

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  14E392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2024
NAME OF PROVIDER OR SUPPLIER  West Chicago Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 928 Joliet Road 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</b></p> <p>Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse. This applies to 1 of 3 residents (R9) reviewed for resident-to-resident physical abuse.</p> <p>The findings include:</p> <p>On 10/29/2024 at 11:15 AM, R9 said last week she told R7 to stop being rude to other residents in the dining room. R9 said R7 became upset and started to yell at her. R9 said when she was standing in line for her medications, R7 walked by her and shoved her against a bookcase. R9 said she sustained an injury to her left arm. R9 showed the surveyor her left arm, R9 had a linear abrasion to her forearm which appeared to be healing. R9 said R7 then walked by her again and punched her cold cut in her left eye. R9 said the staff then separated R7 from her. R9 said V15 (Licensed Practical Nurse/LPN) placed ice on her left eye and thankfully she did not get a bruise. R9 said she was scared. R9 said R7 then continued to be aggressive towards the staff and she had to be taken to the hospital.</p> <p>The EMR (Electronic Medical Record) shows R9 was admitted to the facility on [DATE]. R9 has multiple diagnoses including, bipolar disorder, anxiety disorder, and diabetes. R9's MDS (Minimum Data Set) dated September 30, 2024, shows R9 is cognitively intact and able to perform all ADLs (Activities of Daily Living) independently. R9's care plan, initiated June 20, 2024, shows R9 is at risk for abuse/neglect based on her comprehensive mental health.</p> <p>The EMR shows R7 was admitted to the facility on [DATE], and was involuntarily discharged from the facility on October 22, 2024. R7 had multiple diagnoses including major depressive disorder, generalized anxiety, asthma, suicidal ideation, bipolar disorder, and psychotic disorder. R7's MDS dated [DATE], shows R7 was cognitively intact and was independent with all ADLs. R7's MDS continues to show R7 had verbal behaviors directed towards others for one to three days during the MDS observation period, and other behaviors directed towards others daily.</p> <p>On October 22, 2024, at 6:08 PM, V15 (LPN) documented, [R7] and [R9] started fighting. [R7] hit [R9] to face.</p> <p>On October 22, 2024, at 5:07 PM, V27 (PRSC-Psychiatric Rehab Social Counselor) documented, Staff observed [R7] punch another resident (R9) in the face. Staff immediately intervened. On October 29, 2024, at 2:26 PM, V27 said, I saw [R7] punch [R9] in the face.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 29, 2024, at 1:28 PM, V15 (LPN) said, I was [R9's] nurse the day of the incident. I told the resident to take her medications. She was taking her meds and [R7] came up from behind her and water went everywhere. I saw [R7] punch [R9] in the face. We called a Code Orange because there was a combative situation, and all the CNAs (Certified Nursing Assistants) came. It takes a lot of people to stop [R7]. [V26] (Activity Aide) was also punched by [R7]. [R9's] arm was injured during the situation.</p> <p>On October 29, 2024, at 2:00 PM, V3 (PRSD- Psychiatric Rehab Social Director) said she was present in the facility on the day of the situation between R7 and R9. V3 said R7 was screaming at R9. R7 walked towards R9 and punched R9 in the face. V3 said, I saw [R7] punch [R9] in the face.</p> <p>On October 30, 2024, at 9:07 AM, V26 (Activity Aide) said, I saw an altercation between two residents. [R7] was trying to attack [R9]. We tried to de-escalate the situation, and [R7] kept trying to move forward and she ended up punching me in the face. I had a bruise on my lip and a headache following the incident.</p> <p>The facility's policy entitled, Abuse, effective 3/2022 shows: Policy: This facility affirms the right of our consumers to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of consumers. Definitions: Physical Abuse is the infliction of injury on a consumer that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</b></p> <p>Based on interview and record review, the facility failed to have physician documentation to show the specific resident needs the facility could not meet for residents who were involuntarily discharged , and the efforts the facility made to meet those needs for a resident. The facility also failed to re-evaluate if a resident was able to be readmitted at the time of discharge from the hospital. This applies to 2 of 5 residents (R1 and R7) reviewed for discharges.</p> <p>The findings include:</p> <p>1. The EMR (Electronic Medical Record) shows R7 was admitted to the facility on [DATE], and was involuntarily discharged from the facility on October 22, 2024. R7 had multiple diagnoses including major depressive disorder, generalized anxiety, asthma, suicidal ideation, bipolar disorder, and psychotic disorder.</p> <p>R7's MDS (Minimum Data Set) dated September 13, 2024, shows R7 was cognitively intact and was independent with all ADLs (Activities of Daily Living). R7 was always continent of bowel and bladder. R7's MDS continues to show R7 had verbal behaviors directed towards others for one to three days during the MDS observation period, and other behaviors directed towards others daily.</p> <p>The EMR shows V3 (PRSD-Psychiatric Rehab Social Director) provided a Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents form to R7, dated October 22, 2024. The form shows, The safety of individuals in this facility is endangered and R7 was being transferred or discharged to a local behavioral hospital. The form also shows, As discussed with [V7] on October 22, 2024, and as documented in your clinical record pursuant to Section 3-408 of the state law, the reason for this proposed transfer or discharge is: the physical safety of other residents, the facility's staff or visitors.</p> <p>On October 29, 2024, at 2:26 PM, V27 (Psychosocial Rehab Services Coordinator) said, she saw R7 punch R9 in the face. On October 22, 2024, at 6:08 PM, V15 (LPN-Licensed Practical Nurse) documented an altercation between R7 and R9.</p> <p>Facility documentation shows R7 was sent to the local hospital with emergency personnel and the involuntary discharge paperwork.</p> <p>As of October 30, 2024, at 1:04 PM, the facility did not have documentation by V4 (Physician), V21 (Psychiatrist), or V28 (NP-Nurse Practitioner) to show the specific needs the facility could not meet, the facility efforts to meet those needs, and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met by the current facility.</p> <p>2. R1's EMR showed an admitted [DATE] with diagnoses of schizophrenia, epilepsy, anxiety, myopia, astigmatism, and hyperlipidemia. R1's MDS dated [DATE], shows R1 had behaviors not directed towards others daily. R1's MDS dated [DATE] showed she was permanently discharged from the facility and not anticipated to return.