STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E361	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Quad Cities	1403 9th Avenue Silvis, IL 61282

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(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** 50627 Based on interview, observation and record review, the facility failed to provide supervision to a wandering resident with a known mental health history and previous elopement, conduct an assessment and investigation to determine risk of elopement, develop a care plan addressing elopement risk, and ensure the physician was notified of a resident elopement for one of three residents (R1) reviewed for elopement in the sample of three. These failures resulted in R1, a resident with a known history of multiple psychiatric issues, eloping from the facility at night during freezing temperatures, without staff knowledge, and was later found wandering over a half of a mile from the facility, near a busy highway, with urine saturated pants, confusion, and agitation. These failures resulted in an Immediate Jeopardy. An Immediate Jeopardy situation was identified to have started on 12/27/2024 when R1 eloped from the facility. The facility failed to identify and investigate R1's incident as an elopement and failed to implement interventions to prevent future elopements. On 2/3/2025 at 2:44 PM, V1 (Regional Director of Operations) was notified of the Immediate Jeopardy situation. While the immediacy was removed on 2/4/2025, the facility remained out of compliance at a Severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of the facility's removal plan and quality assurance monitoring. Finding Include: (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's current Care Plan, dated 1/20/25, documents R1 has diagnoses including but not limited to major depressive disorder, anxiety, schizoaffective disorder, bipolar disorder, and bipolar current episode manic severe with psychotic features. This same Care plan documents (R1) has behavior problem related to schizoaffective disorder. (R1) is known to have/has history of hallucinations and/or delusions. Verbal behaviors symptoms: Threatening, allegations of mistreatment by caregivers, cursing, hitting, scratching, pacing related to schizoaffective disorder with history of paranoid behavior. (R1) has conviction history of domestic battery related. Needs additional monitoring to ensure respect of other resident's rights. (R1) has diabetes mellitus. Avoid exposure to extreme heat or cold. (R1) is at risk for falls related to chronic obstructive pulmonary disease (COPD), diabetes mellitus type II, depression, anxiety, schizophrenia, insomnia, and medications that (R1) receives. (R1) has shortness of breath related to COPD. R1's Elopement Evaluation assessment, dated 11/15/24, documents R1 is not at risk for elopement. R1's Behavior Monitoring and Interventions reports for December 1, 2024-January 28, 2024, document R1 had behaviors of cursing, screaming and threatening others, anxious/restless and wandering on 12/12/24 at 10:39 AM. R1 had behaviors of pacing and rummaging on 12/26/24 at 9:46 AM. R1 had behaviors of pacing, refusing care, agitation, cursing, screaming and threatening others. R1's current medical record has no documentation of a new Elopement Risk Assessment being completed following R1's increase in wandering behaviors. R1's current medical record also had no documentation of the development of a comprehensive care plan to address R1's exit seeking behaviors with interventions to prevent R1 from eloping from the facility. R1's current Physician order sheet, dated January 2025, documents R1 has orders to receive the following psychotropic medications to treat R1's current psychotic diagnoses and behaviors: haloperidol decanoate (antipsychotic) intramuscular solution 100 MG/ML (milligrams/milliliter) 1 ml (milliliter) intramuscularly in the morning every 14 day(s); lorazepam (antianxiety) 2 mg (milligrams tablet by mouth every morning, afternoon, and bedtime; divalproex sodium oral capsule delayed release sprinkle 125 mg two capsules orally two times a day; haloperidol 5 mg tablet by mouth two times a day. R1's progress note, dated 12/27/2024 at 5:26 AM, documents (R1) refused all the medications. R1's progress note, dated 12/27/2024 at 9:43 PM documents Around 8:30 pm (R1) approached nurses' office with intention to use the phone. She (R1) called her mother (V3). Shortly after (R1) became agitated with the caller and threw the phone at the nurse. Shortly after (V3) called back and stated she is used to the verbal abuse, and she would be in to bring (R1) some things tomorrow. At this time (R1) was in her room. Around 9:30 PM (R1) was observed walking bumping into any and everything in her way. She appeared upset. (R1) walked out of the facility. The nurse (V17/Licensed Practical Nurse) and two CNAs (Certified Nursing Assistants/V9, V11) followed (R1) outside to await EMTs (Emergency Medical Technicians) and police. When the EMTs arrived (V17) explained (R1) was agitated and had already thrown a phone and could possibly be a danger to the other residents, (R1) was taken to the ER (emergency room) for further evaluation. Nurse notified DON (V2, Director of Nursing) and (V3). