jumping the fence. I have heard stories that residents have tried to escape by jumping the fence in the past. A resident tried to escape from the facility a month ago. I heard that a resident did try to escape. The game room door is locked during meals, and to get to the smoking patio, you have to go through the game room door. The smoking patio is closed for meals and the game room doors are locked. The stairs well in the facility have alarms. If a resident will try to enter the stairwell, the alarm will sound. The exit doors have e-grass locks on the doors, and there is a 15 second delay on the doors, because it's still an emergency exit. The exit doors have a code on them and a e-grass pad lock with a 15 second delay, so the doors will open after 15 seconds, when a resident would attempt to open the exit door without a code. There is a security guard sitting on the first floor. The alarms are for everybody to respond to and once you heard the alarm going off, you have to respond, especially because the alarms are loud. The alarm system in the facility is tested every day. I test the alarm systems throughout the day. I am walking around the facility all day and I make sure that the alarm system works. On 05/15/2024 at 12:31pm V1 (administrator) stated, We had an incident with one particular resident eloping sometime in April. R1 eloped. R1 wanted to leave the facility on a community pass prior to eloping. R1 left the facility, unauthorized. R1 wanted to go on pass, but R1 was not eligible to go out on pass, because R1 was not at the facility long enough to be assessed for safety in the community. R1 left the facility. R1 did not sign out against medical advice. Staff responded by looking for R1. R1 has a cell phone. We called him a few times on his cell phone when he eloped, and he informed us that he is safe. R1 told the nurse that called him that he was with a friend and that he will be returning back to the facility, but he did not return back. From my understanding, R1 left through the back door through the smoking patio. I believe R1 climbed the fence on the smoking patio and left. R1 was not accounted for by his nurse on duty, that is how staff realized that R1 has eloped. R1 was not eligible to go out on pass unsupervised, and he left through the patio, I believe by climbing the fence. We called the police, and the police did a wellbeing check on R1. I did not report this elopement to the state agency. I normally don't report an elopement to the state agency. I report abuse to the state agency, but not resident elopement. R1 was not eligible for a pass because he has not been at the facility long enough to be assessed for a community pass. On 05/15/2024 at 1:10pm, V3 (smoking monitor/psych tech) stated, The smoking patio is opened daily starting at 9am after breakfast, and it stays open until 11:20am, around lunch time. The patio opens up after lunch and closes for dinner time. The smoking patio is closed during breakfast, lunch and dinner, so that the residents can eat. During the mealtimes, when the smoking patio is closed, the patio door stays unlocked, but the door to the game room is locked, so that the residents cannot go out into the smoking patio. The patio closes at 11:20am and the residents go to their floors to eat lunch. Today, I took my break at 12pm and I punched back in at 1pm. Between 11:20am and 12 pm today, I went upstairs to monitor the floors, which is what I normally do. When I left the game room/smoking patio area at 11:20am today, I locked the game room door, so that the residents can't access the smoking patio. When the door to the game room is open, the area has to be monitored by staff because the residents will go out into the outside smoking patio, and they need supervision. I worked on April 26, and that day the patio closed at 11:20 and I went upstairs to monitor the floors. My job is to monitor the game room/smoking patio and I go to monitor the resident floors during meals when the smoking patio is closed. The game room doors should be locked for meals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/2024 at 1:37pm V2 (interim director of nursing) stated, I was working on 04/26/2024. Around 1pm, V5 (licensed practical nurse) came to me and told me that she is looking for R1 and she could not find him. V5 was looking for R1 because the psychiatrist was here, and the nurse could not find R1 in the facility. The nurse could not find R1 on the smoking patio either. At the time that V5 informed me that R1 was missing, I called a code pink (code for elopement) and we did a resident head count. V5 did not tell me what time V5 saw R1 last, and I did not ask V5 when she saw R1 last. R1 is safe to be in the community independently, but he has a history of drug abuse. R1 was trying to get an independent community pass and it was explained to him that by him being new to the