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/2024 at 2:22 PM, V1 (Administrator) said R1 had been a long-term resident at the facility for four years receiving inpatient mental health services. V1 said on 10/18/2024, R1 was upset regarding her pregnancy. V1 said the facility staff allowed R1 to leave the facility unsupervised and said the facility felt [R1] left the facility AMA (Against Medical Advice). V1 said R1 was found by her family and the local police soon after. V1 said the police informed her R1 was still the facility's resident and needed emergency psychiatric services for her safety. V1 said the facility completed R1's petition because they were concerned. V1 said the facility permanently discharged R1 on 10/18/2024 and had made no attempts to follow up with the hospital on R1's condition for readmission because they still felt R1 had left AMA from the facility, despite the facility indicating R1 was a resident at their facility when completing her petition.</p> <p>On 10/25/2024 at 12:00 PM, V2 (Director of Nursing/DON) said she was present on 10/18/2024 when R1 was upset and was allowed to leave the facility unsupervised. V2 said R1 was not informed or given an AMA form and an IVD notice on 10/18/2024 when she left the facility. V2 said the facility did complete a petition for R1 because they were concerned about her safety.</p> <p>On 10/25/2024 at 3:30 PM, V18 (R1's brother) said the facility had R1 petitioned to the hospital on 10/18/2024 due to an episode of a mental crisis. V18 said R1 remained inpatient at the hospital's psychiatric unit receiving mental health services and was being counseled on her pregnancy treatment options.</p> <p>On 10/29/2024 at 2:00 PM, V3 (PRSD/Psychiatric Rehab Social Director) said on 10/18/2024 she was informed R1 left the facility upset and AMA. V3 said R1's family found R1 shortly after she left the facility. V3 said then V1 (Administrator) instructed her to complete R1's petition for involuntary transfer from the facility to the hospital on 10/18/2024. V3 said the facility was concerned for R1's safety after she had an emotional crisis. V3 said R1 was not given an AMA form and an IVD (Involuntary Discharge) notice on 10/18/2024. V3 said V25 (Hospital Social Worker) called her informing her R1 was ready for readmission on 10/25/2024. V3 said she informed V25 that R1 could not be readmitted because she was permanently discharged from the facility on 10/18/2024 after they petitioned her to the hospital.</p> <p>R1's Petition for Involuntary/Judicial admitted d 10/18/2024, showed R1 was asserted to be required to be involuntarily discharged from the facility to an emergency inpatient admission to another acute facility by the facility due to acute mental illness symptoms. The petition said R1 The Respondent is currently detained in a mental health facility or hospital; name of facility where detained: [NAME] Chicago Terrace. The petition said R1 presents with exacerbated psychosis, extreme agitation, aggression, and mania. The resident is pregnant and not taking psychotropic medication. The petition was completed and signed by V3 (PRSD/Psychiatric Rehab Social Director).</p> <p>R1's Progress Note dated 10/18/2024 said The resident [R1] left the facility AMA and was seen walking approximately a mile from the facility by her sister. Police were called, and a petition was made to transport [R1] to the hospital . The progress note does not indicate if R1 was educated or given forms on leaving AMA or the IVD process.</p> <p>As of 10/30/2024 at 3:00 PM, R1's EMR did not include an AMA form or IVD (Involuntary Discharge) notice for 10/18/2024. The EMR does not show any documentation follow-up regarding R1's status at the hospital on 10/18/2024 or after.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled Against Medical Advice (AMA) dated 3/2021, said Guideline: To provide communication to the resident that their request for discharge is against medical advice .3. Documentation should be entered in the residents record and should include education provided to the resident and/or family.</p> <p>The facility's policy titled Involuntary Transfer/discharge date d 3/2021, said It is the policy of the facility to transfer out or discharge from the facility residents/patients in accordance with state and federal laws and guidelines. Standard: According to federal regulations, the facility must permit each resident/patient to remain in the facility, and not involuntarily transfer or discharge the resident/patient from the facility unless: The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility. Procedure: 1. If facility has determined it cannot meet the resident's need, the following information must be documented in the resident record by the physician: a. The specific needs the facility could not meet, b. The facility efforts to meet those needs, and c. The specific services the receiving facility will provide to meet the needs of the resident which cannot be met by the current facility .13. If there are concerns regarding a resident return from the hospital, the facility cannot evaluate the resident based on his or her concern when originally transferred to the hospital. If after evaluation at the end of the hospital stay the facility medical record must show the facility made efforts to: a. Ascertain an accurate status of the resident's condition through communication with hospital staff and/or visits by nursing home staff to the hospital. b. Find out what treatments, medications and services the hospital provided to improve the resident's needs and may consider initiating a discharge .</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</b></p> <p>Based on interview and record review, the facility failed to inform and provide a resident with a notification of involuntary discharge. This applies to 1 of 5 residents (R1) reviewed for discharges.</p> <p>The findings include:</p> <p>R1's EMR (Electronic Medical Record) showed an admitted [DATE] with diagnoses of schizophrenia, epilepsy, anxiety, myopia, astigmatism, and hyperlipidemia. R1's MDS (Minimum Data Set) dated 9/25/2024, shows R1 had behaviors not directed towards others daily. R1's MDS dated [DATE] showed she was permanently discharged from the facility and not anticipated to return.</p> <p>On 10/29/2024 at 2:00 PM, V3 (PRSD/Psychiatric Rehab Social Director) said R1 was confirmed to be pregnant on 10/17/2024. V3 said on 10/18/2024 she was informed R1 left the facility upset AMA (Against Medical Advice). V3 said R1's family found R1 shortly after she left the facility. V3 said then V1 (Administrator) instructed her to complete R1's petition for involuntary transfer from the facility to the hospital on 10/18/2024. V3 said the facility was concerned for R1's safety after she had an emotional crisis. V3 said R1 was not given an AMA form and an IVD (Involuntary Discharge) notice on 10/18/2024 before she was transferred.</p> <p>On 10/25/2024 at 12:00 PM, V2 (Director of Nursing/DON) said she was present on 10/18/2024 when R1 was upset and was allowed to leave the facility unsupervised. V2 said R1 was not informed or given an AMA form and an IVD notice on 10/18/2024 when she left the facility. V2 said the facility did complete a petition for R1 because they were concerned about her safety.</p> <p>On 10/23/2024 at 2:22 PM, V1 (Administrator) said R1 had been a long-term resident at the facility for four years receiving inpatient mental health services. V1 said on 10/18/2024 R1 was upset regarding her pregnancy. V1 said the facility staff allowed R1 to leave the facility unsupervised. V1 said the facility felt R1 left the facility AMA. V1 said R1 was found by her family and the local police soon after. V1 said the police informed her R1 was still the facility's resident and needed emergency psychiatric services. V1 said the facility completed R1's petition because they were concerned. V1 verified the facility permanently discharged R1 on 10/18/2024 and confirmed that R1 was not notified or given an IVD notice. V1 said the facility had been aware R1 was engaging in unprotected sex and had always said she wanted a baby and R1 was confirmed pregnant on 10/17/2024 while residing at the facility. V1 said the facility was unable to care for pregnant residents.