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's current medical record has no documentation of the facility identifying or investigating R1's incident on 12/27/24 as an attempt to elope from the facility. There was also no documentation of a new Elopement Risk Assessment being completed following R1's attempted incident of elopement. R1's current care plan, dated 1/20/25, had no documentation of the development of a comprehensive care plan being developed following R1's attempted elopement. R1's progress note, dated 1/8/2025 at 1:05 PM documents R1 refuses medication every day. R1's progress note, dated 1/12/2025 at 9:37 PM documents (R1) refused supper and medications this shift. R1's progress note, dated 1/13/2025 at 3:04 PM and completed by V2 (DON) documents (R1) was talking to (V3) and got upset and was screaming and yelling this occurrence (happened) several times today. (R1) then wanted to go out and smoke before lunch resident was told she needs to wait until smoke break at 12:45 and she continued to yell at this nurse and locked her wheelchair, stood up and (R1) tried to strike this nurse and just continued to come towards this nurse screaming and trying to hit the nurse, she did make physical contact. Staff were able to get the resident to sit back in her wheelchair and (R1) went to her room, (R1) then came back to the front entry way demanding to be taken out. (R1) was then educated she can go out for a cigarette after lunch then (R1) started yelling and demanding to be taken out. This nurse tried to educate (R1) and she went to her room at that time. R1's Behavior Monitoring and Interventions reports for December 1, 2024- January 28, 2024, document the following behavior occurrences after R1's attempt to elope on 12/27/24: 1/4/25 at 9:52 AM pacing, refusing care, agitation, cursing, screaming and threatening others; 1/7/25 at 10:01 AM pacing; 1/15/25 at 9:49 PM accusing others, cursing, screaming, threatening others, and expressing frustration/anger at others. R1's progress note, dated 1/16/25 at 6:20 PM and completed by V8 (Licensed Practical Nurse) on 1/20/25 at 7:18 AM, documents Late Entry: (R1) came to use the phone to talk to (V3). (R1) got upset about (V3) not coming to see her today. (V8) went to pass meds to another patient. (V8) came back to the nurse's station and (V14, R4's Family member) stated a patient followed her out the door. (V8) ran out the door and to the end of the street after the patient (and) did not see her. (V8) called the DON (V2) and told her (R1) got out the nursing home. I sent two CNAs (V10, V11) to walk around to go look for (R1). The CNAs did not see (R1). I called the (local) police to let them know (R1) got out. The CNAs came back with (R1). I called (V2) back to let her know we found (R1) by the baseball field with the police. R1's Police Report dated 1/16/2025, documents R1 was found in the road by a local grocery store. She was walking west bound with her jacket half hanging off and she seemed out of it. The report also documents V16 spoke with staff who stated they believe R1 snuck out of the building with a family member that came to visit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to Google Maps, the distance from the facility to the location were R1 was found was 0.5 miles. On 1/28/25, observed at the end of the facility's driveway was a frontage road with a speed limit of 30 miles per hour. There is a metal chain link fence separating that road from a four-lane state highway with a speed limit of 45 miles per hour. The chain link fence had several breaks in the fence large enough for an adult to fit through. The location that R1 was found was near a local grocery store on a road with constant traffic with a speed limit of 30 miles per hour. The local weather historical data report from The Weather Channel, located at https://weather.com/weather and retrieved on 1/29/25, documents the weather for [NAME], Illinois on 1/16/25 was a high of 