facility, it would take a while to get that pass. To get an independent pass, the residents have to be here for a certain amount of time, and a lot of assessments have to be done as well in order to determine if a resident is safe in the community. R1 was admitted to the facility on [DATE] and eloped on 04/26/2024. I believe R1 came from the hospital and was being treated for wound infection. When a resident elopes, the administration has not been reporting resident elopements to the state agency. The only time that administration reported an elopement to the state agency is when a resident has altered mental status. At the time that R1 eloped, he did not have an independent community pass, but was alert and oriented. I spoke to R1 on the phone several times after R1 eloped, and R1 said that he was returning back to the facility. I offered to have R1 picked up by a facility staff member, but R1 refused and told me that he will be back. R1 was the responsible party for himself. R1 would have been eligible and qualified to sign an AMA form (against medical advice) to sign himself out of the facility. R1's cognition was intact and R1 was eligible to sign consents for himself and sign an AMA form at the time of the elopement. R1 was independent for activity of daily living (ADL) care and was only at the facility for wound care. I believe the facility policy for reporting resident elopement to the state survey agency is that we only have to report that a resident eloped when the resident's cognition is not intact, and the resident is not alert and oriented. On 05/16/2024 at 10:55am, V5 (licensed practical nurse) stated, On 04/26/2024, I arrived on the unit, and I did resident rounds. I started passing medication at 8:30am. I was passing the medication and the floor got a little busy. It got busy and I had to send a resident to the hospital, so it was busy. At 9am, residents start going downstairs to smoke. The last time that I saw R1 on the unit was when I was doing my rounds at 8am. I think it was close to 11am, the psychiatric nurse practitioner came to do rounds and I wanted the nurse practitioner to see R1, and R1 wasn't on the unit. I called downstairs to see if R1 was outside on the smoking patio. I called down to the security desk and the security went to check the game room and the outside patio. The security called me back and said that R1 was not there. I informed V2 (interim director of nursing) that R1 was missing, and a code 99 (code for missing resident) was called. We made rounds and we had to account for every resident on each unit, and R1 was not located. After that, I turned this over to V2, and V2 took over from that point. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/2024, surveyor was conducting an inspection of the facility alarm system on all exit doors of the facility with V4 (maintenance director). Surveyor noted that all exit doors were secured by a key code pad and e-grass locks. At 11:39am, surveyor (accompanied by V4) entered the game room, which leads to the smoking patio door to perform an inspection of the outside patio. Surveyor observed the door to the game room to be wide open and the door leading to the outside smoking patio unlocked, with no staff member present. Surveyor inspected the area, and returned to the game room at 11:58am, to find the door to the game room wide open and the door leading to the outside smoking patio unlocked, with no staff present to monitor and secure the area. Surveyor returned at 12:25pm and the game room door was observed to be wide open and patio door unlocked with no staff supervision. Surveyor inspected the area again at 12:45pm and observed the game room door wide open with no staff supervision of the game room/patio door. Surveyor tested the patio door each time and when surveyor opened the door leading to the outside smoking area, the alarm did not sound. Guidelines for Standard Supervision and Monitoring Policy (dated 05/17/2024) states: This guideline emphasizes a proactive intervention promoting enhanced physical and psychosocial well-being. The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs. Unplanned Discharge (AMA/AWOL) Policy (undated) states: Discharge AWOL (Absent Without Official Leave) Residents who leave the facility with staff knowledge, without following proper procedure and/or without signing AMA will be considered AWOL. Policy and Procedure Regarding Missing Residents and Elopement (undated) states: It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs. All residents will be assessed for behaviors or conditions that put them at risk of elopement. (5.) Until the resident is located the Administrator/designee will serve as a liaison between the law enforcement agency, the resident's representative, the physician, and the facility. (6.) Report to the State Department of Health if incident meets reportable criteria.