</p> <p>R1's Petition for Involuntary/Judicial admitted d 10/18/2024, showed R1 required an involuntary petition for admission and discharge from the facility to an emergency inpatient admission to another acute facility due to acute mental illness symptoms. The petition said R1 The Respondent is currently detained in a mental health facility or hospital; name of facility where detained: [NAME] Chicago Terrace. The petition said R1 presents with exacerbated psychosis, extreme agitation, aggression, and mania. The resident is pregnant and not taking psychotropic medication. The petition was completed and signed by V3 (PRSD/Psychiatric Rehab Social Director).</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Progress Note dated 10/18/2024 said The resident [R1] left the facility AMA and was seen walking approximately a mile from the facility by her sister a petition was made to transport [R1] to the hospital . The progress note does not indicate that R1 was educated or given forms on leaving AMA or the IVD process.</p> <p>As of 10/30/2024 at 3:00 PM, R1's EMR did not show an AMA (Against Medical Advice) form and IVD (Involuntary Discharge) notice for 10/18/2024.</p> <p>The facility's policy titled Against Medical Advice (AMA) dated 3/2021, said Guideline: To provide communication to the resident that their request for discharge is against medical advice .Procedure .3. Documentation should be entered in the residents record and should include education provided to the resident and/or family.</p> <p>The facility's policy titled Involuntary Transfer/discharge date d 3/2021, said Guideline: It is the policy of the facility to transfer out or discharge from the facility residents/patients in accordance with state and federal laws and guidelines .7. Notice of Involuntary Transfer or Discharge and Opportunity of Hearing must be provided at least 30 days prior to discharge, except that it can be provided as soon as practicable before discharge .8. Copies must be provided to the resident, resident's representative, ombudsman and DPH .</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944</b></p> <p>Based on interview and record review, the facility failed to have a system or any policies in place to identify services needed to meet the intimacy rights of mentally ill female residents of child-bearing age.</p> <p>This failure resulted in one female resident (R1) becoming pregnant by another resident and experiencing psycho-social harm when she was hospitalized and per the hospital Psychiatrist, is now in a catastrophic situation.</p> <p>This failure resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 6/21/2024 when R1 told staff that she had an interest in R2 (a male peer) and refused condoms and other forms of birth control.</p> <p>This applies to 1 of 10 residents (R1) reviewed for intimacy rights and has the potential to affect 6 other female residents (R12-R17) of child-bearing age living in the facility.</p> <p>V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 11/07/2024 at 8:58 AM and the IJ template was provided.</p> <p>V1 provided an Immediacy Removal Plan at 3:15 PM on 11/07/2024, which was rejected and returned to V1 at 4:10 PM. The facility's second Immediacy Removal Plan was provided by V1 at 8:20 AM on 11/08/2024, which was rejected and returned to V1 at 9:20 AM. The facility's third Immediacy Removal Plan was provided by V1 at 12:15 PM on 11/08/2024 and it was accepted at 12:25 PM.</p> <p>The Surveyor confirmed the immediacy was removed on 11/12/2024 at 2:40 PM, however the facility remains out of compliance at a Severity Level II due to the need to evaluate the implementation of new policies and procedures and Quality Assurance monitoring.</p> <p>The findings include:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 11/06/2024 at 1:30 PM, V29 (R1's Hospital Psychiatrist) said R1 was inpatient at the hospital after experiencing a mental health crisis associated with her pregnancy. V29 said R1 was uniquely trapped due to her current situation. V29 said R1 was unable to care for a child because she herself requires 24-hour custodial care for her own mental health. V29 said the facility failed to adequately assess R1's ability to engage in safe sex practices which resulted in R1 becoming pregnant while residing at the facility, and now having no access to an adequate facility that can meet her mental and medical health needs. V29 said all of R1's pregnancy alternatives will result in a poor outcome to her mental health, adding that all of these events have placed her in a catastrophic situation. V29 stated she may have a natural miscarriage, or a judge may grant guardianship and/or she may have an abortion, or if she has the child and it is removed because of her capacity. V29 stated R1 won't understand, which would be catastrophic. V29 stated R1 thinks she is rich and has a rich man- she does not understand her current position. V29 stated a lot of [R1's] thoughts are 'child-like thinking' or 'magical.' V29 stated he feels the facility did not adequately provide contraceptives for her and now has basically kicked her out. V29 stated they give condoms to residents in hopes they use them right- mental patients- where the normal adult has difficulty even using them right. V29 stated it's an environment problem and in his opinion, the facility has failed her ethically.</p> <p>R1's Face Sheet showed R1 was a facility resident since 4/23/2020. Her Face Sheet showed R1's diagnoses included schizophrenia, anxiety disorder, epilepsy, and asthma.</p> <p>R1's 10/17/2024 Gynecology Consultation Summary Report confirmed R1's pregnancy by ultrasound with an Estimated gestational age: 6w3d (or becoming pregnant 9/2/2024), with an Estimated date of delivery: 6/9/2025.</p> <p>On 10/25/2024 at 12:37 PM, V7 (Licensed Practical Nurse/LPN) said on 10/18/2024 she was instructed not to administer R1's antipsychotic medications because R1 was confirmed to be pregnant on 10/17/2024. V7 said she was not aware R1 had been sexually active at the facility.</p> <p>On 10/23/2024 at 8:45 AM, V20 (R1's Brother) stated he was unsure if R1 and R2 (R1's boyfriend and presumed father) understood the consequences of unsafe sex. V20 stated R1 and R2 wanted to leave together on 10/17/2024 with no plan but to get an apartment. V20 stated neither R1 or R2 have no funds except for a little Social Security, but they have no way of getting funds and R1 has no skills to leave and find housing.</p> <p>R1's 9/23/2024 Level of Functioning assessment showed she needs significant assistance in the listed areas of- forming and maintaining friendships; pursuing appropriate leisure and recreational activities; taking care of own possessions and living space; money knowledge and money management skills; and recognizing and avoiding common dangers.