40 degrees daytime temperature and a low of 23 degrees nighttime temperature. This same report documents the time of sunset on 1/16/25 in [NAME], Illinois was 4:58 PM. On 1/28/2025, at 10:10 AM, V8 (LPN/Licensed Practical Nurse) stated, on 1/16/2025, at 4:45 P.M, V14 called the facility and said, R1 is outside the building. V8 stated she dropped the phone and ran outside the front door looking for R1. V8 stated later in the evening after calling V14 back that R1 followed V14 out the front door after V14 entered the passcode to leave. V8 stated once she realized R1 was not anywhere outside the facility within her visual range, she came back into the building and told V10 (CNA/Certified Nursing Assistant), V11, and V9 R1 was missing. V8 stated she instructed V10 and V11 to look by vehicle to search for R1 since V8 was the only nurse in the building. V8 stated she called V2 (DON/Director of Nursing) and told her R1 was missing. V2 instructed V8 to call 911. V8 stated around 5:30 P.M, V10 and V11 returned to the facility with R1, and assisted R1 back to her room. V8 stated R1 has been off her medications for a long time prior to this elopement and refuses daily to take medications and refuses cares daily. V8 stated R1 gets very easily agitated and verbally abusive with staff daily, especially when V3 (R1's Family Member) is unable to visit R1. On 1/28/2025, at 10:34 AM, V9 stated that on 1/16/2025, at 4:45 PM, he was coming down the women's hall when he heard V8 asking Where is R1? V9 stated he and V10 and V11 searched the hall and searched R1's room and could not locate R1. V9 stated at this point V10 and V11 got into V10's car and went to search for R1. V9 stated that this day was cold and cloudy and about 20-30 minutes later V10 and V11 returned with R1 in the V10's car. V9 stated R1 had pajama pants and pajama shirt on but does not recall R1 having a coat on. V9 stated R1 also wandered out another day on 12/27/2024, and he saw R1 in the parking lot upset and verbally abusing V5 (CNA). R1 was refusing to come in. On 1/28/2025, at 10:52 A.M, V10 stated, on 1/16/2025 around dinner time she was asked to look for R1. V10 stated V8 was in a panic and stated she cannot find R1. V10 stated V8 told her that V14 (R4's Family member) called stating she saw R1 walking down the street. V10 stated this day was super cold and freezing outside. V10 stated she took her car and V11 assisted her to look for R1. V10 stated she drove past a local grocery store and headed towards a local pharmacy when she saw R1. V10 stated once she drove up and got out of the car, R1 had her jacket half on with one arm in one side, and her other arm behind her back. V10 stated R1 was holding her pajama pants up with the hand behind her back because her pants were soaking wet with her urine. V10 stated R1 was very upset and being verbally abusive towards V16 (Police Officer) and did not want to return to the facility. V10 stated V16 told R1 that if she did not return to the facility, he would have to call 911 and have her transferred to the local hospital. V10 stated R1 was angry but agreed to get into V10's car and go back to the facility. V10 stated R1 got into her car and said a few profanity statements and allowed V11 to go and get a wheelchair in the facility and take her back to her room at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/28/2025, at 12:21 P.M, V11 stated, on 1/16/2025 at 4:45 PM, she was working on the men's side of the facility. V11 stated V8 came to her with concern in her voice stating R1 got out and was instructed to look for her. V11 stated she got into V10's car and drove across town looking for R1. V11 stated once they saw R1, R1 was in her pajama top and bottoms, R1's pajama bottoms were soaked in her own urine, had a blue coat on, and stated that it was cold outside. V11 stated R1 was combative and verbally abusive towards V16. R1's Psychiatry Note written by V15 (R1's Psychiatric Nurse Practitioner), dated 1/20/2025, documents, (R1) has a history of schizoaffective disorder, generalized anxiety disorder, and nicotine dependance. Previously received Haloperidol, Divalproex Sodium. Has refused per chart review. Visited on this day due to concerns from nursing reporting behavioral concerns directly related to wearing clothes for extended period soiled from incontinence and refusal in care possibly for days. Since not taking her antipsychotic has displayed increasingly impulsive and risky behavior. Recent behaviors include attacking another resident, becoming aggressive towards staff when attempting care, and running into traffic last month. Subsequently