STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146164	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Nursing Center	4314 South Wabash Avenue Chicago, IL 60653

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** 15301 Based on interview and record review, the facility failed to complete an elopement risk assessment, develop and implement an elopement care plan, and provide a secure physical environment to minimize the risk of unwitnessed elopement for a resident with a known history of successful elopement for one of three residents (R1) reviewed for supervision. These failures resulted in an incident of successful elopement that the facility staff were not aware of until the resident had already left the facility. R1 was located two days later at his mother's home. Findings include: R1's medical record (Face Sheet) documents R1 is a [AGE] year old readmitted to the facility on 2.13.2024 with diagnoses including but not limited to: Major Depressive Disorder, Paranoid Schizophrenia, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Delusional Disorders, Bipolar Disorder, and Hallucinations. R1's MDS (Minimum Data Set of 2.20.2024) documents a BIMS score (Brief Interview for Mental Status) of 15 or cognitively intact. Elopement Risk assessment dated 4.1.2024 documents a score of 11 and high risk for elopement, and resident has a history of elopement. Form was completed after resident eloped from the facility. R1's Care plan documents, R1 has history or current behavior of unauthorized departure from the facility. Refusal to stay in the facility. 4.1.24: Resident left the facility unauthorized. Care plan was not developed until after resident had eloped from the facility on 4.1.2024. 4/1/2024 11:42 Incident Note for R1 documents, Approx. 11 am, this writer went to give the resident his monthly injection, but he was not in his room. This writer and the floor staff searched the floor and was still unable to locate him. Security (PRSA) was notified, and the missing person protocol was initiated. All staff searched the premises and the surrounding area and was still unsuccessful with locating him. 911was notified at 11:30 and a police report was filed, case number (JH208833). MD, SS, and the facility administration were all made aware. The POA was notified and tried to reach him by phone but stated his cell phone was turned off. The resident was last seen by this writer going for a smoke break at approx. 9am. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/1/2024 14:34 Social Service Note for R1: Writer was informed around 11:05 am that resident was missing. Staff members on duty searched each floor and resident was not accounted for. His Mother was notified and was asked to call residents phone, but phone was turned off. She was informed to be on the lookout for him and to call if he shows up at her residence. 911 was notified at 11:30am and a police report was filed (case #JH208833). Writer also called the hospitals nearby and no report of resident was listed. MD, DON, and the facility administration were all notified as well. Investigation is open and will update as needed. 4/1/2024 22:30 Daily Note for R1: The resident still did not come back to the facility and his mother called and said she will call us if he comes back. 4/2/2024 12:44 Social Service Note for R1: Resident has yet to return back to the facility at this time. Writer contacted his mother to get an update on his whereabout, she hasn't gotten in contact with him and is currently waiting for his phone to be turned on so they can track his location. The hospitals were also contacted but no record of resident admitted at this time. Staff will continue to follow up as needed. 4/3/2024 13:34 Social Service Note for R1: Resident has yet to return back to the facility at this time. Writer reached out to his mother and got no response at this time. The hospitals were also contacted but no record of resident admitted . Staff will continue to follow up as needed. 4/3/20242 2:54 General Note for R1: Per family member (Mother) resident (R1) came home. Writer instructed her to call 911 and cancel previous missing person's report. 5.7.2024 at 11:40 AM V2 (Director of Nursing) said, regarding R1, We were struggling to get him to take his medications. On the day he eloped, we were getting ready to give (R1) his medication (Haldol Dec). We went to look for him, that's when we noticed he was gone. Staff looked for him throughout the facility. Staff noticed him on the patio, but no one remembered seeing him walk away (from the facility). 5.7.2024 at 11:58 AM V3 (Activity Aide) said, That day (when R1 eloped), there were only two of us (to monitor the smoking patio) at nine (9:00 AM smoking break), me and (V6 Social Service). (V6) led the residents outside onto the patio. I passed out cigarettes to the residents, (V6) lit them. (V6) was by the gate, I was back and forth, pushing residents in wheelchairs (into and out of facility). I left the patio for a split second to return the cigarettes to the front desk, when I came back the majority of the residents were back in the facility. The gate was messed up, you couldn't close it. It's fixed now. There wasn't enough staff on the patio during the nine AM smoking break. There should be three to four on the patio during smoking breaks. The nurses noticed around ten AM that (R1) was gone. We checked the building; we couldn't find him. V3 said R1 would come down to the first floor, and when asked by staff where he was going, R1 would say he called himself an Uber. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5.7.2024 at 12:24 PM V5 (Activity Director) said, I was here when he (R1) eloped. I was in my office in the basement. I went to the second floor to pass out an activity. I overheard staff on the phone, asking other staff if they had seen him. I went back down to the basement to check for him. V5 said, During smoke break, staff monitor residents for safety, that they don't leave. V5 said, There should be at least three staff members on the smoking patio during smoking breaks because we have a lot of smokers and residents in wheelchairs who need to be pushed in and out of the facility, they (resident) could get hit by a car or lost if they are not familiar with the area. Smoke break will be suspended if there are not at last three staff members (to monitor break). 5.7.2024 at 12:52 PM V6 (Social Service) said regarding R1's elopement, At this point I can't remember what happened. I would need to confer with my boss. I was told not answer your questions to a certain extent. 5.7.2024 at 1:18 PM V7 (Psychiatric Rehabilitation Services Coordinator) said, regarding R1, I wasn't here when the incident occurred, I came in at 11, the incident had already occurred. There are three to four staff on the smoking patio during smoking break to monitor for elopement, medical reasons and for paraphernalia. I make sure that there are at least three staff members before I open the door. The patio gate was repaired after R1 eloped. (V6), he's new. He (V6) doesn't understand how this process works. I told him to confer with (V9 Psychiatric Rehabilitation Services Director) to confirm dates, get his facts together before speaking with you, he (V6) should have consulted with me when he knew that you wanted to speak with him. 5.7.2024 at 3:19 PM V8 (Psychiatric Rehabilitation Services Aide) said, I called a code green when I was informed that (R1) was missing. The gate on the west side of the patio was open, I not sure that it's been fixed. I heard he escaped from the previous facility he was at. 5.8.2024 at 10:52 AM R2 said he was on the smoking patio when R1left the facility. R2 said, He (R1) got out the gate. I seen (sic) him when he went out that gate. I didn't want to tell them (staff). They (staff) don't be watching them (residents). (V3) and (V6) were on the patio, that's it. 5.8.2024 at 8:28 AM V11 (R1's Guardian) said R1 has a history of elopement; he walked away from another facility and went to the hospital. 5.8.2024 at 11:53 AM V9 (PRSD) V9 and Surveyor reviewed R1's Quarterly/Annual assessment. V9 said, (R1_) was readmitted to the facility on 2.13.2024. I started but did not complete (R1's) Quarterly/Annual assessment. I completed that he had a history of elopement. (R1) eloped from the previous facility he was at. I would consider him an elopement risk based on his history; he should not be out on his own in the community. Facility's Elopement Policy (Effective Date 3.2021) documents in part: -Residents making an adjustment to the facility, or who do not understand where they are, may be subject to leaving the facility without supervision. -Residents should be evaluated for elopement risk on admission and throughout their stay by the interdisciplinary care planning team. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Resident Incentive and Contingency Management Program policy (updated 8.15.2021) documents I am aware that there is no independent outside pass privilege associated with Level 1. Resident Incentive and Contingency Management Program form signed by R1 and V6 and dated 3.8.2024 documents: I understand that I am currently on Level 1.