</p> <p>On 10/25/2024 at 3:30 PM, V18 (R1's Brother) said R1 was currently at the hospital after the facility had her petitioned out for an involuntary psychiatric admission on 10/18/2024. V18 said R1 had experienced an emotional crisis after R2 reportedly told R1 he did not want to be involved with her pregnancy. R1's 10/18/2024 Petition for Involuntary Admission (timed at 9:30 AM) showed R1 presents with exacerbated psychosis, extreme agitation, aggression, and mania. The resident is pregnant and not taking psychotropic medication.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 10/25/2024 at 12:00 PM, V2 DON (Director of Nursing) said she responded to a code green (resident elopement) for R1 when R1 exited the building and then was subsequently petitioned out to the hospital. V2 said the facility could no longer care for R1 since she became pregnant by another resident while residing at the facility. V2 said the facility did not have policies and processes to monitor menstruation cycles, perform pregnancy testing, distributing contraceptives, completing intimacy assessments and consents, and pregnancy. V2 said she did not know much about the intimacy assessments because psychosocial staff were responsible for completing them.</p> <p>On 10/25/2024 at 11:17 AM, V3 PRSD (Psychiatric Rehab Social Director) said on 10/17/2024 when R1 found out she was pregnant, she expressed wanting to leave with R2. V3 then said on 10/18/2024 she was informed R1 was angry and screaming trying to leave the facility. V3 said after the incident she was asked to assist with R1's emergency transfer petition for acute psychiatric services because R1 was extremely agitated and a danger to herself and others. V3 said psychosocial staff completes intimacy assessments quarterly and annually but they did not maintain a list of residents engaging in intimate relationships. V3 said the questions on the assessments are asked of residents and if they apply, they are checked off. V3 said psychosocial staff also provide residents with condoms, but they did not maintain a tracking list of which residents asked for or received them, the amount provided, when they were given, or with whom the residents planned on having sexual relations.</p> <p>On 10/24/2024 at 4:33 PM, V6 PRSC (Psychosocial Rehab Services Coordinator) said R1 had been a long-term care resident at the facility for four years. V6 said she was familiar with R1's psychosocial needs and R1 required inpatient mental health care services. V6 said R1 had delusions about being pregnant in the past and has required multiple psychiatric hospitalizations. V6 said R1 was obsessed with wanting to get pregnant. V6 said R1 had been refusing contraceptives and was knowingly continuing to engage in unprotected sex with R2 and R3 at the facility. V6 said R1 came to her on 10/17/2024 with her ultrasound result and told her she was pregnant. V6 said she completes intimacy assessments to counsel residents on consensual sex and on the use of contraceptives and the assessment was a guide to help them educate residents about intimacy. V6 said she then initiates an intimacy care plan and updates it based on the assessments.</p> <p>R1's 6/21/2024 Social Services (SS) progress note from 11:35 AM showed Resident will exercise consensual, respectful, and appropriate intimate sexual relations. Resident has been counseled on the importance of using condoms and birth control to prevent pregnancy and any STDs [sexually transmitted diseases]. Writer to provide resident with condoms. Resident is refusing condoms and any form of birth control. Resident stated that she 'is allergic to latex.' Writer educated resident that intimate/sexual partners must be able to provide consent. Consent must be mutual. Writer will monitor. (R1's Electronic Medical Record does not list latex as one of her allergies.) R1's nursing progress note approximately 30 minutes later showed R1 .stated she was [NAME] Rican, and no one can understand her because she speaks another language and that she had an interest in peer [R2]. Writer notified [Psychiatrist] of resident statements. [No new orders.] (R1's 9/24/2024 Minimum Data Set showed R1's race is Black or African American.)</p> <p>R1's 6/26/2024 Intimate Relationship assessment (from five days later) does not show R1's refusal of the use of contraceptives and the consequences if she becomes pregnant, such as medication changes and discharge from the facility, and R1's intimacy care plan was not updated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R1's 9/23/2024 Intimate Relationship assessment does not acknowledge R1 wanting to get pregnant and her engagement in unprotected sex. The assessment does not identify education provided for any consequences for R1 if she became pregnant as a result of not using contraception and R1's intimacy care plan was not updated.</p> <p>The Self-sufficient in section of R1's Level of Functioning assessment (also from 6/26/2024, prior to R1's pregnancy) included boxes to check for 1. nutritional awareness, eating habits, health maintenance; 2. knowing the importance of medication management; 3. forming and maintaining friendships; 4. pursuing appropriate leisure and recreational activities; 5. washing, folding, and doing laundry; 6. taking care of own possessions and living space; 7. money knowledge and money management skills; 8. recognizing and avoiding common dangers. None of the numbered boxes were checked and instead, the 9 box was checked that showed None of the above, needs significant assistance in these areas.</p> <p>R1's Intimacy care plan (initiated 6/21/2024) showed [R1] is alert/aware and coherent about whom [she] chooses to exercise her right to engage with in an intimate/sexual relationship. An undated entry under the problem focus also showed Resident counseled: female contraception/nursing notified. Resident to start three-month Depo-Provera shot. The intimacy care plan goal showed [R1] will exercise safe, respectful and consensual intimate relations through the next review date. All interventions in the intimacy care plan were from 6/21/2024, and they included Discuss birth control options and consider pregnancy testing periodically for females of child-bearing age, Educate [R1] on safe sex practices includes types of condoms/contraception methods and importance of monogamy, Help [R1] maintain and preserve her dignity, integrity, and confidentiality by discussing these matters in a room that affords privacy, Provide [R1] with condoms, and Remind [R1] that intimate/sexual partners must be able to provide consent. Consent must be mutual.</p> <p>On 10/23/2024 at 10:15 AM, V15 (LPN) said she was taking care of R2. V15 said she was not aware of how long R1 and R2 were in a relationship. V15 said the facility does not track which residents are in intimate relationships. V15 said she believed psychosocial staff determines if residents can consent to sexual relationships and obtain resident intimacy contracts. V15 said she was unsure where intimacy assessments, consents, and contracts were in the residents' EMR (Electronic Medical Record). V1 (Administrator) and V5 (Regional Behavioral Director) confirmed the facility does not have intimacy contracts.</p> <p>On 10/23/2024 at 11:00 AM, V14 (Registered Nurse/RN) said residents are allowed to make their own sexual decisions. V14 said he cared for R1 and was not aware of her intimate relationship with R2. V14 said the facility provided condoms to residents but there is not a tracking list. V14 said he assesses residents' neurological function to determine if they know what sex means and educates on options. V14 said he was unsure how to determine if residents can practice safe sex.