discharged from the ED (Emergency Department) with no new orders. Behavior has been noted to stay up many nights per chart. Unable to ascertain sleep hours. Mental status during day includes lying in bed most of the time, behaving aggressively, refusing care, or laying with eyes closed, responding verbally throughout the day. Suspected delirium due to dysregulated sleep-wake cycle, stopping antipsychotic and mood stabilization medications, and frequent dosing of Lorazepam administered per hospice. This same note documents, Observed (R1) on this visit lying awake in her bed, disheveled and disoriented. Asked if she knows where she is, why she is here, no response given, she just stares. Only will scream 'Get the F out.' Presents as medicated with limited insight, poor judgement, and limited cognition. R1's baseline ability to answer questions alert and oriented times three allows her to make decisions, but she is cognitively and legally incapable of keeping herself safe. With (R1) currently off antipsychotics with behaviors posing a physical risk to herself. R1's current care plan, dated 1/20/25, continues to have no documentation of a comprehensive care plan to address R1's behaviors that put R1 at risk for elopement, R1's elopement attempt on 12/27/24, nor R1's elopement on 1/16/25. As of 1/27/25, R1's medical record has no documentation of a revised Elopement Risk Assessment. On 1/28/2025 at 1:00 P.M, V2 (DON/Director of Nursing) stated the facility has not had any residents who have eloped. V2 confirmed there was no investigation regarding R1's elopement on 1/16/25 nor did R1 have a comprehensive care plan addressing R1's risk for elopement prior to or after R1's elopement on 1/16/25. V2 also stated she did not have an elopement risk assessment for R1 after R1's original assessment on 11/15/24. R1's progress note, dated 1/21/25 at 12:49 PM and completed by V2 documents Spoke to (V15) and she agreed with the medication changes and the decline in (R1) being ambulatory. We can discontinue the 15-minute checks. Hospice was here and agreed to this plan of care. R1's current medical record has no documentation of 15-minute wellness checks being completed at any time prior to R1's progress notes on 1/21/25. On 1/29/25 at 11:35 AM, V2 stated the facility does not have documentation to show R1 was provided 15-minute safety checks or one on one supervision upon returning to the facility on [DATE]. V2 stated We did not have to implement 15 min checks with (R1) so there's no documentation of that. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/29/2025, at 12:12 PM, V13 (R1's Physician) stated, on 1/16/2025 he does not recall being notified of R1's elopement. V13 stated that R1 is easily confused and depending on her state of mind that day, it is hard to say if R1 would be able to comprehend safety awareness when out in the community. V13 stated R1 would not have possibly been aware if it was too cold or if she was in any danger in the community due to her unstable mind set. V13 stated that he was aware that R1 is not taking her medications and it is hard to say how unstable R1 will get while being unmedicated. On 1/30/2025, at 9:45 AM, V15 (R1's Psychiatric Nurse Practitioner), stated R1 is confused and has an untreated diagnosis of psychosis and behavioral issues. V15 stated she became aware of R1's elopement on 1/16/2025 by the nursing staff when she came in for R1's first visit on 1/20/2025. V15 stated R1 is not able to make self-decisions and R1 is not in her right state of mind. V15 stated R1 refused to comply with her visit on 1/20/2025 and she feels that a psychiatric facility would be best, but due to R1's verbal and physical abuse towards staff and residents, it makes it very had to find a facility to accept her. The Facility's Code Pink-Missing Resident/Elopement Policy, dated/revised 04/2023, states, Policy Guidelines: The facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a process to assess all residents for risk for elopement, implement risk reduction strategies for those identified as an elopement risk, and institute measure for resident identification at the time of the admission. An Elopement Risk Assessment is completed on all residents a time of admission, quarterly and with any increase in exit seeking or wandering behaviors. A facility-approved risk evaluation tool (or scoring system) is utilized. The evaluation is based on various risk factors that may precipitate an elopement event. Any resident who exits facility unaccompanied is approached according to accepted guidelines as follows. Director of Nursing or designee to contact legal representative/responsibly party, attending physician, and inform them of the incident. If the resident is placed on increased supervision, safety checks are documented in the resident's record each shift for the duration of the increased supervision. Complete a new elopement risk assessment. When a resident is determined to be missing, if the resident has not been found after an immediate initial search, the Administrator or designee calls the local police and files a missing person's report. Administrator provides the officer with a picture and other pertinent information. The Administrator notifies the family and attending physician if the resident is not found and documents in the electronic health record. Incident Report to the state authorities as required. When a resident has been found, Director of Nursing or designee to contact legal representative/responsible party, attending physician, and inform them of the resident's status. The residents plan of care is updated, including, additional measures such as an electronic monitoring device if not in current use, 15-minute safety checks or 1:1 supervision. A Missing Resident form is completed, and all staff involved sign the form. Documentation, all elopement attempts and events are documented in the resident's record. Physician orders following notification, Incident Report, indicating when the resident returned and condition of resident, and complete a new Elopement Risk Assessment. The Facility Assessment, dated 11/2024, documents the facility has an average census of 30 residents with a maximum population of 36 residents. This same assessment documents the facility has 15 residents receiving Mental Health treatment and 15 residents with Behavioral Health needs. An Immediate Jeopardy situation was identified to have started on 12/27/2024 when R1 eloped from the facility. The facility failed to identify and investigate R1's incident as an elopement and failed to implement interventions to prevent future elopements. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/3/2025 at 2:44 PM, V1 (Regional Director of Operations) was notified of the Immediate Jeopardy situation. The facility submitted an abatement plan on 2/3/2025 and was advised by the regional office to make revisions before it would be accepted. The facility submitted the revised abatement plan on 2/4/2025. The final abatement plan was submitted and accepted on 2/4/2025. On 2/4/2025, the abatement plan was confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. Facility ensured all residents are safe and not at risk and psychosocial needs are being met. The facility evaluated all residents' community survival assessments on 1/29/25 by V22 (Regional Social Services Director). 2. New Elopement Assessments were completed on all residents to ensure appropriate services are in place. These were completed on 1/29/25 by V23 (Regional Nurse Consultant). 3. Directives have been posted at timeclock and nurses' station with the procedure to follow when any signs of elopement occur. On 1/29/25 signs were posted at time clock and nurses' station for above by V1 (Regional Director of Operations). 4. All staff educated on elopement policy, mental disorders, change of condition reporting, door alarm policy, and community survival/pass on 1/29/25 by V23. 5. Residents that have severe MI (mental illness), history re-evaluated for appropriate interventions 1/29/25. 6. All residents assessed to ensure resident based intervention care plan services are in place. Initiated and completed on 1/29/25 related to severe MI (mental illness), and elopement by V22 (Regional Social Services Director). 7. All resident charts were audited for elopement, community survival, and community pass on 1/29/25 by the IDT (Interdisciplinary) team. 8. QAPI meeting held to ensure compliance on 1/29/2025. 9. On 1/29/25, it was initiated to review and discuss daily in morning meeting regarding residents identified by the facility as requiring services for mental illness. The facility will notify psychiatry and medical physician for guidance for 1:1, 15-minute checks or hospitalization . Notifications will be made immediately by nursing or social services. This is ongoing. 10. The facility door code was changed. All visitors and family will be assisted with exiting the facility. This was completed by maintenance on 2/4/2025. 11. Agency staff were educated on all policies via their agency portal before starting their shift. They are required to read and acknowledge. They will be in serviced again once in the building. Agency staff were educated on 1/29/2025 by V23.