</p> <p>R1's 7/6/2024 SS progress note from 4:17 PM showed .Writer asked if this is where she wanted to live or if she didn't live [here] where she would live. Resident stated 'here.' Resident commented quietly, 'I have a boyfriend.' That was a surprise to writer. Writer asked who? Resident stated, 'you don't know.' Writer stated, 'I don't.' Resident's boyfriend is [R2] and has been. Writer counseled resident on the importance of having safe, consensual, and appropriate intimate relations using a condom and female contraception (if resident chooses). Writer counseled to go to nursing if resident wants female contraception otherwise condoms will be provided. Writer counseled to always be respectful of roommates. Writer counseled if either changes their mind and does not want to engage to communicate that clearly. Resident receptive to counsel. Writer will monitor.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R1's 7/6/2024 SS progress note from a few minutes later showed Resident stated to writer that [R2] wants to 'bang' all the time. Writer tried to give resident condoms. Resident was embarrassed and told me to give the condoms to [R2]. Writer will do so and re-educate [R2] on consensual relations. Writer will monitor. A second SS note from 7/6/2024 showed Resident [R2] denies having a relationship with resident. Resident may be delusional or other resident may not be telling the truth as is the case at times. Writer will monitor.</p> <p>On 10/24/2024 at 9:05 AM, V11 (LPN) said condoms are provided to residents when they ask for them and there was no tracking list. V11 said she did not know how frequently residents were assessed for sexual consent but believes it is done during admission. V11 said she believes psychosocial does an assessment but does not know the name of the assessment and where it can be found.</p> <p>R1's 7/17/2024 nursing progress note showed It was reported by social services that resident has been having ongoing unprotected sexual intercourse with peer despite education/information related to negative potential consequences and refusal of protection such as condoms/abstinence. Resident agreed that she would be willing to start some sort of birth control and see gynecology. Notified [Nurse Practitioner] and referral left with scheduler to set up resident appointment with gynecology. No issues/concerns. The note does not address the risks if R1 becomes pregnant while residing at the facility. R1's 8/2/2024 nursing progress note showed Resident returned from OB/Gyn appointment in stable condition. Progress note blank. [No new orders] at this time.</p> <p>On 10/14/2024 at 9:45 AM, V8 (RN) said condoms are provided by nurses to residents when residents ask. V8 said he checks for sexual consent by talking to the residents and assessing for verbal cues such as alertness and orientation. V8 said he documents consents in the residents' EMRs. V8 then said he believed psychosocial staff also completes consent forms. V8 said he was not aware of the form's name and where it could be found. V8 said the facility did not have a tracking system for residents in intimate relationships.</p> <p>R1's 8/31/2024 SS progress note showed It was reported [R1] was threatening to harm another resident. This writer spoke with [R1]. [R1] stated another resident is bothering her 'boyfriend.' Staff counseled [R1]. [R1] accepted counseling. Staff re-directed [R1] to allow staff to address the matter .</p> <p>On 10/30/2024 at 11:38 AM, V10 (Certified Nurse Assistant/CNA) said residents were allowed to engage in intimate relationships at the facility. V10 said she reports to nursing and psychosocial if she suspects residents are having intimate relationships. V10 said if residents ask for condoms, she tells the nurses. V10 said she was responsible for monthly tracking of menstruation cycles in a yearly log. V10 said she was currently monitoring R5, R8, R12, R13, R14, R15, R16 and R17's menstrual cycles. V10 said she was never instructed to report or submit the data findings. V10 said she did not report R1's missed periods for August, September, and October 2024. On 11/06/2024 at 4:20 PM, V2 (DON) confirmed that out of those female residents being monitored, only R12, R13, R14, R15, R16, and R17 were able bear children and were not on contraceptives or had no known history of other forms of contraception use. V2 confirmed the menstruation monitoring logs were kept by V10 and not collected for review by other staff.</p> <p>On 10/24/2024, R1's Menstrual Tracking log for 2024 showed R1's last tracked menstruation was on 7/17/2024. The log included instructions to Notify MD or NP of any episodes of two (2) consecutive months without a menstrual cycle.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 10/23/2024 at 2:22 PM, V1 (Administrator) said R1 had always wanted to have a baby. V1 said the facility was aware of R1's intimate activity while residing at the facility. V1 continued to say the facility was also aware that R1 was engaging in unprotected sex and refusing contraceptives. V1 said R1 had an ultrasound on 10/17/2024 which confirmed she was pregnant. V1 said the facility completed R1's petition for involuntary psychiatric admission on 10/18/2024 because they were concerned for her safety after she became extremely upset about her pregnancy situation and said the facility was unable to care for pregnant residents. V1 said the facility did not have policies on caring for residents engaging in intimate relationships, intimacy consent, or caring for residents who become pregnant. V1 said the facility did not have a process to monitor residents in intimate relationships. V1 said the facility provided residents with condoms and if needed, the physician could be contacted for female oral or injection contraceptives. V1 said the facility did not have a policy regarding contraceptives.</p> <p>On 10/24/2024 at 12:31 PM, V5 (Regional Behavioral Director) said the facility did not have policies on intimacy, sexual consent, or pregnancy. V5 said psychosocial staff completed an intimacy assessment on admission and quarterly and residents' intimacy care plans should be updated based on the outcome of the assessment. V5 said the facility's IDT (Interdisciplinary Team) determines if episodic assessments are needed to give residents additional sex education and expectations of intimate relationships. V5 was unable to explain what those expectations were. V5 said that there had not really been a need to complete 'episodic' intimacy assessments at the facility. V5 said the intimacy assessments have questions followed by prompt (explorative) statements for the interviewer to determine if they apply to the resident. V5 continued to say that the assessment was to help check the residents' decisional capacity and judgment and not all the question prompt statements needed to be selected for determining consent. V5 stated the assessment does not give directions and there is no score for the outcome of the assessment and the assessment does not identify who the resident's partner may be or the partner's consensual capacity. V5 said staff were expected to check the assessments when they know residents are engaging in sexual activity. V5 said the facility did not have a process to track intimate relationships or the distribution of condoms. V5 was unsure how the facility would be able to assist residents who become pregnant at the facility.</p> <p>On 10/28/2024 at 3:25 PM, V21 (R1's Facility Psychiatrist) said he had been treating R1 for mental health services at the facility since 2020. V21 stated it is not black and white when it comes to competency, adding a resident can be competent to accept meds but not live independently. V21 said he was not specialized in caring for pregnant residents receiving antipsychotic medications as they require specialized facilities to ensure antipsychotic medications are administered safely since they can be very dangerous to a fetus during pregnancy. V21 said he was not notified R1 was actively trying to get pregnant at the facility. V21 said if V21 had been notified sooner he would have worked with the facility and R1's family to identify other interventions to implement in R1's plan of care. V21 stated R1 still requires 24-hour custodial care and now she knows she can do this- she needs to be monitored closely to make sure she takes meds to not repeat this. V21 said R1 was suffering and would continue to do so because she was now in unfavorable situation as she is unable to care for a baby.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 10/23/2024 at 3:45 PM, V4 (Medical Director) said he was the facility's Medical Director and R1's medical physician. V4 said R1 was sexually preoccupied. V4 stated he was unsure if there was a policy, and the psychiatric physician checks the resident's decisional capacity. V4 stated he did not know how they facility knew who was sexually active and the facility should have a process and policies when residents are sexually active. V4 said he expected the facility to have processes and policies to know how to care for sexually active residents, residents who want to get pregnant, and residents who become pregnant while residing at the facility.</p> <p>R1's comprehensive care plan reviewed on 10/23/2024 showed R1 chooses to exercise her right to engage within an intimate/sexual relationship initiated on 6/21/2024. R1's care plan did not have updated interventions to address R1 wanting to have a baby and engaging in unprotected sex. R1's care plan was not updated on 6/21/2024, 7/6/2024, or 7/17/2024 with interventions to address R1's verbalizations regarding desires to become pregnant and subsequent discharge, engagement in unprotected sex, or discharge planning.</p> <p>R1's Discharge Potential assessment dated [DATE] showed R1 had poor discharge potential and was expected to remain at the facility. The assessment said R1 was not able to be discharged to a less structured level of care because R1 has had problems complying with his/her psychiatric treatment regimen (including taking medications as ordered, following up with mental/psychiatric counseling, and case management recommendations) .has had physical and mental problems increase the resident's vulnerability and hydration/food/clothing and or may become a victim or perpetrator of abuse or neglect to avoid self-neglect lacks a support system that can provide housing, financial support, direction, guidance, physical care, and supervision. R1's Discharge Potential assessment does not address R1's goal of wanting to get pregnant and her risk of discharge if she becomes pregnant while residing at the facility. R1's Goals assessments dated 9/23/2024, showed R1's discharge goal was to age in place.</p> <p>The facility's policy titled Admission Criteria dated 4/2020, said Residents will be admitted to this facility as long as their nursing and medical needs can be met adequately by the facility. The facility does not have the capability for caring for residents who are pregnant . The policy does not address how the facility will care for long-term care residents who become pregnant while residing at the facility, and when to initiate discharge planning in such a case.</p> <p>The facility's policy titled Resident Rights dated 4/2020 said be informed about his or her rights and responsibilities .be informed of, and participate in, his or her care planning and treatment .</p> <p>The facility's March 2021 Care Plan Development policy showed A person-centered care plan that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs, that are identified in the evaluation process, is developed and implemented for each resident .3. Discharge plans- Each resident's care plans will be prepared by an interdisciplinary team .8. Evaluations of the resident are ongoing and care plans are reviewed and revised by the interdisciplinary team after each evaluation .9. The Care Planning/Interdisciplinary Team is responsible for the reviews and updating of care plans; When there has been a significant change in condition, When the desired outcome is not met . 11. The services provided or arranged by the facility, as outlined by the comprehensive care plan will meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The 8/02/2024 Facility Assessment showed the facility provided a wide variety of services designed to maximize physical and emotional wellness, promote independence and healing, and preserve personal dignity .To comply with treatment plan that is focused on individual care planning .</p> <p>The Immediate Jeopardy that began on 6/21/2024 was removed on 11/12/2024 when the facility took the following actions:</p> <p>1.The facility has taken the following actions concerning the Immediate Jeopardy:</p> <p>a) Policies have been developed for the following: Contraception Policy, Menstrual Cycle Monitoring Policy, Intimate Relationship Assessment and Education Form Policy, effective 11-7-2024.</p> <p>b) Nursing and PRSD/PRSC staff have been training re: Contraception Policy, Menstrual cycle Monitoring Policy, Intimate Relationship Assessment and Education Form Policy and responsibilities regarding all policies. Effective 11-8-2024 completion date 11-12-2024.</p> <p>c) Residents of childbearing age and who engage in sex are offered contraceptives by PRSC/PRSD staff. If resident chooses medicine-based contraceptive, they will be referred to nursing who will contact MD for orders.</p> <p>d) New admissions will have admission assessment completed and placed on menstrual cycle tracking as indicated.</p> <p>e) New admissions will have Intimacy assessment and Education Form completed upon admission assessment and will have contraceptives offered. If resident chooses medicine based contraception, MD will be contacted per nursing.</p> <p>2. Measure the facility will take to ensure the problem will be corrected and not recur.</p> <p>a) The facility has developed new policies on Contraception use, Intimate Relationship assessment and education form, and Menstrual Cycle Monitoring. Policies effective 11-7-2024. Policies reviewed with Medical Director 11-8-2024.</p> <p>b) The facility will ensure that Nursing Staff and psych social staff are educated on responsibilities regarding the following policies: Contraception policy, Menstrual Cycle Monitoring Policy, and Intimate Relationship Assessment and Education Form Policy. Employees that are on vacation will be educated prior to returning to the facility. Education effective 11-8-2024, completion date 11-12-2024.</p> <p>c) The facility will audit residents medical record to identify female residents of childbearing age, these residents will have menstrual cycle tracking by nursing staff and will be offered contraception and education regarding contraception. If resident chooses medicine-based contraception, MD will be contacted for orders per nursing. Facility audit initiated by the PRSD on 11- 7-24, completed 11-8-2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>d) The facility PRSD and the PRSCs educated on intimacy assessment and education form policy, including review of intimacy assessment and education form, review of need to educate residents regarding contraception and safe sex practices, review of educating residents regarding risks of pregnancy which include an understanding that they will not be able to continue to reside in facility. Education provided by Regional Director of Behavioral Health beginning on 11-7-2024, completion date 11-12-2024.</p> <p>3. The PRSD or designees will monitor continued compliance via the following Quality Improvement programs:</p> <p>a. A QA tool developed to monitor menstrual tracking. Beginning 11-7-24, Daily, for the next 30 days, during facility rounds, the DON or designee will ensure that menstrual tracking is completed, then 3 times per week for 30 days, and finally 1 time per week for 30 days. New admissions will be added to the QA tool. See attached.</p> <p>b. A QA tool developed to review status of contraceptive use for biological female residents of childbearing age. Beginning 11-7-24, weekly for next 30 days DON or designee will review orders to ensure that biological female residents of childbearing age have orders for medicine-based contraceptives or have documented refusal of medicine-based contraceptives, then monthly for 60 days. New admissions will be added to the QA tool. See attached.</p> <p>c. A QA tool has been developed to review status of intimate relationship assessments and education form. Beginning 11-7-2024, weekly for next 30 days PRSD or designee will review completed intimate relationship assessments and education form for completion and intimacy care plan, then 3 times per week for 30 days, and then 1 time per week for 30 days. New admissions will be added to the QA tool. See attached.</p> <p>d. The results of the monitoring completed under this plan are submitted to the QA/QAPI Committee for review and follow-up and reviewed with Medical Director. Next QAPI meeting scheduled for November 27, 2024.</p>		

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NAME OF PROVIDER OR SUPPLIER  West Chicago Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE  928 Joliet Road 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.			
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48944</p> <p>Based on interview and record review, the facility failed to supervise a pregnant schizophrenic resident (R1) with a history of and known risk for elopement.</p> <p>This applies to 1 of 4 residents (R1) reviewed for safety.</p> <p>The findings include:</p> <p>R1's Face Sheet showed R1 had been residing at the facility since 4/23/2020 for mental health care with diagnoses of schizophrenia, anxiety disorder, epilepsy, and asthma. R1's 9/25/2024 MDS (Minimum Data Set) showed R1 experienced behaviors, including delusions.</p> <p>R1's 10/17/2024 Planned Parenthood progress note showed R1's pregnancy was confirmed by ultrasound with a gestational age of six weeks and three days.</p> <p>On 10/25/2024 at 12:37 PM, V7 (Licensed Practical Nurse/LPN) said she was R1's nurse on 10/18/2024. V7 said she was instructed not to administer R1's antipsychotic medications because R1 was confirmed to be pregnant on 10/17/2024. V7 said she observed R1 calm in the dining room that morning then she heard the announcement for code green (resident elopement). V7 said she went to the reception area and R1 was yelling and stating she wanted to leave. V7 said V1 (Administrator), V2 (DON/Director of Nursing), and other staff were with her, and then R1 was allowed to leave the facility. V7 said the facility usually has residents sign an AMA form (Against Medical Advice). V7 said the facility also calls emergency personnel when residents are a danger to themselves or someone else. V7 said she was unsure if R1 signed an AMA form because V1 (Administrator) and V2 (Director of Nursing) were addressing the situation.</p> <p>On 10/25/2024 at 2:30 PM, V13 (Receptionist) said on the morning of 10/18/2024, she called a code green because R1 was screaming and was attempting to leave the facility. V13 stated some staff walked out with R1 towards the parking lot. V13 said then the staff came back inside and let R1 leave by herself.</p> <p>On 10/25/2024 at 12:00 PM, V2 (DON) said the code green was called when R1 was leaving through the facility's front door. V2 said she responded to the code and R1 was angry and said she wanted to leave. V2 said R1 then left the facility.</p> <p>R1's progress notes showed other ongoing behaviors and history of elopement attempts:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's 4/9/2024 nursing progress note showed .observed [R1] talking to DON in her office expressing not feeling safe, suicidal without a plan, and homicidal without a plan, and then this resident eloped from the facility via front door. The staff attempted to re-direct, but resident would not stop. Then 911 was called and resident has been sent out to [local hospital] via 911 with petition. R1's 4/9/2024 Social Services progress note from the same event showed Resident expressed not feeling safe. Resident expressed /feeling [suicidal/homicidal ideation] with no plan. Resident feeling like she is going crazy, crazy stating 'I want to K-II myself.' Resident ran from the facility into the community with extreme agitation and anxiousness. ADMIN/DON notified. [Psychiatric Physician] ordered petition for hospitalization .</p> <p>R1's Progress Note dated 5/01/2024 said Resident pacing throughout the facility. Exhibits exit seeking behaviors. Resident has [history] of elopement .ADMIN/DON made aware. [Psychiatric Physician] ordered petition for hospitalization .</p> <p>R1's 6/6/2024 progress note showed Resident anxiously pacing throughout the facility daily affecting care and environment .Resident becomes verbally inappropriate if she feels that she does not have the undivided attention of who she is talking to and begins to act out. Resident made an unauthorized exit. Resident's family has made it known that resident has an intellectual disability .</p> <p>R1's 6/21/2024 progress note from 11:43 AM showed .Resident made a delusional statement that she is Guatemalan. Resident showed writer her phone showing that she is [NAME] Rican .Resident is paranoid . (R1's 9/24/2024 MDS showed R1 is not of Hispanic, Latino, or Spanish descent and lists her race as Black/African American.)</p> <p>R1's 6/21/2024 progress note from 12:20 PM showed Resident came to writer stating she was confused about her medications and like an updated list which writer provided stated that she was [NAME] Rican, and nobody can understand her because she speaks another language and that she had an interest in peer [R2] .</p> <p>R1's 7/3/2024 note showed Resident approached nursing station indicating she was feeling stressed out due to trauma from my past and couldn't focus or do anything right now .</p> <p>R1's 7/6/2024 progress note showed Resident expressed that some of these residents are hard to live with. Writer asked if this is where she wanted to live or if she didn't live here where would she live. Resident stated, Here. Resident commented quietly I have a boyfriend [R2] .</p> <p>R1's 7/14/2024 progress note showed Resident pacing back and forth in front lobby with backpack. Resident agitated/frustrated when nurse encouraged resident to come to the nursing station .</p> <p>R1's 7/31/2024 progress note showed Resident very agitated during med pass. Resident expressing paranoia and desire to leave facility .able to be redirected to take her meds .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/2024 at 2:22 PM, V1 (Administrator) said R1 was at the facility for care of her psychiatric illness. V1 said on 10/18/2024 R1 was angry and bolted out the front door because R2 told R1 he did not want to be in a relationship and did not want to support her with her pregnancy. V1 said she then called R1's family to inform them R1 had left the facility AMA. V1 said R1's family drove around and found her. V1 said R1's family informed the facility R1 was enraged and uncontrollable. V1 said then the police called her to inform the facility of R1's situation and requested the facility complete a petition for an emergency petition for involuntary admission. V1 said R1 had history of eloping from the facility. V1 said R1 had always wanted a baby and the facility was unable to care for pregnant women.</p> <p>On 10/25/2024 at 3:30 PM, V18 (R1's brother) said R1 was currently at the hospital. She was petitioned out on 10/18/2024 due to an episode of a mental crisis. V18 said he met with V1 (Administrator), V2 (DON), and V3 (Psychiatric Rehab Social Director/PRSD) on 10/18/2024 after the facility informed R1's family that R1 had been allowed to leave the facility unsupervised. V18 said facility staff told him R1 left AMA (Against Medical Advice) that morning. V18 said R1 was found by another family member and emergency personnel approximately half a mile away from the facility. V18 said R1 was in a crisis reaction related R2's (R1's boyfriend) reaction to her confirmed pregnancy the day before. V18 said he was concerned about the facility's lack of response and letting R1 leave the facility without supervision. V18 said the local police suggested he have the facility petition R1 out. V18 said he told V1 and V3 obtained a petition for involuntary transfer to have R1 sent to an acute hospital for emergency psychiatric services. V18 said he asked V1, V2, and V3 why R1 had been allowed to leave the facility AMA this time when multiple times prior when R1 had tried to leave the facility unauthorized, the facility contacted the police themselves and had R1 petitioned to the hospital for acute psychiatric services. V18 stated when he asked them why their response that day was different, the facility was unable to give him a clear explanation.</p> <p>On 10/25/2024 at 11:17 AM, V3 PRSD (Psychiatric Rehab Services Director) said on 10/17/2024, V3 had contacted R1 and R2's family. V3 said R1's sister came to facility and R1 agreed to stay at the facility. V3 said R1's family had requested a meeting with the facility on 10/18/2024 to discuss R1's pregnancy. V3 said she was not present when the code green was called when R1 left the facility angry. V3 said when residents are aggressive, the facility calls emergency personnel to assist. V3 said after the incident, she was asked to assist with R1's petition. V3 said she was really worried when she found out R1 left the facility.</p> <p>On 10/24/2024 at 4:15 PM, V1 verified that it was R1's family that called the police and not the facility.</p> <p>R1's 10/17/2024 progress note (written by V3) showed The resident [R1] had a confirmed pregnancy evaluation, and she was counseled about the result. The resident's sister and brother were notified. [R1] stated she wanted to walk out of the facility, and staff counseled her to stay and talk with her sister. [R1's] sister came to the facility, spoke with the resident, and told her to stay until tomorrow. Sister stated she will come tomorrow and requested to meet with the Administrator. Staff will observe.</p> <p>A timeline of events was provided by V1 on 10/24/2024. The timeline showed 6. 10-17-2024- PRSD spoke with [R1's] family with [R1] present to inform of pregnancy per phone call. Resident's family indicated that they would be at facility in the AM to meet with resident and Administrator to discuss next steps.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/24/2024 at 4:15 PM, V1 stated the phone meeting was amicable and there was no yelling or screaming and they talked about moving out together, but nothing was set in concrete. V1 stated the meeting lasted around 15 minutes. V1's timeline continued 8. 10-18-2024- Resident left building due to being upset with boyfriend who informed her that he decided he did not want to be a father.</p> <p>On October 24, 2024, at 4:15 PM, V1 stated R1 left the building between 9 AM and 9:05 AM. R1's 10/18/2024 Petition for Involuntary Admission was timed at 9:30 AM (25-30 minutes later) and showed R1 presents with exacerbated psychosis, extreme agitation, aggression, and mania. The resident is pregnant and not taking psychotropic medication.</p> <p>R1's elopement care plan (initiated 5/4/2024) showed [R1] has a history of unauthorized departure from the facility. On 04/09/2024 Resident ran out of the facility into the community with extreme agitation and anxiousness. On 5/01/2024 resident exhibiting exiting seeking behavior. Interventions include Encourage [R1] to verbalize to psych-social her needs i.e , needing a pass to go with family, take a walk, transfer, etc., and monitor for any sign or symptoms or preparation for unauthorized departure . A 5/9/2024 intervention showed Provide safety-checks as appropriate.</p> <p>R1's care plan showed a focus from 3/8/2024 as [R1] is making paranoid delusional statements and having auditory hallucinations. Eight dates are listed where R1 experienced these delusions, including one from 9/25/2024 where Resident made a delusional statement about paying off a home/caring for a child. The care plan goal is to accept redirection with interventions to assess ability to maintain reality orientation.</p> <p>On 10/24/2024, V1 stated Our stance is that [R1] left AMA on 10/18/2024 because [R2] would not support her related to her pregnancy. R1's most recent Goals assessment from 9/23/2024 showed R1's discharge goal was to age in place.</p> <p>R1's 9/23/2024 Level of Functioning assessment showed she was not self-sufficient in recognizing and avoiding common dangers.</p> <p>R1's Progress Note dated 10/18/2024 said The resident [R1] left the facility AMA and was seen walking approximately a mile from the facility by her sister. Police were called, and a petition was made to transport [R1] to the hospital . The progress note does not indicate if R1 was educated on leaving AMA and R1's electronic medical record does not show an AMA (Against Medical Advice) form was completed 10/18/2024.</p> <p>R1's 9/23/2024 Risk of Self-Harm assessment showed R1 was at risk for self-harm because of her suicidal or self-harm ideations of Pessimism, anticipation of the worst. R1's 9/23/2024 Community Survival assessment showed R1 was not considered for independent privilege pass.</p> <p>The facility's 03/2021 Elopement policy showed 'Elopement' means the unplanned, unauthorized leaving of the facility by a resident who is unable to understand the risks of leaving the facility</p>		